Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **California** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
HCBS Waiver for Californians with Developmental Disabilities

C. Waiver Number:CA.0336
Original Base Waiver Number: CA.0336.

D. Amendment Number:CA.0336.R05.28

E. Proposed Effective Date: *(mm/dd/yy)*

03/01/26

Approved Effective Date: 10/08/26
Approved Effective Date of Waiver being Amended: 01/01/23

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to add Trainer as a new provider type and payment methodology under Communication Aides, add a new service titled Remote Support Services and a corresponding provider type and payment methodology for the service, add supplemental payments for excess mileage, and the implementation final adjustments as a result of rate reform; individual providers of the following services whose existing rates are above the benchmarks established by rate reform will have their rates set at the benchmark as a result of the implementation of these final adjustments: employment services, behavioral intervention services, community living arrangement services, day services, homemaker services, prevocational services, respite care services, transportation services, dental services, occupational therapy services, physical therapy services, psychology services, skilled nursing services, and speech, hearing, and language services.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A - Waiver Administration and Operation	
☐ Appendix B - Participant Access and Eligibility	
☑ Appendix C - Participant Services	C-1/C-3
☐ Appendix D - Participant Centered Service Planning and Delivery	
☐ Appendix E - Participant Direction of Services	
☐ Appendix F - Participant Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☑ Appendix I - Financial Accountability	I-2, I-3
☑ Appendix J - Cost-Neutrality Demonstration	J-1, J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☑ **Add/delete services**

☑ **Revise service specifications**

☑ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☑ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **California** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

HCBS Waiver for Californians with Developmental Disabilities

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: CA.0336
Waiver Number:CA.0336.R05.28
Draft ID: CA.014.05.09

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/23
Approved Effective Date of Waiver being Amended: 01/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. 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 (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **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:

- ○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

- ○ **Nursing Facility 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:

- ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

This waiver will serve individuals who, in the absence of this waiver, would require care in either an intermediate care facility for the developmentally disabled (ICF/DD), ICF/DD-H (habilitative) or ICF/DD-N (nursing.)

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- ● **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

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.

California's HCBS DD Waiver offers community-based services not otherwise available through a participant's Medicaid program. The purpose of the HCBS DD Waiver is to serve participants in their own homes and communities as an alternative to placing Medicaid-eligible individuals in intermediate care facilities for persons with developmental disabilities. The HCBS DD Waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

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, their 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; 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 plans of care [or 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 are responsible for ensuring that eligible consumers who want to participate on the Waiver are enrolled, service providers meet the qualifications for providing Waiver services, IPPs are developed and monitored, consumer health and welfare is addressed and monitored, and financial accountability is assured.

DDS ensures, under the oversight of the Department of Health Care 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.

California's first Home and Community-based Services Waiver for Californians with developmental disabilities was approved effective July 1982 with a total enrollment cap of 3,360. This Waiver amendment application seeks to enroll up to 179,000 individuals by December 31, 2027.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

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.

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.

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).

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. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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.

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.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services 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 in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Public input was sought by making the draft waiver amendment application available for comment. The application was posted on the Department of Developmental Services' (DDS) internet site on October 10, 2025, at the following link: https://www.dds.ca.gov/wp-content/uploads/2025/10/Application_1915c_HCBS_WaiverDraft_CA-014-05-09.pdf accompanied by an announcement published in the California Regulatory Notice Register. Additionally, hard copy versions of the draft waiver renewal application were able to be secured at regional centers as well as through email requests to an inbox operated by DDS.

The public comment period ran October 10, 2025, through November 9, 2025. Stakeholders were able to make public comment via regular mail or email. At the end of the 30-day public comment period, the department received two comments. A summary of the comments follows:

Comment (1): One comment addressed the difficulties individuals and families face in accessing at-home private duty nursing services. Response: The suggestion was outside the scope of the proposed amendment but will be noted for future consideration.

Comment (2): One comment expressed support for the proposed updates in the amendment. Response: The state made no changes in response to this comment.

No changes were made as a result of these comments.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Watkins-Breschi

First Name:

Xiomara

Title:

Acting Division Chief

Agency:

Department of Health Care Services

Address:

1515 K Street

Address 2:

P.O. Box 997436

City:

Sacramento

State: **California**

Zip:

95899-7413

Phone:

(916) 713-8309 **Ext:** ☐ **TTY**

Fax:

(916) 440-5720

E-mail:

Xiomara.watkins-breschi@dhcs.ca.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Hill

First Name:

Jonathan

Title:

Branch Manager, Waiver and Rates

Agency:

Department of Developmental Services

Address:

1215 O Street

Address 2:

MS 7-40

City:

Sacramento

State: **California**

Zip:

95814

Phone:

(916) 654-2300 **Ext:** ☐ **TTY**

Fax:

(916) 654-3256

E-mail: jonathan.hill@dds.ca.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Tyler Sadwith

State Medicaid Director or Designee

Submission Date: Oct 6, 2026

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Sadwith

First Name: Tyler

Title: State Medicaid Director

Agency: Department of Healthcare Services

Address: 1501 Capitol Ave., Ste. 6000

Address 2: P.O. Box 977413, MS 0000

City: Sacramento

State: **California**

Zip: 95899-7413

Phone: (916) 440-7400 **Ext:** ☐ **TTY**

Fax: (916) 440-7404

E-mail: tyler.sadwith@dhcs.ca.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**

- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

N/A

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Tribal programs applying to become Community Care Facilities under the Waiver are exempt from DSS licensing requirements as provided in 25 United State Code section 1647a(a).

CONTINUATION OF C-5: HOME AND COMMUNITY-BASED SERVICES

Delivery of Service via Telehealth:

Waiver services, as identified in item #9 below, can be provided pursuant to California's Medi-Cal's Telehealth Policy, in alignment with California Welfare and Institutions Code section 14132.725, and as agreed upon by the applicant, beneficiary, legal representative, and provider. All authorized waiver service providers rendering Medi-Cal covered benefits or services under this policy must comply with all applicable state and federal laws. Telehealth delivery services must meet HIPAA requirements, and the methodology must be accepted by the state's HIPAA compliance officer.

Waiver services provided via telehealth must also comply with all the following requirements:

1. Participants may be offered the choice to receive services as identified in item #9 below, via telehealth or in person but the decision must be made by the individual.

2. Services provided via telehealth must meet the individual's needs, as included in their individual program plan (IPP).

3. Services will only be provided via telehealth if the needs of the individual can be met remotely. Telehealth must not replace direct care that can only be provided in-person.

4. Services provided via telehealth must be delivered in a way that respects the privacy of the individual, especially in the instances of toileting, dressing, etc. If personal care is needed while telehealth is being provided, the individual and/or person supporting the individual would conduct personal care activities out of the line of sight of the telehealth provider, turn off video/audio communication during that time, or reschedule the telehealth visit. In instances where privacy cannot be secured by the individual, the telehealth provider would pause the telehealth service until confirming it was appropriate to resume.

5. Providing the service via telehealth must not impede, replace, or prevent the successful delivery of HCBS for individuals who need hands-on assistance/physical assistance. The goal of using technology is not to replace human assistance, but to increase access to care and maximize the use of technology to support people where appropriate.

6. Providing the service via telehealth must not prevent the facilitation of community integration as defined under Final Regulation CMS-2249-F/CMS-2296-F. Remotely delivered services can be provided to multiple individuals at one time (without sharing private health information), which presents individuals the opportunity to interact with others, while receiving services in their preferred delivery method.

7. Support must be provided to individuals who need assistance with using the technology required for the delivery of the HCBS via telehealth. The individual's person-centered planning team is responsible for determining the extent of training necessary for the individual to access their services remotely. If needed, this training would be provided by those individuals already supporting the waiver participant where they live, including existing providers of residential services or other services that support community inclusion, as well as natural supports and generic resources as identified by the planning team. Family members may also be eligible for training, as appropriate, to support the provision of services if determined to be beneficial for the participant.

8. Service coordinators follow up regularly with all individuals served to check in regarding whether they are receiving services identified in the IPP and whether they are making progress. These check ins include an assessment of the individual's health and safety. Further, those individuals living in out of home placements receive quarterly face to face monitoring visits, during which the individual's health and safety is also evaluated.

9. The following services can be provided via Telehealth, in alignment with the above requirements:
- Habilitation - Day Service
- Behavioral Intervention Services
- Speech, Hearing and Language Services
- Psychology Services
- Remote Support Services

CONTINUATION OF I-2(a) RATE DETERMINATION METHODS:

Community Crisis Homes (Vendor-Operated) Rate Methodology -As described in California Welfare and Institutions Code section 4698 and California Code of Regulations, Title 17, section 59022, the rates for Community Crisis homes have three components:

a) the facility component: the allowable costs used to calculate the facility component include payroll costs of facility staff and facility related costs such as lease, facility maintenance, repairs, cable/internet, etc. The facility rate is set upon approval of cost information submitted by the vendor to the regional center. Rates are reviewed as part of the contract renewal between the vendor and the regional center, pursuant to 17 CCR 59014.

b) the individualized services and supports component: the allowable costs used to calculate the individualized services and supports component include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports and other consumer specific program costs. These rates are set upon approval of cost information submitted by the vendor to the regional center. The rate is reviewed within 30 days of initial placement and at least every six months thereafter.

c) and the transition plan component: the allowable costs used to calculate the transition component includes the salaries, wages, payroll taxes and benefits of direct care staff providing additional services and supports needed to support a consumer during times of transition out of the Community Crisis Home. These rates are set upon approval of cost information submitted by the vendor to the regional center. The rate is reviewed at least monthly.

Administrative costs for the above may not exceed 15%.

As part of the certification process for CCHs, the Department reviews the proposed facility component rate and supporting documentation for each CCH to determine if the included costs are reasonable and economical. These rates must be approved by the Department prior to the delivery of service at each CCH. If the facility has an unexpected increase, they must justify the need for an increased budget and show that the cost is higher. The new rate is effective once the Department approves the revised budget. Note: This is not the rate that is claimed for FFP.

Prior to submission of claims for reimbursement, the state uses the following steps to determine the portion of the claim that is eligible for federal reimbursement, using information submitted at the time of facility rate approval:
Step 1: Costs are identified as direct or indirect, consistent with cost principles in 45 CFR Part 75
Step 2: Costs are identified as allowable or unallowable (room and board), consistent with the above cost principles
Step 3: Allowable indirect costs are divided by total direct costs (allowable and unallowable) to determine the indirect cost percentage.
Step 4: Cost percentage is applied to all direct costs
Step 5: Allowable direct costs and the allocated indirect costs are added together to determine the federally reimbursable portion of the monthly facility rate.
Step 6: The federally reimbursable portion of the facility rate is divided by the maximum residency of the home to determine the monthly federally reimbursable per person rate of the facility.
Step 7: The individual rate associated with Medicaid-eligible individuals is submitted for federal reimbursement.

As a result of the above methodology, room and board costs, as well as the allocated portion of indirect associated with these costs, are excluded from the portion of the claim that the state submits for federal reimbursement.

Provider rate adjustments occurring as a result of the above described alignment with the rate reform benchmarks, proposed in Waiver amendment CA.0336.R05.25, affect the following services: Employment Services, Habilitation-Behavioral Intervention Services, Habilitation-Community Living Arrangement Services, Habilitation-Day Services, Homemaker Services, Prevocational Services, Respite Care, Transportation Services, Dental Services, Occupational Services, Physical Therapy Services, Psychology Services, Skilled Nursing Services, and Speech, Hearing, and Language Services. The State conducted the public processes described in 42 CFR 447.203(c)(4) and 204 and the process did not yield significant access to care concerns from beneficiaries, providers, or other interested parties regarding the services for which the payment rate reduction or payment restructuring was proposed.

Community Crisis Homes (State-Operated) Rate Methodology: The rates for state operated community crisis homes are set as follows:

An interim rate for direct and indirect service is paid according to the methodology below: Annually, the state will reconcile

costs for the year and settle costs for all overpayments and underpayments.
Specific Components:
Interim rate:
Cost information consisting of allowable direct costs (direct services) and allowable indirect costs that meet the primary cost objective are captured on a monthly basis via the statewide accounting system. Allowable costs are identified by applying cost principles specified at 2 CFR, part 200 as implemented by the Department of Health and Human Services at 45 CFR, part 75.
Claim amount per individual: Each facility compiles daily attendance for each individual which the state receives in whole at the conclusion of each month. Utilizing daily attendance information in conjunction with the calculation of allowable costs described above (the interim rate), the state utilizes the daily attendance to assign an allocation per bed for each day it is occupied. The allowable costs are divided by the number of bed occupancy days, resulting in the allocated amount per individual per day for each home minus non-allowable costs. Only costs associated with Medi-Cal eligible individuals are submitted for reimbursement. Allocation of costs consists of the following:

Direct:
Monthly salaries, wages, and benefits of individuals (state employees) providing the direct service; contracted services which provide a direct service component; and payroll taxes.

Indirect:
Determined by applying the Department's cognizant agency approved indirect rate to the allowable direct costs as identified above.

Unallowable costs are captured in the same format via the statewide accounting system. Allocation of such costs consists of the following:
Lease or mortgage for facility and/or facility grounds; facility maintenance and repairs, utilities, food; furniture, and laundry equipment, transportation, and information technology services that do not meet the primary cost objective.

Reconciliation:
The state reviews submitted costs for the past fiscal year and determines the facility-specific costs for that year (minus any unallowable costs) based on the same cost components described above for the interim rate. After the facility-specific costs are established, claims for federal reimbursement are reconciled based on the actual cost of delivering the service. Federal claims are submitted if the final costs are higher than the interim rate or reimbursed to CMS if the final cost is lower than the interim rate. The state is responsible for reimbursing CMS for all FFP overpayments identified.

Computation of allowable costs and their allocation methodology for both the interim and final reconciliated rates must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation an apportioning those expenses to the Medicaid program, except as expressly modified below.

New homes:
For new homes in which the facility-specific first-year costs are not available, the state will use an estimated average of costs based on similar homes as the estimate for the interim rate. After the first year of operation, the same reconciliation process is followed as described above.

State-Operated Mobile Crisis Team Rate Methodology: The rates for state-operated mobile crisis teams are set as follows:
An interim rate for direct and indirect services is paid according to the methodology below. Annually the state will reconcile costs for the year and settle costs for all overpayments and underpayments. Only costs associated with Medi-Cal eligible individuals are submitted for reimbursement.

Specific Components:
Interim rate:
Cost information consisting of the following allowable direct costs (direct services) and allowable indirect costs that meet the primary cost objective are captured via the statewide accounting system. Allowable costs are identified by applying cost principles specified at 2 CFR, part 200 as implemented by the Department of Health and Human Services at 45 CFR, part 75 and include the following:

Direct:
Monthly salaries, wages, and benefits of individuals (state employees) providing the direct service; contracted services which provide a direct service component; and payroll taxes.

Indirect:
Determined by applying the Department's cognizant agency approved indirect rate to the allowable direct costs as identified above.

Unallowable costs consistent with the Selected Items of Cost as described at 45 CFR 75.420 are excluded from the interim rate and final costs submitted for federal reimbursement.

Reconciliation:
The state reviews submitted costs for the past fiscal year and determines the costs, based on the same components described above for the interim rate. After the costs are established, claims for reimbursement are reconciled based on the actual cost of delivering the service. Federal claims are submitted if the final costs are higher than the interim rate or reimbursed to CMS if final costs are lower than the interim rate. The state is responsible for reimbursing CMS for all FFP payments for all overpayments identified.

Computation of allowable costs and their allocation methodology for both the interim and final reconciliated rates must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning these expenses to the Medicaid program, except as expressly modified.

Intensive Transition Services
The following rate methodology applies for these providers: The costs included in this rate are: salaries, wages, payroll taxes, and benefits of direct care staff providing services and supports, in addition to travel and operating costs needed to support a consumer during times of transition out of an IMD.

Community Living Arrangement Services
This service is comprised of the following subcategories:

A. Licensed/Certified Residential Services - Providers in this subcategory utilize the following rate methodologies:

Rate Model Fee Schedule Methodology This rate methodology is used for Foster Family Agency-Certified Family Homes (Children Only), Foster Family Homes (FFH) (Children Only), Small Family Homes (Children Only), Group Homes (Children Only), Adult Residential Facilities (ARF) , Residential Care Facility for the Elderly (RCFE), Family Home Agency (FHA), Adult Family Home (AFH)/Family Teaching Home (FTH), and In-Home Day Program. Rate model fee schedule is available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

Specialized Licensed Residential Rate Methodology: This methodology is used when the needs of individuals living in licensed residential settings exceed the level of support reflected in the pre-defined rate model fee schedules for community living arrangement services. The rate model fee schedule has a standard number of hours, staffing levels and qualifications of staff; when the needs of the individuals exceed these standards, this rate methodology builds upon those created for the rate model fee schedules by including variable inputs for the number of staffing hours, consultation hours, and specialized personnel qualifications, with set assumed costs for these components. The following provider types use the specialized licensed residential rate methodology: Adult Residential Facility for Persons with Special Health Care Needs, Group Homes for Children with Special Health Care Needs, and licensed/certified residential providers whereas described above existing rate models do not reflect the level of support that individuals living in the home require. This rate methodology is available by regional center at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

Out-of-state rate methodology - This methodology is applicable for out-of-state residential providers. The rate paid is the established rate for that service, paid by that State in the provision of that service to their own service population of individuals with developmental disabilities.

Enhanced Behavioral Supports Homes (Vendor Operated) Rate Methodology - There are two components to the monthly rate for Enhanced Behavioral Supports Homes:

1) the facility component:
The allowable costs used to calculate the facility component include payroll costs of facility staff and facility related costs such as lease, facility maintenance, repairs, cable/internet, etc. The facility rate is a negotiated amount based on cost estimates. The provider submits a facility budget to the regional center and the two determine a rate based upon where the facility is located

(cost of living, lease, electricity, garbage, county minimum wage rates, the qualification of staff and consultants, and payroll costs). After detailed regional center review, that budget is then sent to the State department for further review and evaluation. The State department then analyzes the rates for each line item and compares it to the state average of other EBSHs. The provider is required to justify all costs and provide explanations of any estimated costs. The rate is effective upon approval from the state and providers are notified in writing by the vendoring regional center. As part of the certification process for Enhanced Behavioral Support Homes (EBSHs), the Department reviews the proposed facility component rate and supporting documentation for each EBSH and compares it to state averages to determine if the included costs are reasonable and economical. All rates must be approved by the Department director prior to the delivery of service at each EBSH. Rates are not reviewed annually, only as required and as agreed upon by the vendoring regional center. The state continues to receive the previous year's rate until the new rate is needed. Salaries are based upon the geographical area and the experience, education, and professional licensures held. Rate updates can happen due to cost changes in approved or active providers. For example, an increase can occur due to an increase in a vendor's lease or where another cost was higher than expected. The facility is required to show the Department their lease and contract. If the facility has an unexpected increase, they must justify the need for an increased budget and show that the cost is higher. Once the Department approves the budget an approval letter is generated to the regional center and a copy is sent to the provider. The regional center may submit a new budget to the Department for review and approval of any updates to the rate. When a rate is updated, the new rate is effective once the state department approves. A letter is sent out to the facility approving the new rate. The initial rate is effective upon the first consumer's admission into the facility.

Maximum rates may not exceed the rate limit determined by the department and administrative costs may not exceed 15%. It takes from 1-3 months to set a facility rate depending on the review process. The department may take up to three months due to additional documentation requests to ensure the accuracy of the rate requested.

Prior to submission of claims for reimbursement, the state uses the following steps to determine the portion of the claim that is eligible for federal reimbursement, using information submitted at the time of facility rate approval:

Step 1: Costs are identified as direct or indirect, consistent with cost principles in 45 CFR Part 75
Step 2: Costs are identified as allowable or unallowable (room and board), consistent with the above cost principles.
Step 3: Allowable indirect costs are divided by total direct costs (allowable and unallowable) to determine the indirect cost percentage.
Step 4: cost percentage is applied to all direct costs.
Step 5: Allowable direct costs and the allocated indirect costs are added together to determine the federally reimbursable portion of the monthly facility rate.
Step 6: The federally reimbursable portion of the facility rate is divided by the maximum residency of the home to determine the monthly federally reimbursable per person rate of the facility.
Step 7: The individual rate associated with Medicaid-eligible individuals is submitted for federal reimbursement.

As a result of the above methodology, room and board costs, as well as the allocated portion of indirect associated with these costs, are excluded from the portion of the claim that the state submits for federal reimbursement.

2) the individualized services and supports component: The allowable costs used to calculate the individualized services and supports component include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports and other consumer specific program costs. The individual rate is determined by the Individual Program Plan (IPP) process. The providers are invited to a meeting along with a regional center representative to review consumer needs and a rate is set and agreed upon at the meeting. As part of the IPP review process, it is the responsibility of the regional center to ensure that services authorized meet the needs of the consumer. The rate is reviewed within 60 days of initial placement, and at least annually thereafter.

The facility submits a completed Department form cost sheet to the regional center within 30 days, for review and written approval. The provider receives a copy of the new rate at the time of the IPP meeting when it is initially determined and notified by the regional center when that rate is confirmed. The effective date is determined at the time of the IPP and is typically in effect either immediately or at the time the cost sheet form is signed. The cost sheet form can be found on the CA DDS website here: https://www.dds.ca.gov/transparency/dds-forms/

The individualized services and supports component described above includes direct care and behavioral support staff with identifiable experience and qualifications as is referenced in the state plan. Providers receive payment via the identified rate methodology described above for services provided as part of the individualized services and supports component. Any provider delivering services through a bundle will be paid through that bundle's payment rate and cannot bill separately; Medicaid providers delivering separate services outside of the bundle may bill for those separate services in accordance with the state's Medicaid billing procedures.

Within the individualized services and supports component, at least one (1) service must be provided by identified direct care staff described above to bill according to the individualized services and supports rate methodology. The state ensures appropriate billing through its audit process, as well as the remission of payment to CMS in the case of overpayments for (1) services that were not provided in accordance with the regional center's contract or authorization with the provider, or with applicable state laws or regulations, or (2) the rate paid is based on inaccurate data submitted by the provider on a provider cost statement.

Enhanced Behavioral Supports Homes (State-Operated) Rate Methodology - An interim rate for direct and indirect services is paid according to the methodology below. Annually, the state will reconcile costs for the year and settle costs for all overpayments and underpayments.

Provider rate adjustments occurring as a result of the above described alignment with the rate reform benchmarks, proposed in Waiver amendment CA.0336.R05.25, affect the following services: Employment Services, Habilitation-Behavioral Intervention Services, Habilitation-Community Living Arrangement Services, Habilitation-Day Services, Homemaker Services, Prevocational Services, Respite Care, Transportation Services, Dental Services, Occupational Services, Physical Therapy Services, Psychology Services, Skilled Nursing Services, and Speech, Hearing, and Language Services. The State conducted the public processes described in 42 CFR 447.203(c)(4) and 204 and the process did not yield significant access to care concerns from beneficiaries, providers, or other interested parties regarding the services for which the payment rate reduction or payment restructuring was proposed.

Specific Components:

Interim rate:
Cost information consisting of allowable direct costs (direct services) and allowable indirect costs that meet the primary cost objective are captured on a monthly basis via the statewide accounting system. Allowable costs are identified by applying cost principles specified at 2 CFR, part 200 as implemented by the Department of Health and Human Services at 45 CFR, part 75.

Claim amount per individual: Each facility compiles daily attendance for each individual which the state receives in whole at the conclusion of each month. Utilizing daily attendance information in conjunction with the calculation of allowable costs described above (the interim rate), the state utilizes the daily attendance to assign an allocation per bed for each day it is occupied. The allowable costs are divided by the number of bed occupancy days, resulting in the allocated amount per individual per day for each home minus non-allowable costs. Only costs associated with Medi-Cal eligible individuals are submitted for reimbursement. Allocation of costs consists of the following:

Direct:
Monthly salaries, wages, and benefits of individuals (state employees) providing the direct service; contracted services which provide a direct service component; and payroll taxes.

Indirect:
Determined by applying the Department's cognizant agency approved indirect rate to the allowable direct costs as identified above.
Unallowable costs are captured in the same format via the statewide accounting system. Allocation of such costs consists of the following:
Lease or mortgage for facility and/or facility grounds; facility maintenance and repairs, utilities, food; furniture and laundry equipment, transportation, and information technology services that do not meet the primary cost objective.

Reconciliation:
The state reviews submitted costs for the past fiscal year and determines the facility-specific cost for that year (minus any unallowable costs) based on the same cost components described above for the interim rate. After the facility-specific costs are established, claims for federal reimbursement are reconciled based on the actual cost of delivering the service. Federal claims are submitted if the final cost is higher than the interim rate or reimbursed to CMS if the final cost is lower than the interim rate. The state is responsible for reimbursing CMS for all FFP overpayments identified Computation of allowable costs and their allocation methodology for both the interim and final reconciliated rates must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation an apportioning those expenses to the Medicaid program, except as expressly modified below.

New homes:
For new homes in which the facility-specific first-year costs are not available, the state will use an estimated average of costs based on similar homes as the estimate for the interim rate. After the first year of operation, the same reconciliation process is followed as described above.

B. Supported Living Services provided in a consumer's own home (non-licensed/certified) - The rates for supported living providers are set using the Rate model fee schedules, as defined previously and are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

C. Personal Assistance provided in a consumer's own home (non-licensed/certified) - There are two rate setting methodologies for providers in this category.
a. The rates for agency and individual providers are set using the Rate Model Fee Schedule as defined previously and available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/
b. Individual provider (participant-directed): the rate will be $20.72 per hour, effective January 1, 2025.

Day Services
This service is comprised of the following subcategories:

A. Community-Based Day Services - There are two rate setting methodologies for providers in this subcategory when providers do not have a usual and customary rate:

Rate Model Fee Schedules: as defined previously, apply to the following: Community-Based Day Services: Activity Center, Adaptive Skills Trainer, Adult Developmental Centers Community Integration Training Programs, Community Activities Supports Services, Behavior Management Program providers, Independent Living Programs, and Social Recreation Programs. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

Median rates: as defined previously, are used to determine the applicable rate for Creative Arts Programs and Socialization Training Program.

B. Therapeutic/Activity-Based Day Services - All providers in this category are paid the usual and customary rate as described above, if they have one. When the following providers in this subcategory do not have a usual and customary rate, the rate methodology is as follows:

Median rates: as defined previously, are used to determine the rate for Specialized Recreational Therapist, Special Olympics, Sports Club, Art Therapist, Dance Therapist, Music Therapist and Recreational Therapist.

C. Mobility Related Day Services - Driver Trainer receives the usual and customary rate as described previously. All other providers are paid the usual and customary rate as described above, if they have one. When the following providers in this subcategory do not have a usual and customary rate, the rate methodology is as follows:

Rate Model Fee Schedules: as defined previously, apply to the following: Mobility Training Services Agency and Mobility Training Services Specialist.

Home Health Aide
The maximum rates for home health aides are based on the DHCS Fee Schedule, as defined previously.

Homemaker
There are two rate setting methodologies for homemakers. If the provider does not have a "usual and customary" rate, then the maximum rate is established using the Rate Model Fee Schedule. Usual and customary and Rate Model Fee Schedule methodologies are defined previously.

Prevocational Services
There are two rate setting methodologies for providers in this subcategory.

Rate Model Fee Schedules: as described previously, apply to Work Activity Program providers and Supported Employment Programs.

Incentive Payments: Incentive payments may be earned by service providers in this category.

Effective as of July 1, 2021, until June 30, 2025, incentive payments will be paid to work activity service providers and supported employment providers of prevocational services. Incentive payments include:
1) A one-time payment of $2,000 made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days.
2) An additional one-time payment of $2,500 made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months.
3) An additional one-time payment of $3,000 made to a provider when an individual has been employed consecutively for one year.
4) Effective January 5, 2024, in addition, after a provider assists four individuals to achieve competitive integrated employment, for each individual thereafter, an additional payment is made to provider consisting of:
- $500 for achieving competitive integrated employment after 30 consecutive days.
- $1000 for continued employment for six (6) months.

Respite Care
There are two subcategories for this service.

A. In-Home Respite Care rates are set via the Rate Model Fee Schedules, described previously, and are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

B. Out-of-Home Respite Care - There are two rate setting methodologies for providers in this subcategory.

Rate Model Fee Schedules: Daily rates for out of home respite care are 1/21 of the established monthly rate for licensed residential facilities that also provide respite.

Usual and customary rate methodology - This methodology, as defined previously, applies to adult day care and camping services providers.

Family Support Services
There are two rate setting methodologies for this service. If the provider does not have a "usual and customary," then the maximum rate is set using the median rate setting methodology. Usual and customary and median rates are defined previously.

Supported Employment
There are two rate setting methodologies for providers in this subcategory:

Rate Model Fee Schedules, described previously, apply to providers of Supported Employment. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

Incentive payments may be earned by service providers in this category.
Effective as of July 1, 2021, until June 30, 2025, incentive payments will be paid to supported employment service providers of supported employment services. Incentive payments include:
1. A one-time payment of $2,000 made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days.
2. An additional one-time payment of $2,500 made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months.
3. An additional one-time payment of $3,000 made to a provider when an individual has been employed consecutively for one year.
4. Effective January 5, 2024, in addition, after a provider assists four individuals to achieve competitive integrated employment, for each individual thereafter, an additional payment is made to provider consisting of:
- $500 for achieving competitive integrated employment after 30 consecutive days.
- $1000 for continued employment for six (6) months.
5. Effective January 5, 2024, for each individual who exits an internship and subsequently obtains competitive integrated employment, an additional payment is made to provider consisting of:
- $500 for achieving competitive integrated employment after 30 consecutive days.
- $500 for continued employment for six (6) months.

Effective as of July 1, 2025, amounts for above-described incentive payments 1, 2 and 3 will be updated as follows: Incentive payments include 1) A one-time payment of $1,000 made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days. 2) An additional one-time payment of $1,250 made to a provider

when an individual obtains competitive integrated employment and is still employed after six consecutive months. 3) An additional one-time payment of $1,500 made to a provider when an individual has been employed consecutively for one year.

Incentive payments for individuals working through an internship includes:
- A one-time payment of $750 made to a provider when an individual obtains employment through an internship and is still employed after 30 consecutive days.
- An additional one-time payment of $1,000 when an individual remains in an internship for 60 consecutive days.

Self-Directed Support Services - included in this rate are wages, benefits, travel, and administrative costs for direct staff providing the service. The rate schedule, effective July 1, 2021, can be found at the following link: https://www.dds.ca.gov/wp-content/uploads/2022/03/Self_Directed_Support_Services_Rates.pdf

Speech, Hearing and Language Services
There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.
DHCS Fee Schedules - as defined previously.
Rate Model Fee Schedules, as defined previously will be used if the provider has at least one year experience working with persons with developmental disabilities.

Dental Services
There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.
DHCS Fee Schedules - as defined previously.
Rate Model Fee Schedules, as defined previously, will be used if the provider has at least one year experience working with persons with developmental disabilities.

Optometric/Optician Services
The maximum rates for this service are based on the DHCS Fee Schedules, as defined previously.

Prescription Lenses and Frames
The maximum rates for this service are based on the DHCS Fee Schedules, as defined previously.

Psychology Services
There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.
DHCS Fee Schedules - as defined previously.
Rate Model Fee Schedules - as defined will be used if the provider has at least one year experience working with persons with developmental disabilities.

Occupational Therapy
There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.
DHCS Fee Schedule - as defined previously.
Rate Model Fee Schedules - as defined previously, will be used if the provider has at least one year experience working with persons with developmental disabilities.

Physical Therapy
There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.
DHCS Fee Schedule - as defined previously.
Rate Model Fee Schedules - as defined previously will be used if the provider has at least one year experience working with persons with developmental disabilities.

Family/Consumer Training
There are two rate setting methodologies to determine the hourly rates for providers in this subcategory.
Schedule Maximum Allowance (SMA) - as defined previously.
Rate Model Fee Schedules - as described previously, will be used if the provider has at least one year experience working with persons with developmental disabilities.

Chore Services
The rates for chore services providers are determined utilizing the usual and customary rate methodology, as previously defined.

Community Based Adult Services
The rates for this service are based on the DHCS Fee Schedules, as defined previously.

Community Based Training Service
The rates for this service are set via the Rate Model Fee Schedules, described previously. Rate model fee schedules are available at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

Communication Aides
There are three rate setting methodologies for Communication Aides providers. For Interpreters, Facilitators, and Translators, either the provider has a "usual and customary" rate, or the maximum rate is established using the median rate setting methodology.

For Trainers, the rates are set via the Rate Model Fee Schedules. Included in this rate are wages, benefits, travel and administrative costs for direct staff providing this service. The rate schedule can be found at the following link: https://www.dds.ca.gov/wp-content/uploads/2025/06/ASL_TrainingAndSupport_Rates.pdf

Environmental Accessibility Adaptations
The rates for contractors providing this service are determined utilizing the "usual and customary" rate methodology, as previously defined.

Financial Management Services (FMS)
The rates for Financial Management Service providers are based on whether the provider functions as a fiscal agent or a sole/co-employer and are available at the following link https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendor-rates. Rates are set as of January 1, 2025, and are effective for services provided on or after that date. These rates were increased following consultation with existing FMS providers and a review of rates throughout the nation of services with a similar scope.

Non-Medical Transportation
There are three rate setting methodologies for this service:
Usual and Customary rate methodology: - This methodology, as defined previously, applies to transportation assistants and public transit authorities.
Rate Model Fee Schedules -- This methodology, as defined previously is used to establish the maximum rate for the following providers: transportation company, transportation-additional component and transportation broker.
https://www.dds.ca.gov/VendorInfo/docs/Supplemental_Rate_Increases.pdf
Rate based on regional center employee travel reimbursement - The maximum rate paid to individual transportation providers is the IRS standard mileage rate.

Nutritional Consultation
The rates for nutritional consultation providers are determined utilizing the usual and customary rate methodology, as previously defined.

Personal Emergency Response Systems (PERS)
The rates for PERS providers are determined utilizing the usual and customary rate methodology, as previously defined.

Skilled Nursing
The maximum rates for this service are based on the DHCS Fee Schedules, as defined previously.

Specialized Medical Equipment and Supplies
The maximum rates for this service are based on the DHCS Fee Schedules, as defined previously.

Transition/Set-Up Expenses
The rates for transition/set-up expenses are determined utilizing the usual and customary rate methodology, as previously defined.

Vehicle Modifications and Adaptations
The rates for vehicle modifications and adaptations are determined utilizing the usual and customary rate methodology, as previously defined.

Housing Access Service- The rate for Housing Access Service is determined utilizing the usual and customary: rate methodology as previously defined.

Coordinated Family Supports

Included in this rate are wages, benefits, travel, and administrative costs for direct staff providing the service. The State gathered information on reported California wages from the Occupational, Employment and Wage Statistics from the Bureau of Labor Statistics. The average hourly wage was found to be approximately $24. In addition, the cost for employer taxes, workers' compensation, health benefits and paid time off are also built into the rate, resulting in a per hour employee cost of approximately $40. Further, the assumed cost for staff mileage, supervision, and administrative expenses (at 12 percent) were also factored into to build the rate for this service. The rate schedule, can be found at the following link: https://www.dds.ca.gov/wp-content/uploads/2023/01/CFS-Service-Code-076-rates-1.1.23ac.pdf

Participant-Directed Services
The rates for Participant-directed services are determined utilizing the usual and customary rate methodology, as previously defined.

Person-Centered Future Planning
Included in this rate are wages, benefits, travel, and administrative costs for direct staff providing the service. The rate schedule, effective January 1, 2025, can be found at the following link: https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendor-rates/

Rate determination methodologies are set in State statute and/or by regulations. The Legislature conducts hearings that are open to the public and allow for public comment prior to amending state law. Prior to finalization of any proposed regulation, interested stakeholders have the opportunity to provide comment on proposed regulations during the 45-day comment period. Stakeholders are notified of the proposed regulatory change in the following manner: by direct notification by the State agency, publication of the proposed change in regulation in the California Regulatory Notice Register, and publication on the agency's website.

The state makes service provider rate information available to the public on the Department of Developmental Services' website: https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendor-rates/

Remote Support Services
There are two rate setting methodologies for Remote Support Services:
The rates for related technology purchases are reimbursed using the usual and customary rate, as defined earlier.
The rates for assessment and training, on-call response, and remote monitoring are set via the Rate Model Fee Schedules, as defined earlier. Included in the rate are wages, benefits, and administrative costs for direct staff providing this service. The rate schedules, effective March 1, 2026, can be found at the following link: https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendor-rates/

CONTINUATION OF I-3-c. SUPPLEMENTAL OR ENHANCED PAYMENTS

4. Direct Service Professional Training:
DDS is providing supplemental payments to eligible providers across all services for the successful completion of Direct Service Professional (DSP) training and development courses. The supplemental payments consist of up to two $500 payments (plus $150 for taxes administrative fees). To receive the first payment, DSPs must complete the Code of Ethics training produced by the National Association of Direct Support Professionals (NADSP). To receive the second payment, DSPs may choose from a list of approved training and development courses.

5. Service Access:
DDS is providing a supplemental monthly payment for Direct Service Professionals providing all services who self-certify their use of a language or communication medium other than English for more than 50% of their time. The supplemental payment consists of $100 paid to the Direct Service Professional and $25 paid to the employer as an administrative fee for each non-English language up to 2 distinct languages or communication mediums.

The State distributes information to stakeholders through various communication channels and in-person/virtual meetings/webinars. Communication channels include directives to regional centers, postings on the DDS website, and notifications to stakeholder groups regarding supplemental payments and eligibility requirements. Additionally, the state held multiple training webinars regarding the supplemental payments' eligibility and requirements.

6. Provider Supplemental Payments for Excess Mileage:

For services provided on or after March 1, 2026, to support and expand access to services, the State makes supplemental payments to providers of in-home services whose routine travel costs exceed those mileage assumptions included in the Rate Model Fee Schedule rates. The amount of the supplemental payment is calculated using the actual miles that exceed the miles funded through paid claims for services and the applicable per-mile rate. The service categories eligible for these supplemental payments include respite, behavior intervention services, dental services, family consumer training, psychology services, skilled nursing, occupational therapy, physical therapy, and hearing and speech. The source of the non-Federal share of these supplemental payments is from an appropriation of funds to DDS through the California Budget Act. Eligible providers will retain 100% of the payment. The base mileage assumptions and supplemental payment information can be found at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-reform/rate-models/. Providers of the above-mentioned services will be notified by their regional center that they are eligible for supplemental payments and provided with a Mileage Cost Calculator worksheet to calculate and submit to regional centers on a monthly basis when mileage costs exceeds the mileage assumptions included in the Rate Model Fee Schedule rates. The workbook allows providers to input their mileage and calculates the supplemental payment relative to the specific mileage assumptions tied to their rate. This information will also be shared with new providers at the time of vendorization.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- ○ **The waiver is operated by the state Medicaid agency.**

  Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

  - ○ **The Medical Assistance Unit.**

    Specify the unit name:

    (Do not complete item A-2)

  - ○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

    Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

    (Complete item A-2-a).

- ● **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

  Specify the division/unit name:

  California Department of Developmental Services

  In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella

agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Department of Health Care Services (DHCS) is the California Medicaid Agency. DHCS has established an Interagency Agreement (IA) with the Department of Developmental Services (DDS), as the Organized Health Care Delivery System to administer the HCBS Waiver for persons with developmental disabilities and the current waiver renewal request (control #0336; January 1, 2023-December 31, 2027).

The IA specifies the functions to be performed by both DHCS and DDS to ensure the administration of the waiver; the cost allocation plan; and the transfer of federal funds to DDS. The IA additionally specifies the oversight activities of DHCS, as well as billing and payment responsibilities of DHCS and DDS. The IA is reviewed annually and updated, as needed.

DHCS exercises administrative oversight, on an ongoing and/or as-needed basis (unless otherwise specified), in the administration and supervision of the Waiver and reviews the performance of DDS in operating the Waiver as follows:
1. Reviews and approves Waiver manuals, program advisories, technical letters and any other policies, procedures, rules or regulations that DHCS may identify as specific to the Waiver.
2. Ensures the technical compliance and correctness of the IA between DHCS and DDS and any subsequent related subcontracts.
3. Prepares required annual Waiver reports, i.e., CMS 372.
4. Reviews, negotiates and approves amendment requests for the IA.
5. Develops documents and guidelines that are used for monitoring fiscal and programmatic elements of the IA.
6. Coordinates with DDS in the administration of the Waiver Monitoring Protocol. The Protocol specifies the performance monitoring, analysis and evaluation of the regional centers. The on-site monitoring reviews are conducted jointly by DHCS and DDS.
7. Monitors DDS follow-up to ensure that areas of non-compliance discovered during monitoring reviews of the regional centers are remediated.
8. Conducts follow-up reviews with DDS as necessary, to determine if the areas of non-compliance have been corrected. The scope of the follow-up review is based upon the nature and extent of the areas of noncompliance.
9. Retains the authority to conduct independent focused reviews (announced and unannounced) to investigate DDS follow-up on significant special incident reports. Selection criteria may include, but is not limited to, severity of the event, unusual nature of circumstances, participant/advocate complaints or Centers for Medicare & Medicaid Services (CMS) concerns/requests for investigation.
10. Retains the authority to initiate a full-scope monitoring review in addition to routine monitoring reviews when: (a) there is a failure of fiscal audit; (b) there is a lack of response to a corrective action plan; (c) in the course of a monitoring review, DHCS or DDS needs assistance from other departmental branches; or (d) DHCS elects to conduct a full scale review based on evidence of inadequate case management and or poor fiscal management by regional center.
11. Exercise oversight of Waiver operations by quarterly reviewing the performance data compiled through the Waiver QMS. Through the Quality Management Executive Committee, DHCS collaborates with DDS in setting priorities for the Waiver quality improvement, in developing, implementing and monitoring remedial (system improvement) strategies; evaluating the effectiveness of interventions; and evaluating the effectiveness of the Waiver QMS.
12. DHCS exercises ongoing financial administration of the Waiver as follows:
a. Monitors DDS compliance with fiscal provisions specified in the IA regarding audits of regional center.
b. Reviews DDS audit protocol to ensure compliance with the Waiver and to ensure that DDS audits of regional centers are performed in accordance with established protocols and meet Generally Accepted Governmental Auditing Standards (GAGAS) requirements.
c. Reviews DDS regional center audit working papers on a sample basis and attends entrance and exit conferences of selected regional center audits.
d. DHCS reviews DDS audits of regional centers. These audits are designed to "wrap around" the independent CPA audit to ensure comprehensive financial accountability.
e. DHCS reviews DDS fiscal reviews of service providers and vendors as specified in the Waiver and the IA.
f. Refer and follow up on any program integrity issues that are identified as a result of oversight activities to DHCS, DDS for follow up, DDS Audits and DHCS for information.
g. Issues an annual report to the DHCS director and to CMS that summarizes oversight functions performed. A copy of the annual report is submitted to the DDS Director.

A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the

Medicaid agency.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

  The independent risk management contractor is an independent entity, contracted under DDS for the following activities:

  • Tracking and analyzing SIR trends
  • Provide tools, training, and technical support to regional centers
  • Support risk management related meetings within the DDS system
  • Ad hoc reports and risk management related projects

- ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ( ) **Not applicable**
- (●) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:

  ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

  Specify the nature of these agencies and complete items A-5 and A-6:

  ☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  Specify the nature of these entities and complete items A-5 and A-6:

Home and 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, their 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; 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 plans of care [or 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 are responsible for ensuring that eligible consumers who want to participate on the Waiver are enrolled, service providers meet the qualifications for providing Waiver services, individual program plans are developed and monitored, consumer health and welfare is addressed and monitored, and financial accountability is assured.

The vendorization process is the process for identification, selection, and utilization of service providers based on the qualifications and other requirements necessary in order to provide services, including but not limited all applicable Medi-Cal provider enrollment requirements. The vendorization process allows regional centers to verify, prior to the provision of services to individuals, that a provider applicant meets all of the requirements and standards specified in regulations.

The regional center is responsible for ensuring that the applicant meets licensing, certification, education, staffing, provider enrollment, and other California Code of Regulations (CCR), Title 17 requirements for vendorization and approving vendorization based upon their review of the documentation submitted by the applicant.

All individuals who receive services through regional centers have access to independent advocacy provided by the Office of Client's Rights Advocacy (OCRA), which is within Disability Rights California (DRC).

DDS ensures, under the oversight of the Department of Health Care 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: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

It is DDS' responsibility to ensure, with the oversight of DHCS, that the waiver is implemented by regional centers in accordance with Medicaid statute and regulation.

DDS is responsible for assessing the performance of the Independent Risk Management Contractor.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DHCS and DDS perform operational oversight and monitoring of regional center DD Waiver operational performance through fiscal compliance audits and program policy compliance. When taken together, the oversight and monitoring methods test all six assurances.

Audits and Financial Accountability:
DDS performs fiscal compliance 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 required independent CPA audit to ensure comprehensive financial accountability.

DDS coordinates its activities with DHCS Audits and Investigations, who review DDS' audit reports of the regional centers on an ongoing basis.

Program Policy Compliance
• The State's Biennial on-site HCBS' Waiver Monitoring review team includes DDS staff, and when necessary, DHCS staff with specific duties assigned to prevent duplication of effort by the two departments.
o The review cycle is conducted every two years.
o 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 statewide sample size is 1,050. The sample size at each regional center is calculated based on the individual regional center's percentage of total consumers served in each of three major residence types; Own Home-Parent, Community Care Facility, and Independent Living or Supported Living. Were the state to use a sample size that had a 95% confidence level with a 5% margin of error for the 155,000 population, the statewide sample size would be 384. As noted in the application, the state's sample size of 1,050 provides a 95% confidence level with a 3.02% margin of error.

o 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.
o 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.
o 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.
As needed, during the off-year cycle of the two-year reviews, DHCS and DDS conduct follow-up monitoring and compliance reviews at the 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. DHCS and DDS provide 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
DHCS and DDS jointly oversee 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 (at least annually) of an individualized program plan for each consumer that addresses his or her health, living, and support needs.
• For licensed community care facilities, annual licensing evaluations by the Department of Social Services.
• Quarterly monitoring visits by the regional center for each person living in licensed community care facilities or receiving services from supported living or family home agencies.
• Enhanced case management (at a minimum, face to face monitoring every 30 days for the first 90 days after transition to the community) for individuals moving from developmental centers to community living arrangements.

• Daily, DDS 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.
• On an ongoing basis, review and investigation of health and safety complaints by protective services agencies, area boards, Disability Rights California, DDS, regional centers, licensing agencies, and/or law enforcement agencies.
• On an ongoing basis and at a minimum, quarterly, training and technical assistance provided by the Department and regional centers to enhance service quality.
• Contracts with Disability Rights California to provide ongoing clients' rights advocacy services to individuals with developmental disabilities residing in the community.
• On an annual basis, DDS issues a report card to each center on Performance Contract outcomes. Each regional center is required to share these results with their community. DDS takes follow-up action as appropriate when decreases in the desired measures are noted.
• On an ongoing basis, DDS collects information about the fair hearing process including type(s) of services in dispute, the resolution of the appeals, and at what level (informal, mediation or state level) the appeal was resolved. DDS disseminates semi-annual reports to regional centers, and reviews the data for anomalies or irregularities with fair hearing filings, and monitors as needed.

DDS monitors and assesses the performance of the Independent Risk Management Contractor in the following ways:

• On an ongoing basis, DDS meets with the contractor to review the progress of deliverables, technical assistance and training initiatives, and overall risk management project activities. DDS internally monitors the status of reports, dashboards, communications, and quality assessment of contractor's work.

• On an annual basis, DDS meets with the contractor for a statewide review of risk management activities of monitoring, redesign, remediation, and improvement session.

• Additionally, at the end of each contract cycle, DDS compares the contractor's completed work to the contracts scope of work, thereby determining the quality and completeness of contractual obligations to DDS.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☐	☑
Waiver enrollment managed against approved limits	☑	☑	☐	☑
Waiver expenditures managed against approved levels	☑	☑	☐	☐
Level of care waiver eligibility evaluation	☑	☐	☐	☑

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Review of Participant service plans	☑	☑	☐	☑
Prior authorization of waiver services	☑	☐	☐	☑
Utilization management	☑	☑	☐	☑
Qualified provider enrollment	☑	☑	☐	☑
Execution of Medicaid provider agreements	☑	☑	☐	☑
Establishment of a statewide rate methodology	☑	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of eligibility files submitted to and reviewed by DHCS to ensure consumer eligibility. Numerator = number of eligibility files reviewed by DHCS. Denominator = total number of eligibility files submitted to DHCS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Eligibility Files Submitted to DHCS

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Number and percent of HCBS Waiver Monitoring Protocols, policies and procedures reviewed by the Medicaid Agency found to be compliant. Numerator = number of HCBS Waiver monitoring Protocols, policies and procedures reviewed by the Medicaid Agency that are found to be compliant. Denominator = total number of HCBS Waiver monitoring protocols, policies and procedures reviewed by the Medicaid Agency

Data Source (Select one):
Other
If 'Other' is selected, specify:
Periodic policy updates, waiver applications/ amendments.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of required oversight/monitoring meetings conducted between DDS and the Medicaid agency. Numerator = number of oversight meetings conducted. Denominator = number of planned oversight meetings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Oversight/monitoring meetings conducted between DDS and Medicaid Agency.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: At least semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of DDS invoices reviewed to ensure expenditures are managed against approved limits. Numerator = number of DDS invoices reviewed to ensure expenditures are managed against approved limits. Denominator = total number of invoices submitted by DDS.

Data Source (Select one):

Other
If 'Other' is selected, specify:
DDS Invoices

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of oversight/monitoring review reports reviewed by DHCS. Numerator = number of reports submitted to and reviewed by DHCS. Denominator = total number of reports submitted to DHCS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during state's biennial collaborative on-site HCBS waiver monitoring reviews.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of required coordination meetings conducted between the Medicaid Agency, DDS and DSS (As required). Numerator = number of coordination meetings conducted. Denominator = total number of planned coordination meetings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Coordination meetings conducted between the Medicaid Agency, DDS and DSS.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: At least quarterly	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of DDS Quality Management Executive Committee (QMEC) Meetings conducted. Numerator = number of QMEC Meetings conducted. Denominator = total number of planned QMEC Meetings.

Data Source (Select one):
Other

If 'Other' is selected, specify:
QMEC meetings

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: At least semi-annually.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Other** Specify: At least semi-annually.

Performance Measure:
Number and percent of settings that meet the HCBS settings requirements. Numerator = Number of settings that meet the HCBS settings requirements. Denominator = number of settings reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of a randomly selected sample of settings to ensure the home and community characteristics required in HCBS waiver are maintained.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Statewide sample size determined using sample size calculator that yields results with a 95% confidence level with a 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

When individual problems are discovered, DDS, with oversight from DHCS, works with the regional centers to resolve the problem. For example, individual issues identified during the State's Biennial on -site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Depending on the situation, resolution may require further site visits from the regional center or the Department of Social Services. The regional center's plans for correction submitted in response to the State's recommendations are evaluated and approved by DHCS and DDS before the final monitoring report is issued to the regional center and forwarded to CMS. Individual problems identified through the other discovery methods identified above and elsewhere in this application are addressed in a similar fashion. Documentation of individual issues and resolution is maintained and aggregated by DDS and allows for system wide analysis by the Quality Management Executive Committee.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Regional Centers	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	0		☑
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

• California uses the State's definition of "developmentally disabled" and "substantial disability" for the target population of this waiver, as defined in the California Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, §4512, 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 intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability , but shall not include other handicapping conditions that are solely physical in nature.

"Substantial disability" means the existence of significant functional limitations (requires assistance) in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:
(1) Self-care.
(2) Receptive and expressive language.
(3) Learning.
(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

Additionally, children (0) zero to (4) four years of age with a disability who have significant functional limitations in at least two of the above listed areas of major life activity (does not apply to capacity for independent living, or economic sufficiency given the age of the person), are also eligible for services. Regional center consumers are Medi-Cal beneficiaries who meet the level of care for this waiver. Consumers shall only be enrolled in one Section1915(c) waiver at any one time.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the state is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

- **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants

who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	155000
Year 2	161000
Year 3	167000
Year 4	173000
Year 5	179000

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

All individuals who express an interest and are eligible for enrollment are enrolled in the DD Waiver.

California will submit necessary DD Waiver amendments to accommodate all individuals who are eligible for and express an interest in participating in the DD Waiver should the approved DD Waiver capacity be insufficient to accommodate all interested persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR

§ 435.217)

☑ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**

☑ **Pregnant Women (42 CFR § 435.116)**

☑ **Infants and Children under Age 19 (42 CFR § 435.118)**

☑ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**

☑ **Optional state supplement recipients**

☑ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

◉ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR § 435.330)**

☑ **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**

☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

All other mandatory and optional eligibility groups included under the State Plan including any who would otherwise be eligible for SSI/SSP as provided in Section 1902(a)(10)(A)(ii)(I), including those who are eligible under section 1634(a)(c) and (d).

Special home and community-based waiver group under 42 CFR § 435.217) *Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

◉ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

  Specify percentage: [ ]
- ○ **A dollar amount which is lower than 300%.**

  Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

  Specify percentage amount: [ ]

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

- ● **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

- (●) **Use spousal post-eligibility rules under section 1924 of the Act.**
  (Complete Item B-5-b (SSI State) and Item B-5-d)
- ( ) **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

( ) **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

( ) **The following standard included under the state plan**

Select one:

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The special income level for institutionalized persons**

(*select one*):

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of the FBR, which is less than 300%**

  Specify the percentage:
- ( ) **A dollar amount which is less than 300%.**

  Specify dollar amount:

( ) **A percentage of the Federal poverty level**

Specify percentage:

( ) **Other standard included under the state plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

● **The following formula is used to determine the needs allowance:**

Specify:

The maximum amount of income to be eligible under the 435.217 group including any income disregards or exemptions.

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

● **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

● **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: [ ] The amount specified 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 42 CFR § 435.811 for a family of the same size. If this amount

changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

- **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The state does not establish reasonable limits.**
- **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines

the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional state supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage:
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- **The following formula is used to determine the needs allowance:**

  Specify formula:
- **Other**

  Specify:

  The maximum amount of income to be eligible under the 435.217 group including any income disregards or exemptions.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the

reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Qualified Intellectual Disability Professional (QIDP) performs level of care evaluations and is qualified as defined in 42 CFR §483.430(a), which requires QIDP staff to possess:

a) at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities.

b) is either a physician or surgeon, or an osteopathy physician and surgeon, a registered nurse, or a human services professional possessing at least a bachelor's degree in a human services field, including but not limited to sociology, special education, rehabilitation counseling, or psychology.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care (LOC) criteria are based on California Code of Regulations (CCR) Title 22 §§ 51343, 51343.1 and 51343.2 which specify the LOC requirements for admittance to an intermediate care facility for the developmentally disabled (ICF/DD), ICF/DD-H (habilitative) or ICF/DD-N (nursing.) The Client Development Evaluation Report (CDER) is utilized in making LOC determinations.

These regulations indicate that an individual must have at least two moderate or severe support needs (qualifying conditions) in one or a combination of the following areas: self-help (e.g. dressing, personal care, etc.); social-emotional (e.g. aggression, running away, etc.) ; or health (e.g. tracheostomy care, apnea monitoring, etc.)

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

When assessing level-of-care (LOC), the regional center QIDP reviews the CDER data including the diagnostic, special conditions and personal outcomes sections. In addition to the CDER data, the QIDP reviews other pertinent information in the consumer's record, such as the individual program plan, progress reports, medical and psychological evaluations and case management notes, to determine the Waiver qualifying conditions that significantly affect the consumer's ability to perform activities of daily living and/or participate in community activities. The qualifying conditions identified in this analysis are documented on the "Medicaid Waiver Eligibility Record" (DS 3770). The consumer must have a minimum of two qualifying conditions to meet the LOC requirements for this Waiver.

The state thoroughly defines all Level of Care (LOC) requirements associated with eligibility for the waiver and provides all required instruments to the regional center, including state-issued guidance, policies, procedures, and forms, to meticulously evaluate and make a Level of Care determination. Furthermore, only a Qualified Intellectual Disability Professional (QIDP), as outlined in 42 CFR 483.430(a) may perform a LOC evaluation. While the preliminary eligibility assessments are conducted through the regional center, the state monitors LOC determinations and has final authority on all LOC determinations.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

The qualifications are different.
Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Monthly State computer-generated reports of consumers who are due for reevaluation are provided to regional centers one month in advance of the annual reevaluation date. The processes in place to monitor this requirement are detailed in the Quality Improvement section below.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are kept at each of the 21 regional centers in each participant's file.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new enrollees who had a LOC indicating a need for institutional level of care prior to receipt of waiver services. Numerator = number of new enrollees that received an initial LOC determination prior to receipt of waiver services. Denominator = total number of new enrollees.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Federal Programs Division

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of LOC determinations that were completed accurately. Numerator = number of consumer records reviewed that documented accurate LOC determinations. Denominator = total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's biennial on-site HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual level-of-care (LOC) issues (e.g. appropriateness, timeliness, etc.) identified during the State's Biennial on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. The regional center's plans for correction submitted in response to the State's recommendations are evaluated and approved by DHCS and DDS before the final monitoring report is issued to the regional center and forwarded to CMS. Typically, the remediation for identified individual LOC issues involves 1) a reassessment of LOC to determine the areas of need, and 2) correction of documentation to ensure only qualifying conditions (issues requiring moderate or severe support needs) are used in making LOC determinations. When the results of these reassessments indicate the LOC criteria are not met, then the individual's waiver eligibility is terminated.

As referenced in Appendix B-6(i), timeliness of LOC reevaluations is also monitored on a statewide basis through automated monthly reports. DDS follows-up on each occurrence to ensure appropriate action is taken.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon

request through the Medicaid agency or the operating agency (if applicable).

When an individual is determined to be likely to require a level of care described in Appendix B-6 of this request, the individual, or where appropriate his/her legal representative will be informed of any feasible alternatives under the DD waiver and given the choice of either institutional or services under the DD waiver.

The regional center will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home and community-based services as an alternative to institutional services, or who are denied the service(s), of their choice, or the providers of their choice. Individuals will be notified, in writing, of their fair hearing rights. The regional center case manager is responsible for informing individuals of the feasible alternatives for obtaining necessary services and giving each eligible individual the choice of receiving necessary care and services in an institutional health facility or through the HCBS Waiver for regional center consumers.

The regional center case manager ensures that:
1. Individuals, their legal representative, parents, relatives, or involved persons are informed of the choice of either participating or not participating in the DD waiver, if the consumer is determined to be eligible for DD waiver services and chooses to receive DD waiver services in lieu of institutional services.
2. The individual's choice is documented on the Medicaid Waiver Consumer Choice of Services/Living Arrangement form (DS 2200) at the time of any of the following:
- Determination of initial eligibility for the DD waiver.
- Reactivation of the DD waiver eligibility after an individual's termination from participation in the DD waiver.
- Transition from minor to adult status.

3. The consumer's choice to participate in the waiver is documented in a dated and signed DS 2200.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed DS 2200 is retained in the participant's record at the regional center.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Under the provisions of the California Welfare and Institutions Code (WIC) §4641, regional centers are required to conduct outreach activities to inform their communities of their services and to actively pursue individuals in need of services. Outreach and other information developed and used by regional centers must be available in English and other languages that are reflective of the populations in the service area of the regional center. Outreach activities lead to persons with developmental disabilities finding or being referred to regional centers for intake and assessment and a determination of eligibility for services. DDS monitors and facilitates this requirement.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Behavioral Intervention Services**		
Statutory Service	**Community Living Arrangement Services**		

Service Type	Service		
Statutory Service	Day Service		
Statutory Service	Homemaker		
Statutory Service	Prevocational Services		
Statutory Service	Respite Care		
Statutory Service	Supported Employment		
Extended State Plan Service	Dental Services		
Extended State Plan Service	Home Health Aide		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Optometric/Optician Services		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Prescription Lenses and Frames		
Extended State Plan Service	Psychology Services		
Extended State Plan Service	Speech, Hearing and Language Services		
Supports for Participant Direction	Financial Management Service		
Other Service	Chore Services		
Other Service	Communication Aides		
Other Service	Community Based Adult Services		
Other Service	Community-Based Training Service		
Other Service	Coordinated Family Supports		
Other Service	Environmental Accessibility Adaptations		
Other Service	Family Support Services		
Other Service	Family/ Consumer Training		
Other Service	Housing Access Services		
Other Service	Intensive Transition Services		
Other Service	Non-Medical Transportation		
Other Service	Nutritional Consultation		
Other Service	Participant-Directed Services		
Other Service	Person-Centered Future Planning		
Other Service	Personal Emergency Response Systems (PERS)		
Other Service	Remote Support Services		
Other Service	Self-Directed Support Services		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Transition/Set Up Expenses		
Other Service	Vehicle Modifications and Adaptations		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Behavioral Intervention Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Habilitation-Behavioral Intervention Services include two components:
A) Individual/Group Practitioners -which may provide Behavioral Intervention Services in multiple settings, including the individual's home, and workplace, depending on the individual's needs. These practitioners may also provide non-facility-based crisis services when needed. Conditions that indicate a need for crisis services include aggression to others, self-injurious behavior, property destruction, or other pervasive behavior issues that may jeopardize the individual's current living arrangement. Use of state-operated mobile crisis services are available for individuals continuing to experience crises and have exhausted all other available crisis services. Crisis teams are unique in providing partnerships, assessments, training and support to individuals experiencing crises and who are at risk of having to move from their own or family home or from an out-of-home placement to a more restrictive setting. Mobile crisis teams are available for deployment 24-hours a day, 7 days a week. Participants have the choice of either a state-operated or vendor operated crisis team.

B) Crisis Support - If relocation becomes necessary, emergency housing in the person's home community is available. Crisis Support provides a safe, stable, highly structured environment by combining concentrated, highly skilled staffing and intensive behavior modification programs. Conditions that would qualify an individual for crisis support include aggression to others, self-injurious behavior, property destruction, or other pervasive behavior issues that have precluded effective treatment in the current living arrangement. While the location and intensity of the components of this service vary based on the individual's needs, all components of behavioral intervention services include use and development of intensive behavioral intervention (see #1 below) programs to improve the recipient's development; and behavior tracking and analysis. The intervention programs will be restricted to generally accepted, evidence-based, positive approaches.

Behavioral intervention services are 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. These services include staff training, cross-training, or supports needed specifically to assist individuals transitioning into or out of a Community Crisis Home. Services may be provided to family members if they are for the benefit of the recipient.

Services for family members may include training and instruction about treatment regimens and risk management strategies to enable the family to support the recipient. The person-centered planning team determines the extent of participation necessary to meet the individual's needs. "Participation" means: Completion of group instruction on the basics of behavior intervention; Implementation of intervention strategies, according to the intervention plan; If needed, collection of data on behavioral strategies and submission of that data to the provider for incorporation into progress reports.

Participation in any needed clinical meetings; provision of suggested nominal behavior modification materials or community involvement if a reward system is used. If the absence of sufficient participation prevents successful implementation of the behavioral plan, other services will be provided to meet the individual's identified needs.
(1) "Intensive behavioral intervention" means any form of applied behavioral analysis (ABA) based treatment (see #2 below) that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as

appropriate.
(2) "Applied behavioral analysis-based treatment" means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction. Behavioral Habilitation services do not include services otherwise available to the person under the Individuals with Disabilities Education Act or the Rehabilitation Act of 1973.

Behavioral Intervention Services will not supplant Behavioral Health Treatment services available through EPSDT.

The participant may choose to receive Behavior Intervention Services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under appendix C-5.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Consumers are limited to no more than 12 months in a community crisis home in a service plan year and up to 18 consecutive months in total, per occurrence. Any additional day(s) must be approved by the Department and reviewed monthly thereafter. Should these limits be reached, the regional center and community crisis home will follow the transition plan developed for the consumer to identify an alternative residential setting with services and supports that meet the consumer's needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Psychologist
Agency	Behavior Management Consultant: (Psychologist)
Individual	Marriage & Family Therapist (MFT)
Agency	Family Counselor (MFCC), Clinical Social Worker (CSW)
Agency	Behavior Management Consultant: Marriage Family Child Counselor
Agency	Client/Parent Support Behavior Intervention Training Provider
Individual	Behavior Management Consultant: (Psychologist)
Individual	Social Worker
Individual	Chemical Addiction Counselor
Agency	State-Operated Mobile Crisis Team
Individual	Individual or Family Training Provider
Individual	Psychologist
Agency	Crisis Intervention Facility
Agency	Chemical Addiction Counselor
Individual	Behavior Analyst
Agency	Behavior Management Consultant: Licensed Clinical Social Worker
Individual	Psychiatrist
Agency	Community Crisis Homes
Individual	Crisis Team-Evaluation and Behavioral Intervention
Individual	Client/Parent Support Behavior Intervention Training
Agency	Individual or Family Training Provider
Agency	Behavioral Technician / Paraprofessional

Provider Category	Provider Type Title
Individual	Behavior Management Consultant: Licensed Clinical Social Worker
Agency	Licensed Psychiatric Technician
Individual	Parenting Support Services Provider
Agency	Parenting Support Services Provider
Agency	Associate Behavior Analyst
Agency	Behavior Analyst
Individual	Behavior Management Consultant: Marriage Family Child Counselor
Agency	Crisis Team-Evaluation and Behavioral Intervention
Agency	Social Worker
Agency	Marriage Family Therapist (MFT)
Agency	Psychiatrist
Agency	Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)
Individual	Family Counselor (MFCC), Clinical Social Worker (CSW)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Psychologist: Licensed Psychologist by the Board of Psychology pursuant to Business and Professions Code§§2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Management Consultant: (Psychologist)

Provider Qualifications

License *(specify):*

Licensed Psychologist by the Board of Psychology pursuant to Business and Professions Code, §§2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified by the Board of Psychology

Other Standard *(specify):*

1) Complete twelve semester units in applied behavior analysis; and
2) Have two years experience designing and implementing behavior modification intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Marriage & Family Therapist (MFT)

Provider Qualifications

License *(specify):*

Marriage & Family Therapist (MFT): Licensed MFT by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4980-4989

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Family Counselor (MFCC), Clinical Social Worker (CSW)

Provider Qualifications

License *(specify):*

Licensed Marriage Family Therapist by the Board of Behavioral Sciences pursuant to Business and Professions Code §§4980 (b)

Licensed Clinical Social worker by the California Board of Behavioral Science Examiners pursuant to Business and Professions Code §§4996-4996.2

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Management Consultant: Marriage Family Child Counselor

Provider Qualifications

License *(specify):*

Licensed Marriage and Family Therapist by the Department of Consumer Affairs, Board of Behavioral Sciences pursuant to Business and Professions Code §4980(b).

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Client/Parent Support Behavior Intervention Training Provider

Provider Qualifications

License *(specify):*

Licensed in accordance with Business and Professions Code as appropriate to the skilled professions of staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Client/Parent Support Behavior Intervention Training services may be provided by a Behavior Analyst, Associate Behavior Analyst, Psychologist, Psychiatric Technician or Psychiatrist.
Specific qualifications and training of providers are as specified in the requirements established in this section.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Behavior Management Consultant: (Psychologist)

Provider Qualifications

License *(specify):*

Licensed Psychologist by the Board of Psychology pursuant to Business and Professions Code, §§2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified by the Board of Psychology

Other Standard *(specify):*

1) Complete twelve semester units in applied behavior analysis; and
2) Have two years experience designing and implementing behavior modification intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Social Worker: Licensed Social Worker by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4996-4997.1

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Chemical Addiction Counselor

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Chemical Addition Counselor: Certified in accordance with Title 9 CCR § 9846-13075

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

State-Operated Mobile Crisis Team

Provider Qualifications

License *(specify):*

Licensed pursuant to Business and Professions Code as appropriate to the skilled professions staff assigned to the team.

Certificate *(specify):*

Certified as appropriate to the skilled professions staff assigned to the team.

Other Standard *(specify):*

Program utilizes licensed and/or certified state personnel as appropriate to provide, develop and implement individualized crisis behavioral services plans. Specific qualifications and training of personnel per agency guidelines consistent with requirements for Behavior Specialist I, Psychologist, Psychiatric Technician, Psychiatric Technician Instructor, and Registered Nurse.

This provider is authorized under WIC 4474.2.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Individual or Family Training Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Psychologist: Licensed Psychologist by the Board of Psychology pursuant to Business and Professions Code§§2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Crisis Intervention Facility

Provider Qualifications

License *(specify):*

Licensed Crisis Intervention Facility by the State Department of Social Services pursuant to Health & Safety Code §§1567.80 -1567.87.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

A certificate of program approval issued by the State Department of Developmental Services, pursuant to Health and Safety code § 1567.81 (a)(1)

Other Standard *(specify):*

Crisis services may be provided in any of the types of 24-hour care services identified in Habilitation Community Living Arrangement Services (CLAS) section. Refer to the CLAS section for standards found in the Health and Safety Code §§1500-1567.87.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Chemical Addiction Counselor

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

Chemical Addition Counselor: Certified in accordance with Title 9 CCR § 9846-13075

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification by the Behavior Analyst Certification Board accredited by the National Commission for Certifying Agencies.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Management Consultant: Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*

Licensed clinical social worker by the California Board of Behavioral Sciences Examiners pursuant to Business and Professions Code §§4996-4996.2

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

issued and certified by the Board of Behavioral Sciences

Other Standard *(specify):*

1) Complete twelve semester units in applied behavior analysis; and
2) Have two years experience designing and implementing behavior modification intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Licensed psychiatrist, a physician and surgeon by the Medical Board of California pursuant to Business and Professions Code § 2000.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified by the American Board of Psychiatry and Neurology

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Community Crisis Homes

Provider Qualifications

License *(specify):*

Licensed Adult Residential Facility or group home by the Department of Social Services pursuant to Health and Safety Code §§ 1567.80 - 1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified by the Department of Developmental Services pursuant to WIC 4698

Other Standard *(specify):*

In addition to the requirements in Title 22, CCR, §§85000-85092, requirements from Title 17, CCR, §§59004 - 59005 also apply.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Crisis Team-Evaluation and Behavioral Intervention

Provider Qualifications

License *(specify):*

Licensed pursuant to Business and Professions Code as appropriate to the skilled professions staff assigned to the team.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified as appropriate to the skilled professions staff assigned to the team.

Other Standard *(specify):*

Program utilizes licensed and/or certified personnel as appropriate to provide develop and implement individualized crisis behavioral services plans. Specific qualifications and training of personnel per agency guidelines consistent with requirements for Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant: Psychologist, Psychiatric Technician or Psychiatrist established in this section.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially ongoing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Client/Parent Support Behavior Intervention Training

Provider Qualifications

License *(specify):*

Licensed in accordance with Business and Professions Code as appropriate to the skilled professions of staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Client/Parent Support Behavior Intervention Training services may be provided by a Behavior Analyst, Associate Behavior Analyst, Psychologist, Psychiatric Technician or Psychiatrist.

Specific qualifications and training of providers are as specified in the requirements established in this section.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Individual or Family Training Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavioral Technician / Paraprofessional

Provider Qualifications

License *(specify):*

No state licensing category

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant.

(1) Has a High School Diploma or the equivalent, has completed 30 hours of competency-based training designed by a certified behavior analyst, and has
six months experience working with persons with developmental disabilities;
or
(2) Possesses an Associates Degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution, and has six months experience working with persons with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Behavior Management Consultant: Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*

Licensed Clinical Social Worker by the California Board of Behavioral Science Examiners pursuant to Business and Professions Code §§4996-4996.2

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Issued and certified by the Board of Behavioral Sciences.

Other Standard *(specify):*

1) Complete twelve semester units in applied behavior analysis; and
2) Have two years experience designing and implementing behavior modification intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Licensed Psychiatric Technician

Provider Qualifications

License *(specify):*

Licensed Psychiatric Technician by the California State Board of Vocational Nurse and Psychiatric Technician pursuant to Business and Professions Code §4510

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Parenting Support Services Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Parenting Support Services Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Associate Behavior Analyst

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification by the national Behavior Analyst Certification Board and accredited by the National Commission for Certifying Agencies.

Other Standard *(specify):*

Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification by the Behavior Analyst Certification Board accredited by the National Commission for Certifying Agencies.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Behavior Management Consultant: Marriage Family Child Counselor

Provider Qualifications

License *(specify):*

Licensed Marriage and Family Therapist by the Department of Consumer Affairs, Board of Behavioral Sciences pursuant to Business and Professions Code §4980(b)

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Crisis Team-Evaluation and Behavioral Intervention

Provider Qualifications

License *(specify):*

Licensed pursuant to Business and Professions Code as appropriate to the skilled professions staff assigned to the team.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified as appropriate to the skilled professions staff assigned to the team.

Other Standard *(specify):*

Program utilizes licensed and/or certified personnel as appropriate to provide develop and implement individualized crisis behavioral services plans. Specific qualifications and training of personnel per agency guidelines consistent with requirements for Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant: Psychologist, Psychiatric Technician or Psychiatrist established in this section.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Social Worker: Licensed Social Worker by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4996-4997.1

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Marriage Family Therapist (MFT)

Provider Qualifications

License *(specify):*

Marriage & Family Therapist (MFT): Licensed MFT by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4980-4989

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Licensed Psychiatrist, a physician and surgeon by the Medical Board of California pursuant to Business and Professions Code § 2000.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified by the American Board of Psychiatry and Neurology

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)

Provider Qualifications

License *(specify):*

Licensed Psychology Assistant by the Medical Board of California pursuant to Business and Professions Code §2913

Licensed Associate Clinical Social Worker by the California Board of Behavioral Science Examiners pursuant to Business and Professions Code §4996.18.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Registered as either:
1. A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or
2. An Associate Licensed Clinical Social Worker pursuant to Business and Professions Code, Section 4996.18.

Other Standard *(specify):*

Possesses a Bachelor of Arts or Science Degree and has either:
1. Twelve semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services; BPC Sec. 2913(b)or
2. Two years of experience in designing and/or implementing behavior modification intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Family Counselor (MFCC), Clinical Social Worker (CSW)

Provider Qualifications

License *(specify):*

Licensed Marriage Family Therapist by the Board of Behavioral Sciences pursuant to Business and Professions Code §§4980 (b)

Licensed Clinical Social worker by the California Board of Behavioral Science Examiners pursuant to Business and

Professions Code §§4996-4996.2

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Community Living Arrangement Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Habilitation-Community Living Arrangement Services (CLAS) includes two components, based on the setting:

A) Licensed/certified settings - CLAS provided in these settings include assistance with acquisition, retention, or improvement in skills related to living in the community. Services and supports include assistance with activities of daily living, community inclusion, social and leisure skill development and the adaptive skills necessary to enable the individual to reside in a non-institutional setting.

B) Supported living services (provided in residences owned or leased by the recipients.) -CLAS provided in these settings are tailored supports that provide 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 meals, including planning, shopping, cooking, and storage activities;
- Social and adaptive skills necessary for participating in community life: such as building and maintaining interpersonal relationships, including a Circle of Support;
- Locating and scheduling appropriate medical services;
- Managing personal financial affairs;
- Selecting and moving into a home;
- Locating and choosing suitable house mates;
- Acquiring household furnishings;
- Recruiting, training, and hiring personal attendants;
- Acquiring, using, and caring for canine and other animal companions specifically trained to provide assistance;
- Acquiring, using and maintaining devices to facilitate immediate assistance when threats to health, safety, and well-being occur.

CLAS may include additional activities, as appropriate, to meet the recipients' unique needs. These activities include those that address social, adaptive, behavioral, and health care needs as identified in the individual program plan. CLAS may also include the provision of medical and health care services that are integral to meeting the daily needs of residents. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents are not included.

The specific services provided to each recipient vary based on the residential setting chosen and needs identified in the individual program plan.

Payments will not be made for the routine care and supervision which would be expected to be provided by a family, or for activities or supervision for which a payment is made by a source for which the state is obligated, nor will payments be made for any maintenance and supervision costs for children in foster care. Such costs are paid by the child's county of residence, not by the regional center. Payments for CLAS in licensed/certified settings do not include the cost for room and board. The method by which the costs of room and board are excluded from payment in these settings is specified in Appendix I-5.

The service plan development process identifies all waiver and non-waiver services and ensures that there is no duplication of those services. Service plans are reviewed and updated no less than annually.

Provider owned or leased facilities where Community Living Arrangement Services are furnished must be compliant with the Americans with Disabilities Act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Assistant
Agency	Foster Family Homes (FFHs) (Children Only)
Agency	Group Homes for Children with Special Health Care Needs
Agency	Group Homes for Children with Special Health Care Needs (GHCSHN)
Agency	Foster Family Agency (FFA)-Certified Family Homes (Children Only)
Agency	Group Homes (Children Only)
Agency	Personal Assistant
Agency	Supported Living Provider
Agency	In-Home Day Program (CB)
Agency	Residential Facility (out of state)
Agency	Enhanced Behavioral Supports Homes (EBSH)
Agency	Adult Residential Facility for Persons with Special Health Care Needs
Agency	Adult Residential Facilities (ARF)
Individual	Supported Living Provider
Individual	In-Home Day Program (CB)
Agency	Small Family Homes (Children Only)
Agency	Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)
Agency	Residential Care Facility for the Elderly (RCFE)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Individual

Provider Type:

Personal Assistant

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Ability to provide assistance and support to meet Community Living Arrangement Service needs as outlined in an individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Foster Family Homes (FFHs) (Children Only)

Provider Qualifications

License *(specify):*

Licensed Foster Family Agency by the Department of Social services pursuant to Health and Safety Code §§1500-1567.8.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified Family Homes under Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes

Other Standard *(specify):*

Title 22, CCR §§89200-89587.1
Regulations adopted by DSS to specify requirements for licensure of Foster Family Homes.

Qualifications/Requirements for FFH providers:
1. Comply with applicable laws and regulations and:
2. Provide care and supervision to meet the childs needs including communicating with the child;
3. Maintain all child records, safeguard cash resources and personal property;
4. Direct the work of others in providing care when applicable,
5. Apply the reasonable and prudent parent standard;
6. Promote a normal, healthy, balanced, and supported childhood experience and treat a child as part of the family;
7. Attend training and professional development;
8. Criminal Records/Child Abuse Registry clearance;
9. Report special incidents;
10. Ensure each child's personal rights; and,
11. Maintain a clean, safe, health home environment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Group Homes for Children with Special Health Care Needs

Provider Qualifications

License *(specify):*

Licensed Group Home for Children with Special Health Care Needs by the Department of Social Services pursuant to Health and Safety Code § 1567.51(b)
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Per Health and Safety Code §1567.51, the State Department of Developmental Services shall be responsible for granting the certificate of program approval.

Other Standard *(specify):*

Welfare and Institutions Code, § 4684.50 et seq.
The administrator must:
1. Complete the 40-hour administrator certification program pursuant to paragraph (1) of subdivision
(c) of Section 1522.41 of the Health and Safety Code without exception
2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:
a. A licensed registered nurse.
b. A licensed nursing home administrator.
c. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.

d. An individual with a bachelor's degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Group Homes for Children with Special Health Care Needs (GHCSHN)

Provider Qualifications

License *(specify):*

Licensed Group Home for Children with Special Health Care Needs by the Department of Social Services pursuant to Health and Safety Code § 1567.51(b)
As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

Per Health and Safety Code §1567.51, the State Department of Developmental Services shall be responsible for granting the certificate of program approval.

Other Standard *(specify):*

Welfare and Institutions Code, § 4684.50 et seq.
The administrator must:

1. Complete the 40-hour administrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1522.41 of the Health and Safety Code without exception
2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:
a. A licensed registered nurse.
b. A licensed nursing home administrator.
c. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.

d. An individual with a bachelor's degree or more advanced degree in the health or human services field and two years of experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Foster Family Agency (FFA)-Certified Family Homes (Children Only)

Provider Qualifications

License *(specify):*

Licensed Foster Family Agency by the Department of Social Services pursuant to Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified Family Homes under Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes

Other Standard *(specify):*

Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFA's, certification and use of homes.

FFA administrator qualifications:
(1) A Master's Degree in social work or a related field. Three years of experience in the field of child or family services, two years of which have been administrative/ managerial; or,

(2) A Bachelor's Degree in a behavioral science from an accredited college or university. A minimum of five years of experience in child or family services, two years of which have been in an administrative or managerial position.

Certified family home providers meet requirements for foster family homes (Refer to Foster Family Homes below).

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic

degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Group Homes (Children Only)

Provider Qualifications

License *(specify):*

Licensed group homes by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR, § 84000-84808
Regulations adopted by DSS to specify requirements for licensure of Group Homes.
Administrator Qualifications:
1. Master's degree in a behavioral science, plus a minimum of one year of employment as a social worker in an agency serving children or in a group residential program for children;
2. Bachelor's degree, plus at least one year of administrative or supervisory experience (as above);
3. At least two years of college, plus at least two years administrative or supervisory experience (as above); or
4.Completed high school, or equivalent, plus at least three years administrative or supervisory experience (as above); and,
5. Criminal Records/Child Abuse Registry Clearance

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Personal Assistant

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Ability to provide assistance and support to meet Community Living Arrangement Service needs as outlined in an individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

SLS requirements:
1. Service design including:
- Staff hiring criteria, including any minimum qualifications requirements; and
- Procedures and practices the agency will use to screen paid staff, consultants, and volunteers who will have direct contact with consumers.
2. Staff appropriate to services rendered with skills to establish and maintain constructive and appropriate personal relationship with recipients, minimize risks of endangerment to health, safety, and well-being of recipients, perform CPR and operate 24-hour emergency response systems, achieve the intended results of services being performed and maintenance of current and valid licensure, certification, or registration as are legally required for the service.
3. Staff orientation and training in theory and practice of supported living services and recipient training in supported living services philosophy, recipient rights, abuse prevention and reporting, grievance procedures and strategies for building and

maintaining a circle of support.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

In-Home Day Program (CB)

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualifications and training for staff in agency guidelines.
Must have a provision for an annual assessment process to ensure consumer participation in this type of program remains appropriate.
Providers may include employees of community-based day, pre-vocation, or vocational programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Regional Centers
DDS
Family Home Agency

Frequency of Verification:

Verified upon application for vendorization and biennally thereafter.
Annually
Biennially
Monthly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Residential Facility (out of state)

Provider Qualifications

License *(specify):*

Appropriate Facility License, as required by State law.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Department approval is required per the Welfare and Institutions Code, § 4519. Residential facility providers must meet state of residence waiver standards and requirements in all respects.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Enhanced Behavioral Supports Homes (EBSH)

Provider Qualifications

License *(specify):*

Licensed Adult Residential Facility or group home by the Department of Social Services pursuant to
Health and Safety Code §§ 1567.61 - 1567.80
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified by the Department of Developmental Services pursuant to WIC 4684.80

Other Standard *(specify):*

In addition to the requirements in Title 22, CCR, §§85000-85092, the following requirements from Title
17, CCR, §§59050 also apply:
Administrator Qualifications

(a) An administrator must:
(1) Have a minimum of 2 years of prior experience providing direct care or supervision to individuals
with developmental disabilities; and be one of the following:
(A) A registered behavior technician.

(B) A licensed psychiatric technician.
(C) A qualified behavior modification professional.

(b) An administrator must complete the residential services orientation as required per Section 56003(b)
Direct Care Staff Qualifications.

(a) A direct care lead staff person must:
(1) Have at least one year prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; and
(2) Become a registered behavior technician within 60 days of initial employment; or, be either:
(A) A licensed psychiatric technician; or
(B) A qualified behavior modification professional.

(b) A direct care staff person must:
(1) Have at least six months prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; and
(2) Become a registered behavior technician within twelve months of initial employment; or be:
(A) Be a licensed psychiatric technician

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Regional Centers

DDS

Family Home Agency

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Biennially

Monthly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Adult Residential Facility for Persons with Special Health Care Needs

Provider Qualifications

License *(specify):*

Licensed Adult Residential Facility for Persons with Special Health Care Needs by the Department of Social Services pursuant to Health and Safety Code § 1567.50(b)(c)

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Per Health and Safety Code §1567.50, the State Department of Developmental Services shall be responsible for granting the certificate of program approval.

Other Standard *(specify):*

Welfare and Institutions Code, § 4684.50 et seq.

The administrator must:
1. Complete the 35-hour administrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1562.3 of the Health and Safety Code without exception,
2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:
a. A licensed registered nurse.
b. A licensed nursing home administrator.
c. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
d. An individual with a bachelors degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Adult Residential Facilities (ARF)

Provider Qualifications

License *(specify):*

Licensed Adult Residential facilities by the Department of Social Services pursuant to Health and Safety code §§ 1500 - 1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR, §§85000-85092: Establish licensing requirements for persons 18 years of age through 59 years of age; and persons 60 years of age and older by exception.

Administrator Qualifications

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

Additional Administrator Qualifications may also include:
- Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:
(A) A licensed registered nurse.
(B) A licensed nursing home administrator.
(C) A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
(D) An individual with a bachelors degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Individual

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

No state licensing Category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

SLS requirements:
1. Service design including:
-Staff hiring criteria, including any minimum qualifications requirements; and
-Procedures and practices the agency will use to screen paid staff, consultants, and volunteers who will have direct contact with consumers.
2. Staff appropriate to services rendered with skills to establish and maintain constructive and appropriate personal relationship with recipients, minimize risks of endangerment to health, safety, and well-being of recipients, perform CPR and operate 24-hour emergency response systems, achieve the intended results of services being performed and maintenance of current and valid licensure, certification, or registration as are legally required for the service.
3. Staff orientation and training in theory and practice of supported living services and recipient training in supported living services philosophy, recipient rights, abuse prevention and reporting, grievance procedures and strategies for building and maintaining a circle of support.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Regional Centers
DDS
Family Home Agency

Frequency of Verification:

Verified upon application for vendorization and biennally thereafter.
Annually
Biennially
Monthly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Individual

Provider Type:

In-Home Day Program (CB)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualifications and training for staff in agency guidelines.

Must have a provision for an annual assessment process to ensure consumer participation in this type of program remains appropriate.

Providers may include employees of community-based day, pre-vocation, or vocational programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Regional Centers
DDS
Family Home Agency

Frequency of Verification:

Verified upon application for vendorization and biennally thereafter.

Annually
Biennially
Monthly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Small Family Homes (Children Only)

Provider Qualifications

License *(specify):*

Licensed Small Family Home by the Department of Social Services pursuant to the Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR §§ 83000-83088.
Regulations adopted by DSS to specify requirements for licensure of Small Family Homes.
Licensee/Administrator Qualifications
- Criminal Records/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 is 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;
  - Bonding and/or safeguarding of childrens property;
  - Ability to keep financial and other records;
  - Ability to recruit, employ, train, direct the work of and evaluate qualified staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

AFH Title 17, CCR, §56088
Authorizes the FHA to issue a Certificate of Approval to each family home which has:
1. Completed the criminal record review ;
2. Been visited by the FHA and a determination ensuring safe and reasonable and the prospective providers experience, knowledge, cooperation, history and interest to
become an approved family home.
3. Completed required orientation and training.

Other Standard *(specify):*

Welfare and Institutions Code 4689.1-4689.6 provides definition and statutory authority for FHA.

FHA employs sufficient staff with the combined experience, training and education to perform the following duties:
1. Administration of the FHA;
2. Recruitment of family homes;
3. Training of FHA staff and family homes;
4. Ensuring an appropriate match between the needs and preferences of the consumer
and the family home;
5. Monitoring of family homes;
6. Provision of services and supports to consumers and family homes which are
consistent with the consumer's preferences and needs and the consumer's IPP; and
7. Coordination with the regional center and others.

In order to accomplish these duties, selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic

degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Regional Centers
DDS

Family Home Agency

Frequency of Verification:

Verified upon application for vendorization and thereafter.

Annually
Biennially

Monthly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangement Services

Provider Category:

Agency

Provider Type:

Residential Care Facility for the Elderly (RCFE)

Provider Qualifications

License *(specify):*

Licensed Residential Care Facility of the Elderly by the Department of Social Services pursuant to Health and Safety Code §§1569-1569.889

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR, §§87100-87793: Establish licensing requirements for facilities where 75 percent of the residents are sixty years of age or older. Younger residents must have needs compatible with other residents.

Administrator Qualifications:
1. Knowledge of the requirements for providing care and supervision appropriate to the residents.
2. Knowledge of and ability to conform to the applicable laws, rules and regulations.
3. Ability to maintain or supervise the maintenance of financial and other records.
4. Ability to direct the work of others.
5. Good character and a continuing reputation of personal integrity.
6. High school diploma or equivalent.
7. At least 21 years of age.
8. Criminal Record Clearance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Habilitation - Day Services includes three components:
A) Community-Based Day Services - (Providers identified with "CB" below)
These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a non-residential setting. Services may 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. These services enable 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. Transportation services are not included in this service.

B) Activity-Based/Therapeutic Day Services - (Providers identified with "AT" below)
These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills through therapeutic and/or physical activities and are designed to:
• Gain insight into problematic behavior
• Provide opportunities for expression of needs and feelings

• Enhance gross and fine motor development
• Promote language development and communication skills
• Increase socialization and community awareness
• Improve communication skills
• Provide visual, auditory and tactile awareness and perception experiences
• Assist in developing appropriate peer interactions

C) Mobility Related Day Services - (Providers identified with "MT" below)
These services foster the acquisition of greater independence and personal choice by teaching individuals how to use public transportation or other modes of transportation which will enable them to move about the community independently.

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 USC 1401(16 and 17).

The participant may choose to receive Habilitation - Day Services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Appendix C-5.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☑ **Participant-directed as specified in Appendix E**
☑ **Provider managed**
☑ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Social Recreation Program (CB)
Agency	Personal Assistant (CB)
Individual	Special Olympics (AT)
Individual	Art Therapist (AT)
Individual	Dance Therapist (AT)
Individual	Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)
Agency	Specialized Recreational Therapist (AT)
Individual	Creative Art Program (AT)
Individual	Mobility Training Services Specialist (MT)
Agency	Recreational Therapist (AT)
Agency	Music Therapist (AT)
Agency	Sports Club (AT)
Individual	Personal Assistant (CB)
Agency	Driver Trainer (MT)
Agency	Behavior Management Program (CB)
Agency	Adult Development Centers (CB)

Provider Category	Provider Type Title
Agency	Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)
Agency	Art Therapist (AT)
Agency	Dance Therapist
Agency	Independent Living Program (CB)
Individual	Driver Trainer (MT)
Individual	Music Therapist (AT)
Agency	Special Olympics (AT)
Agency	Creative Art Program (AT)
Individual	Adaptive Skills Trainer (CB)
Individual	Specialized Recreational Therapist
Individual	Recreational Therapist (AT)
Individual	Independent Living Specialist (CB)
Agency	Adaptive Skills Trainer (CB)
Agency	Activity Center (CB)
Agency	Mobility Training Services Agency (MT)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Social Recreation Program (CB)

Provider Qualifications

License *(specify):*

Licensed Facility by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Requires written program design, recipient entrance and exit criteria, and staff training.
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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Personal Assistant (CB)

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Ability to provide assistance and support to meet Habilitation-Day Services needs as outlined in an individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Special Olympics (AT)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Knowledge and training sufficient to ensure consumer participation in Special Olympics.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Art Therapist (AT)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Current registration issued by the American Art Therapy Association.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Dance Therapist (AT)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Validly registered as a dance therapist by the American Dance Therapy Association

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)

Provider Qualifications

License *(specify):*

Licensed facility by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualifications and training of staff per agency guidelines.

For Community Integration Training Program: Program directors must have at least a bachelors degree. Direct service workers may be qualified by experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Specialized Recreational Therapist (AT)

Provider Qualifications

License *(specify):*

Credentialed and/or licensed as required by the State in the field of therapy being offered.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Equestrian therapists shall possess a current accreditation and instructor certification.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Creative Art Program (AT)

Provider Qualifications

License *(specify):*

Licensed creative art program by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Mobility Training Services Specialist (MT)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individuals providing this service 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 Drivers license and current insurance;
3. Ability to work independently, flexibility and adaptive skills to facilitate individual recipient needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Recreational Therapist (AT)

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification issued by either the National Council for Therapeutic Recreation Certification or the California Board of Recreation and Park Certification.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Music Therapist (AT)

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Valid registration issued by the National Association for Music Therapy.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Sports Club (AT)

Provider Qualifications

License *(specify):*

No state licensing Category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

All 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 consumers needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Personal Assistant (CB)

Provider Qualifications

License *(specify):*

No state licensing category

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Ability to provide assistance and support to meet Habilitation-Day Services needs as outlined in an individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Driver Trainer (MT)

Provider Qualifications

License *(specify):*

Valid California driver's license
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Current certification by the California Department of Motor Vehicles as a driver instructor.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Day Service

Provider Category:

Agency

Provider Type:

Behavior Management Program (CB)

Provider Qualifications

License *(specify):*

Licensed Facility by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Requires written program design, recipient entrance and exit criteria, and staff training.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Adult Development Centers (CB)

Provider Qualifications

License *(specify):*

Licensed facility by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Requires written program design, recipient entrance and exit criteria, and staff training.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)

Provider Qualifications

License *(specify):*

License facility by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualifications and training of staff per agency guidelines.

For Community Integration Training Program: Program directors must have at least a bachelors degree. Direct service workers may be qualified by experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Art Therapist (AT)

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Current registration issued by the American Art Therapy Association

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Dance Therapist

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Validly registered as a dance therapist by the American Dance Therapy Association

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Independent Living Program (CB)

Provider Qualifications

License *(specify):*

Licensed facility by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Requires written program design, recipient entrance and exit criteria, and staff training.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Driver Trainer (MT)

Provider Qualifications

License *(specify):*

Valid California drivers license

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Current certification by the California Department of Motor Vehicles as a driver instructor.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Music Therapist (AT)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Valid registration issued by the National Association for Music Therapy.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Special Olympics (AT)

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Knowledge and training sufficient to ensure consumer participation in Special Olympics.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Creative Art Program (AT)

Provider Qualifications

License *(specify):*

Licensed creative art program by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Adaptive Skills Trainer (CB)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual providing this service shall possess:
1. Masters degree in education, psychology, counseling, nursing, social work, applied behavior analysis, behavioral medicine, speech and language or rehabilitation; and
2. At least one year of experience in the designing and implementation of adaptive skills training plans.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Day Service

Provider Category:

Individual

Provider Type:

Specialized Recreational Therapist

Provider Qualifications

License *(specify):*

Credentialed and/or licensed as required by the State in the field of therapy being offered.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Equestrian therapists shall possess a current accreditation and instructor certification.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Recreational Therapist (AT)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification issued by either the National Council for Therapeutic Recreation Certification or the California Board of Recreation and Park Certification.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Independent Living Specialist (CB)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Possesses the skill, training, or education necessary to teach recipients to live independently and/or to provide the supports necessary for the recipient to maintain a self-sustaining, independent living situation in the community, such as one year experience providing services to individuals 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 eligible individuals.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Adaptive Skills Trainer (CB)

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual providing this service shall possess:
1. Master's degree in education, psychology, counseling, nursing, social work, applied behavior analysis, behavioral medicine, speech and language or rehabilitation; and
2. At least one year of experience in the designing and implementation of adaptive skills training plans.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and ongoing at least biennially thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Activity Center (CB)

Provider Qualifications

License *(specify):*

Licensed facility by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.87.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Requires written program design, recipient entrance and exit criteria, and staff training.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Mobility Training Services Agency (MT)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Personnel providing this service 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:
a) previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns;
b) a valid California Drivers license and current insurance;
c) ability to work independently with minimal supervision according to specific guidelines; and
d) flexibility and adaptive skills to facilitate individual recipient needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

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.

The service plan development process identifies all waiver and non-waiver services and ensures that there is no duplication of those services. Service plans are reviewed and updated no less than annually.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

N/A

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Service Agency
Individual	Paid individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Service Agency

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Must employ, train and assign personnel who maintain, strengthen, or safeguard the care of individuals in their homes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Paid individual

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual providers of homemaker services shall have the ability to maintain, strengthen, or safeguard the care of individuals in their homes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Prevocational services are services that are delivered for the purpose of furthering habilitation goals of learning and work experience through a habilitation service plan required by 17 CCR § 58812 to outline a specific path to competitive, integrated employment in the community. The service plan is to be reviewed not less than annually or more frequently if requested by the individual.

Services are intended to develop and teach general skills that lead to competitive and integrated employment including: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community work place conduct and dress; ability to follow directions; ability to attend to asks; work place problem solving skills and strategies; general work place safety and mobility training. Additionally, both work adjustment and supportive habilitation services as defined in Title 17 CCR § 58820 (c)(2), should allow for the development of productive skills, physical and psychomotor skills, interpersonal and communicative skills, health and hygiene maintenance, personal safety practices, self-advocacy training, and other skills aimed at maintaining a job and as outlined in the individual's person-centered services and supports plan. Individuals may be compensated based upon their performance and upon prevailing wage. However, compensation is not the sole purpose of participation in this service.

Prevocational services are designed to prepare individuals in non-job-task-specific strengths and skills that contribute towards obtaining a competitive and integrated employment, as opposed to vocational services whose sole purpose is to provide employment without habilitation goals geared towards skill building.

Transportation services are not included under Prevocational Services.

The reimbursement for Prevocational Services, (except for services provided to individuals working through an internship), includes incentive payments for measurable milestones identified below:

1. A one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days.
2. An additional one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months.
3. An additional one-time payment made to a provider when an individual has been employed consecutively for one year.

4. After a provider assists four individuals to achieve CIE placement, an additional payment is made to provider for each consumer thereafter who obtains competitive integrated employment
and is still employed:
   a. after 30 consecutive days
   b. after six consecutive months.

Only a single provider may receive an incentive payment for supporting an individual into a specific CIE placement.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or payments that are passed through to users of supported employment services.

o 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)).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Programs
Agency	Work Activity Program

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency

Provider Type:
Supported Employment Programs

Provider Qualifications

License *(specify):*
No state licensing category.

Federal/State Tax Exempt Letter.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services pursuant to Title 17 § 58810(f)(1)(2).

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Commission on Accreditation of Rehabilitation Facilities (CARF). CARF communicates with DDS on all CARF accreditation renewals in process. The information is shared with regional centers as needed.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.
Within four years at start-up; every one to three years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Work Activity Program

Provider Qualifications

License *(specify):*

Licensed facility by the Department of Social Services pursuant to the Health and Safety Code §§ 1500-1567.87

If applicable Federal/State Tax Exempt Letter.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services per Welfare and Institutions Code § 4851

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Commission on Accreditation of Rehabilitation Facilities (CARF). CARF communicates with DDS on all CARF accreditation renewals in process. The information is shared with regional centers as needed.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Within four years at start-up; every one to three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Intermittent, temporary non-medical care (with the exception of colostomy, ileostomy, catheter maintenance, and gastrostomy) and supervision provided in the recipient's own home or in an approved out of home location to do all of the following:

1. Assist family members in maintaining the recipient at home;
2. Provide appropriate care and supervision to protect the recipient's safety in the temporary absence of family members;
3. Temporarily relieve family members from the constantly demanding responsibility of caring for a recipient; and
4. Attend to the recipient'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 family members.

FFP will not be claimed for the following:
- Respite services provided beyond thirty consecutive days.
- 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 may be provided in the following locations:

Private residence

- Residential licensed by the Department of Social Services.
- Respite facility licensed by the Department of Social Services
- Other community setting approved by the State that is not a private residence, such as:
  - Adult Family Home/Family Teaching Home
  - Certified Family Homes for Children
  - Adult Day Care Facility
  - Camp
  - Licensed Preschool

A regional center may offer family members or adult consumers the option to self-direct their own respite services.
Respite services do not duplicate services provided under the Individuals with Disabilities Education Act (IDEA) of 2004.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☑ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Agency
Individual	Adult Day Care
Agency	Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
Agency	Respite Facility; Residential Facility: Small Family Homes (Children Only)
Agency	Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
Agency	Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
Agency	Respite Facility; Residential Facility: Group Homes (Children Only)
Agency	Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)
Agency	Adult Day Care Facility
Agency	Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)
Individual	Individual
Agency	Respite Facility; Residential Facility: Residential Care Facility for the Elderly (RCFE)
Agency	Camping Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Agency

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency director shall posses at a minimum:
1. A bachelors degree and a minimum of 18 months experience in the management of a human services delivery system, or;
2. Five years experience in a human services delivery system, including at least two years in a management or supervisory position.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Individual

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

Licensed as an Ault Care facility by the Department of Social Services pursuant to Health and Safety code §§ 1500-1567.8
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

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.
8.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 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 recipients 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)

Provider Qualifications

License *(specify):*

Licensed Foster Family Agency by the State Department of Social Services pursuant to Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified Family Homes; Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes.

Other Standard *(specify):*

Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFAs, certification and use of homes,

FFA administrator qualifications:
(1) A Master's Degree in social work or a related field. Three years of experience in the field of child or family services, two years of which have been administrative/ managerial; or,

(2) A Bachelor's Degree in a behavioral science from an accredited college or university. A minimum of five years of experience in child or family services, two years of which have been in an administrative or managerial position.

Certified family home providers meet requirements for foster family homes (Refer to Foster Family Homes below).

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service

design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Small Family Homes (Children Only)

Provider Qualifications

License *(specify):*

Licensed Small Family Home by the Department of Social Services pursuant to Health and Safety Code §§1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR §§ 83000-83088.
Regulations adopted by DSS to specify requirements for licensure of Small Family Homes.
Licensee/Administrator Qualifications
- Criminal Records/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 is 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;
  - Bonding and/or safeguarding of childrens property;
  - Ability to keep financial and other records;
  - Ability to recruit, employ, train, direct the work of and evaluate qualified staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Adult Residential Facilities (ARF)

Provider Qualifications

License *(specify):*

Licensed Adult Residential Facility by the Department of Social Services pursuant to Health and Safety Code §§ 1500 - 1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR, §§85000-85092: Establish licensing requirements for persons 18 years of age through 59 years of age; and persons 60 years of age and older by exception.

Administrator Qualifications
- At least 21 years of age;
- High school graduation or a GED;
- Complete a program approved by DSS that consists of 35 hours of classroom instruction
o 8 hrs. in laws, including residents personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities;
o 3 hrs. in business operations;
o 3 hrs. in management and supervision of staff;
o 5 hrs. in the psychosocial needs of the facility residents;
o 3 hrs. in the use of community and support services to meet the residents needs;
o 4 hrs. in the physical needs of the facility residents;
o 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents;
o 4 hrs. on admission, retention, and assessment procedures;
- Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%.
- Criminal Record/Child Abuse Registry Clearance.

Additional Administrator Qualifications may also include:
- Has at least one year of administrative and supervisory experience in a licensed residential program for persons
- with developmental disabilities, and
is one or more of the following:
(A) A licensed registered nurse.
(B) A licensed nursing home administrator.
(C) A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
(D) An individual with a bachelors degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennial thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs

Provider Qualifications

License *(specify):*

Licensed Adult Residential Facility for Persons with Special Health Care Needs by the Department of Social Services pursuant to Health and Safety Code §1567.50

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

The State Department of Social Services shall not issue a license unless the applicant has obtained a certification of program approval from the State Department of Developmental Services pursuant to Health and Safety Code 1567.50(1)

Other Standard *(specify):*

Welfare and Institutions Code, § 4684.50 et seq.

The administrator must:
1. Complete the 35-houradministrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1562.3 of the Health and Safety Code without exception,
2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:
a. A licensed registered nurse.
b. A licensed nursing home administrator.
c. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
d. An individual with a bachelor's degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Group Homes (Children Only)

Provider Qualifications

License *(specify):*

Licensed group homes by the Department of Social Services pursuant to Health and Safety Code §§ 1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR, § 84000-84808
Regulations adopted by DSS to specify requirements for licensure of Group Homes.
Administrator Qualifications:
1. Master's degree in a behavioral science, plus a minimum of one year of employment as a social worker in an agency serving children or in a group residential program for children;
2. Bachelor's degree, plus at least one year of administrative or supervisory experience (as above);
3. At least two years of college, plus at least two years administrative or supervisory experience (as above); or
4.Completed high school, or equivalent, plus at least three years administrative or supervisory experience (as above); and,
5. Criminal Records/Child Abuse Registry Clearance

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

AFH Title 17, CCR, §56088
Authorizes the FHA to issue a Certificate of Approval to each family home which has:
1. Completed the criminal record review ;
2. Been visited by the FHA and a determination ensuring safe and reasonable and the prospective providers experience, knowledge, cooperation, history and interest to
become an approved family home.
3. Completed required orientation and training.

Other Standard *(specify):*

Welfare and Institutions Code 4689.1-4689.6 provides statutory authority for FHA.

FHA employs sufficient staff with the combined experience, training and education to perform the following duties:
1. Administration of the FHA;
2. Recruitment of family homes;
3. Training of FHA staff and family homes;
4. Ensuring an appropriate match between the needs and preferences of the consumer
and the family home;
5. Monitoring of family homes;
6. Provision of services and supports to consumers and family homes which are
consistent with the consumer's preferences and needs and the consumer's IPP; and
7. Coordination with the regional center and others.

In order to accomplish these duties, selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Adult Day Care Facility

Provider Qualifications

License *(specify):*

Licensed Adult Care Facility by Department of Social Services pursuant to Health and Safety Code §§ 1500 - 1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

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 facilitys 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.
8. 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 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 recipients 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 administrators responsibilities during any absence of the administrator by a person who meets the qualification of an administrator.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Provider Qualifications

License *(specify):*

Licensed Foster Family Home by the State Department of Social Services pursuant to Health and Safety Code §§1500-1567.87

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

The licensed Family Home Agency must certify Family Homes pursuant to Title 22, CCR, § 88030

Other Standard *(specify):*

Title 22, CCR §§89200-89587.1
Regulations adopted by DSS to specify requirements for licensure of Foster Family Homes.

Qualifications/Requirements for FFH providers:
1. Comply with applicable laws and regulations and:
2. Provide care and supervision to meet the childs needs including communicating with the child;
3. Maintain all child records, safeguard cash resources and personal property;
4. Direct the work of others in providing care when applicable,
5. Apply the reasonable and prudent parent standard;
6. Promote a normal, healthy, balanced, and supported childhood experience and treat a child as part of the family;
7. Attend training and professional development;
8. Criminal Records/Child Abuse Registry clearance;
9. Report special incidents;
10. Ensure each child's personal rights; and,
11. Maintain a clean, safe, health home environment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training. Such training, including but not limited to, the American Red Cross; and must have the skill, training, or education necessary to preform the required services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Residential Care Facility for the Elderly (RCFE)

Provider Qualifications

License *(specify):*

Licensed Residential Care Facility for the elderly by the Department of Social Services pursuant to Health and Safety Code §§1569-1569.889
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR, §§87100-87793: Establish licensing requirements for facilities where 75 percent of the residents are sixty years of age or older. Younger residents must have needs compatible with other residents.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Camping Services

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

The camp submits to the local health officer either
1) Verification that the camp is accredited by the American Camp Association or
2) A description of operating procedures that addresses areas including supervisor qualifications and staff skill verification criteria.

Other Standard *(specify):*

Camp Director Qualifications: must be at least 25 years of age, and have at least two seasons of administrative or supervisory experience in camp activities.

Health Supervisor (physician, registered nurse or licensed vocational nurse) employed full time will verify that all counselors have been trained in first aid and CPR.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Supported employment services is paid work at competitive wages, including through an internship as defined in Welfare and Institutions Code § 4870 that is integrated in the community for individuals with developmental disabilities. Supported Employment services means job coaching and other services for regional center-funded consumers in a supported employment placement at a job coach-to-consumer ratio of one-to-one, and that decrease over time until stabilization is achieved. Individualized services may be provided on or off the jobsite. These services are received by eligible adults who are employed in integrated settings in the community. These individuals are unable to maintain this employment without an appropriate level of ongoing employment support services. Transportation services are not included under supported employment individual services.

Supported Employment Services include:
• 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):
• Job development - The process of working with a consumer, based on the individuals interests and abilities to identify potential jobs, meet with the hiring business, and assist
the consumer to apply for and compete for the job.
• Job analysis Classifying each of the required duties of a job to identify the support needed by the consumer.
• Training in adaptive functional skills
• Social skill training
• Ongoing support services -Services that are provided, typically off the job, to assist a consumer with concerns or issues that could affect his or her ability to maintain employment.
• Family counseling necessary to support the individual's employment
• Advocacy related to the employment, such as assisting individuals in understanding their benefits
• Advocacy or intervention to resolve problems affecting the consumer's work adjustment or retention.

Recipients receiving individual services earn minimum wage or above and are on the employer's payroll. Individuals receiving these services usually receive supervision 5-20% of the time by the program. The remainder of the time, the employer provides all supervision and training. 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 USC 1401(16 and 17).

The reimbursement for Supported Employment (except for services provided to individuals working through an internship), includes incentive payments for measurable milestones identified below:
1. A one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after 30 consecutive days.
2. An additional one-time payment made to a provider when an individual obtains competitive integrated employment and is still employed after six consecutive months.
3. An additional one-time payment made to a provider when an individual has been employed consecutively for one year.
4. After a provider assists four individuals to achieve CIE placement, an additional payment is made to provider for each consumer thereafter who obtains competitive integrated
employment and is still employed:
   a. after 30 consecutive days
   b. after six consecutive months.
5. For each individual who achieves CIE after exiting an internship, incentive payments will be paid to service providers when an individual achieves competitive integrated employment and is still employed:
   a. after 30 consecutive days.

b. after six consecutive months.

Only a single provider may receive an incentive payment for supporting an individual into a specific CIE placement.

The reimbursement for Supported Employment provided to individuals working through an internship includes the following incentive payments:

1. A one-time payment made to a provider when an individual obtains employment through an internship and is still employed after 30 consecutive days.
2. An additional one-time payment when an individual remains in an internship for 60 consecutive days.

Federal financial participation is not 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 supported employment; or
2. Payments that are passed through to users of supported employment services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Supported Employment Programs

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify):*
No state licensing category.
Federal/State Tax Exempt Letter.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*

Providers of supported employment shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Programs

Provider Qualifications

License *(specify):*

No state licensing category. Federal/State Tax Exempt Letter. As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services pursuant to Title 17 § 58810(f)(1)(2).

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Within four years at start-up; every one to three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Dental Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:

Dental services are defined in Title 22, California Code of Regulations, Section 51059 as professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.

Dental services will not supplant dental services available through EPSDT. Dental services in this waiver are only provided to individuals age 21 and over and only when the limits of dental services furnished under the approved state plan are exhausted.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dental Hygienist
Agency	Dentist
Individual	Dentist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:

Agency

Provider Type:

Dental Hygienist

Provider Qualifications

License *(specify):*

Dental Hygienist: Licensed Dental Hygienist by the Dental Hygiene Committee of California pursuant to Business and Professions Code §§1900-1966.6

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Dental Board of California

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:

Agency

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

Licensed Dentist by the Dental Board of California pursuant to Business & Professions Code §§ 1611-1621

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Dental Board of California

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.
Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:

Individual

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

Licensed Dentist by the Dental Board of California pursuant to Business & Professions Code §§ 1611-1621

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Dental Board of California

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Home Health Aide

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:

Home health aide services defined in 42 CFR §440.70 are provided to individuals age 21 and over and only when the limits of home health aide services furnished under the approved State plan limits are exhausted. Home health aide services under the state plan are limited to the amount that is determined medically necessary.

Home health aide services will not supplant home health aide services available through EPSDT. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Aide
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Home Health Aide

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified pursuant to Health and Safety Code § 1736.1.

Other Standard *(specify):*

Complete a training program approved by the California Department of Public Health.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Department of Public Health

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

licensed Home Health Agency by the Department of Public Health pursuant to Health and Safety Code §§1725-1742

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Medi-Cal certification using Medicare standards, Title 22, CCR, §51217.

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

California Department of Public Health

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17,

CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope)*:

Occupational Therapy services are defined in Title 22, California Code of Regulations, Sections 51085, and 51309 as services designed to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psychosocial disabilities, physical illness or advanced age. Occupational therapy includes evaluation, treatment planning, treatment, instruction and consultative services.

Occupational therapy services will not supplant Occupational Therapy services available through EPSDT. Occupational therapy in this waiver is only provided to individuals age 21 and over and only when the limits of occupational therapy services furnished under the approved state plan are exhausted.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapy
Agency	Occupational Therapy
Agency	Occupational Therapist Assistant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapy

Provider Qualifications

License *(specify):*

Occupational Therapist: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Occupational Therapy

Provider Qualifications

License *(specify):*

Occupational Therapist: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Occupational Therapist Assistant

Provider Qualifications

License *(specify):*

Occupational Therapist Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Optometric/Optician Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Optometric/Optician Services are defined in Title 22, California Code of Regulations, Sections 51093 and 51090, respectively. Optometric services means any services an optometrist may perform under the laws of this state. Dispensing optician means an individual or firm which fills prescriptions of physicians for prescription lenses and kindred products and fits and adjusts such lenses and spectacle frames. A dispensing optician is also authorized to act on the advice, direction and responsibility of a physician or optometrist in connection with the fitting of a contact lens or contact lenses.

Optometric/Optician services will not supplant Optometric/Optician services available through EPSDT. Optometric/Optician services in this waiver are only provided to individuals age 21 and over and only when the limits of Optometric/Optician services furnished under the approved state plan are exhausted.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Orthoptic Technician
Individual	Optometrist
Agency	Optometrist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Optometric/Optician Services

Provider Category:

Agency

Provider Type:

Orthoptic Technician

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

An orthoptic technician is validly certified by the American Orthoptic Council

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

American Orthoptic Council

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Every three years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Optometric/Optician Services

Provider Category:

Individual

Provider Type:

Optometrist

Provider Qualifications

License *(specify):*

Licensed Optometrist by the California State Board of Optometry pursuant to Business and Professions Code §§3041-3041.3
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Before engaging in the practice of optometry, each licensed optometrist shall notify the board in writing of the address or addresses where he or she is to engage in the practice of optometry pursuant to BPC Sec. 3070

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Optometric/Optician Services

Provider Category:

Agency

Provider Type:

Optometrist

Provider Qualifications

License *(specify):*

Licensed Optometrist by the California State Board of Optometry pursuant to the Business and Professions Code §§3041-3041.3

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Before engaging in the practice of optometry, each licensed optometrist shall notify the board in writing of the address or addresses where he or she is to engage in the practice of optometry pursuant to Business and Professions Code § 3070

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

California State Board of Optometry

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Physical Therapy services are defined in Title 22, California Code of Regulations, Sections 51081, and 51309 as services of any bodily condition by the use of physical, chemical, and or other properties of heat, light, water, electricity or sound, and by massage and active, resistive or passive exercise. Physical therapy includes evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications.

Physical therapy services will not supplant physical therapy services available through EPSDT. Physical therapy in this waiver is only provided to individuals age 21 and over and only when the limits of physical therapy services furnished under the approved state plan are exhausted.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Physical Therapist
Individual	Physical Therapist
Agency	Physical Therapy Assistant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

An appropriate business license as required by the local jurisdiction for the adaptations to be completed

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Physical Therapy Assistant

Provider Qualifications

License *(specify):*

Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Prescription Lenses and Frames

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

This service covers prescription lenses and frames for consumers over 21 as prescribed by a physician and only when the limits of prescription lenses and frames furnished under the approved state plan are exhausted. Prescription Lenses and Frames will not supplant prescription lenses and frames services available through EPSDT.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dispensing Optician
Agency	Dispensing Optician

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Prescription Lenses and Frames

Provider Category:

Individual

Provider Type:

Dispensing Optician

Provider Qualifications

License *(specify):*

Licensed dispensing optician by the state board of Optometry Professions pursuant to Business and Professions Code §§ 2550 - 2569

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Registered as a dispensing optician by the Division of Allied Health Professions of the Medical Board of California pursuant to Business and Professions Code §§ 2550 - 2569

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Medical Board of California

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Prescription Lenses and Frames

Provider Category:

Agency

Provider Type:

Dispensing Optician

Provider Qualifications

License *(specify):*

Licensed dispensing optician by the state board of Optometry Professional pursuant to Business and Professions Code §§ 2550-2569.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Registered as a dispensing optician by the Division of Allied Health Professions of the Medical Board of California pursuant to Business and Professions Code §§ 2550 - 2569

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Medical Board of California

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Psychology Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Psychology Services are defined in Title 22, California Code of Regulations, Section 51099 as the services of a person trained in the assessment, treatment, prevention, and amelioration of emotional and mental health disorders.

All medically necessary psychology services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Psychology services in this waiver are only provided to individuals age 21 and over and only when the limits of psychology services furnished under the approved state plan are exhausted. The approved state plan limits this service to the amount that is medically necessary.

The participant may choose to receive Psychology Services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Appendix C-5.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Clinical Psychologist
Individual	Clinical Psychologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Psychology Services

Provider Category:

Agency

Provider Type:

Clinical Psychologist

Provider Qualifications

License *(specify)*:

Licensed Psychologist by the Board of Psychology pursuant to Business and Professions Code, §§2940-2948.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify)*:

N/A

Other Standard *(specify)*:

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Board of Psychology

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Psychology Services

Provider Category:

Individual

Provider Type:

Clinical Psychologist

Provider Qualifications

License *(specify):*

Licensed Psychologist by the Board of Psychology pursuant to Business and Professions Code, §§2940-2948.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Board of Psychology

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Speech, Hearing and Language Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Speech, Hearing and Language services are defined in Title 22, California Code of Regulations, Sections 51096, 51098, and 51094.1 as speech pathology audiology services, and hearing aids, respectively. Speech pathology services mean services for the purpose of identification, measurement and correction or modification of speech, voice or language disorders and conditions, and counseling related to such disorders and conditions. Audiological services means services for the measurement, appraisal, identification and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and the recommendation and evaluation of hearing aids. Hearing aid means any aid prescribed for the purpose of aiding or compensating for impaired human hearing loss.

Speech, hearing and language services will not supplant speech, hearing, and language services available through EPSDT. Speech, hearing and language services in this waiver are only provided to individuals age 21 and over and only when the limits of speech, hearing and language services furnished under the approved state plan are exhausted.

The participant may choose to receive Speech, Hearing and Language services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described under Appendix C-5.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hearing and Audiology Facilities
Individual	Audiology
Agency	Speech Pathologist
Agency	Speech Language Pathology Assistant
Agency	Audiology
Individual	Speech Therapist
Agency	Speech Therapist

Provider Category	Provider Type Title
Individual	Speech Pathologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Agency
Provider Type:
Hearing and Audiology Facilities
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
An audiology facility:
1. Employs at least one audiologist who is licensed by the Speech Pathology and Audiology Examining Committee of the Medical Board of California; and
2. Employs individuals, other than 1. above, who perform services, all of whom shall be:
Licensed audiologists; or
Obtaining required professional experience, and whose required professional experience application has been approved by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
Frequency of Verification:
Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Individual
Provider Type:
Audiology
Provider Qualifications

License *(specify):*

Licensed Audiologist by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs pursuant to Business and Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Biennally if non-dispensing audiologist; annually if dispensing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Speech Pathologist

Provider Qualifications

License *(specify):*

Licensed speech pathologist by the Speech-Language Pathology and Audiology and Hearing Aid by the Board of the California Department of Consumer Affairs pursuant to Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Speech Language Pathology Assistant

Provider Qualifications

License *(specify):*

Registered as a Speech-Language Pathology Assistant by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs, pursuant to Business and Professions Code §2538-2538.7 and Title 16 CCR § 1399.170.11.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Minimum continuing professional development requirements for the speech-language pathology assistant, of 12 hours in a two-year period.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.
Biennially if non-dispensing audiologist; annually if dispensing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Audiology

Provider Qualifications

License *(specify):*

Licensed Audiologist by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs pursuant to Business and Professions Code §§ 2532-2532.8
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Biennially if non-dispensing audiologist; annually if dispensing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Individual

Provider Type:

Speech Therapist

Provider Qualifications

License *(specify):*

Speech Therapist: Licensed Speech-Language Therapist by the Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board pursuant to Business and Professions Code §2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.
Biennially if non-dispensing audiologist; annually if dispensing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Speech Therapist

Provider Qualifications

License *(specify):*

Speech Therapist: Licensed Speech-Language Therapist by the Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board pursuant to Business and Professions Code §2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.
Biennially if non-dispensing audiologist; annually if dispensing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Individual

Provider Type:

Speech Pathologist

Provider Qualifications

License *(specify):*

Licensed speech pathologist by the Speech-Language Pathology and Audiology and Hearing Aid by the Board of the California Department of Consumer Affairs pursuant to Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Financial Management Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Financial Management Services (FMS) are designed to serve as a fiscal intermediary that performs financial transactions (paying for goods and services and/or processing payroll for adult consumers' or their families' workers included in the IPP) on behalf of the consumer. FMS is an important safeguard because it ensures that consumers are in compliance with Federal

and state tax, labor, workers' compensation insurance and Medicaid regulations. The term "Financial Management Services" or "FMS" is used to distinguish this important participant direction support from the activities that are performed by intermediary organizations that function as Medicaid fiscal agents.
All FMS services shall:
1. Assist the family member or adult consumer in verifying worker citizenship status.
2. Collect and process timesheets of workers.
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
4. Track, prepare and distribute reports to appropriate individual(s)/entities.
5. Maintain all source documentation related to the authorized service(s) and expenditures.
6. Maintain a separate accounting for each participant's participant-directed funds.
7. Process and pay invoices for goods and services approved in the service plan.

FMS services are available only for the following self-directed services: respite, family support services, transportation, community-based training service, supported employment, day service, participant-directed services, and skilled nursing.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**
- [ ] **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Financial Management Services Provider
Agency	Financial Management Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Service

Provider Category:
Individual

Provider Type:
Financial Management Services Provider

Provider Qualifications

License *(specify)*:
As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Service

Provider Category:

Agency

Provider Type:

Financial Management Services Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

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 payer 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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

As appropriate for the services to be done.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual chore service providers shall possess the following minimum qualifications:
1. The ability to perform the functions required in the individual plan of care;
2. Demonstrate dependability and personal integrity.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.
State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

As appropriate for the services to be done.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual chore service providers shall possess the following minimum qualifications:
1. The ability to perform the functions required in the individual plan of care;
2. Demonstrate dependability and personal integrity.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Communication Aides

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Communication aides are those human services necessary to facilitate, assist, and train 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- Provide assistance and training as necessary to an individual to support the use of augmentative communication devices to communicate, and do not interpret or translate language;
2.Interpreters and interpreter services- Facilitate communication between hearing-impaired and hearing individuals using American Sign Language and spoken language; and
3.Translators and translator services- Translate written material from one language to another; and
4.Trainers and training services- Instruct individuals in the use of formal American Sign Language.

Communication aide services include evaluation for communication aides and training in the use of communication aides. Training in the use of communication aides refers to the training and technical assistance that is provided to the individual and/or support providers in the use of augmentative communication devices necessary to facilitate and guide individuals

with hearing, speech, or vision impairment to be able to effectively communicate.

Communication Aide services are not intended for purely diversional/recreational purposes and are only provided when the services cannot be obtained from other sources.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Interpreter
Agency	Interpreter
Agency	Translator
Agency	Facilitator
Individual	Translator
Agency	Trainer
Individual	Facilitator
Agency	Trainer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:

Individual

Provider Type:

Interpreter

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

An interpreter must demonstrate:
1. Fluency in both English and in sign language; 2. Proficiency in facilitating communication between hearing-impaired and hearing persons using American sign language and spoken language.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:

Agency

Provider Type:

Interpreter

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

An interpreter must demonstrate:
1. Fluency in both English and in sign language; 2. Proficiency in facilitating communication between hearing-impaired and hearing persons using American sign language and spoken language.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:

Agency

Provider Type:

Translator

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:

Agency

Provider Type:

Facilitator

Provider Qualifications

License *(specify):*

No state licensing category.
An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualifications and training as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:

Individual

Provider Type:

Translator

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:

Agency

Provider Type:

Trainer

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Staff providing the service must:
1. Have language proficiency from an accredited or nationally recognized institution such as, but not limited to, the American Sign Language Proficiency Interview (ASLPI), Sign Language Proficiency Interview (SLPI), or other recognized language proficiency body.
2. Be assessed proficient to provide at least superior level ratings or higher on ASLPI, SLPI ratings scale.
3. Possess the ability to have a fully shared conversation with in-depth elaboration for both social and work topics, and excellent comprehension in receptive skills.

4. Demonstrate the use of a very broad sign language vocabulary, near native-like production, fluency and prosody and excellent use of sign language grammatical features, and classifiers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:

Individual

Provider Type:

Facilitator

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualifications and training as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:

Agency

Provider Type:

Trainer

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Staff providing the service must:
1. Have language proficiency from an accredited or nationally recognized institution such as, but not limited to, the American Sign Language Proficiency Interview (ASLPI), Sign Language Proficiency Interview (SLPI), or other recognized language proficiency body.
2. Be assessed proficient to provide at least superior level ratings or higher on ASLPI, SLPI ratings scale.
3. Possess the ability to have a fully shared conversation with in-depth elaboration for both social and work topics, and excellent comprehension in receptive skills.
4. Demonstrate the use of a very broad sign language vocabulary, near native-like production, fluency and prosody and excellent use of sign language grammatical features, and classifiers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Based Adult Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Services furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in the community, 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. Community Based Adult Services will not supplant services available through the approved Medicaid State plan, 1115 Medi-Cal 2020 Demonstration Waiver or the EPSDT benefit.

Transportation between the individual's place of residence and the community-based adult services center will be provided as a component part of community based adult services. The cost of this transportation is included in the rate paid to providers of community based adult services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Based Adult Services will be a continuation of services beyond the amount, duration and scope of State Plan and/or 1115 demonstration benefit, not to exceed 12 hours per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Based Adult Services

Provider Category:

Agency

Provider Type:

Adult Day Health Care Center

Provider Qualifications

License *(specify):*

Health and Safety Code §§1570-1596.5.

As appropriate, a business license as required by the local jurisdiction where the agency is located.

Certificate *(specify):*

Title 22, CCR, §54301

Other Standard *(specify):*

Title 22, CCR, §§ 78201-78233

Verification of Provider Qualifications

Entity Responsible for Verification:

California Department of Public Health (Licensing)

California Department of Aging (Certification)
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

At least every two years
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community-Based Training Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Community-based training service is a participant-directed service that allows recipients the opportunity to customize day services to meet their individualized needs. As determined by the person-centered individual program planning process, the

service may include opportunities and assistance to: further the development or maintenance of employment and volunteer activities; pursue post secondary education; and increase recipients' ability to lead integrated and inclusive lives. These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. These services enable 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.

Educational services consist of special education and related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

Federal financial participation is not 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 supported employment; or
2. Payments that are passed through to users of supported employment services.

Services are authorized distinctly through the IPP process, which prevents duplication with other services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community-Based Training Services are limited to a maximum of 150 hours per quarter.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Based Training Provider
Individual	Community-Based Training Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community-Based Training Service

Provider Category:

Agency

Provider Type:

Community Based Training Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers of community-based training service shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.
State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community-Based Training Service

Provider Category:

Individual

Provider Type:

Community-Based Training Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers of community-based training service shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Coordinated Family Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

This service assists adults living in the family home to maximize their independence by helping them navigate existing services and supports. Coordinated Family Supports (CFS) engages with individuals and providers to facilitate access to services and supports by:

• Promoting consistency across providers specific to the unique needs of the individual by offering consultation/guidance.
• Assisting the individual in understanding, scheduling, and utilizing services and supports.
• Assisting the individual with accessing community services and supports specified in the IPP (i.e., assisting the individual with the application process or understanding and/or tracking benefits).

This service does not duplicate services provided by the individual's regional center case manager. Providers of this service will not provide any other waiver services to the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

N/A

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Coordinated Family Supports Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Coordinated Family Supports

Provider Category:

Agency

Provider Type:

Coordinated Family Supports Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

CFS Supervisor qualifications require:
• a Bachelors-level degree in a human services field of study or an Associates-level degree in a human services field of study and
• at least 3 years of experience in the developmental disabilities service delivery system.
Minimum qualifications for CFS staff are:
• Associates-level degree in a human services field of study or 3 years of experience in the developmental disabilities service delivery system,
• Knowledge of the regional center system.
• Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the individual as specified in the individual's IPP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Those physical adaptations to the private residence of the participant or the participant's family, 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 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. 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 place of residence 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 consecutive 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 expenses have been incurred, the State will claim these expenses as administrative costs at the administrative FFP rate for services which 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.

Environmental accessibility adaptations are only provided to individuals age 21 and over. All medically necessary environmental accessibility adaptations services for children under the age of 21 are covered in the state plan pursuant to EPSDT benefit. Environmental accessibility adaptations services will not supplant services available through the approved Medicaid State plan under the home health benefit or the EPSDT benefit.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Contractor
Individual	Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

Contractors are licensed through the Contractors' State License Board pursuant to Business and Professions Code, Sections 7000-7191.

A current license, certification or registration with the State of California as appropriate for the type of modification being purchased.

Certificate *(specify):*

See "License"

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

Contractors are licensed through the Contractors' State License Board pursuant to Business and Professions Code, Sections 7000-7191.

A current license, certification or registration with the State of California as appropriate for the type of modification being purchased.

Certificate *(specify):*

See License

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Support Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver are out of the home. This service is provided in the recipient's own home or in an approved out of home location to do all of the following:

1. Assist family members in maintaining the recipient at home;
2. Provide appropriate care and supervision to protect the recipient's safety in the absence of family members;
3. Relieve family members from the constantly demanding responsibility of caring for a recipient; and
4. Attend to the recipient'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 family members.

Family Support Services may be provided in the following out of home locations:

- Child Day Care Facility
- Child Day Care Center
- Family Child Care Home

Family support services may only be provided when the care and supervision needs of a consumer exceed that of a person of the same age without developmental disabilities. Additionally, payment may only be made when the cost of the service exceeds the cost of providing services to a person of the same age without disabilities.

Providers of family support services are distinct from providers of other services and are only authorized to provide this service, which prevents duplication of services.

A regional center may offer family members the option to self-direct their own family support services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Child Day Care Facility; Child Day Care Center; Family Child Care Home
Agency	Child Day Care Facility; Child Day Care Center; Family Child Care Home
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Family Support Services

Provider Category:

Individual

Provider Type:

Child Day Care Facility; Child Day Care Center; Family Child Care Home

Provider Qualifications

License *(specify):*

Licensed Child Day Care Facility by the Department of Social Services pursuant to Health and Safety Code §§ 1596.90 - 1597.621
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Child Day Care Center: Title 22 CCR, §§101151-101239.2
Family Child Care Home: Title 22 CCR §§102351.1-102424

Other Standard *(specify):*

Licensing requirements listed under HSC 1596.95
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 children need and the ability to communicate with such children.
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 establish the center's policy, program and budget.
6. Ability to recruit, employ, train, direct and evaluate qualified staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Support Services

Provider Category:

Agency

Provider Type:

Child Day Care Facility; Child Day Care Center; Family Child Care Home

Provider Qualifications

License *(specify):*

Licensed Child Day Care Facility by the Department of Social Services pursuant to Health and Safety Code §§ 1596.90 - 1597.621
As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

Child Day Care Center: Title 22 CCR, §§101151-101239.2
Family Child Care Home: Title 22 CCR §§102351.1-102424

Other Standard *(specify):*

Licensing requirements listed under HSC 1596.95
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 children need and the ability to communicate with such children.
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 establish the center's policy, program and budget.
6. Ability to recruit, employ, train, direct and evaluate qualified staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Support Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

No state licensing category.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training. Must have The skill, training, or education necessary to perform the required services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services - Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family/ Consumer Training

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Family/consumer support and training services are provided, as needed, in conjunction with extended state plan services in this waiver. These services include training by licensed providers to maintain or enhance the long-term impact of treatment provided. This includes support or counseling for the consumer and/or family to ensure proper understanding of the treatment provided and what supports are needed in the recipient's home environment to enhance the treatments. These services will be provided to individuals age 21 and over.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist
Individual	Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, RN, LVN
Individual	Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist
Agency	Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, RN, LVN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/ Consumer Training

Provider Category:

Agency

Provider Type:

Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist

Provider Qualifications

License *(specify):*

Dentist: Licensed Dentist by the Dental Board of California pursuant to Business and Professions Code§§1628-1636.6

Dental Hygienist: Licensed Dental Hygienist by the Dental Hygiene Committee of California pursuant to Business and Professions Code §§1900-1966.6

Marriage & Family Therapist (MFT): Licensed MFT by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4980-4989

Social Worker: Licensed Social Worker by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4996-4997.1

Speech Therapist: Licensed Speech-Language Therapist by the Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board pursuant to Business and Professions Code §2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/ Consumer Training

Provider Category:

Individual

Provider Type:

Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, RN, LVN

Provider Qualifications

License *(specify):*

Occupational Therapist and Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Licensed Registered Nurse by the California Board of Registered Nursing pursuant to Business and Professions Code §§ 2725-2742

Licensed Vocational Nurse by the California Board of Vocational Nursing and Psychiatric Technicians pursuant to Business and Professions Code §§ 2859-2873.6 2873.7

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/ Consumer Training

Provider Category:

Individual

Provider Type:

Dentist, Dental Hygienist, Marriage & Family Therapist, Social Worker, Speech Therapist

Provider Qualifications

License *(specify):*

License (specify)
Dentist: Licensed Dentist by the Dental Board of California pursuant to Business and Professions Code§§1628-1636.6

Dental Hygienist: Licensed Dental Hygienist by the Dental Hygiene Committee of California pursuant to Business and Professions Code §§1900-1966.6

Marriage & Family Therapist (MFT): Licensed MFT by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4980-4989

Social Worker: Licensed Social Worker by the California Board of Behavioral Sciences pursuant to Business and Professions Code §§4996-4997.1

Speech Therapist: Licensed Speech-Language Therapist by the Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board pursuant to Business and Professions Code §2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/ Consumer Training

Provider Category:

Agency

Provider Type:

Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, RN, LVN

Provider Qualifications

License *(specify):*

Occupational Therapist and Assistant: Licensed Occupational Therapist by the California Board of Occupational Therapy pursuant to Business and Professions Code §§2570-2571

Physical Therapist: Licensed Physical Therapist by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Physical Therapy Assistant: Licensed Physical Therapy assistant by the Physical Therapy Board of California pursuant to Business and Professions Code §§2635-2639.1

Licensed Registered Nurse by the California Board of Registered Nursing pursuant to Business and Professions Code §§ 2725-2742

Licensed Vocational Nurse by the California Board of Vocational Nursing and Psychiatric Technicians pursuant to Business and Professions Code §§ 2859-2873.6 2873.7

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Housing Access Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Housing Access Services includes two components:
A) Individual Housing Transition Services
These services are:
1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
3. Assisting the individual with the housing application process. Assisting the individual with the housing search process.
4. Assisting the individual with identifying resources to cover set-up fees for utilities or service access, including telephone, electricity, heating and water, and services necessary for the individual's health and safety, consisting of pest eradication and one-time cleaning prior to occupancy.
5. Assisting the individual with coordinating resources to identify and address conditions in the living environment prior to move-in that may compromise the safety of the consumer.
6. Assisting the individual with details of the move including communicating with the landlord to negotiate a move-in date, reading and understanding the terms of the lease, scheduling set-up of utilities and services, and arranging the move of consumers' belongings.
7. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

B) Individual Housing & Tenancy Sustaining Services - This service is made available to support individuals to maintain tenancy once housing is secured. The availability of ongoing housing-related services in addition to other long-term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support networks. These tenancy support services are:
1. Providing the individual with early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
2. Providing the individual with education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching the individual on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Assisting the individual in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
5. Providing the individual with advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized.
6. Assisting the individual with the housing recertification process.
7. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
8. Providing the individual with continuous training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

Housing Access Services do not include payment for room and board.

Persons receiving Health Homes or California Community Transitions services will not receive this service unless additional Housing Access through the waiver is necessary to maintain the consumers' health, safety and wellbeing in the home and/or community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business Entity
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Access Services

Provider Category:

Agency

Provider Type:

Business Entity

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Access Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Intensive Transition Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Intensive Transition Services (ITS) is a service providing support to those individuals who have been assessed to have complex behavioral health needs and who have transitioned into a community living option. Provision of waiver services will begin once the individual has transitioned into the community setting. The IPP team determines if ITS would be of benefit to the consumer based on an individualized need of a more intensive service that would make the transition possible.

ITS provides a team that will work in a person-centered approach to create a network of resources that will eventually allow the individual to live independently in the community. Services are directly provided by the team members consisting of the following:

- Assessment - Initial and ongoing assessment to provide the below services in an individualized approach and continuously pivot based on the ongoing needs;
- substance use recovery treatment;
- anger management;
- self-advocacy;
- medication management;
- health and dietary education;
- sex education/fostering healthy relationships;
- behavioral support and modification training for the individual. ITS engages with service providers and circle of support to provide consultative information on managing the consumers behavior if deemed appropriate and necessary to support the consumers transition;
- Outpatient therapy - counseling by professionals who specialize with intellectual/developmental disability crisis work;
- Co-occurring disorders integrated treatment - a treatment organizational approach that allows all counseling, trainings, and treatments to work cohesively together in order to address every impacting disorder to successfully transition;
- Transition Planning - Ongoing planning throughout the services that adjusts based on progression of the individual.

ITS team members operate 24 hours a day, 7 days a week, including holidays, and are available in the event of a crisis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services shall not exceed 24 total months.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Registered Nurse (Agency)
Agency	Mental Health Professional (Agency)
Agency	Program Director (Agency)
Agency	Intensive Transition Services Agency
Agency	Transition/Care Coordinator (Agency)
Agency	Behavior Specialist (Agency)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Transition Services

Provider Category:

Agency

Provider Type:

Registered Nurse (Agency)

Provider Qualifications

License *(specify):*

Licensed Registered Nurse by the Department of Consumer Affairs Board of Registered Nursing pursuant to Business and Professions Code, §§ 2725-2742
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Work experience in either the intellectual disability or mental health system.

Valid CA Driver's License and ability to pass appropriate state and federal clearances.

Verification of Provider Qualifications

Entity Responsible for Verification:

ITS Agency, Regional Center, through the annual quality assurance review and contract reviews when a new professional is hired.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Transition Services

Provider Category:

Agency

Provider Type:

Mental Health Professional (Agency)

Provider Qualifications

License *(specify):*

Licensed Psychologist by the Board of Psychology pursuant to Business and Professions Code§§2940-2948

Or

Licensed Clinical Social Worker by the California Board of Behavioral Science Examiners pursuant to Business and Professions Code §§4996-4996.2
Or

Licensed Marriage Family Therapist by the Board of Behavioral Sciences pursuant to Business and Professions Code §4980 (b)

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Must possess two years' experience designing and implementing behavior modification intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

ITS Agency, Regional Center, through the annual quality assurance review and contract reviews when a new professional is

hired.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Transition Services

Provider Category:

Agency

Provider Type:

Program Director (Agency)

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Doctoral PhD or master's level Psychologist licensed in the state of practice or a licensed master's level therapist who holds a license in the state of practice. This may include: LPC, LSW, LCSW, LICSW, or Licensed Behavioral Specialist where accepted with no less than 6 years' experience in the behavioral health field.

These 6 years should be composed of a minimum of two years of experience in a mental health setting; two years working with individuals with intellectual disabilities; and at least two years of program management experience.

An unlicensed masters level staff can be considered with 10 or more years' experience outlined above with approval from the Regional Center that Merakey is Vendorized

Verification of Provider Qualifications

Entity Responsible for Verification:

ITS Agency, Regional Center, through the annual quality assurance review and contract reviews when a new professional is hired.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Transition Services

Provider Category:

Agency

Provider Type:

Intensive Transition Services Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

ITS agency staff include a Board Certified Behavior Analyst (BCBA), Transition Coordinator, Licensed Transition Coordinator, Program Director, and Registered Nurse
The agency shall employ staff who possess the skill, training and education necessary to support individuals with complex service needs during the transition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and at least biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Transition Services

Provider Category:

Agency

Provider Type:

Transition/Care Coordinator (Agency)

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Must have bachelor's degrees in social work, Psychology, or another human service-related field.
No less than three years of experience in the behavioral health field with at least one year of experience in a mental health setting and one year working in a developmental disability setting.

Verification of Provider Qualifications

Entity Responsible for Verification:

ITS Agency, Regional Center, through the annual quality assurance review and contract reviews when a new professional is hired.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Transition Services

Provider Category:

Agency

Provider Type:

Behavior Specialist (Agency)

Provider Qualifications

License *(specify):*

Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification by the Behavior Analyst Certification Board and accredited by the National Commission for Certifying Agencies.

Other Standard *(specify):*

Must demonstrate through the interview process, knowledge and experience working with both individuals who have an intellectual disability as well as a serious mental illness; have knowledge and be certified, in one of the established behavior modification techniques, such as Applied Behavioral Analysis (ABA) or Functional Behavioral Analysis (FBA) as well as have experience with EBP such as CBT and Trauma Informed Care; and have prior experience providing clinical supervision to non-clinical staff

Valid CA Driver's License and appropriate state and federal clearances.

Verification of Provider Qualifications

Entity Responsible for Verification:

ITS Agency, Regional Center, through the annual quality assurance review and contract reviews when a new professional is hired.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

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.

Non-medical 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. Private, specialized transportation will be provided to those individuals who cannot safely access and utilize public transportation services (when available.) Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.
A regional center may offer family members or adult consumers the option to self-direct their own non-medical transportation services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transportation Company: Transportation Broker; Transportation Provider--Additional Component
Agency	Public Transit Authority
Individual	Individual Transportation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Transportation Company: Transportation Broker; Transportation Provider--Additional Component

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Welfare and Institutions Code Section 4648.3

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Public Transit Authority

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Welfare and Institutions Code Section 4648.3

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual Transportation Provider

Provider Qualifications

License *(specify):*

Valid California drivers license

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Welfare and Institutions Code Section 4648.3

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nutritional Consultation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

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.

Nutritional consultation services will not supplant nutritional consultation services available through EPSDT.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dietitian; Nutritionist
Agency	Dietitian; Nutritionist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:

Individual

Provider Type:

Dietitian; Nutritionist

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Dietician: Registered Dietitian by a public or private agency or institution recognized by the State Department of Public Health pursuant to Business and Professions Code § 2585; Valid registration as a member of the American Dietetic Association

Other Standard *(specify):*

Nutritionist must possess a master's degree in one of the following:
a. Food and Nutrition;
b. Dietetics; or
c. Public Health Nutrition;
or is employed as a nutritionist by a county health department.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:

Agency

Provider Type:

Dietitian; Nutritionist

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Dietician: Registered Dietitian by a public or private agency or institution recognized by the State Department of Public Health pursuant to Business and Professions Code § 2585; Valid registration as a member of the American Dietetic Association

Other Standard *(specify):*

Nutritionist must possess a Masters Degree in one of the following:
a. Food and Nutrition;
b. Dietetics; or
c. Public Health Nutrition;
or is employed as a nutritionist by a county health department.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant-Directed Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Participant-Directed Services are services and activities not otherwise provided through this waiver or through the Medicaid state plan that improve and maintain the participant's opportunities for full inclusion in the community, and enable the development of social skills, independence, and personal relationships. Eligible services or activities must promote active participation in the community, address an identified need in the service plan, be documented in the participant's Individual Program Plan, and purchased from the participant's Individual Budget. Participant-Directed Services meet the following requirements: the service or activity would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND, the participant does not have the funds to purchase the service or activity or the service or activity is not available through another source. Experimental or prohibited treatments are excluded. Services and activities that are primarily recreational and diversionary are excluded.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**
- [ ] **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business entity provider of services
Individual	Individual provider of services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant-Directed Services

Provider Category:

Agency

Provider Type:

Business entity provider of services

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

As appropriate and/or required by law for provision of service being provided.

Other Standard *(specify):*

As appropriate and/or required by law for provision of the service being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS will verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant-Directed Services

Provider Category:

Individual

Provider Type:

Individual provider of services

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

As appropriate and/or required by law for provision of the service being provided.

Other Standard *(specify):*

As appropriate and/or required by law for provision of the service being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS will verify that the provider possesses the necessary license and/or certificate and meets other standards as applicable.

Frequency of Verification:

Upon selection and prior to service provision. Annually thereafter through the IPP process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Person-Centered Future Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Person-Centered Future Planning (PCFP) is identified in the Individual Program Plan (IPP) process and is an optional temporary service that provides consultation on the person-centered framework to individuals facing significant barriers to achieving their goals or a significant transition. This service provides future planning consultation to the individual and their support team to enhance the quality of life for the individual using the person-centered framework. Consultation and assistance will be provided to identify and develop their circle of support, evaluate their current living arrangement, including the setting, schedule, and typical daily activities, and develop long-term person-centered goals and outcomes as the individual approaches a transitional stage of life. Additionally, person-centered future planning may include training and technical assistance to the individual and their planning team in the person-centered framework. The planning process will take into consideration actions that require long term planning and decision making and set goals for financial investments, establishing other resources, or investing in training or education that may take longer than one year.

Person-centered planning is available when the individual's needs are complex or they have encountered challenges utilizing existing supports to achieve their goals. The service also provides support in the lead up to major milestone life events that require a heightened level of planning and expertise to navigate.

The plan developed through PCFP will include the results of the evaluation of the individual's system of support and provide recommendations for successfully navigating major life milestones and/or guidance for overcoming barriers to success encountered by the individual. The overall Individual Program Plan documents how the team will work towards the individual's goals, including specific services and supports as necessary, and incorporates recommendations and strategies for overcoming barriers and preparing for upcoming major life milestones.

Person-centered future planning is a short-term service that is not designed to be ongoing but may be needed intermittently when individuals face a significant change or are at times of significant transitional stages of their lives, or when barriers challenge the success of the individual in achieving their long-term goals.

Person-centered future planning does not duplicate activities provided by the TCM provider or regional center service provider or any activities provided under other 1915(i) services. Additionally, this service is limited to additional activities not otherwise covered under the state plan, including EPSDT, and is consistent with 1915(i) benefit objectives. Providers of this service will not provide any other 1915(i) services to the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to 10 hours per milestone event or significant change in status as determined by the planning team. Additional hours may be authorized by the regional center as determined necessary to meet the goals specified in the participant's Individual Program Plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Person-Centered Future Planning
Individual	Person-Centered Future Planner

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Person-Centered Future Planning

Provider Category:

Agency

Provider Type:

Person-Centered Future Planning

Provider Qualifications

License *(specify)*:

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify)*:

N/A

Other Standard *(specify):*

Demonstrated successful completion of a course designed for Person-Centered Thinking or Planning Development. Certification must come from organizations that demonstrate expertise in developing recognized models of person-centered planning, or by meeting the five core competency standards established through the National Center on Advancing Person-Centered Practices and Systems (NCAPPS).
Must also demonstrate knowledge of people with developmental disabilities via:
- Lived experience of a family member or self-advocate; and/or
- Minimum of 5 years of formal paid experience

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Person-Centered Future Planning

Provider Category:

Individual

Provider Type:

Person-Centered Future Planner

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Demonstrated successful completion of a course designed for Person-Centered Thinking or Planning Development. Certification must come from organizations that demonstrate expertise in developing recognized models of person-centered planning, or by meeting the five core competency standards established through the National Center on Advancing Person-Centered Practices and Systems (NCAPPS).
Must also demonstrate knowledge of people with developmental disabilities via:
- Lived experience of a family member or self-advocate; and/or
- Minimum of 5 years of formal paid experience

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

PERS is a 24-hour emergency assistance service which enables the recipient to secure immediate assistance in the event 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;
9. Telephone adaptive devices not available from the telephone company

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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response Systems Provider
Individual	Personal Emergency Response Systems Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Personal Emergency Response Systems Provider

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification / registration as appropriate for the type of system being purchased.

Other Standard *(specify):*

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 manufacturers 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Individual

Provider Type:

Personal Emergency Response Systems Provider

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certification / registration as appropriate for the type of system being purchased.

Other Standard *(specify):*

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 manufacturers 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Remote Support Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Remote support services involve the use of technology and/or equipment to support individuals to live independently and participate in their communities without relying on in-person staff and promotes skill acquisition and maintenance by providing coaching, prompts, supervision, or consultation remotely rather than in-person, as well as building life skills through independent learning via cueing, coaching, and on-call support. The service includes the evaluation and functional assessment of technology available, purchase of equipment, installation and training on equipment usage, and monthly service provision and monitoring. Services are provided in home and community-based settings in a manner that contributes to the individual's independence, health, and well-being while creating environments where individuals feel connected to their communities, and cannot be used for provider convenience. Individuals may receive Remote Supports in their home or while accessing integrated natural community settings in which individuals live, work, learn, conduct personal business, engage in recreational or social activities, and otherwise participate in community life. As necessary, equipment may be taken out of the home to support community access.

The technology equipment in an individual's remote support services plan is monitored and supported by Virtual Support Providers (VSPs) twenty-four hours a day, seven days a week. A VSP is a trained remote support provider such as an agency or qualified provider who provides virtual remote support from a remote location utilizing the remote support technology system that has been designed for the individual. VSPs cannot provide other 1915(c) services. Equipment must allow for two-way real-time communication that allows staff to monitor and respond to an individual's health and safety needs when needed. Individual interaction may be scheduled, on demand, or in response to an alert, determined on the basis of the individual's need and documented in the Individual Program Plan.

Equipment used shall include one or more of the following:
1. Communication and Video Equipment
2. Environmental and Safety Sensors
3. Personal Safety and Alert Devices
4. Smart Home Technology
5. Communication and Computing Devices
6. Health Monitoring Sensors

All equipment needed to provide Remote Support Services is the responsibility of the Virtual Support Providers (VSP) and is only covered under this service. Any equipment that must be purchased in order to deliver the Remote Support Service belongs to the individual receiving the service. Remote Support Services does not cover internet access, landline telephone service, or cellular and/or data plans.

Installation, removal, re-installation, maintenance and repair of equipment is provided by this service. Allowable remote support services also include the evaluation of technology needs of a participant and the training or technical assistance for the individual, or where appropriate their family members to support the provision of remote support services. When Remote Support Services is added to an individual's home, every member of the household must consent to the use of the Remote Support Services devices during the person-centered planning process. The individual can choose an area within the home to video call or video chat with their Remote Support provider for privacy.

The use of Remote Support Services and associated equipment will be determined as part of an individualized assessment, which includes how the individual was given the informed choice between receiving this support through remote supports or

through other in-person services, how the service will meet the individual's needs and how the individual's health and welfare needs will be addressed. Contacts from the VSP may be scheduled, on-demand, or in response to an alert from a device, based on the individual's unique needs and strengths. Regional centers will ensure that the individual and/or their conservator agrees to use remote support services and that everyone living in the home has given informed consent for the use of remote supports. The individual's goals will be written and agreed upon in the person-centered Individual Program Plan (IPP) before purchasing, installing, or using the equipment or services. At the time of IPP development when remote support services has been identified, the planning team will identify a contact list of natural supports that will be included in the individual's IPP plan in case of instances where the individual does not respond to contacts by the VSP within a specified time period for any reason, including when the equipment/technology fails. Additionally, the Remote Support Services providers will maintain emergency operations procedures that outline their operational protocols in the event of an emergency, including weather related emergencies, fires, power outages, active threats, and equipment/technology failures. The provider must have safeguards and backup systems in place for electronic devices in the event of electrical outages or if the electronic device(s) are inoperable or fail.

The individual or their conservator will clearly understand how the remote support technology works, what it monitors, and how to report malfunctions or system inoperability. Individuals are informed of how to operate their technology by the VSP upon receipt of their equipment, including how to turn devices on and off. Individuals will receive initial training in the technology to be used in their home and how to reach out for help if needed when the service is put into place. The individual's planning team must ensure the individual understands any relevant privacy protections, explaining them in plain language or using other communication methods to support their understanding. The VSP will be able to provide technical assistance to the individual as needed.

Only authorized personnel can access the system, and protections will prevent tampering or unauthorized access. The system must have indicators to inform the individual that it is active and in use. Video equipment will only be installed in the home if the individual or their conservator requests it. If the home is shared with others, the equipment will be installed so it does not invade others' privacy. The individual controls the remote device and can turn it on or off as needed. To ensure the individual's privacy, contact through the remote supports equipment will be initiated by the individual and providers will not be able to remotely turn on the remote supports equipment. Remote Support Services cannot be used to purchase video monitors or cameras for bedrooms and bathrooms. Video monitors or cameras cannot record video or audio.
The IPP will include a backup plan for power outages, equipment failures, and emergencies. Any critical actions identified during the assessment will be added to the emergency planning section of the IPP. The individual or their conservator will be informed that remote support services are not intended to replace critical services during life-threatening situations when the power goes out or equipment stops working.

The IPP will also document a plan to send in-person assistance when situations require physical intervention or upon request of the individual. The plan will specify who to contact and what steps to take during these situations. In the event an individual requires on-site assistance, the VSP will first contact the natural supports identified in the individual's IPP to alert them the individual is in need of assistance that cannot be addressed virtually. The VSP will then follow up with the individual within thirty minutes to verify if their need for assistance has been satisfied. If the individual's natural support network contacts are not available, the VSP is responsible for responding to the individual's residence to provide assistance; any required in person supports are provided as a part of this service and included in the monthly rate.

The service plan development process identifies all waiver and non-waiver services and ensures that there is no duplication of those services. Service plans are reviewed and updated no less than annually.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Remote Support Provider
Agency	Remote Support Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Support Services

Provider Category:

Agency

Provider Type:

Remote Support Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Support Services

Provider Category:

Agency

Provider Type:

Remote Support Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Self-Directed Support Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service guides and assists the individual and/or the participant's family or representative, as appropriate, in arranging for, directing, and managing their services. With planning team oversight, providers assist the participant or family in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. In addition, this service provides training on managing an annual budget for service expenditures.

This service is available to consumers who have identified an interest in self-directing some or all their services. Assistance provided to participants and/or their families consists of guidance and advisement in ensuring a thorough understanding of responsibilities involved with self-direction of services, to make informed planning decisions about services and supports through the person-centered planning process, development of their initial budget and spending plan, and appropriate practices of hiring, managing, and communicating with staff. The extent of the assistance furnished to the participant or family is specified in the Individual Program Plan (IPP).

This service does not duplicate, replace, or supplant other waiver services, including case management.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to 40 hours. Additional hours must be reviewed by the Department and may be authorized if deemed necessary to meet the needs of the consumer.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self-Directed Support Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

Other Standard *(specify):*

Completion of training course on the roles and responsibilities of participant directed services and the associated rules, and;

Demonstration of knowledge of people with developmental disabilities via:
Lived experience of a family member or self-advocate; and/or
Minimum of one-year of formal paid experience

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self-Directed Support Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

Other Standard *(specify):*

Completion of training course on the roles and responsibilities of participant directed services and the associated rules, and;

Demonstration of knowledge of people with developmental disabilities via:
Lived experience of a family member or self-advocate; and/or
Minimum of one-year of formal paid experience

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

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.

Skilled nursing services will not supplant skilled nursing services available through EPSDT.

A regional center may offer family members or adult consumers the option to self-direct their own skilled nursing services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nurse Practitioner
Agency	Home Health Agency: RN or LVN
Agency	Registered Nurse (RN)
Agency	Licensed Vocational Nurse (LVN)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Nurse Practitioner

Provider Qualifications

License *(specify):*

Nurse Practitioner: Licensed Nurse Practitioner by the California Board of Registered Nursing pursuant to Business and Professions Code §§2834-2837

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Every 2 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency: RN or LVN

Provider Qualifications

License *(specify):*

Licensed Registered Nurse by the Department of Consumer Affairs the Board of Registered Nursing pursuant to Business and Professions Code, §§ 2725-2742
Licensed Vocational Nurse by the California State Board of Vocational Nursing and Psychiatric Technicians (BPC §2841) pursuant to Business and Professions Code, §§ 2859-2873.7

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Medi-Cal Certification using Medicare standards

Title 22, CCR, §§ 51069-51217.

Other Standard *(specify):*

RN: Policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing pursuant to BPC Sec. 2725 (2)

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse (RN)

Provider Qualifications

License *(specify):*

Licensed Registered Nurse by the Department of Consumer Affairs Board of Registered Nursing pursuant to Business and Professions Code, §§ 2725-2742

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Board of Registered Nursing, Licensing and regional centers

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Licensed Vocational Nurse (LVN)

Provider Qualifications

License *(specify):*

Licensed Vocational Nurse by the California State Board of Vocational Nursing and Psychiatric Technicians (BPC §2841) pursuant to Business and Professions Code, §§ 2859-2873.7

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Board of Vocational Nursing and Psychiatric Technicians, Licensing and regional centers

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address participant functional limitations; and, (e) necessary medical supplies. The repair, maintenance, installation, and training in the care and use, of these items is also included. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the mandatory State plan home health benefit and exclude those items that are not of direct medical or remedial benefit to the participant. 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.

Specialized medical equipment and supplies will not supplant Specialized medical equipment and supplies available through EPSDT.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Dealer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Dealer

Provider Qualifications

License *(specify):*

If applicable, a current license with the State of California as appropriate for the type of equipment or supplies being purchased.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

If applicable, a current certification with the State of California as appropriate for the type of equipment or supplies being purchased.

Other Standard *(specify):*

Be authorized by the manufacturer to install, repair and maintain such systems if such a manufacturers program exists.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition/Set Up Expenses

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Transition/Set Up Expenses are one-time, non-recurring set-up expenses to assist the individual's health and safety needs when transitioning 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:
• 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 occupy and use a community domicile.

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 consecutive 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 these expenses as administrative costs at the administrative FFP rate for services which 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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company Landlord, property management
Individual	Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company Landlord, property management

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition/Set Up Expenses

Provider Category:

Agency

Provider Type:

Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company Landlord, property management

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition/Set Up Expenses

Provider Category:

Individual

Provider Type:

Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company Landlord, property management

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications and Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

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

The following modifications or adaptations are excluded:
1. Adaptations or improvements to the vehicle that are of general utility and are not of direct remedial benefit to the individual; and
2. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of modifications.

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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Modification and Adaptation
Individual	Vehicle Modification and Adaptation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications and Adaptations

Provider Category:
Agency

Provider Type:
Vehicle Modification and Adaptation

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Registration with the California Department of Consumer Affairs, Bureau of Automotive Repairs.

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications and Adaptations

Provider Category:

Individual

Provider Type:

Vehicle Modification and Adaptation

Provider Qualifications

License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*

Registration with the California Department of Consumer Affairs, Bureau of Automotive Repairs.

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and biennially thereafter.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ● **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Regional centers are responsible for providing case management services to waiver participants. Case management includes:
• Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services;
• Development (and periodic revision) of an individual program plan (IPP) that is based on the information collected through the assessment;
• Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services;
• Monitoring and follow-up activities to ensure the IPP is implemented effectively and adequately addresses the consumer's needs.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Behavioral Intervention Services
Day Service
Psychology Services
Speech, Hearing and Language Services
Remote Support Services

1. Will any in-person visits be required?

- ○ **Yes.**
- ● **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☑ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

Services provided via telehealth must be delivered in a way that respects the privacy of the individual, especially in the instances of toileting, dressing, etc. If personal care is needed while telehealth is being provided, the individual and/or person supporting the individual would conduct personal care activities out of the line of sight of the telehealth provider, turn off video/audio communication during that time, or reschedule the telehealth visit. In instances where privacy cannot be secured by the individual, the telehealth provider would pause the telehealth service until confirming it was appropriate to resume.

☑ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

Providing the service via telehealth must not prevent the facilitation of community integration as defined under Final Regulation CMS-2249-F/CMS-2296-F. Remotely delivered services can be provided to multiple individuals at one time (without sharing private health information), which presents individuals the opportunity to interact with others, while receiving services in their preferred delivery method.

☑ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

Providing the service via telehealth must not impede, replace, or prevent the successful delivery of HCBS for individuals who need hands-on assistance/physical assistance. The goal of using technology is not to replace human assistance, but to increase access to care and maximize the use of technology to support people where appropriate.

☑ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

Support must be provided to individuals who need assistance with using the technology required for the delivery of the HCBS via telehealth. The individual's person-centered planning team is responsible for determining the extent of training necessary for the individual to access their services remotely. If needed, this training would be provided by those individuals already supporting the waiver participant where they live, including existing providers of residential services or other services that support community inclusion, as well as natural supports and generic resources as identified by the planning team. Family members may also be eligible for training, as appropriate, to support the provision of services if determined to be beneficial for the participant.

☑ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

Service coordinators follow up regularly with all individuals served to check in regarding whether they are receiving services identified in the IPP and whether they are making progress. These check-ins include an assessment of the individual's health and safety. Service coordinators follow up with all individuals served through face-to-face monitoring at least annually to evaluate individuals' ongoing health and safety, with individuals living in out-of-home placements receiving quarterly face-to-face visits.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal

history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ● **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The types of positions requiring fingerprint clearance:

1. All staff persons, employees or volunteers who have contact with consumers in community care facilities licensed by the Department of Social Services.
a. Any person other than a consumer residing in the facility.
b. Adults responsible for administration or direct supervision of staff.
c. If the applicant is a firm, partnership, association, or corporation, the chief executive officer or other person serving in like capacity.
d. Additional officers of the governing body of the applicant, or other persons with a financial interest in the applicant.

Caregiver background checks are conducted by the California Department of Justice and are maintained by the Department of Social Services (DSS)/Community Care Licensing Division (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 California 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. Also, DSS/CCL can take administrative action against an individual associated with a licensed facility when there is an allegation of rights violations that involve abuse. Based on a preponderance of evidence in this situation, an individual could be excluded from working in a licensed facility. DSS maintains a database of excluded individuals which is checked, in addition to the DOJ and FBI criminal history checks, as part of the screening process. Per statute, DSS is required to conduct reviews of facilities. Included in these reviews are verification that personnel records contain criminal record clearances.

Further, various professions licensed under the provisions of the California Business and Professions Code must undergo a criminal record review as a condition of licensure and license renewal. Under this waiver, licensed individuals may provide services including skilled nursing and behavior intervention services. Criminal record reviews are performed by the California Department of Justice. The regional center verifies that licensed individuals selected by the participant are properly licensed.

As specified in 42 CFR 455.450, criminal history and/or background checks are conducted as a condition for the provision of services and are verified by regional centers.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ● **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The California Department of Justice maintains the Child Abuse Central Index and conducts screening against the registry.

Background checks are required to include a check with the Child Abuse Central Index for the following individuals who are associated with children's facilities:

1. All staff persons, employees or volunteers who have contact with consumers in community care facilities licensed by the Department of Social Services.
a. Any person other than a consumer residing in the facility.
b. Adults responsible for administration or direct supervision of staff.
c. If the applicant is a firm, partnership, association, or corporation, the chief executive officer or other person serving in like capacity.
d. Additional officers of the governing body of the applicant, or other persons with a financial interest in the applicant.

As noted in section C-2-a, Department of Social Services is required to conduct reviews of licensed facilities. Included in these reviews are verification that personnel records contain all required clearances and screenings.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ● **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for*

which payment may be made to legally responsible individuals under the state policies specified here.

Legally responsible individuals, including parents of minor children and spouses, may receive payment to provide community living arrangement services. These services may only be provided when the care and supervision needs of a consumer exceed that of a person of the same age without developmental disabilities (extraordinary care).

As part of the person-centered service planning process, the planning team reviews the unique needs and strengths of the individual and determines services necessary to meet their best interest. The regional center service coordinator is responsible for following up to confirm individuals are receiving services as identified in the IPP and that these services continue to meet the needs of the individual as identified in the person-centered service plan.

Individuals having services provided by LRI also work with a Financial Management Service (FMS) that reviews and processes timesheets, and maintains all source documentation related to the authorized service and expenditures to verify that payments are only being made for provided services. As noted above the service coordinator regularly follows up with the individual on the provision of services; other quality controls include regional center audits of providers, state fiscal audits of regional centers and service providers, and programmatic monitoring visits completed by the state.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  Relatives/legal guardians may provide any waiver service as long as the relative/legal guardians possesses the skill, training and/or education to provide the service and that the individual meets the provider qualifications specified for that service. Relatives/legal guardians are required to complete the same vendorization requirements that all providers must adhere to, as well as being subject to the monitoring requirements for the specified service.

- **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

The vendorization process, including provider qualifications, is referenced in the California Code of Regulations, Title 17, Division 2, Chapter 3, Subchapter 2. All applicants who meet the required provider qualifications are eligible to provide waiver services. Information on the vendorization process and provider qualifications is continuously available via the internet at https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of providers licensed by the Department of Social Services (DSS) that initially and continually meet all required licensure standards. Numerator = number of DSS licensed providers that initially and continually meet all required licensure standards. Denominator = total number of providers licensed by DSS

Data Source (Select one):
Other
If 'Other' is selected, specify:
Facilities Automated System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Department of Social Services (DSS)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Department of Social Services (DSS)	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: DHCS, DSS and DDS meet quarterly to review issues concerning DSS licensed facilities

Performance Measure:
Number and percent of licensed/certified providers that initially and continually meet all required standards prior to furnishing waiver services. Numerator = number of licensed/certified providers that initially and continually meet all required standards prior to furnishing waiver services; denominator = number of all licensed/certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Vendor Master File records indicate regional center verification of provider qualifications

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional Centers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of non-licensed/non-certified providers that initially and continually meet all required standards prior to furnishing waiver services. Numerator = number of non-licensed/non-certified providers that initially and continually meet all required standards prior to furnishing waiver services; denominator = number of all non-licensed/non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Vendor Master File records indicate regional center verification of provider qualifications

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional Centers	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of direct support professionals (DSPs) that successfully complete 70 hours of competency based training within two years of hire. Numerator = number of DSPs who successfully complete the competency-based training; denominator = number of DSPs who are required to complete the competency-based training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSP Training Program Annual Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual issues identified during the State's Biennial on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the State's recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the State's recommendations and corrective actions taken, are issued to the regional centers and forwarded to CMS.

All deficiencies noted during DSS inspections of licensed facilities result in the development of a plan of correction. All plans of correction require follow-up, which may include a repeat inspection, to ensure the plan was successfully completed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify:	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Regional Centers, DSS	
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

In addition to private residences, the following are setting types where individuals will receive Home and Community-Based Services under this 1915(c) waiver:
- Adult Day Program
- Adult Family Home/Family Teaching Home
- Child Day Care Facility: Child Day Care Center; Family Child Care Home
- Day Type Services (Activity Center, Adult Day Care Facility, Adult Development Center, Behavior management program and socialization training program)
- Supported Employment (Group Services)
- Work Activity Program
- Adult Residential Facility; Adult Residential Facility for Persons with Special Health care Needs; Group Homes for Children with Special Health Care Needs; Residential Care Facility for the Elderly; Group Homes; Small Family Homes; Enhanced Behavior Supports Home; Community Crisis Homes
- Certified Family Home; Foster Family Home
- Community-Based Adult Services (Adult Day Health Care Facility)

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

The Department of Developmental Services (DDS) and the Department of Health care Services (DHCS) conducted site assessments and desk reviews as a part of the state's systemic assessment process to determine compliance with all of the HCBS settings requirements. Individuals were also surveyed to obtain their input regarding the home and community-based services they receive in the above settings; these surveys included questions reflecting all aspects of the HCBS settings criteria. To address necessary changes, remediation plans for providers were created based on the outcomes of assessments, desk reviews, and interviews - DDS, working alongside the regional centers, reviewed these plans and followed up as needed to support providers in meeting compliance. As part of ongoing monitoring, the state has processes in place to monitor ongoing compliance with the settings criteria across all services, including services provided in settings presumed to be compliant. The regional centers' ongoing and annual review of providers will include an evaluation of settings to verify they continue to comply with HCBS Settings requirements. Additionally, biennial on-site monitoring is completed jointly by DHCS and DDS. The state is incorporating all elements of the HCBS Settings Requirements into the existing monitoring procedures, with a focus on obtaining information from individuals served about their experiences, in addition to onsite observations, provider and staff interviews, and documentation reviews.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☑ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***
- ☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☑ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☑ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ● **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☑ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☑ **Each individual has privacy in their sleeping or living unit:**
    - ☑ **Units have entrance doors lockable by the individual.**
    - ☑ **Only appropriate staff have keys to unit entrance doors.**
    - ☑ **Individuals sharing units have a choice of roommates in that setting.**
    - ☑ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**
  - ☑ **Individuals have the freedom and support to control their own schedules and activities.**

☑ **Individuals have access to food at any time.**

☑ **Individuals are able to have visitors of their choosing at any time.**

☑ **The setting is physically accessible to the individual.**

☑ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application)*.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Program Plan (IPP)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

● **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct**

waiver services to the participant. ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) The service plan, commonly referred to as the individual program plan (IPP), 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. Each individual is paired with a case manager to assist in the IPP development.

Information available for supporting recipients in the IPP process includes but is not limited to the following documents, all of which are available using the links below or through the DDS website at www.dds.ca.gov:

1. "Individual Program Plan Resource Manual" - This resource manual is designed to facilitate the adoption of the values that lead to person-centered individual program planning. It is intended for use by all those who participate in person-centered planning. It was developed with extensive input from service recipients, families, advocates and providers of service and support: https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_IPPManualFull_20190304.pdf

2. "Person Centered Planning" - This publication consists of excerpts taken from the Individual Program Plan Resource Manual to provide recipients and their families information regarding person-centered planning: https://www.dds.ca.gov/wp-content/uploads/2019/03/Publications_PersonCtdPlanning_20190319.pdf

3. "From Conversations to Actions Using the IPP" - This booklet shares the real life stories of how recipients can set their goals and objectives and work through the IPP process to achieve them: https://www.dds.ca.gov/wp-content/uploads/2020/07/CAC_IPP_2004.pdf

4. "From Process to Action: Making Person-Centered Planning Work" -This guide provides a quick look at questions that can help a planning team move the individual program plan from process to action focusing on the person and the person's dreams for a preferred future: https://www.dds.ca.gov/wp-content/uploads/2019/03/Publications_FromProcesstoAction_20190318.pdf

b) The IPP planning team, at a minimum, consists of the recipient 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 recipient/conservator, other individuals, may receive notice of the meeting and participate.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The IPP is developed through a person-centered process of individualized needs determination with active participation by the individual/representative in the plan development and takes into account the individual's needs and preferences. Person-centered planning is an approach to determining, planning for, and working toward the preferred future of the individual and her or his family. In this approach to planning that is focused on the individual, other members of the planning team adopt the role of consultants or advisors who help the individual achieve their preferred future. Decisions regarding the goals, services and supports included in the IPP are driven by the individual. The IPP is prepared jointly by the planning team which at a minimum, consists of the HCBS Waiver recipient (consumer) and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and the regional center case manager. With the consent of the consumer/conservator, other individuals, including service providers, may receive notice of the meeting and participate in the development of the IPP.

The IPP development process includes gathering information and conducting assessments (ex. the Client Development Evaluation Report or CDER) to determine the life goals, capabilities and strengths, preferences, barriers, and concerns or problems of the consumer. For children, this process includes a review of the strengths, preferences, and needs of the child and the family unit as a whole. Assessments are conducted to identify potential health, behavioral or safety risks that may require the development of mitigation strategies. Information is obtained from the consumer, his or her parents and other family members, his or her friends, advocates, providers of services and supports, and other agencies. The assessment process reflects awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and the family.

Utilizing information obtained during the assessment process, the IPP is prepared jointly by the planning team. Decisions regarding goals, objectives, needed services and providers of services are made with the agreement of the planning team. The goals included in the IPP, and objectives to implement those goals, are based on the consumer's needs, preferences and life choices. During the IPP meeting, consumers are informed of services available to them that could be options to meet their needs or choices. As changes arise, consumers are given information regarding services available to meet the change in need or choice. The IPP must also include a schedule of all services purchased by the regional center or obtained from generic resources. The receipt of these services is coordinated during the planning process to ensure any needed services available through generic resources are provided prior to accessing available waiver services.

The IPP must be reviewed (at least annually) and modified by the planning team when necessary. The annual review of the IPP will often include the development of a new IPP. In some cases, a new IPP is completed biennially or triennially. If a new IPP is not completed annually, case managers will continue to use the DDS "Standardized Annual Review" form to document the annual review of the consumer's IPP, CDER and health status. Annually, and as changes arise, consumers are given information regarding services available to meet that change in need or choice. This allows the consumer and the planning team to choose services and supports to meet the changing need or choice. 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. Regardless of the planned schedule for review and modification of the IPP, a review of the IPP can be requested at any time and will be modified in response to the consumer's needs upon agreement of the planning team. Further information on monitoring the implementation of the service plan is contained in Appendix D-2(a).

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**

- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As noted above, the IPP person-centered planning process includes an assessment of risk and identification of mitigation strategies as necessary. With input from the State's independent risk management contractor, DDS distributed a tool that can be used to aid the IPP planning team in identifying risk factors and developing interventions to minimize risks. Individual risk and safety considerations are identified during the person-centered planning process. Potential interventions that promote independence and safety with the informed involvement of the participant are included in the IPP when the planning team agrees that it is an identified need.

For consumers that are supported in their own residence, services are available to assist in responding to emergencies or other unusual situations. Available services include 24-hour emergency assistance, such as direct service in response to calls for assistance. Additionally, support to become aware of and effectively use the police, fire, and emergency help available in the community is available. Services may also include assisting and facilitating the consumer's efforts to acquire, use, and maintain devices needed to summon immediate assistance when threats to health, safety, and well-being occur. The IPP planning team makes decisions regarding which, if any, of these services will be included in the IPP based on the consumer's needs and preferences.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The case manager informs the consumer and/or his or her legal representative of qualified providers of services determined necessary through the IPP planning process. Consumers may meet with qualified providers prior to the final decision regarding providers to be identified in the service plan. The consumer's choice of providers includes consideration of, among other things, the provider's ability to deliver quality services or supports that can accomplish all or part of the person's program plan and the provider's success in achieving the objectives set forth in the consumer's IPP. Information regarding providers, including the name, type of service, and contact information, is required to be posted on regional center websites.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

As part of the State's Biennial on-site HCBS Waiver Monitoring Reviews, DHCS in conjunction with DDS reviews a random, representative sample of consumer IPPs to ensure all service plan requirements have been met.

As described in appendix A.6 of this application, the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews consist of a variety of activities that include verification of a statistically valid random sample of consumer IPPs. Please refer to Appendix A-6 for more detail.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Regional Centers

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Regional center case managers are responsible for monitoring the implementation of all consumer IPPs, including those consumers with changing needs. At least annually (or more frequently as needed), all IPPs are reviewed to determine that planned services have been provided, that sufficient progress has been made on the consumers' goals and objectives, and that consumers and families are satisfied with the individual program plan and its implementation. IPP monitoring conducted by regional center case managers consists of a review of the consumer's overall health status, to include noted concerns and need for referral to clinicians or other health resources. Additionally, case managers review current services and supports, as well as the effectiveness of back-up plans, to determine if changes are necessary and if the IPP remains responsive to consumer needs and choice. For those consumers that reside in out-of-home settings (e.g., residential community care facilities, adult family homes, supported or independent living settings), this review of the IPP is completed during quarterly, face-to-face visits.

Further, as part of the State's Biennial on-site HCBS Waiver Monitoring Reviews, DHCS in conjunction with DDS reviews a random, representative sample of consumer IPPs to ensure IPP implementation monitoring is being completed. Service providers that furnish services to all consumers, including those with changing needs, are required to report special incidents to the regional center within 24 hours. In turn, the regional center is obligated to submit SIRs to DDS within two working days of as mandated by Title 17 54327.1.

Regional centers are responsible for evaluating, tracking and providing remediation to maintain the health and safety of all consumers. If the State's on-site review identifies an unaddressed issue or non-remediation of an issue, it would result in a recommendation made to the regional center towards compliance in this area. DDS and DHCS request a regional center response within 30 days of receipt of the recommendation.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of consumer IPPs that addressed all of the consumer's goals. Numerator = number of consumer IPPs reviewed that addressed all of the consumers' goals. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify:	

	On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumers/parents who are satisfied with the services received. Numerator = number of positive responses. Denominator = total number of interviews conducted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Interviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other**	

	Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of reviewed individual program plans (IPPs) that adequately addressed all of the consumers' assessed needs. Numerator = number of consumer IPPs reviewed that addressed all assessed needs. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumer IPPs that addressed all of the consumer's identified health needs and safety risks. Numerator = number of consumer IPPs reviewed that addressed all of the consumers' identified health needs and safety risks. Denominator = total number of consumer IPPs reviewed that identified health needs and safety risks.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring

Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of consumer IPPs developed in accordance with State policies and procedures. Numerator = number of consumer IPPs developed in accordance with State policies and procedures. Denominator=total number of IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level.
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group:

		The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Reviews are conducted at each regional center (RC) every two years. Focused follow up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of consumer IPPs that were revised, when needed, to address changing needs. Numerator = number of consumer IPPs that were revised to address change in consumer needs. Denominator = number of consumer records reviewed that indicated a revision to the IPP was necessary to address changing needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample**

		Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify:	

	On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumer IPPs that were reviewed or revised at required intervals (at least annually). Numerator = number of consumer IPPs that were reviewed or revised at required intervals. Denominator = total number of IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants who received services, including the type, scope, amount, duration and frequency, specifically identified in the IPP. Numerator = number of consumers who received services that matched the services identified in the IPP. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group:

		The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of IPPs that that are signed by the consumer/parent/legal representative indicating agreement with the services and providers identified in the IPP. Numerator = number of IPPs that are signed by the consumer/parent/legal representative indicating agreement with services and providers. Denominator = total number of IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence

		Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify:	

	On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual issues identified during the State's Biennial on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the State's recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the State's recommendations and corrective actions taken, are issued to the regional centers and forwarded to CMS.

Remediation plans for individual issues typically involve technical corrections to the IPP (e.g. obtaining a consumer signature or clarification of wording to reflect the agreed upon services that are being provided.) When indicated, a planning

team meeting (at minimum includes the consumer and regional center representative) is held to discuss and obtain agreement on necessary modifications to the IPP.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ● **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ● **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take

advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

In support of personal control over supports and services, self-direction is an option that enables participants to procure their own services. Self-direction of services empowers participants and families by giving them direct control over how and when the services are provided. Families and consumers will have the freedom to directly control and decision making authority over how and when the services are provided as an alternative to receiving services provided by staff hired by an authorized agency through the regional center.

For those participants who receive respite, self-directed support services, family support services, skilled nursing, non-medical transportation, supported employment, day service, community living arrangement services and/or community-based training services identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. As required by Title 17, CCR section 58886, when the decision to self-direct the above services is made, the regional center is required to provide the consumer/family member with information regarding their responsibilities and functions as either an employer or co-employer. For participants who receive participant-directed services, the individual will utilize budget authority to self-direct this service. The amount of the budget is determined by and agreed upon by all members of the planning team.

For those selecting to self-direct the indicated services, a Financial Management Service (FMS) provider, vendored by the regional center, will perform selected administrative functions such as payroll, taxes, unemployment insurance, etc. This relieves the participant of the burden of these administrative functions while still having the freedom to exercise decision making authority over the provision of services.

Additionally, Self-Directed Support Services are able to provide guidance and advisement in ensuring a thorough understanding of responsibilities involved with self-direction of services. The purpose is to set consumers up for success in directing their services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ● **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☐ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☑ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Participants who live in their own private residence or the home of a family member can participant direct their services. Participants who live in a community living arrangement (as defined in appendix C1/C3) can participant direct the following services:

- Non-medical transportation
- Community-Based Training Services
- Supported Employment
- Day Services
- Participant-Directed Services
- Self-Directed Support Services
- Community Living Arrangement services

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

During the IPP planning team meeting, the regional center case manager is responsible for informing the waiver participant of their choice of agency providers or to self-direct for respite, family support services, non-medical transportation, community-based training services, supported employment, day services, participant-directed services, community living arrangement services and/or skilled nursing services. The case manager will provide participants with information and requirements of this choice as required by Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer or co-employer, requirements regarding the use of a financial management service, etc.). This information is provided so the participant can make an informed decision about choosing agency or self-directed method of service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a

representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ● **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Consumers (or their authorized, legal representative) have the opportunity to choose who may assist them in self-directing respite, family support services, non-medical transportation, community-based training services, supported employment, day services, participant-directed services, community living arrangement services and/or skilled nursing services. However, the same requirements as specified in Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer or co-employer, requirements regarding the use of a financial management service, etc.) apply. Further, all FMS providers must be vendorized by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326 (e.g. submission of required applicant identifying information, records maintenance requirements, etc.); and regional centers will ensure that FMS providers and providers of all self-directed services meet applicable laws ongoing and thereafter through oversight and monitoring activities.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Day Service	☑	☐
Participant-Directed Services	☐	☑
Skilled Nursing	☑	☐
Community Living Arrangement Services	☑	☐
Self-Directed Support Services	☑	☐
Family Support Services	☑	☐
Respite Care	☑	☐
Supported Employment	☑	☐
Community-Based Training Service	☑	☐
Non-Medical Transportation	☑	☐
Financial Management Service	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- (●) **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - [ ] **Governmental entities**
  - [x] **Private entities**

- ( ) **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- (●) **FMS are covered as the waiver service specified in Appendix C-1/C-3**

  The waiver service entitled:

  Financial Management Services

- ( ) **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The adult consumer or family member utilizing participant-directed services can act as a common law employer or a co-employer.

An FMS is an entity that functions as the adult consumers agent or family members agent in performing selected duties as follows:
• Fiscal Employer/Agent: An FE/A ensures that Federal, state and local employment taxes and labor and workers compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner and that services are paid for appropriately and in a timely manner;
• Co-employer: When the individual is a co-employer, the FMS ensures that the necessary employer-related duties and tasks, including payroll, are carried out.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers are paid a flat rate set by the State.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

• Track, prepare, and distribute reports (e.g., expenditure) to appropriate individual(s)/entities.
• Maintain all source documentation related to the authorized service(s) and expenditures.
• Maintain a separate accounting for each participant's participant-directed funds.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [ ] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

FMS providers are subject to periodic random audits by both regional centers and DDS. Additionally, specified providers pursuant to State law must obtain an independent audit or review or their financial statements annually. The results and accompanying management letters must be forwarded to the appropriate regional center. Subsequently, the regional center must require resolution of issues identified in the reports and notify DDS of all qualified opinion reports or reports noting significant issues that directly or indirectly impact regional center services. Further, a sample of claims at each regional center is reviewed as part of the biennial regional center audits conducted by DDS and reviewed by DHCS.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services,

participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

As noted in appendix E-1(e), regional center case managers are responsible for informing the waiver participant of their choice of agency providers or to self-direct for respite, family support services, non-medical transportation, community-based training service, supported employment, day service, participant-directed services, community living arrangement services and/or skilled nursing services. The case manager will provide participants with information and requirements of this choice as required by Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer of co-employer, requirements regarding the use of a financial management service (FMS), etc.)

☑ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Day Service	☐
Participant-Directed Services	☐
Person-Centered Future Planning	☐
Skilled Nursing	☐
Homemaker	☐
Dental Services	☐
Communication Aides	☐
Vehicle Modifications and Adaptations	☐
Community Living Arrangement Services	☐
Self-Directed Support Services	☑
Personal Emergency Response Systems (PERS)	☐
Family/ Consumer Training	☐
Specialized Medical Equipment and Supplies	☐
Occupational Therapy	☐
Prevocational Services	☐
Family Support Services	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Housing Access Services	☐
Respite Care	☐
Transition/Set Up Expenses	☐
Environmental Accessibility Adaptations	☐
Supported Employment	☐
Community-Based Training Service	☐
Physical Therapy	☐
Community Based Adult Services	☐
Coordinated Family Supports	☐
Behavioral Intervention Services	☐
Prescription Lenses and Frames	☐
Remote Support Services	☐
Non-Medical Transportation	☐
Financial Management Service	☐
Intensive Transition Services	☐
Optometric/Optician Services	☐
Speech, Hearing and Language Services	☐
Home Health Aide	☐
Nutritional Consultation	☐
Chore Services	☐
Psychology Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Participants are able to switch to non-participant directed services at any time. A planning team meeting is held to update the IPP, and the case manager facilitates the transition and assures no break in service.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participant direction of services may be involuntarily terminated when the regional center determines the individual's health and safety is not being supported or when the delivery of services cannot be verified. When there is a disagreement with a change in service delivery, the individual is provided with a Notice of Proposed Action and notified of their Fair Hearing rights. Regardless of the reason for termination of participant-direction, a planning team meeting is held to update the individual program plan and facilitate the transition from participant-direction to prevent a break in service.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		12700
Year 2		14800

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 3		15300
Year 4		15800
Year 5		16300

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

FMS Co-Employer (a.k.a. agency with choice) entities function as legal employers in collaboration with family members or adult consumers, acting as Co-Employers. As required by CCR, Title 17 §58884, the family member or adult consumer, acting as the Co-Employer, makes recommendations to the Financial Management Services Co-Employer on who to hire to provide Participant-Directed Services. The FMS Co-Employer must possess the ability to collect and process employee time records, assist family members or adult consumers, acting Co-Employers, in verifying the worker's eligibility for employment, process payroll, withholding, filing and payment of applicable federal, state and local employment related taxes and insurance, prepare and distribute monthly expenditure reports to the Co-Employer and the regional center; maintain all source documentation related to the authorized service(s) and expenditures, maintain separate accounting of funds used for each adult consumer or family member, and ensure payments do not exceed the amounts and rates authorized.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**

☑ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☑ **Hire staff common law employer**

☑ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

No variation from Appendix C-2-a.

☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☑ **Schedule staff**

☑ **Orient and instruct staff in duties**

☑ **Supervise staff**

☑ **Evaluate staff performance**

☑ **Verify time worked by staff and approve time sheets**

☑ **Discharge staff (common law employer)**

☑ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☑ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☑ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☑ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☑ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individual budget is based on the estimated amounts that are authorized in the service plan for Participant-Directed Services. The authorized amount is determined by the IPP team, through a person-centered planning process and demonstrated assessed need. This process is applied to each participant who has elected to receive Participant-Directed Services.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual is informed of the budget amount during the IPP development process. The budget amount is documented in the IPP and signed by all members of the planning team and the participant receives a copy. The budget amount can be adjusted, up or down, if the IPP team determines that the participant's needs have changed. As described in Appendix F, participants are afforded the opportunity to request a fair hearing when the participant's request for a budget adjustment is denied or the amount of the budget is reduced.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS provides the participant and the regional center service coordinator with a monthly individual budget statement that describes the amount of funds allocated to participant directed services, the amount spent in the previous 30- day period and the amount of funding that remains available under the participant's individual budget. These budget statements can be used to help identify potential issues that may require a review or modification to either the individual budget or individual program plan.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request 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 specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

As required by the State Medicaid Manual (SMM) §2900.1, DD waiver recipients are afforded the right to a fair hearing if there is a disagreement with any actions taken by the regional center including the following: denial of eligibility, termination or reduction in services, denial of choice of services, denial of chosen provider, or disagreement with the amount of service. Pursuant to 42 CFR 431.206 and SMM §2900.2, information (in 12 different languages) regarding the fair hearing process, including related forms and a brochure describing the process, are available at https://www.dds.ca.gov/general/appeals-complaints-comments/fair-hearings-complaint-process/. Regional centers provide information to individuals and their families on the process and rights of appeals and complaints at intake as well as during the IPP process. Additionally, this information is provided to every recipient in a notice whenever any of the events described previously occur. Participants have access to fair hearing brochures, notification of resolution, and fair hearing request forms through their regional center and are available on the DDS' website at www.dds.ca.gov. Regional centers and vendors that contract with a regional center to provide services to recipients are required to noticeably post on their websites, if any, a link to the DDS website page that provides a description of the appeals procedure, and a DDS telephone number for recipients and applicants who have questions about the appeals procedure.

When stopping or reducing services, a Notice of Proposed Action is provided to individuals, and specifies that services will not be terminated or reduced if a fair hearing is requested (as required by 42 CFR 431.230). If a recipient or authorized representative requests a fair hearing, a number of options are available to resolve the disagreement. The recipient or authorized representative may request a voluntary, informal meeting with the regional center, or mediation. Consistent with SMM §2902.1 and Welfare and Institutions Code (WIC) §4710.5(a), these steps are optional and do not take the place of the State level fair hearing. The recipient or authorized representative may choose to go straight to the fair hearing or may choose to try resolution at either an informal meeting or mediation. Even if the recipient initially chooses one of these two options, they may at any time choose to proceed to the fair hearing.
Fair hearings are conducted by independent hearing officers with the State's Office of Administrative Hearings (OAH.) Pursuant to WIC §4712.7, and consistent with SMM §2903.5, the Director of DHCS, the State Medicaid Agency, has delegated the authority to adopt final decisions to the Director of OAH. Fair hearing decisions and files are maintained at the Office of Administrative Hearings. DDS is copied on all final documentation.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register**

grievances or complaints concerning the provision of services under this waiver

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

DDS

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Pursuant to the California Welfare and Institutions Code, § 4731, a participant may pursue a Consumer Complaint against a regional center or service provider. The Consumer Complaint Process is the procedure to use if you believe that the regional center or a provider has violated or improperly withheld a right to which you are entitled under the law. Under this process, you are asking that the regional center or provider change its procedures for dealing with you and others in the future.

The initial referral of the complaint shall be to the Executive Director of the regional center. Upon receipt of the complaint, the Executive Director has 20 working days to investigate the matter and send a written proposed resolution to the participant or authorized representative. If the participant or authorized representative is not satisfied with the proposed resolution, the participant or authorized representative shall refer the matter in writing to the Director of the DDS within 15 working days of receipt of the proposed resolution. The Director shall, within 45 days of receiving the complaint, issue a written administrative decision, and send a copy of the decision to the participant and Executive Director of the regional center.

All participants are informed that filing a grievance or making a complaint is not a pre-requisite or substitute for Fair Hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS has promulgated regulations that describe special incident reporting (SIR) requirements and define the incident types that require a SIR, including:

• The participant is missing, and a missing person's report has been filed with a law enforcement agency.
• Reasonably suspected abuse/exploitation including physical, sexual, fiduciary, emotional/mental, or physical/chemical restraint.
• Reasonably suspected neglect including failure to provide medical care for physical and mental health needs, prevent malnutrition or dehydration, protect from health and safety hazards, assist in personal hygiene or the provision of food, clothing or shelter or exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult.
• A serious injury/accident including lacerations requiring sutures or staples, puncture wounds requiring medical treatment beyond first aid, fractures; dislocations, bites that break the skin and require medical treatment beyond first aid, internal bleeding requiring medical treatment beyond first aid, any medication errors, medication reactions that require medical treatment beyond first aid, or burns that require medical treatment beyond first aid.
• Any unplanned or unscheduled hospitalization due to the following conditions: respiratory illness, including but not limited, to asthma, tuberculosis, and chronic obstructive pulmonary disease; seizure-related; cardiac-related, including but not limited to, congestive heart failure, hypertension, and angina; internal infections, including but not limited to, ear, nose and throat, GI, kidney, dental, pelvic, or urinary tract; diabetes, including diabetes-related complications; wound/skin care, including but not limited to, cellulitis and decubitus; nutritional deficiencies, including but not limited to, anemia and dehydration; or involuntary psychiatric admission; unplanned hospitalizations.
• Deaths, regardless of cause.
• The consumer is a victim of a crime including the following: robbery, including theft using a firearm, knife, or cutting instrument or other dangerous weapons or methods which force or threaten a victim; aggravated assault, including a physical attack on a victim using hands, fist, feet or a firearm, knife or cutting instrument or other dangerous weapon; larceny, including the unlawful taking, carrying, leading, or riding away of property, except for motor vehicles, from the possession or constructive possession of another person; burglary, including forcible entry; unlawful non-forcible entry; and, attempted forcible entry of a structure to commit a felony or theft therein; or rape, including rape and attempts to commit rape.

Qualified providers that furnish services to all regional center consumers, regardless if the consumer is on the waiver, are required to report a SIR to the regional center within 24 hours after learning of the incident occurrence. The initial report may be by telephone; however, a written report with specified information (as outlined in California Code of Regulations (CCR) Title 17 § 54327) must be submitted to the regional center within 48 hours of learning of the incident occurrence. Regional centers, in turn, are mandated by CCR Title 17, §54327.1 to submit SIRs (via the State's electronic SIR system) to DDS within two working days following initial receipt of the incident report or within two working days of learning of the incident and then must provide a final report to DDS within 30 days.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DDS has overall state-level responsibility for planning, coordinating and overseeing implementation of the State's risk mitigation and management system for persons with developmental disabilities, of which training and education is a component.

Both DDS and the State's independent risk management contractor provide regional centers and/or qualified providers training and technical assistance on the legal obligations in abuse reporting; SIR documentation requirements; the definition of special incident; best practices for identifying consumer abuse; using and maintaining the automated SIR system; risk assessment; and proactive risk assessment and prevention planning through the individualized program planning process. This training and education to regional center staff and providers enables these entities to adequately disseminate training and education materials to consumers/families on abuse, risk assessment and mitigation.

Further, regional centers, pursuant to CCR, Title 17 §54327.2, must have a risk management and mitigation plan that addresses training for various parties mentioned above that is monitored by an internal risk management, assessment and planning committee.

Regional centers make information available to caregivers and participants on regional center and DDS websites, through social media outreach, and hard copies.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Regional centers receive the initial SIR from appropriate entities and in turn report the SIR to DDS. As appropriate, licensing and/or protective services entities are notified by the regional center. The timelines for initial SIR reporting are outlined in G-1-b.

SIR Evaluation, Examination and Follow-up

Regional centers have local-level responsibility for evaluation, examination and follow-up of SIRs. Regional centers are required to report special incidents and follow-up activities to DDS via the electronic SIR system. Regional centers are required to pursue follow-up activities until there is a satisfactory resolution of the immediate issue and mitigation of future risk to participants. Upon receipt of the special incident report, the regional center:

1. Reviews the incident report, ensures participant's safety and contacts the participant's authorized representative, as appropriate.
2. Reports the incident to investigative/protective services agencies, as appropriate.
3. Enters the initial information into special incident reporting system within two working days of learning of the incident.
4. Engages in activities to protect the participant's health and welfare and to prevent future incidents.
5. Records medical and other health related care received by the participant for his/her significant medical conditions in the period prior to the special incident.
6. Reviews medical records and coroner reports to ensure appropriate medical attention was sought and/or given.
7. Coordinates 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.
8. Conducts on-site and chart review activities to gather and report initial and follow-up SIR information.
9. Adds required information to the initial SIR within 30 working days following initial report and updates SIR on a flow basis.
10. Closes the SIR when all required information and all follow-up activities are completed and entered into the electronic reporting system.

DDS Report Review and Evaluation Process DDS has state-level responsibility for evaluation and follow-up of SIR reports; DDS evaluates and follows up on special incidents by:
1. Daily review of SIR transmissions to ensure regulatory compliance and proper notifications have been made to legally required entities, and that appropriate follow-up activities are occurring. Immediate follow-up with regional centers is conducted, as needed, to ensure consumer health and safety has been assured.
2. Aggregating and analyzing SIR data by certain characteristics (i.e., regional centers, providers, incident types, residence and other relevant factors) on an ad-hoc basis.
3. Providing input to the State's independent risk management contractor for further analysis and to regional centers for follow-up as appropriate.

Regional centers are required to report additional information to DDS within 30 days of receiving the SIR, but this timeframe does not apply a requirement that the investigation must be completed by that time. The requirement is that the regional center must add information on a flow basis and close the SIR when all required information and all follow-up have been completed.

Critical incidents are referred to protective agencies by the regional center or vendor (Child Protective Services, Adult Protective Services, Community Care Licensing, Long-Term Ombudsman, Law Enforcement) who each have policies regarding sharing information relative to the investigation outcomes.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DDS has overall state-level responsibility for planning, coordinating and overseeing the implementation of the State's Risk Mitigation and Management System for all individuals with developmental disabilities, including those that are Waiver participants. DDS carries out this responsibility on an ongoing basis by:

1. Developing, implementing and maintaining a uniform, statewide automated SIR database system.
2. Reviewing individual SIRs daily to identify issues or concerns requiring additional follow-up.
3. Revising regulations, as needed, related to SIR requirements to address system requirements.
4. Providing SIR data (such as risk indicators, client characteristics, corrective actions, etc.) to the State's independent risk management contractor for further analyses and to regional centers for follow-up, as appropriate.
5. Providing training and technical assistance to regional centers on legal obligations in abuse reporting; documentation requirements; the definition of special incident; best practices for identifying consumer abuse; using and maintaining the automated SIR system; risk assessment; and proactive risk assessment and prevention planning through the individualized program planning process.
6. Developing and maintaining a statewide mortality review system that includes development and maintenance of a statewide database of all persons who have died, and conducting studies to educate and inform the service system so as to improve quality of life outcomes for participants.
7. Preparing, implementing and managing the risk assessment and mitigation contract.
8. Reviewing on-site highly unusual, suspicious and/or very sensitive individual incidents where DDS Headquarters involvement is indicated.

DHCS is the single state agency for the DD Waiver. DDS is the operating agency for the DD Waiver. DHCS and DDS exercise oversight of the waiver through the Biennial On-Site HCBS Waiver Monitoring reviews at the 21 regional centers. Several components of the review address risk management activities, including SIRs.

1. DHCS and DDS review compliance with reporting, meeting mandated timelines and appropriate and complete follow-up activity through the review of DD Waiver participant records at the regional center and at day and living service providers for the review sample.
2. Additionally, DHCS and DDS review compliance with reporting, meeting mandated timelines and appropriate and complete follow-up activity for 10 SIRs for DD Waiver participants who are not in the sample.

DHCS performs additional focused on site reviews of SIRs when it is deemed necessary.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

● **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

California prohibits using restraint(s) on any person with a developmental disability, pursuant to CCR, Title 17 §50515 unless applicable licensing regulations regarding the use of bodily restraints are strictly adhered to and approved by the State's licensing entity, DSS CCL. Pursuant to Ca. Health and Safety Code § 1180.4(b), Group homes and Community Care Facilities may use seclusion or behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to self or others. Please note that this citation references general licensing laws, however, pursuant to CCR, Title 17 §50515(a), seclusion is prohibited for a person with a developmental disability.

Restraints may be used only in an emergency, typically known as behavioral restraints, to protect the participant and others from injury and after alternative procedures have been attempted and failed. As defined in Health and Safety Code Section 1180.1, "Behavioral restraint" means "mechanical restraint" or "physical restraint" as defined in this section, used as an intervention when a person presents an immediate danger to self or to others. It does not include restraints used for medical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure, or postural restraints, or devices used to prevent injury or to improve a person's mobility and independent functioning rather than to restrict movement.

Per Health and Safety Code 1180.4, the following types of restraints are prohibited:
• Restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places his or her body weight against the person's torso or back.
• A pillow, blanket, or other item covering the person's face as part of a physical or mechanical restraint or containment process.
• Physical or mechanical restraint or containment on a person who has a known medical or physical condition and there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition.
• Prone mechanical restraint on a person at risk for positional asphyxiation as a result of one of the following risk factors that are known to the provider:(A) Obesity,(B) Pregnancy,(C) Agitated delirium or excited delirium syndromes,(D) Cocaine, methamphetamine, or alcohol intoxication, (E) Exposure to pepper spray,(F) Preexisting heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders,(G) Respiratory conditions, including emphysema, bronchitis, or asthma.
• Placing a person in a facedown position with the person's hands held or restrained behind the person's back.

An Emergency Intervention Plan is developed by the facility and approved by the Department of Social Services (DSS) prior to the use of manual restraints specifying the less restrictive or non-physical de-escalation methods that may be used to identify and prevent behaviors that lead to the use of manual restraint. The Emergency Intervention Plan shall include:
1) Staff qualifications sufficient to implement the plan
2) A list of job titles of the staff required to be trained to use manual restraint
3) A list of emergency intervention techniques beginning with the least restrictive intervention with a description of each emergency intervention technique that may be used;
4) A description of the circumstances and the types of client behaviors for which the use of emergency interventions are needed;
5) Procedures for maintaining care and supervision and reducing the trauma of other clients when staff are required for the use of emergency interventions;
6) Procedures for crisis situations, when more than one client requires the use of emergency interventions simultaneously;
7) Procedures for re-integrating the client into the facility routine after the need for an emergency intervention has ceased;
8) Criteria for assessing when an Emergency Intervention Plan needs to be modified or terminated;
9) Criteria for assessing when the licensee does not have adequate resources to meet the needs of a specific client;
10) Criteria for assessment when community emergency services are necessary to assist staff during an emergency intervention;
11) Procedures to ensure a client in crisis does not injure or endanger self or others;
12) Criteria for assessing when an Individual Emergency Intervention Plan needs to be modified or terminated;

13) A statement clarifying that only trained staff may use emergency interventions.

Facility personnel who are involved in the administration of restraints must complete "Emergency Intervention Training", defined in CCR, Title 22 §85101, which includes a curriculum based on techniques to prevent injury and maintain safety as an alternative to physical restraints.

By state law, service providers are required to report instances of suspected abuse as a "mandated reporter" as outlined in WIC 15630 (b). Additionally, per CCR, Title 17 §54327(b)(1)(B) and (D); CCR, Title 17 §54327(b)(2)(A), unauthorized use of restraints, including reasonably suspected abuse/exploitation, including physical and/or chemical restraint, must be reported, regardless of cause to the regional center and client's authorized representative, within 24 hours verbal and 48 hours written report.

All instances of restraints are required to be reported to the regional center and subsequently DDS.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Oversight of the use of restraints is conducted by both CDSS and DDS. As noted previously, all instances of restraints are required to be reported to CDSS and the regional center and subsequently to DDS. Reports can be made verbally and follow written reports are also required. Data on all incidents including the use of restraints, is used to identify trends that may indicate a need for further intervention. The State's risk management contractor assists DDS and regional centers in the development of reports that identify trends and strategies used to identify potential factors influencing these trends. DDS uses these trend reports to identify instances that may require further follow up and continues to monitor these trends and the results of mitigating actions taken. The risk management contractor develops these reports quarterly.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

- [x] **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The unauthorized use of restrictive interventions is monitored in the DD Waiver through:
- Daily review of special incident reports by DDS.
- Quarterly monitoring visits conducted by the regional center case manager and the ongoing contact with the participant by the case worker.
- Annual visits by DSS CCL.
- Unannounced visits by DSS CCL.

In California, the discovery of the unauthorized use of restraints and seclusion would result in the cancellation of the contract of the responsible provider. A special incident report would be filed with the regional center and licensing/law enforcement agencies (if applicable) which would investigate and take action. DDS would be notified of any outcomes pursuant to the special incident reporting process.

CCR, Title 17, §50823, requires each regional center to prepare and submit a Behavior Modification Review Committee report to the Director of DDS by February 15 of each year.

- [ ] **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- [x] **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The unauthorized use of seclusion is monitored in the DD Waiver through:
• Quarterly monitoring visits conducted by the regional center case manager and the ongoing contact with the participant by the case worker.
• Annual visits by DSS CCL.
• Unannounced visits by DSS CCL.

In California, the discovery of the unauthorized use of seclusion would result in the cancellation of the contract of the responsible provider. A special incident report would be filed with the regional center and licensing/law enforcement agencies (if applicable) which would investigate and take action. DDS would be notified of any outcomes pursuant to the special incident reporting process.

- [ ] **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ● **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For consumers who reside in community living arrangements where the provider has round-the-clock responsibility in residences that are not the participant's own home or home of a family member, the following entities have responsibility for monitoring those living arrangements:

First-line monitoring for medication regimens is the responsibility of the consumer's prescribing physician (ongoing).

Second-line monitoring is conducted in the following ways:
• The Person-centered planning team, which includes a regional center representative, through their monitoring of the IPP (as needed, and annually at a minimum) includes a review of the consumer's health status.
• Regional centers' monitor provider compliance with assisting consumers to receive medical care and medication management follow-up pursuant to the IPP (as needed, and quarterly at a minimum.)
• Community Care Licensing monitoring of providers for maintenance of individual consumer medication records, including physician direction and the need for assistance with self-administration, in addition to proper storage and access of medications. (annually)
• DDS and DHCS monitoring reviews of providers for maintenance of individual consumer medication records, storage, and proper disposal, in addition to interviews of direct care staff to verify knowledge of the safeguarding and assistance with self-administration of medications (biennially)
• DDS' Risk Management contractor compiles data of consumers who utilize multiple (10 or more) medications for chronic conditions including diabetes, cardiac, and respiratory conditions, and for individuals who utilize multiple (5 or more) psychiatric medications for more than two consecutive months. This information is shared with regional centers to inform the need for medication consultation with clinicians and to assess the need and use of medications with consumers during IPP meetings (semi-annually).

All regional centers have personnel with clinical expertise who routinely provide training and/or information to individuals who conduct second-line monitoring to help recognize situations that present a potential risk to the consumer. In these situations, regional center clinical personnel are available to consult with the consumer's prescribing physician as necessary.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The State monitors medication management through the activities detailed in appendix H, which include (but are not limited to), the State's overall risk mitigation and management system and the Biennial on-site HCBS Waiver Monitoring Review. The State's risk management contractor reviews electronic special incident report data for trends in medication errors and unplanned hospitalizations due to medication errors. As part of its contract with DDS, the risk management contractor also performs polypharmacy reviews and follow-up. Technical assistance and/or tools are developed on an as needed basis in response to SIR trends to prevent the occurrence of incidents. Further, in the state mandated DSP training (for all direct support professionals employed in regional center vendored community care facilities), there is a component on medication management.

Additionally, if the provider is licensed by the Department of Social Services (DSS), a review of medication policies/procedures is conducted. DSS and regional centers monitor ongoing thereafter through oversight and monitoring activities to address any issues relative to medication management.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ● **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Assistance with self-administration of medication may be performed by trained, non-medical personnel. The State requires mandatory direct support professional training, which includes medication management, handling, and assistance with self-administration of medication. Additionally, the licensee must receive training from a licensed professional, obtain written documentation from the licensed professional, and ensure that the licensed professional reviews staff performance as the licensed professional deems necessary, at least once a year.

Once ordered by the physician, the medication is given according to the physician's directions. Pursuant to 22 CCR § 80075, the following regulations shall apply to the oversight of assistance with self-administration:

A record of each dose is maintained in the client's record. The record shall include the date and time the PRN medication was taken, the dosage taken, and the client's response. If the client is unable to determine his/her own need for a prescription or nonprescription PRN medication, and is unable to communicate his/her symptoms clearly, facility staff designated by the licensee, shall be permitted to assist the client with self-administration, provided all of the following requirements are met:
• Facility staff shall contact the client's physician prior to each dose, describe the client's symptoms, and receive direction to assist the client in self-administration of that dose of medication.
• The date and time of each contact with the physician, and the physician's directions, shall be documented and maintained in the client's facility record.
• The date and time the PRN medication was taken, the dosage taken, and the client's response, shall be documented and maintained in the client's facility record.
• For every prescription and nonprescription PRN medication for which the licensee provides assistance, there shall be a signed, dated written order from a physician on a prescription blank, maintained in the client's file, and a label on the medication.

- **Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Pursuant to state regulations, all medication errors for participants who are under a providers care are required to be reported to (1) the regional center and (2) the appropriate licensing entity.

Regional centers, in turn, are required to notify DDS of medication errors.

(b) Specify the types of medication errors that providers are required to *record:*

Medication errors that occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

(c) Specify the types of medication errors that providers must *report* to the state:

Medication errors that occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Please see Appendix G-3-b-i & G-3-b-ii.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of special incidents reported within required timeframes. Numerator = number of special incidents reported within required timeframes; denominator = number of special incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group:

		The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☑ **Other** Specify: In addition to reviewing any special incidents for consumers included in the random sample, a supplemental sample is reviewed of ten consumers with a reported special incident at each regional center.
	☑ **Other** Specify:	

	On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special incident report (SIR) database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional centers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Daily	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Regional centers Independent risk management contractor	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of individuals without incidents of abuse, neglect, exploitation, and unexplained death. Numerator = number of individuals without reported incidents of abuse, neglect, exploitation, and unexplained death Denominator = number of individuals on waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIR Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Regional Centers	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of reported special incidents referred to appropriate investigative entities (e.g. Law Enforcement, APS/CPS) for follow-up Numerator = Number of reported special incidents that were appropriately referred to appropriate

investigative entities Denominator = Number of reported special incidents that required referral to appropriate investigative entities

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special Incident Report (SIR) database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: regional centers	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of special incidents for which appropriate actions were taken. Numerator = number of special incidents for which appropriate actions were taken; denominator = number of special incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☑ **Other** Specify: Regional centers Independent risk management contractor	☑ **Annually**	☑ **Stratified** Describe Group: stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☑ **Other** Specify:

		In addition to reviewing any special incidents for consumers included in the random sample, a supplemental sample is reviewed of ten consumers with a reported special incident at each regional center.
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special incident report (SIR) database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional Centers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Daily	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Regional centers Independent risk management contractor	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of instances in which state policies regarding restrictive intervention were followed. Numerator=number of special incidents reported on use of restrictive interventions in which state policies were followed; denominator = total number of special incidents reported on use of restrictive interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special incident report (SIR) database.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional Centers	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Regional centers, independent risk management contractor	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of consumers whose special health care requirements or safety needs are met. Numerator = number of consumers whose special health care requirements or safety needs are met; denominator = total number of consumers reviewed with special health care requirements or who have safety needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during state's biennial collaborative on site HCBS waiver monitoring reviews.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group:

		The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow -up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Regional centers have the primary responsibility for ensuring appropriate steps are taken in response to special incidents. These steps may include; identifying the factors that led to the incident, ensuring service providers responded appropriately, assessing the need for provider training and determining if modifications to the consumers IPP are needed. The actions taken are documented in the incident report or consumer record.

Daily, DDS staff review submitted special incident and, when necessary, follow-up with the regional center.

Individual issues identified during the State's Biennial on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the State's recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the State's recommendations and corrective actions taken, are issued to the regional centers and forwarded to CMS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify:	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Regional centers Independent risk management contractor	
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

- ● **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

California has systems and structures in place that provide information and/or guide the quality improvement strategy (QIS). These include risk management and mitigation, regional center performance contracts, biennial on-site HCBS Waiver Monitoring Reviews, biennial regional center fiscal audits, and the direct support professional (DSP) training program. All of these components are based on the quality model that starts with establishing clear expectations for performance (design), collecting data to determine if the expectations are met (discovery), taking steps to correct deficiencies (remediation), and utilizing information obtained to implement improvements and continuously monitor the system to determine if desired results were achieved (improvement).

As noted previously in this application, in California, all community-based services for individuals with developmental disabilities are provided through a statewide system of 21 regional centers, who are funded by the Department of Developmental Services (DDS). Within this structure, and under the oversight of the Department of Health Care Services (DHCS), DDS ensures that the HCBS Waiver is implemented in accordance with Medicaid law and the State's approved Waiver application. It is through this same service delivery system that California also provides services under the 1915(i) State Plan Amendment (SPA), 21-0002. As a result, the overall QIS described in this appendix applies to services provided under both programs. For federal reporting, California will collect and report information specific to each program for the performance measures under the federal assurances, with the exception of Administrative Authority, Qualified Providers, and Financial Accountability, which are reported in a consolidated format.

The state's Quality Management Executive Committee (QMEC) consists of executive level personnel from both DHCS and DDS. The involvement of DHCS in the QMEC ensures that the State Medicaid agency is actively involved in the assessment of waiver performance. QMEC analyzes data and trends identified through the multiple discovery activities and sources described in this and other sections throughout this application. This analysis enables the QMEC to assess the efficacy of the system's design, discovery, remediation, and improvement activities. As a result of this analysis, the state is able to prioritize suggested policy changes or system enhancements that may be necessary in response to identified trends.

Implementing system enhancement activities is accomplished through utilizing information from an independent, specialized risk management and mitigation contractor possessing a multidisciplinary (clinical, research, data analysis, training, business) capacity, with a critical responsibility for analyzing information from the State's electronic special incident reporting system.

The State also directs targeted technical assistance for regional centers experiencing an increase in incidents; working with a group of regional center risk management personnel in an effort to gather better actionable data and technical support in the development of remediation plans.

Additionally, reviews of regional centers and service providers inform a comprehensive overview of individual health and safety metrics.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: Semi-annually

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The QIS is designed to incorporate continuous quality monitoring of all HCBS Waiver assurances. This enables the State to utilize data from the various discovery activities for the purpose of performing on-going assessments of the QIS, including the effectiveness of any system enhancements. As described in the previous section, the Quality Management Executive Committee (QMEC) has the primary role in making a coordinated system assessment. Assessing the efficacy of QIS activities includes reporting of outcomes as well as input from and on-going communication with stakeholders, including consumers/families, service providers, regional center staff and State representatives, demonstrated by the following:

Regional Center Monitoring Activities - Regional center-specific reviews at an individual record level to identify if individual needs are being met and are documented appropriately.

Reviews of service providers include site visits, accomplished through a combination of provider record reviews, facility walkthroughs, and interviews of provider staff and participants. Provider record reviews are completed to ensure documentation of medical, behavioral, and other identifying information for participants, in addition to appropriate handling of critical incidents. Facility walkthroughs (residential and non-residential) are conducted to identify general safety assurances, for example with the existence of adequate fire exits, working adaptive equipment, and the proper storage of medication, chemicals, and food. Interviews of staff are intended to confirm familiarity with emergency procedures as well as medications and health needs of individual participants.

Participant interviews include general observations to ensure overall health and hygiene needs are effectively addressed and to determine participant satisfaction with services.

The above information is compiled into a biennial report that requires initial response from regional centers to address deficient areas, followed by an overall review process involving DDS and DHCS. The finalized report is distributed to DHCS, regional centers, and Regional Center Boards of Directors, and is also posted to the DDS website upon completion.

Regional Center Performance Contracts - Performance contracts measure progress on public policy and compliance measures for each regional center. These contracts are developed through a public process that includes input on performance objectives. The data for the measures in each contract is provided to regional centers every six months, including a year-end final report that is available to the public.

Independent Risk Management Contractor Activities - The risk management contractor produces quarterly reports of incident trends to the QMEC, and hold meetings with DDS to review and discuss emerging risks trends and areas of concern. Further, the risk management contractor produces real-time data dashboards and analytical reports, which are posted on the DDS website. The risk management contractor participates, along with DDS representatives, in quarterly meetings with regional center risk management personnel as well as the risk management subcommittee of the regional centers Chief Counselor's committee (see below). These regular meetings provide a forum for reviewing the efficacy of systems improvements.

Regional Center Committees - DDS meets regularly with groups of regional center representatives who are organized in a number of topic and/or function specific standing committees. These committees include the regional center Chief Counselors (case management executives), risk management representatives, and HCBS Waiver personnel (i.e. qualified intellectual disabilities professionals). Participation in these committees affords DDS and regional center stakeholders regular opportunities to review and communicate about system performance and HCBS Waiver related policies. DDS' regular participation in these committees is a mechanism through which technical assistance is provided, implementation and compliance issues discussed, and communication regarding system issues and performance occurs.

Regional Center Boards of Directors - As private, non-profit entities, each regional center is governed by a board of directors. Board composition requirements identify the minimum number of board members that must be persons with developmental disabilities or family members/legal guardians. Additionally, each board must have an advisory committee comprised of a wide variety of providers of regional center services. These boards conduct regular public meetings and are tasked with the governance of all regional center activities.

Consumer Advisory Committee (CAC) - The CAC meets quarterly and collaborates with DDS. During these meetings, DDS discusses and disseminates information on topics raised by CAC members, including new or

potential policy changes.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Quality Management Executive Committee (QMEC) meets at least semi-annually to review data related to the quality of DDS programs and services and to identify and address opportunities for improvement to the service system to incorporate into a revised QIS as appropriate. The QMEC reviews and analyzes data results, identifies the need for system improvements, discusses and applies data results to statewide priorities, and reviews all aspects of the service delivery system.

The QMEC may delegate to a workgroup, subcommittee, or to divisions within DDS, focused work on identified priorities related to findings or to remediate issues identified by the QMEC. The lead for each focused team is a member of the QMEC and may include various staff or subject matter experts. Upon completion of the focused work, the workgroup or division reports to the QMEC the outcome and any resulting recommendations or program changes. The QMEC assesses the need to continue the activities or determines the project or assignment to be complete, with outcomes leading to suggested policy changes and/or system improvements, as appropriate. These analyses and activities enable the QMEC to continuously evaluate the efficacy of the system's design, discovery, remediation and improvement activities described in this application.

Additionally, ongoing discovery and reporting activities throughout the waiver period provide further opportunities for analyzing the QIS using through actionable data received through the monitoring of regional centers, service providers, and participant experiences and other feedback. This level of data collection and analysis provides a comprehensive review of progress toward meeting system priorities, maintaining overall compliance with waiver assurances, and informing the renewal process at the end of the waiver period.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

DDS performs fiscal audits of each regional center every two years and completes follow-up audits of each regional center in alternate years or more frequently as needed. Regional centers are also required to contract with independent auditors to conduct an annual audit. The DDS audit is designed to "wrap around" the required independent audit to ensure comprehensive financial accountability. DDS reviews each regional center's annual independent audit report and follows up with the regional center regarding corrective action for each management comment identified in the independent auditor's report. DDS and regional centers also conduct audits of service providers. Upon the issuance of the Final Audit report, all consumer billings identified for reimbursement by the vendor are remitted to the Home and Community Based Waiver by the DDS Waiver Section. This is done prior to the outcome of any vendor appeal or administrative hearing. If the findings of the audit are non-monetary, the vendoring regional center(s) are responsible for ensuring future vendor compliance with the DDS audit recommendation(s). If the audit findings are monetary, the vendor is required to reimburse the DDS directly. Once the vendor has agreed to pay the DDS Accounting Section tracks and monitors the vendor's payment(s). If the vendor refuses to pay, the DDS Accounting follows collection procedures.

Specified providers pursuant to State law must obtain an independent audit or review of their financial statements annually. A specified provider is an entity that receives payments between $500,000 and $2,000,000 from one or more regional centers and must obtain an independent review report of its financial statements. Providers who receive more than $2,000,000 in regional center payments must obtain an independent audit. The results of these audits or reviews and accompanying management letters must be forwarded to the appropriate regional center. Subsequently, the regional center must require resolution of issues identified in the reports and notify DDS of all qualified opinion reports or reports noting significant issues that directly or indirectly impact regional center services. A periodic independent audit of the waiver program is required by the Single Audit Act and conducted by the California state auditor.

DHCS maintains on-going oversight of the audit functions of this Waiver as follows:
1. DHCS Audits and Investigations (A&I) reviews DDS regional center Pre-Audit Review Package which contains: DDS' contracts and Contract Budget Summaries; summary of regional center budget; summary of state claims; summary of advances and offsets; independent audit reports and management letters; regional center response to management letters; and DDS review of independent audit work papers.
2. DHCS A&I reviews DDS draft regional center audit reports and notifies DDS if material findings are noted.
3. DHCS A&I participates in vendor audit entrance/exit conferences as appropriate.
4. DHCS A&I reviews draft DDS vendor audit reports and audit working papers.
5. DHCS submits annual report of DHCS A&I's oversight activities to CMS. In the DDS draft regional center audit reports, DHCS A&I looks for any potential problems or special issues.
The following are examples of material findings based on past audit reports where vendors were referred to DOJ:
•Lack of documentation/support for significant percentage/amount of the cost claimed by the regional center and/or vendor. A general rule is more than 30% of their costs.
•Timesheets appeared to have altered or overstated hours, appeared excessive (vendor claiming services provided by individuals which exceed 8 hours per day)
•Individual's hours are being billed directly and also included on vendor's timesheets
•Regional Center/Vendor does not have payroll records to evidence individuals providing services were paid.

DDS is implementing Electronic Visit Verification (EVV), which is a telephone and computer-based system that electronically verifies in-home Personal Care Service and Home Health Care Service visits. EVV systems must verify the type of service performed; the individual receiving the service; date of the service; location of service delivery; the individual providing the service; and the time the service begins and ends.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.
i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims paid in accordance with the consumers authorized services. Numerator = number of claims paid in accordance with the consumers authorized services; denominator = total number of claims for participants reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☑ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☑ ***Representative Sample*** *Confidence Interval =* *3.02 Based on sample size of 1050, population of 155,000 and 95% confidence level*
☐ ***Other*** *Specify:*	☑ ***Annually***	☑ ***Stratified*** *Describe Group:*

		The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☑ ***Other*** *Specify:* *On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☑ ***Operating Agency***	☑ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of consumers who were enrolled on the waiver prior to the generation of claims for federal reimbursement. Numerator = number of consumers who were enrolled on the waiver prior to the generation of claims for federal reimbursement; denominator = total number of consumer records reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Record reviews conducted during States Biennial on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☑ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☑ ***Representative Sample*** *Confidence Interval =* *3.02 Based on sample size of 1050, population of 155,000, and 95% confidence level*
☐ ***Other*** *Specify:*	☑ ***Annually***	☑ ***Stratified*** *Describe*

		Group: *The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☑ ***Other*** *Specify:* *On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☑ ***Operating Agency***	☑ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other***	☑ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
Specify:	
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims coded and paid in accordance with the reimbursement methodology in the approved waiver only for services rendered. Numerator = number of claims paid in accordance with the reimbursement methodology in the approved waiver only for services rendered; denominator = total number of claims reviewed only for the services rendered.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DDS audits of regional center vendors

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☑ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☑ ***Continuously and Ongoing***	☑ ***Other*** *Specify:*

		DDS fiscal vendor audits are conducted based on a random sample of vendors with annual expenditures over $100,000 or upon referral.
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Vendor audits conducted by regional centers

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☑ ***Other*** *Specify:* *Regional centers*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☑ ***Other*** *Specify:* *Each regional center must conduct a fiscal audit no less than 4% of the total number of vendors in specified service categories for which payments in the prior year totaled $100,000 or less.*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DDS Biennial Regional Center audits

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☑ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*

☐ ***Other*** *Specify:*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☑ ***Other*** *Specify:* *5-10% of the most heavily utilized services are sampled to verify accuracy of billing. Lesser utilized services are also sampled for review at a rate of less than 5%.*
	☑ ***Other*** *Specify:* *Fiscal audits are conducted at each regional center every two years. Follow-up fiscal audits are conducted annually or more frequently as needed.*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of funds identified for repayment in DDS fiscal audits that were repaid to CMS within 12 months. Numerator = dollar amount of funds identified for repayment in DDS fiscal audits that were repaid to CMS within 12 months. Denominator = total dollar amount identified for repayment to CMS

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DDS fiscal audits

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☑ ***100% Review***
☑ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☑ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***
	☑ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims paid at the approved service rate. Numerator = Number of claims paid at the approved service rate. Denominator = Total number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DDS audits of Regional Center claims

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☑ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☑ ***Other*** *Specify:*

		5-10% of the most heavily utilized services are sampled to verify accuracy of billing. Lesser utilized services are also sampled for review at a rate of less than 5%.
	☑ ***Other*** *Specify:* *Fiscal audits are conducted at each regional center every two years. Follow-up fiscal audits are conducted annually or more frequently as needed.*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☑ ***Operating Agency***	☑ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

N/A

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Individual issues identified during any of the audit and oversight activities above require corrective actions to be developed by either the regional center or vendor. These corrective actions are evaluated and approved by DDS and included in the final audit reports. DHCS provides oversight of this process.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☑ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***
	☑ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Rate Methodologies
As described in appendix A-4 and C-1/C-3, at the time of vendorization the regional center verifies provider requirements and standards specified in regulation and the appropriate rate is agreed upon using the following rate methodologies.

The rate methodologies for services provided in this waiver are as follows:

1) The usual and customary rate methodology - A usual and customary rate "means the rate which is regularly charged by a vendor for a service that is used by both regional center consumers and/or their families and where at least 30% of the recipients of the given service are not regional center consumers or their families. If more than one rate is charged for a given service, the rate determined to be the usual and customary rate for a regional center consumer and/or family shall not exceed whichever rate is regularly charged to members of the general public who are seeking the service for an individual with a developmental disability who is not a regional center consumer, and any difference between the two rates must be for extra services provided and not imposed as a surcharge to cover the cost of measures necessary for the vendor to achieve compliance with the Americans With Disabilities Act."
DDS does not establish or review usual and customary rates, as these rates are for services accessed by the general public.

2) Rate model fee schedule methodology - In March 2019, pursuant to Welfare and Institutions Code Section 4519.8, the Department of Developmental Services (DDS) submitted a rate study addressing the sustainability, quality, and transparency of community-based services for individuals with developmental disabilities to the California Legislature. The rate study included an assessment of the effectiveness of the methods used to pay each category of community service provider and included stakeholder meetings and surveys of the provider and recipient community. As a part of the study, rate models were developed for specified services that include specific assumptions related to the various costs associated with delivering each service, including direct care worker wages, benefits, and 'productivity' (i.e., billable time); staffing ratios; mileage; facility expenses; and agency program support and administration. Separate models were established for each regional center to account for costs differences related to wages, travel, and nonresidential real estate. January 1, 2025, the Rate Model Fee Schedules will be fully implemented as described below. The rate models will be implemented using two components, a base rate equaling 90 percent of the regional center specific rate model, and a supplemental payment, equaling up to 10 percent of the rate model, to be implemented through the quality incentive program described in Appendix I-3c. The rate models will be updated whenever there is a change to either the Statewide California Minimum Wage or the federal mileage reimbursement rates. The rate model will be implemented as follows:
•Rate Model Fee Schedules: Effective January 1, 2025, all providers included in the Rate Study will have their rates set at 90% of rate study benchmark, with the opportunity to earn the remaining 10% through the quality incentive program described in Appendix I-3c. Exceptions:
o Rates in effect December 31, 2024, will remain the same for existing providers whose rates are above 90% of the benchmark through February 28, 2026. For services provided on or after March 1, 2026, all provider rates will be set at 90% of the benchmark with the opportunity to earn the remaining 10% as described above.

Provider rate adjustments occurring as a result of the above described alignment with the rate reform benchmarks, proposed in Waiver amendment CA.0336.R05.25, affect the following services: Employment Services, Habilitation-Behavioral Intervention Services, Habilitation-Community Living Arrangement Services, Habilitation-Day Services, Homemaker Services, Prevocational Services, Respite Care, Transportation Services, Dental Services, Occupational Services, Physical Therapy Services, Psychology Services, Skilled Nursing Services, and Speech, Hearing, and Language Services. The State conducted the public processes described in 42 CFR 447.203(c)(4) and 204 and the process did not yield significant access to care concerns from beneficiaries, providers, or other interested parties regarding the services for which the payment rate reduction or payment restructuring was proposed.

Fee schedules are available by regional center at the following link: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

3) The median rate setting methodology The Department calculates median rates for each regional center, and these rates are subsequently certified by each of the regional centers. The Department calculates the statewide median rates based on the individual regional center median rates. Verification of individual regional center median rates is subject to verification through the department's biennial fiscal audit of the regional center. Rates for new providers where rates are set through negotiation with regional centers are capped at either the statewide median rate or the vendoring regional center's median rate, whichever is lower.

Regardless of when a provider began providing services or their rate was originally established, if a regional center demonstrates an increase in an individual provider's rate is necessary to protect a beneficiary's health and safety needs, the Department of Developmental Services may authorize reimbursement at a rate up to the actual cost of providing the service, for as long as the need exists. In the process of establishing a rate under this exception, the regional center and department will utilize current cost data. Participant's ongoing health and safety needs are reviewed no less than quarterly.

As required by the contract between regional centers and the State, regional centers must maintain documentation on the process to determine, and the rationale for granting, any negotiated rate, including consideration of the type of service and any education, experience and/or professional qualifications required for the service. In addition, contracts or agreements between the regional center and service providers shall expressly require that no more than 15 percent of regional center funds be spent on administrative expenditures.

This methodology requires that rates negotiated with new providers may not exceed the regional center's current median rate for the same service, or the statewide current median rate, whichever is lower.

4) Department of Health Care Services (DHCS) Fee Schedules - State regulations define the DHCS Fee Schedule as the current rate established by the single-state Medicaid agency for services reimbursable under the Medi-Cal program. The DHCS Fee Schedule rate is the maximum amount that can be paid for the service. These rates can be found here: https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx and https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates. For providers who have a usual and customary rate that is less than the DHCS Fee Schedule rate, the regional center shall pay the provider's usual and customary rate.

DHCS Fee Schedule rates are set by DHCS. The Medi-Cal Fee Schedule containing these rates are updated on the 15th day of every month. Most adjustments to rates are tied to the annual Healthcare Common Procedure Coding System (HCPCS) process (which may adjust codes/rates across multiple services and provider types), or other state/federal authorized/mandated adjustments. DHCS develops a policy justification for rate changes, outlines authorities relevant and needed to adjust the rates, and works with the Fiscal Intermediary (FI) to update rates. DHCS reviews their fee schedule rates on a monthly basis assuring payments are consistent with efficiency, economy, and quality of care. DHCS updates the fee schedule accordingly.

Behavior Intervention Services
This service is comprised of the following subcategories:

A. Non-Facility-Based Behavior Intervention Services- All providers are paid the usual and customary rate as described above, if they have one. If the provider does not have a usual and customary rate as described above, then the rate is established as described below:

Rate Model Fee Schedule: The following providers use the Rate Model Fee Schedules: Behavior Analyst, Associate Behavior Analyst, Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker), Behavior Management Consultant: Licensed Clinical Social Worker, Behavior Management Consultant: Psychologist, Behavior Management Consultant: Marriage Family Child Counselor, Psychiatrist, Licensed Psychiatric Technician, Client/Parent Support Behavior Intervention Training, Parenting Support Services Provider, and Individual or Family Training Provider, Family Counselor (MFCC), Marriage & Family Therapist, Psychologist, Social Worker, Clinical Social Worker (CSW), and Chemical Addiction Counselor.

Median Rate: The following provider types have rates set via the Median rate methodology: crisis team-evaluation and behavior intervention.

DHCS Fee Schedule Rate: The rates for psychiatrists and psychiatric technicians are set using the DHCS Fee Schedule rate as described above.

B. Crisis Support - There are four types of Crisis Intervention Facilities: Crisis Intervention Facility, Vendor-Operated Community Crisis Home, State-Operated Community Crisis Home, and Mobile Crisis Team. If the provider does not have a usual and customary rate as described above, then the rate is established as described below:

Median Rate: The rates for Crisis Intervention Facilities are set via the Median rate methodology when they do not have a "usual and customary rate".

CONTINUATION OF I-2-a. RATES, BILLING AD CLAIMS CAN BE FOUND UNDER MAIN(B) OPTIONAL.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Claims for services provided are submitted to regional centers by providers, referred to as regional center vendors. These claims are subsequently submitted to DDS, the Organized Health Care Delivery System (OHCDS) for this Waiver. Under an interagency agreement with DHCS, DDS prepares and submits invoices to DHCS for valid, reimbursable costs (see item I-2-d.) 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. Providers are not required to contract and/or bill via the regional centers. Please refer to appendix A.6 of this waiver for information regarding Program Policy Compliance.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ○ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ● ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☑ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

DDS, with DHCS oversight, certifies that the public expenditures for waiver services are based only on the total costs of services provided. By using the methods described in items I-2-d and I-3-a, DDS ensures that only those costs that 1) are provided to eligible individuals, and 2) are for services identified in the waiver, are included on invoices sent to DHCS to claim FFP. As detailed in item I-1, claims for waiver services are subjected to regular periodic audits and reviews by State, regional center and independent auditors.

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment 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 participant's approved service plan; and, (c) the services were provided:*

Claims are processed and validated at all levels through automated processes. Only claims for services for which a purchase authorization, based on decisions made in development of the individual service plan (IPP), is in place are able to be processed for provider payment by the regional center.

Regional centers transmit all expenditures (claims) to DDS through a system of main frame computers. At DDS the expenditures are processed though a specialized filter program to determine if:
1. The service recipient (consumer) was enrolled on the Waiver at the time of service.
2. The consumer was eligible for Medi-Cal at the time of service.
3. The service provided is eligible for FFP. A claim for FFP is only completed if all three of the conditions above are met.

As described in appendix A.6 of this application, the State's Biennial on-site HCBS Waiver Monitoring Reviews also include verification that a statistically valid random sample of consumer IPPs identify all services purchased by regional centers. Further, each year all consumers are provided a complete listing of all the services funded (and paid for) on their behalf, pursuant to their IPP. This listing includes the service type, units, and month of service and the amount paid. The state law requiring the provision of an annual statement was implemented for the purpose of assuring that the services and supports paid for, were delivered to the recipient.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ● ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments to providers for authorized services are processed through the Uniform Fiscal System (UFS). The system establishes and tracks regional center authorization and billing data including vendor (provider) number, purchase authorization number, consumer identification and eligibility information, service code, service rate, claim amount, and claim date. Waiver services will not be paid unless the appropriate authorization and billing data are present. Regional centers transmit to DDS all service authorization and billing data necessary to support the provider claims to provide a complete audit trail. Regional centers vendors, regional centers and DDS are required to maintain documentation to support financial accountability in accordance with federal requirements. In addition to the controls contained in UFS to prevent possible erroneous payments, oversight of appropriate claiming also includes provider audits conducted by regional centers and DDS.

Only claims determined valid by DDS through the process described in item I-2-d are submitted to DHCS for FFP and reporting as expenditures on the CMS-64.

Alternatively, providers may enroll directly with the state agency as a Medi-Cal provider and therefore would be able to bill Medicaid directly, rather than the OHCDS.

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☑ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

DDS, as the operating agency and OHCDS for this Waiver, acts as the limited fiscal agent for all waiver services. In this role, through processes described previously, DDS verifies the appropriateness of claims submitted by regional centers and submits invoices to DHCS for FFP. The requirements for DDS in this role, as well as the financial accountability oversight responsibility of DHCS, are outlined in an interagency agreement between DHCS and DDS. As referenced in I-3-a above, those who choose to enroll directly with the Medicaid Agency will be informed of the process for billing the Medicaid Agency directly.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ○ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ● ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

In conjunction with the Department of Developmental Services (DDS) 2019 Rate Study, DDS is implementing the Quality Incentive Program (QIP) as well as additional supplemental payments, to improve individual outcomes, service provider performance, and the quality of services. DDS is providing supplemental payments to eligible providers for a variety of activities as described below:

The source of the non-Federal share of the following Supplemental payments is from an appropriation of funds to DDS through the California Budget Act. Eligible providers will retain 100% of the payment.

Quality Incentive Program (QIP)
The initial phase of the QIP will establish the foundation for future quality measures and will focus on building capacity, developing reporting systems and gathering baseline data while working towards meaningful outcome measures at the individual consumer level for all services.

Effective January 1, 2025, providers may earn supplemental payments under this phase of the QIP by taking part in the creation of a statewide provider service directory. This service directory will bring statewide consistency and access to provider data to a variety of users including the state, regional centers, service providers and individuals receiving services and will eventually include a series of data elements that will be used to drive quality (e.g., access, language availability, capacity). It will also form the foundation for future measures by enabling the digital, comprehensive, statewide collection of service provider data to be utilized to provide greater insight into provider networks and corporate structure and more closely monitor the availability of a variety of service providers across the state. Public facing elements of the directory will allow individuals and families to access provider information regarding the types of services offered locally and capacity to serve. As described in Appendix I-2a, providers whose rates are set at 90% of the rate identified in the regional center specific rate model are eligible to earn supplemental payments equal to 10% of the rate identified in the regional center specific rate model for participation in this initial phase of the Quality Incentive Program (QIP). Providers will be eligible to receive this supplemental payment by inputting and validating requested data, including, contact information, corporate structure, and parent company specifics. The information will be reviewed and verified by the State and/or regional center. Upon completion of this review, providers will be notified of any supplemental rate add-on they will receive for services provided on or after January 1, 2025.

Additional Supplemental Payments
1. Prevention and Wellness
DDS is providing supplemental payments to eligible residential providers who provide licensed/certified Community Living Arrangement Services for the completion of an annual survey in a given calendar year. The survey will collect data on the percentage of individuals who received select preventative health services based on medically recommended frequency using nationally recognized standards. The payment will work as follows:
• A payment of $1000 per resident will be paid after completion and submission of this data collection survey for all individuals residing in the facility for 6 months or longer in a given calendar year.
• An additional $200 per resident will be paid to eligible providers for each of three preventative health screenings received at recommended intervals. Survey data will be submitted for eligible individuals residing in facility for 6 months or longer in the given calendar year.

There is one payment available per calendar year per provider.

2. Employment Capacity:
DDS is providing supplemental payments to eligible providers whose employees become certified or re-certified as trained employment specialists. These supplemental payments are designed to expand systemwide capacity to support individuals with intellectual and developmental disabilities in achieving competitive integrated employment.

a) A supplemental payment of $3000 will be paid to the service provider for each employee who becomes certified or re-certified in ACRE (Association of Community
Rehabilitation Educators) Basic Employment Services or ACRE Basic Customized Employment Services.
b) A supplemental payment of $625 will be paid to the service provider for each employee who becomes certified in CESP (Certified Employment Support Professionals)
Training.
c)A supplemental payment of $425 will be paid to the service provider for each employee who becomes re-certified in CESP.

3. Workforce Capacity:
DDS is providing supplemental payments to eligible providers across all services for completion of an annual data collection survey that will establish baseline information from which DDS, agencies and stakeholders may assess challenges, evaluate the impact of existing initiatives and shape future policies to improve workforce stability.

The survey collects data pertaining to Direct Service Professional tenure, turnover, vacancy rates, wages, and other compensation including benefits, recruitment and retention, and front-line supervisor support.

A single payment of $8,000 will be paid to provider agencies after completion and submission of this data collection survey. There is one payment available per provider organization per year.

CONTINUATION OF I-3-c. SUPPLEMENTAL OR ENHANCED PAYMENTS CAN BE FOUND UNDER MAIN(B) OPTIONAL.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- (●) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) Waiver services will be reimbursed through an Organized Health Care Delivery System (OHCDS) operated by DDS, which is the enrolled Medicaid provider for these services. DDS provides Medicaid services (outside the waiver) through its operation of state developmental centers. HCBS waiver and case management services are provided through 21 private non-profit entities known as regional centers which are under contract with DDS to coordinate, counsel, advocate and arrange for individualized services and supports for people with developmental disabilities and their families. Regional centers were created as a result of Legislation passed in 1969 which mandated that a network of regional centers be created in California. Each regional center provides services to individuals with developmental disabilities in their "catchment area." DDS contracts with each regional center's governing board for a term of five years. The contract includes required program and fiscal provisions. Regional centers are enrolled Med-Cal providers.

(b)The DDS OHCDS is an open network. Regional centers evaluate and approve prospective providers through a process referred to as vendorization. The purpose of vendorization is to ensure that the provider meets DDS and HCBS waiver qualifications and is enrolled in the regional center payment system. The regional centers do not have the ability to contract selectively or otherwise restrict the number of providers reimbursed for DDS services.

(c) Consumers select their providers through the development and implementation of an individual program plan (IPP). A consumer is not limited to providers already vendored by the regional center. If a consumer selects another provider, that provider is then vendored to ensure that it meets provider qualifications and is enrolled in the regional center's payment system.

(d) DDS establishes the qualifications for providers. The regional centers, as agents of DDS, are responsible for ensuring that providers meet all applicable qualifications, including but not limited to, applicable provider enrollment requirements. If they do, they are then vendored and included in the OHCDS.

(e) DDS is responsible for overseeing the operation of the OHCDS. This includes assuring that the regional centers review the qualifications of all providers (through the vendor process) and require providers to meet all applicable Medicaid requirements (e.g., the maintenance of necessary documentation).

(f) The regional centers pay enrolled providers based on the submission of claims. DDS then reimburses the regional centers for these expenditures, plus administrative expenses based on time studies. DDS certifies these expenditures to DHCS for reimbursement of the federal share. There is no mark up of expenditures. The amount that the DDS OHCDS bills for Waiver services equals the amount that it reimburses the regional centers plus its administrative costs. Providers are not required to contract and/or bill via the regional center.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid***

ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

- ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☑ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

DDS directly incurs the full cost of waiver services. The non-federal share for these costs is appropriated directly to DDS through the State budget process. The source of all non-federal, or matching, funds used in computing the waiver costs is from State revenues. Therefore, no federal funds are used to match other federal funds.

As described in item I-2-c, the total amount paid for waiver services is submitted to DHCS by DDS via certified public expenditures as the basis for claiming of FFP.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- (●) ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*
- ( ) ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

When establishing reimbursement rates as described in Appendix I-2-a for Habilitation-Community Living Arrangement Services (CLAS), with the exception of vendor and state-operated Enhanced Behavioral Supports Homes (EBSH), no expenses associated with room and board are considered. The costs of room and board are not a consideration when determining reimbursement rates.

For vendor operated EBSHs in CLAS and for vendor operated Community Crisis Homes in Behavioral Intervention Services, prior to submission of claims for reimbursement, the state identifies the portion of the claim that is eligible for reimbursement, using information submitted at the time of facility rate approval. Room and board costs, as well as the allocated portion of indirect associated with these costs, are excluded from the portion of the claim that the state submits for federal reimbursement.

For state operated EBSHs in CLAS and for state-operated Community Crisis Homes in Behavioral Intervention Services, costs are captured in the statewide accounting system and those costs associated with room and board are excluded from claims submitted for reimbursement. Only costs associated with direct service are submitted for federal reimbursement.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used 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 and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	39288.50	22230.00	61518.50	73726.00	10739.00	84465.00	22946.50
2	39719.30	22230.00	61949.30	75938.00	10739.00	86677.00	24727.70
3	43886.31	22230.00	66116.31	78216.00	10739.00	88955.00	22838.69
4	43534.60	22230.00	65764.60	80562.00	10739.00	91301.00	25536.40
5	43292.20	22230.00	65522.20	82979.00	10739.00	93718.00	28195.80

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	155000	155000
Year 2	161000	161000
Year 3	167000	167000
Year 4	173000	173000
Year 5	179000	179000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) is calculated by dividing the total number of enrolled days of all waiver participants by the unduplicated recipients reported in the CMS 372 for waiver year 2019.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The Factor D utilization factors for waiver services are derived from actual expenditures and unduplicated users from the CMS 372 for 2019 for services provided to persons enrolled on the Home and Community-based Services Waiver for the Developmentally Disabled (HCBS DD Waiver).

The per capita cost, by service, was trended forward to reflect increases in the number of persons who will be served during the renewal period. Utilization adjustments take into account the ALOS calculation above. Where appropriate, rates have been adjusted to reflect increases due to rate reform.

Self-Directed Support Services has been added as a new service beginning in waiver year 1. The estimated number of users utilizes actual usage data for a similar state-funded service as a baseline. This baseline is trended forward for waiver years 2-5 based on the year-over-year increase (as a percentage) of estimated unduplicated waiver participants. Estimated units per user is based on trends of actual usage for a similar state-funded service. The cost per unit is derived from estimated allowable direct and indirect cost components (staff wages and benefits, transportation, and administrative costs).

Coordinated Family Supports has been added as a new service beginning in waiver year one. The estimated number of users in waiver year one was calculated based on anticipated service utilization given the projected number of individuals in family home settings. This baseline is trended forward for waiver years 2-5 based on the year-over-year increase (as a percentage) of estimated unduplicated waiver participants. Estimated units were based on trends of actual usage for a similar state-funded service. The state will monitor actual service utilization and update future estimates for this service where appropriate. The rates for this service were established for each regional center to account for geographic cost differences related to wages, travel, and nonresidential real estate, and were averaged for purposes of inclusion in Appendix J.

Participant-directed services has been added as a new service beginning in waiver year two. The estimated number of users in waiver year two was calculated based on anticipated service utilization given the projected number of individuals using recreational services. This baseline is trended forward for waiver years 3-5 based on the year-over-year increase (as a percentage) of estimated unduplicated waiver participants. Estimated units were based on trends of actual usage for a similar state-funded service. The state will monitor actual service utilization and update future estimates for this service where appropriate. The cost per unit is derived from estimated allowable cost of similar services.

Financial management services (FMS): The estimated users for FMS are being increased to reflect additional users accessing FMS in support of participant-directed services.

Community based day services: participant-directed personal assistance, and participant-directed independent living program rates are being increased based on the California minimum wage effective 1/5/2024. Effective January 5, 2024, the rate model for independent living program providers is being increased based on updated wage assumptions which reflect more equivalent occupations and duties performed by those occupations.

Supported Employment Individual: participant-directed supported employment rates are being increased based on the California minimum wage effective 1/5/2024. Competitive integrated employment incentive amounts are being updated to include additional incentive payments for attaining new milestones as described in appendix C.

Prevocational Services: Competitive Integrated Employment incentives for reaching 30-day, 6-month, and 12-month milestones are being added for Waiver Years 2-5.

Community Living Arrangement Services: Licensed/certified residential services rates are being increased for providers utilizing ARM rates based on the California minimum wage effective 1/5/2024. Group Homes for Children with Special Health Care Needs has been added as a service provider in the Licensed/Certified Residential Services category. The estimated increase of users in waiver year two was calculated based on the projected number of group homes slated to open in waiver year two and the number individuals that will reside in the setting. This baseline is trended forward for waiver years 3-5 based on the year-over-year increase (as a percentage) of estimated unduplicated waiver participants.

Rates for services included in the full implementation of the rate study to reflect increases to the 90% benchmark as described in Appendix I, effective January 1, 2025, increasing the estimate for waiver years 3-5. Effective

March 1, 2026, provider rates that exceed 90% of the benchmark were adjusted to align with other provider rates in their category.

Financial management services (FMS): The rates for providers of FMS are being increased effective January 1, 2025, impacting Waiver Years 3-5.

Person-centered future planning has been added as a new service beginning in waiver year three. The number of users in waiver year three was calculated based on estimated number of individuals who the State has determined will utilize this service (those approaching various milestones or individuals with complex needs. This baseline is trended forward for waiver years 4-5 based on the year-over-year increase (as a percentage) of estimated unduplicated waiver participants.

Remote Support Services has been added as a new service beginning in waiver year 4. The number of users in waiver year 5 was calculated based on estimated number of individuals who the State has determined will utilize this service. This baseline is trended forward for waiver year 5 based on the year-over-year increase of estimated unduplicated waiver participants.

The estimated number of users of Communication Aide has been increased in waiver years 4 and 5 to reflect the addition of a new provider type. The increase in number of users is based on an estimated number of individuals likely to access the service and trended forward in waiver year 5 based on anticipated year-over-year increases.

Based on anticipated providers likely to receive supplemental payments as described in the waiver application, corresponding service rates identified in Appendix J were adjusted to account for an estimated per person fiscal impact in waiver years 4 and 5.

The number of eligible recipients was estimated based on an analysis of current recipient data and historical estimates for prior waiver amendments, starting in waiver year one with 155,000 and estimating a caseload increase of 6,000 in each subsequent year to reach 179,000 in waiver year 5. Estimates of eligible recipients by service for each proposed year of the Waiver were based on the total number of actual recipients of each service reported in the 2019 CMS 372 report as a baseline for waiver year 1 and is trended forward for waiver years 2-5 based on the year-over-year increase (as a percentage) of estimated unduplicated waiver recipients.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' equals the average per capita annual costs for all other Medicaid services (ancillary) to HCBS DD Waiver recipients (excluding HCBS DD Waiver costs). These estimates are based on actual costs from the CMS 372 report for calendar year 2019.

The following are used in deriving the Factor D':
The cost of all State Plan services furnished in addition to HCBS DD Waiver services while the participant was on the HCBS DD Waiver, including, but not limited to:
o State Plan home health services;
o State Plan personal care services authorized through the county's In Home Supportive Services program;
o Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services;
o State Plan Community Based Adult Services;
o Short-term institutionalization (hospitalization or Nursing Facility) which began after the participants first day of waiver services and ended before the end of the waiver year, if the person returned to the waiver.
o Medical equipment and supplies covered under the State Plan;
o Non-emergency transportation services covered under the State Plan; and
o Outpatient clinic and physician services covered under the State Plan.
Factor D' does not include the following:
o The costs of institutional care, if the person did NOT return to the HCBS DD Waiver following institutionalization;
o Institutional costs incurred BEFORE the person is first served under the HCBS DD Waiver in the specified waiver year;
o Costs for institutional respite care provided as a service under the HCBS DD Waiver. Such costs are included in the calculation of costs under Factor D; or
o Medicare Part D drug costs are not included in the Factor D' estimates.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G equals the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/DD care that would be incurred for individuals served in the Waiver, were the Waiver not granted. The factor G estimates for inpatient intermediate care facility subacute, and hospital LOC are based on actual costs reported in the CMS 372 reports for calendar year 2019, plus a 3% compound annual increase.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G' ***estimates for all other Medicaid costs for services utilization for inpatient intermediate care facility, subacute and hospital level of care based on actual costs reported in the CMS 372 report calendar year 2019.***

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Behavioral Intervention Services	
Community Living Arrangement Services	
Day Service	
Homemaker	
Prevocational Services	
Respite Care	
Supported Employment	

Waiver Services	
Dental Services	
Home Health Aide	
Occupational Therapy	
Optometric/Optician Services	
Physical Therapy	
Prescription Lenses and Frames	
Psychology Services	
Speech, Hearing and Language Services	
Financial Management Service	
Chore Services	
Communication Aides	
Community Based Adult Services	
Community-Based Training Service	
Coordinated Family Supports	
Environmental Accessibility Adaptations	
Family Support Services	
Family/ Consumer Training	
Housing Access Services	
Intensive Transition Services	
Non-Medical Transportation	
Nutritional Consultation	
Participant-Directed Services	
Person-Centered Future Planning	
Personal Emergency Response Systems (PERS)	
Remote Support Services	
Self-Directed Support Services	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Transition/Set Up Expenses	
Vehicle Modifications and Adaptations	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						137051292.89
Community Crisis Homes - Transition Costs	Daily	6	1.00	1643.58	9861.48	
Community Crisis Homes - Facility Costs	Month	41	11.00	10888.61	4910763.11	
Community Crisis Homes - Individual Costs	Month	42	11.00	24540.34	11337637.08	
State-Operated Community Crisis Homes	Month	20	12.00	57052.58	13692619.20	
Behavior Intervention Services	Hour	15477	106.96	55.56	91975130.76	
Crisis Support	Daily	101	173.73	862.00	15125281.26	
Community Living Arrangement Services Total:						3070956381.31
Licensed/Certified Residential Services	Month	30385	11.00	5393.51	1802699814.85	
In-Home Day Program	Daily	440	206.38	97.81	8881852.23	
Supported Living Services	Hour	11916	2349.66	44.98	1259374714.23	
Day Service Total:						1679084229.23
Therapeutic/Activity-Based Day Services	Hour	451	115.88	44.05	2302135.81	
Mobility-Related Day Services	Hour	136	49.94	54.35	369136.50	
Community-based Day Services	Hour	32984	689.11	23.91	543464837.38	
Community-based Day Services	Daily	67038	206.46	81.85	1132858469.54	
Therapeutic/Activity-Based Day Services	Month	163	11.00	50.00	89650.00	
Homemaker Total:						28103613.69
Homemaker	Hour	1768	747.33	21.27	28103613.69	
Prevocational Services Total:						67461125.97
Rehab Work Activity Program	Daily	4059	161.98	37.28	24510735.85	
Supported Employment Programs	Daily	2383	384.71	46.85	42950390.12	
CIE Incentives 30-					0.00	

GRAND TOTAL: 6089717637.43

Total Estimated Unduplicated Participants: 155000

Factor D (Divide total by number of participants): 39288.50

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day	One-Time	0	0.00	2439.00		
CIE Incentives 6-Month	One-Time	0	0.00	2939.00	0.00	
CIE Incentives 12-Month	One-Time	0	0.00	3000.00	0.00	
Respite Care Total:						597553903.69
Out-of-Home Respite Care	Daily	3660	35.58	90.31	11760421.07	
In-Home Respite Care	Hour	74689	296.75	26.43	585793482.62	
Supported Employment Total:						15543431.95
Supported Employment Individual	Hour	2028	128.89	44.95	11749431.95	
Competitive Integrated Employment Incentive Payments - 12 months	One-time	500	1.00	3000.00	1500000.00	
Competitive Integrated Employment Incentive Payments - 30 days	One-time	553	1.00	2000.00	1106000.00	
Competitive Integrated Employment Incentive Payments - 6 months	One-time	416	1.00	2500.00	1040000.00	
Incentives for Internships - 30 Days	One-time	104	1.00	750.00	78000.00	
Incentives for Internships - 60 Days	One-time	70	1.00	1000.00	70000.00	
Dental Services Total:						3396480.00
Dental Services	Visit	5307	2.00	320.00	3396480.00	
Home Health Aide Total:						22422326.85
Home Health Aide	Hour	900	878.79	28.35	22422326.85	
Occupational Therapy Total:						261410.95
Occupational Therapy	Hour	403	9.09	71.36	261410.95	
Optometric/Optician Services Total:						17074.14
Optometric/Optician Services	Visit	120	3.83	37.15	17074.14	

GRAND TOTAL: 6089717637.43

Total Estimated Unduplicated Participants: 155000

Factor D (Divide total by number of participants): 39288.50

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Total:						103469.27
Physical Therapy	Hour	112	13.42	68.84	103469.27	
Prescription Lenses and Frames Total:						192040.80
Prescription Lenses and Frames	Piece	276	1.00	695.80	192040.80	
Psychology Services Total:						557094.13
Psychology Services	Hour	630	21.16	41.79	557094.13	
Speech, Hearing and Language Services Total:						101538.85
Speech, Hearing and Language Services	Hour	107	12.76	74.37	101538.85	
Financial Management Service Total:						9376055.04
Financial Management Service	Month	12864	11.00	66.26	9376055.04	
Chore Services Total:						2000.00
Chore Services	Hour	4	1.00	500.00	2000.00	
Communication Aides Total:						6122571.68
Communication Aides	Hour	7022	23.98	36.36	6122571.68	
Community Based Adult Services Total:						3449356.51
Community Based Adult Services	Day	240	188.44	76.27	3449356.51	
Community-Based Training Service Total:						171698.62
Community-Based Training Service	Hour	20	456.16	18.82	171698.62	
Coordinated Family Supports Total:						1894800.00
Coordinated Family Supports	Hour	1579	20.00	60.00	1894800.00	
Environmental Accessibility Adaptations Total:						3509269.92
Environmental Accessibility Adaptations	Adaptation	318	1.00	11035.44	3509269.92	
Family Support Services Total:						38717393.22
Family Support Services	Hour	3769	566.92	18.12	38717393.22	

GRAND TOTAL: 6089717637.43

Total Estimated Unduplicated Participants: 155000

Factor D (Divide total by number of participants): 39288.50

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family/ Consumer Training Total:						23026.88
Family/ Consumer Training	Hour	15	26.67	57.56	23026.88	
Housing Access Services Total:						2595842.60
Housing Access Services	Hour	1882	21.22	65.00	2595842.60	
Intensive Transition Services Total:						4806000.00
Intensive Transition Services	Month	45	12.00	8900.00	4806000.00	
Non-Medical Transportation Total:						370120033.67
Transportation Companies	Daily	61292	179.32	29.07	319504923.46	
Individual Transportation Providers	Miles	4383	3051.75	0.66	8828041.36	
Public Transit/Rental/Taxi	Month	15414	34.85	77.79	41787068.84	
Nutritional Consultation Total:						75622.38
Nutritional Consultation	Hour	486	3.36	46.31	75622.38	
Participant-Directed Services Total:						0.00
Participant-Directed Services	Month	1	0.00	0.01	0.00	
Person-Centered Future Planning Total:						0.00
Person-Centered Future Planning	Month	0	0.00	0.01	0.00	
Personal Emergency Response Systems (PERS) Total:						3325194.18
Personal Emergency Response Systems (PERS)	Month	8694	11.00	34.77	3325194.18	
Remote Support Services Total:						0.00
Remote Support Services - Equipment	Item	0	0.00	0.01	0.00	
Remote Support Services - Monitoring	Month	0	0.00	0.01	0.00	
Remote Support Services - Assessment	Hour	0	0.00	0.01	0.00	
Self-Directed Support Services Total:						467500.00
Self-Directed					467500.00	

GRAND TOTAL: 6089717637.43

Total Estimated Unduplicated Participants: 155000

Factor D (Divide total by number of participants): 39288.50

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Services	Hour	187	50.00	50.00		
Skilled Nursing Total:						10393559.27
Licensed Vocational Nurse	Hour	597	362.04	37.67	8141913.94	
Registered Nurse	Hour	859	43.07	60.86	2251645.33	
Specialized Medical Equipment and Supplies Total:						5564464.52
Specialized Medical Equipment and Supplies	Piece	3326	1.00	1673.02	5564464.52	
Transition/Set Up Expenses Total:						17970.80
Transition/Set Up Expenses	Transition	4	1.00	4492.70	17970.80	
Vehicle Modifications and Adaptations Total:						6279864.42
Vehicle Modifications and Adaptations	Modification	438	1.00	14337.59	6279864.42	

GRAND TOTAL: 6089717637.43
Total Estimated Unduplicated Participants: 155000
Factor D (Divide total by number of participants): 39288.50
Average Length of Stay on the Waiver: 343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						142649577.26
Community Crisis Homes - Transition Costs	Daily	6	1.00	1643.58	9861.48	
Community Crisis Homes - Facility Costs	Month	43	11.00	10888.61	5150312.53	
Community Crisis Homes - Individual Costs	Month	44	11.00	24540.34	11877524.56	

GRAND TOTAL: 6394806501.01
Total Estimated Unduplicated Participants: 161000
Factor D (Divide total by number of participants): 39719.30
Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
State-Operated Community Crisis Homes	Month	21	12.00	57052.58	14377250.16	
Behavior Intervention Services	Hour	16075	106.92	55.57	95510326.23	
Crisis Support	Daily	105	173.73	862.00	15724302.30	
Community Living Arrangement Services Total:						3219599637.27
Licensed/Certified Residential Services	Month	31577	11.00	5476.32	1902183323.04	
In-Home Day Program	Daily	457	206.38	97.81	9225014.70	
Supported Living Services	Hour	12378	2349.64	44.98	1308191299.52	
Day Service Total:						1757069314.14
Therapeutic/Activity-Based Day Services	Hour	468	115.91	44.05	2389531.01	
Mobility-Related Day Services	Hour	142	49.93	54.35	385344.76	
Community-based Day Services	Hour	34261	689.11	24.46	577490759.99	
Community-based Day Services	Daily	69633	206.46	81.85	1176710728.38	
Therapeutic/Activity-Based Day Services	Month	169	11.00	50.00	92950.00	
Homemaker Total:						29184521.91
Homemaker	Hour	1836	747.33	21.27	29184521.91	
Prevocational Services Total:						70147706.47
Rehab Work Activity Program	Daily	4216	161.98	37.28	25458798.31	
Supported Employment Programs	Daily	2475	384.71	46.85	44608567.16	
CIE Incentives 30-Day	One-Time	11	1.00	2439.00	26829.00	
CIE Incentives 6-Month	One-Time	8	1.00	2939.00	23512.00	
CIE Incentives 12-Month	One-Time	10	1.00	3000.00	30000.00	
Respite Care Total:						620685944.40
Out-of-Home Respite Care	Daily	3802	35.58	90.32	12218052.45	

GRAND TOTAL: 6394806501.01

Total Estimated Unduplicated Participants: 161000

Factor D (Divide total by number of participants): 39719.30

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Respite Care	Hour	77580	296.75	26.43	608467891.95	
Supported Employment Total:						16599493.39
Supported Employment Individual	Hour	2108	128.89	44.95	12212920.39	
Competitive Integrated Employment Incentive Payments - 12 months	One-time	520	1.00	3000.00	1560000.00	
Competitive Integrated Employment Incentive Payments - 30 days	One-time	574	1.00	2439.00	1399986.00	
Competitive Integrated Employment Incentive Payments - 6 months	One-time	433	1.00	2939.00	1272587.00	
Incentives for Internships - 30 Days	One-time	108	1.00	750.00	81000.00	
Incentives for Internships - 60 Days	One-time	73	1.00	1000.00	73000.00	
Dental Services Total:						3527680.00
Dental Services	Visit	5512	2.00	320.00	3527680.00	
Home Health Aide Total:						23294306.23
Home Health Aide	Hour	935	878.79	28.35	23294306.23	
Occupational Therapy Total:						271140.88
Occupational Therapy	Hour	418	9.09	71.36	271140.88	
Optometric/Optician Services Total:						17785.56
Optometric/Optician Services	Visit	125	3.83	37.15	17785.56	
Physical Therapy Total:						107164.60
Physical Therapy	Hour	116	13.42	68.84	107164.60	
Prescription Lenses and Frames Total:						199694.60
Prescription Lenses and Frames	Piece	287	1.00	695.80	199694.60	
Psychology Services Total:						578590.07

GRAND TOTAL: 6394806501.01

Total Estimated Unduplicated Participants: 161000

Factor D (Divide total by number of participants): 39719.30

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Psychology Services	Hour	654	21.17	41.79	578590.07	
Speech, Hearing and Language Services Total:						105141.31
Speech, Hearing and Language Services	Hour	111	12.74	74.35	105141.31	
Financial Management Service Total:						10662547.50
Financial Management Service	Month	15075	11.00	64.30	10662547.50	
Chore Services Total:						2000.00
Chore Services	Hour	4	1.00	500.00	2000.00	
Communication Aides Total:						6359731.96
Communication Aides	Hour	7294	23.98	36.36	6359731.96	
Community Based Adult Services Total:						3578707.38
Community Based Adult Services	Daily	249	188.44	76.27	3578707.38	
Community-Based Training Service Total:						180283.56
Community-Based Training Service	Hour	21	456.16	18.82	180283.56	
Coordinated Family Supports Total:						23616000.00
Coordinated Family Supports	Hour	1640	240.00	60.00	23616000.00	
Environmental Accessibility Adaptations Total:						3641695.20
Environmental Accessibility Adaptations	Adaptation	330	1.00	11035.44	3641695.20	
Family Support Services Total:						40217191.42
Family Support Services	Hour	3915	566.92	18.12	40217191.42	
Family/ Consumer Training Total:						24562.00
Family/ Consumer Training	Hour	16	26.67	57.56	24562.00	
Housing Access Services Total:						2696531.50
Housing Access Services	Hour	1955	21.22	65.00	2696531.50	
Intensive Transition Services Total:						4806000.00

GRAND TOTAL: 6394806501.01

Total Estimated Unduplicated Participants: 161000

Factor D (Divide total by number of participants): 39719.30

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intensive Transition Services	Month	45	12.00	8900.00	4806000.00	
Non-Medical Transportation Total:						384443720.27
Transportation Companies	Daily	63664	179.32	29.07	331869761.91	
Individual Transportation Providers	Miles	4552	3051.75	0.66	9168433.56	
Public Transit/Rental/Taxi	Month	16011	34.85	77.79	43405524.80	
Nutritional Consultation Total:						78578.81
Nutritional Consultation	Hour	505	3.36	46.31	78578.81	
Participant-Directed Services Total:						3384768.09
Participant-Directed Services	Month	1713	11.00	179.63	3384768.09	
Person-Centered Future Planning Total:						0.00
Person-Centered Future Planning	Month	0	0.00	0.01	0.00	
Personal Emergency Response Systems (PERS) Total:						3454086.57
Personal Emergency Response Systems (PERS)	Month	9031	11.00	34.77	3454086.57	
Remote Support Services Total:						0.00
Remote Support Services - Equipment	Item	0	0.00	0.01	0.00	
Remote Support Services - Monitoring	Month	0	0.00	0.01	0.00	
Remote Support Services - Assessment	Hour	0	0.00	0.01	0.00	
Self-Directed Support Services Total:						485000.00
Self-Directed Support Services	Hour	194	50.00	50.00	485000.00	
Skilled Nursing Total:						10815540.30
Licensed Vocational Nurse	Hour	620	363.07	37.66	8477394.04	
Registered Nurse	Hour	892	43.07	60.86	2338146.26	
Specialized Medical Equipment and Supplies Total:						5780284.10

GRAND TOTAL: 6394806501.01

Total Estimated Unduplicated Participants: 161000

Factor D (Divide total by number of participants): 39719.30

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies	Piece	3455	1.00	1673.02	5780284.10	
Transition/Set Up Expenses Total:						17970.80
Transition/Set Up Expenses	Transition	4	1.00	4492.70	17970.80	
Vehicle Modifications and Adaptations Total:						6523603.45
Vehicle Modifications and Adaptations	Modification	455	1.00	14337.59	6523603.45	

GRAND TOTAL: 6394806501.01
Total Estimated Unduplicated Participants: 161000
Factor D (Divide total by number of participants): 39719.30
Average Length of Stay on the Waiver: 343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						156097586.10
Community Crisis Homes - Transition Costs	Daily	6	1.00	1643.58	9861.48	
Community Crisis Homes - Facility Costs	Month	44	11.00	10888.61	5270087.24	
Community Crisis Homes - Individual Costs	Month	45	11.00	24540.34	12147468.30	
State-Operated Community Crisis Homes	Month	22	12.00	57052.58	15061881.12	
Behavior Intervention Services	Hour	16674	108.03	59.56	107284964.62	
Crisis Support	Daily	109	173.73	862.00	16323323.34	
Community Living Arrangement Services Total:						3689070933.09

GRAND TOTAL: 7329013064.06
Total Estimated Unduplicated Participants: 167000
Factor D (Divide total by number of participants): 43886.31
Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Licensed/Certified Residential Services	Month	32755	11.00	6175.06	2224904993.30	
In-Home Day Program	Daily	474	206.38	191.87	18769513.90	
Supported Living Services	Hour	12840	2349.61	47.91	1445396425.88	
Day Service Total:						2072696128.44
Therapeutic/Activity-Based Day Services	Hour	485	115.94	44.04	2476408.84	
Mobility-Related Day Services	Hour	148	49.93	55.04	406725.79	
Community-based Day Services	Hour	35538	689.11	27.16	665137296.45	
Community-based Day Services	Daily	72228	206.46	94.19	1404579447.37	
Therapeutic/Activity-Based Day Services	Month	175	11.00	50.00	96250.00	
Homemaker Total:						30265430.13
Homemaker	Hour	1904	747.33	21.27	30265430.13	
Prevocational Services Total:						75563705.54
Rehab Work Activity Program	Daily	4373	161.98	37.58	26619362.33	
Supported Employment Programs	Daily	2567	384.71	49.48	48864002.20	
CIE Incentives 30-Day	One-Time	11	1.00	2439.00	26829.00	
CIE Incentives 6-Month	One-Time	8	1.00	2939.00	23512.00	
CIE Incentives 12-Month	One-Time	10	1.00	3000.00	30000.00	
Respite Care Total:						667695695.67
Out-of-Home Respite Care	Daily	3944	35.57	90.34	12673625.15	
In-Home Respite Care	Hour	80471	296.75	27.43	655022070.53	
Supported Employment Total:						18344108.55
Supported Employment Individual	Hour	2188	128.89	48.90	13790353.55	
Competitive Integrated Employment	One-time	540	1.00	3000.00	1620000.00	

GRAND TOTAL: 7329013064.06

Total Estimated Unduplicated Participants: 167000

Factor D (Divide total by number of participants): 43886.31

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Incentive Payments - 12 months						
Competitive Integrated Employment Incentive Payments - 30 days	One-time	595	1.00	2439.00	1451205.00	
Competitive Integrated Employment Incentive Payments - 6 months	One-time	450	1.00	2939.00	1322550.00	
Incentives for Internships - 30 Days	One-time	112	1.00	750.00	84000.00	
Incentives for Internships - 60 Days	One-time	76	1.00	1000.00	76000.00	
Dental Services Total:						3812209.94
Dental Services	Visit	5717	2.00	333.41	3812209.94	
Home Health Aide Total:						24166285.61
Home Health Aide	Hour	970	878.79	28.35	24166285.60	
Occupational Therapy Total:						281106.98
Occupational Therapy	Hour	433	9.09	71.42	281106.98	
Optometric/Optician Services Total:						18496.99
Optometric/Optician Services	Visit	130	3.83	37.15	18496.98	
Physical Therapy Total:						111039.24
Physical Therapy	Hour	120	13.43	68.90	111039.24	
Prescription Lenses and Frames Total:						207348.40
Prescription Lenses and Frames	Piece	298	1.00	695.80	207348.40	
Psychology Services Total:						654939.25
Psychology Services	Hour	678	21.17	45.63	654939.25	
Speech, Hearing and Language Services Total:						109753.88
Speech, Hearing and Language Services	Hour	115	12.72	75.03	109753.88	
Financial Management Service Total:						28895455.93

GRAND TOTAL: 7329013064.06

Total Estimated Unduplicated Participants: 167000

Factor D (Divide total by number of participants): 43886.31

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Service	Month	15637	11.00	167.99	28895455.93	
Chore Services Total:						2000.00
Chore Services	Hour	4	1.00	500.00	2000.00	
Communication Aides Total:						6596892.24
Communication Aides	Hour	7566	23.98	36.36	6596892.24	
Community Based Adult Services Total:						3708058.25
Community Based Adult Services	Daily	258	188.44	76.27	3708058.25	
Community-Based Training Service Total:						206832.07
Community-Based Training Service	Hour	22	456.16	20.61	206832.07	
Coordinated Family Supports Total:						24494400.00
Coordinated Family Supports	Hour	1701	240.00	60.00	24494400.00	
Environmental Accessibility Adaptations Total:						3774120.48
Environmental Accessibility Adaptations	Adaptation	342	1.00	11035.44	3774120.48	
Family Support Services Total:						41716989.61
Family Support Services	Hour	4061	566.92	18.12	41716989.61	
Family/ Consumer Training Total:						26097.13
Family/ Consumer Training	Hour	17	26.67	57.56	26097.13	
Housing Access Services Total:						2797220.40
Housing Access Services	Hour	2028	21.22	65.00	2797220.40	
Intensive Transition Services Total:						4806000.00
Intensive Transition Services	Month	45	12.00	8900.00	4806000.00	
Non-Medical Transportation Total:						440331336.95
Transportation Companies	Daily	66036	179.32	32.58	385798530.44	
Individual Transportation Providers	Miles	4721	3051.75	0.66	9508825.76	

GRAND TOTAL: 7329013064.06

Total Estimated Unduplicated Participants: 167000

Factor D (Divide total by number of participants): 43886.31

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Public Transit/Rental/Taxi	Month	16608	34.85	77.79	45023980.75	
Nutritional Consultation Total:						81535.24
Nutritional Consultation	Hour	524	3.36	46.31	81535.24	
Participant-Directed Services Total:						3511227.61
Participant-Directed Services	Month	1777	11.00	179.63	3511227.61	
Person-Centered Future Planning Total:						719883.60
Person-Centered Future Planning	Month	789	10.00	91.24	719883.60	
Personal Emergency Response Systems (PERS) Total:						3582978.96
Personal Emergency Response Systems (PERS)	Month	9368	11.00	34.77	3582978.96	
Remote Support Services Total:						0.00
Remote Support Services - Equipment	Item	0	0.00	0.01	0.00	
Remote Support Services - Monitoring	Month	0	0.00	0.01	0.00	
Remote Support Services - Assessment	Hour	0	0.00	0.01	0.00	
Self-Directed Support Services Total:						502500.00
Self-Directed Support Services	Hour	201	50.00	50.00	502500.00	
Skilled Nursing Total:						11383350.83
Licensed Vocational Nurse	Hour	644	363.95	38.20	8953461.16	
Registered Nurse	Hour	927	43.07	60.86	2429889.67	
Specialized Medical Equipment and Supplies Total:						5996103.68
Specialized Medical Equipment and Supplies	Piece	3584	1.00	1673.02	5996103.68	
Transition/Set Up Expenses Total:						17970.80
Transition/Set Up Expenses	Transition	4	1.00	4492.70	17970.80	
Vehicle Modifications and Adaptations Total:						6767342.48

GRAND TOTAL: 7329013064.06

Total Estimated Unduplicated Participants: 167000

Factor D (Divide total by number of participants): 43886.31

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications and Adaptations	Modification	472	1.00	14337.59	6767342.48	

GRAND TOTAL: 7329013064.06
Total Estimated Unduplicated Participants: 167000
Factor D (Divide total by number of participants): 43886.31
Average Length of Stay on the Waiver: 343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						160714433.99
Community Crisis Homes - Transition Costs	Daily	7	1.00	1643.58	11505.06	
Community Crisis Homes - Facility Costs	Month	46	11.00	10888.61	5509636.66	
Community Crisis Homes - Individual Costs	Month	47	11.00	24540.34	12687355.78	
State-Operated Community Crisis Homes	Month	22	12.00	57052.58	15061881.12	
Behavior Intervention Services	Hour	17272	107.98	59.26	110521710.99	
Crisis Support	Daily	113	173.73	862.00	16922344.38	
Community Living Arrangement Services Total:						3790777941.02
Licensed/Certified Residential Services	Month	33933	11.00	6092.07	2273944324.41	
In-Home Day Program	Daily	491	206.38	191.87	19442682.12	
Supported Living Services	Hour	13302	2349.59	47.91	1497390934.48	
Day Service Total:						2123900455.19

GRAND TOTAL: 7531486194.69
Total Estimated Unduplicated Participants: 173000
Factor D (Divide total by number of participants): 43534.60
Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic/Activity-Based Day Services	Hour	502	115.97	44.04	2563874.04	
Mobility-Related Day Services	Hour	154	49.93	55.06	423368.45	
Community-based Day Services	Hour	36815	689.11	26.73	678128997.69	
Community-based Day Services	Daily	74823	206.46	93.39	1442684665.01	
Therapeutic/Activity-Based Day Services	Month	181	11.00	50.00	99550.00	
Homemaker Total:						34500130.73
Homemaker	Hour	1972	747.33	23.41	34500130.73	
Prevocational Services Total:						71966180.89
Rehab Work Activity Program	Daily	4530	161.98	28.98	21264637.21	
Supported Employment Programs	Daily	2659	384.71	49.48	50615263.68	
CIE Incentives 30-Day	One-Time	11	1.00	2439.00	26829.00	
CIE Incentives 6-Month	One-Time	9	1.00	2939.00	26451.00	
CIE Incentives 12-Month	One-Time	11	1.00	3000.00	33000.00	
Respite Care Total:						691676260.93
Out-of-Home Respite Care	Daily	4086	35.56	90.31	13121876.83	
In-Home Respite Care	Hour	83362	296.75	27.43	678554384.10	
Supported Employment Total:						19015508.23
Supported Employment Individual	Hour	2268	128.89	48.90	14294571.23	
Competitive Integrated Employment Incentive Payments - 12 months	One-time	560	1.00	3000.00	1680000.00	
Competitive Integrated Employment Incentive Payments - 30 days	One-time	616	1.00	2439.00	1502424.00	
Competitive Integrated Employment Incentive Payments -	One-time	467	1.00	2939.00	1372513.00	

GRAND TOTAL: 7531486194.69

Total Estimated Unduplicated Participants: 173000

Factor D (Divide total by number of participants): 43534.60

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
6 months						
Incentives for Internships - 30 Days	One-time	116	1.00	750.00	87000.00	
Incentives for Internships - 60 Days	One-time	79	1.00	1000.00	79000.00	
Dental Services Total:						3948908.04
Dental Services	Visit	5922	2.00	333.41	3948908.04	
Home Health Aide Total:						25038264.98
Home Health Aide	Hour	1005	878.79	28.35	25038264.98	
Occupational Therapy Total:						290845.09
Occupational Therapy	Hour	448	9.09	71.42	290845.09	
Optometric/Optician Services Total:						19208.41
Optometric/Optician Services	Visit	135	3.83	37.15	19208.41	
Physical Therapy Total:						114825.98
Physical Therapy	Hour	124	13.44	68.90	114825.98	
Prescription Lenses and Frames Total:						215002.20
Prescription Lenses and Frames	Piece	309	1.00	695.80	215002.20	
Psychology Services Total:						678122.94
Psychology Services	Hour	702	21.17	45.63	678122.94	
Speech, Hearing and Language Services Total:						113392.84
Speech, Hearing and Language Services	Hour	119	12.70	75.03	113392.84	
Financial Management Service Total:						29933970.11
Financial Management Service	Month	16199	11.00	167.99	29933970.11	
Chore Services Total:						2000.00
Chore Services	Hour	4	1.00	500.00	2000.00	
Communication Aides Total:						7778145.82
Communication					7778145.82	

GRAND TOTAL: 7531486194.69

Total Estimated Unduplicated Participants: 173000

Factor D (Divide total by number of participants): 43534.60

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Aides	Hour	8284	24.35	38.56		
Community Based Adult Services Total:						3837409.12
Community Based Adult Services	Daily	267	188.44	76.27	3837409.12	
Community-Based Training Service Total:						212351.60
Community-Based Training Service	Hour	23	456.16	20.24	212351.60	
Coordinated Family Supports Total:						25372800.00
Coordinated Family Supports	Hour	1762	240.00	60.00	25372800.00	
Environmental Accessibility Adaptations Total:						3906545.76
Environmental Accessibility Adaptations	Adaptation	354	1.00	11035.44	3906545.76	
Family Support Services Total:						43216787.81
Family Support Services	Hour	4207	566.92	18.12	43216787.81	
Family/ Consumer Training Total:						32082.41
Family/ Consumer Training	Hour	18	26.67	66.83	32082.41	
Housing Access Services Total:						2897909.30
Housing Access Services	Hour	2101	21.22	65.00	2897909.30	
Intensive Transition Services Total:						4806000.00
Intensive Transition Services	Month	45	12.00	8900.00	4806000.00	
Non-Medical Transportation Total:						452345213.39
Transportation Companies	Daily	68408	179.32	32.27	395853591.01	
Individual Transportation Providers	Miles	4890	3051.74	0.66	9849185.68	
Public Transit/Rental/Taxi	Month	17205	34.85	77.79	46642436.71	
Nutritional Consultation Total:						84491.67
Nutritional Consultation	Hour	543	3.36	46.31	84491.67	
Participant-Directed Services Total:						3637687.13

GRAND TOTAL: 7531486194.69

Total Estimated Unduplicated Participants: 173000

Factor D (Divide total by number of participants): 43534.60

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant-Directed Services	Month	1841	11.00	179.63	3637687.13	
Person-Centered Future Planning Total:						745430.80
Person-Centered Future Planning	Month	817	10.00	91.24	745430.80	
Personal Emergency Response Systems (PERS) Total:						3711871.35
Personal Emergency Response Systems (PERS)	Month	9705	11.00	34.77	3711871.35	
Remote Support Services Total:						400298.00
Remote Support Services - Equipment	Item	100	3.00	500.00	150000.00	
Remote Support Services - Monitoring	Month	100	2.00	1205.42	241084.00	
Remote Support Services - Assessment	Hour	100	2.00	46.07	9214.00	
Self-Directed Support Services Total:						520000.00
Self-Directed Support Services	Hour	208	50.00	50.00	520000.00	
Skilled Nursing Total:						11834743.37
Licensed Vocational Nurse	Hour	669	364.32	38.20	9310489.06	
Registered Nurse	Hour	963	43.07	60.86	2524254.31	
Specialized Medical Equipment and Supplies Total:						6211923.26
Specialized Medical Equipment and Supplies	Piece	3713	1.00	1673.02	6211923.26	
Transition/Set Up Expenses Total:						17970.80
Transition/Set Up Expenses	Transition	4	1.00	4492.70	17970.80	
Vehicle Modifications and Adaptations Total:						7011081.51
Vehicle Modifications and Adaptations	Modification	489	1.00	14337.59	7011081.51	

GRAND TOTAL: 7531486194.69

Total Estimated Unduplicated Participants: 173000

Factor D (Divide total by number of participants): 43534.60

Average Length of Stay on the Waiver: 343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						166326194.95
Community Crisis Homes - Transition Costs	Daily	7	1.00	1643.58	11505.06	
Community Crisis Homes - Facility Costs	Month	47	11.00	10888.61	5629411.37	
Community Crisis Homes - Individual Costs	Month	49	11.00	24540.34	13227243.26	
State-Operated Community Crisis Homes	Month	23	12.00	57052.58	15746512.08	
Behavior Intervention Services	Hour	17870	107.94	59.20	114190157.76	
Crisis Support	Daily	117	173.73	862.00	17521365.42	
Community Living Arrangement Services Total:						3897218003.18
Licensed/Certified Residential Services	Month	35111	11.00	6075.52	2346493409.92	
In-Home Day Program	Daily	508	216.32	191.71	21067119.26	
Supported Living Services	Hour	13764	2349.57	47.30	1529657474.00	
Day Service Total:						2182405022.03
Therapeutic/Activity-Based Day Services	Hour	519	115.88	44.04	2648641.35	
Mobility-Related Day Services	Hour	160	49.93	55.06	439863.33	
Community-based Day Services	Hour	38092	689.11	26.25	689051425.65	
Community-based Day Services	Daily	77418	206.46	93.23	1490162241.70	
Therapeutic/Activity-Based Day Services	Month	187	11.00	50.00	102850.00	
Homemaker Total:						35689790.41
Homemaker	Hour	2040	747.33	23.41	35689790.41	
Prevocational Services						73153196.24

GRAND TOTAL: 7749303830.75

Total Estimated Unduplicated Participants: 179000

Factor D (Divide total by number of participants): 43292.20

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Rehab Work Activity Program	Daily	4687	161.98	27.27	20703391.09	
Supported Employment Programs	Daily	2751	384.71	49.48	52366525.15	
CIE Incentives 30-Day	One-Time	11	1.00	2439.00	26829.00	
CIE Incentives 6-Month	One-Time	9	1.00	2939.00	26451.00	
CIE Incentives 12-Month	One-Time	10	1.00	3000.00	30000.00	
Respite Care Total:						712081906.63
Out-of-Home Respite Care	Daily	4228	35.55	90.34	13578589.84	
In-Home Respite Care	Hour	86253	296.75	27.29	698503316.80	
Supported Employment Total:						19686907.91
Supported Employment Individual	Hour	2348	128.89	48.90	14798788.91	
Competitive Integrated Employment Incentive Payments - 12 months	One-time	580	1.00	3000.00	1740000.00	
Competitive Integrated Employment Incentive Payments - 30 days	One-time	637	1.00	2439.00	1553643.00	
Competitive Integrated Employment Incentive Payments - 6 months	One-time	484	1.00	2939.00	1422476.00	
Incentives for Internships - 30 Days	One-time	120	1.00	750.00	90000.00	
Incentives for Internships - 60 Days	One-time	82	1.00	1000.00	82000.00	
Dental Services Total:						4085606.14
Dental Services	Visit	6127	2.00	333.41	4085606.14	
Home Health Aide Total:						25910244.36
Home Health Aide	Hour	1040	878.79	28.35	25910244.36	
Occupational Therapy Total:						300583.21

GRAND TOTAL: 7749303830.75

Total Estimated Unduplicated Participants: 179000

Factor D (Divide total by number of participants): 43292.20

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy	Hour	463	9.09	71.42	300583.21	
Optometric/Optician Services Total:						19919.83
Optometric/Optician Services	Visit	140	3.83	37.15	19919.83	
Physical Therapy Total:						118530.05
Physical Therapy	Hour	128	13.44	68.90	118530.05	
Prescription Lenses and Frames Total:						222656.00
Prescription Lenses and Frames	Piece	320	1.00	695.80	222656.00	
Psychology Services Total:						701306.63
Psychology Services	Hour	726	21.17	45.63	701306.63	
Speech, Hearing and Language Services Total:						117112.08
Speech, Hearing and Language Services	Hour	123	12.69	75.03	117112.08	
Financial Management Service Total:						30970640.58
Financial Management Service	Month	16761	11.00	167.98	30970640.58	
Chore Services Total:						2000.00
Chore Services	Hour	4	1.00	500.00	2000.00	
Communication Aides Total:						8015659.51
Communication Aides	Hour	8556	24.34	38.49	8015659.51	
Community Based Adult Services Total:						3966759.99
Community Based Adult Services	Daily	276	188.44	76.27	3966759.99	
Community-Based Training Service Total:						225634.98
Community-Based Training Service	Hour	24	456.16	20.61	225634.98	
Coordinated Family Supports Total:						26251200.00
Coordinated Family Supports	Hour	1823	240.00	60.00	26251200.00	
Environmental Accessibility Adaptations Total:						4038971.04

GRAND TOTAL: 7749303830.75

Total Estimated Unduplicated Participants: 179000

Factor D (Divide total by number of participants): 43292.20

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations	Adaptation	366	1.00	11035.44	4038971.04	
Family Support Services Total:						44716586.01
Family Support Services	Hour	4353	566.92	18.12	44716586.01	
Family/ Consumer Training Total:						33864.77
Family/ Consumer Training	Hour	19	26.67	66.83	33864.77	
Housing Access Services Total:						2998598.20
Housing Access Services	Hour	2174	21.22	65.00	2998598.20	
Intensive Transition Services Total:						4806000.00
Intensive Transition Services	Month	45	12.00	8900.00	4806000.00	
Non-Medical Transportation Total:						467268473.23
Transportation Companies	Daily	70780	179.32	32.21	408818003.82	
Individual Transportation Providers	Miles	5059	3051.74	0.66	10189576.76	
Public Transit/Rental/Taxi	Month	17802	34.85	77.79	48260892.66	
Nutritional Consultation Total:						87448.10
Nutritional Consultation	Hour	562	3.36	46.31	87448.10	
Participant-Directed Services Total:						3764146.65
Participant-Directed Services	Month	1905	11.00	179.63	3764146.65	
Person-Centered Future Planning Total:						770978.00
Person-Centered Future Planning	Month	845	10.00	91.24	770978.00	
Personal Emergency Response Systems (PERS) Total:						3840763.74
Personal Emergency Response Systems (PERS)	Month	10042	11.00	34.77	3840763.74	
Remote Support Services Total:						2970352.00
Remote Support Services - Equipment	Item	200	3.00	500.00	300000.00	
Remote Support					2651924.00	

GRAND TOTAL: 7749303830.75

Total Estimated Unduplicated Participants: 179000

Factor D (Divide total by number of participants): 43292.20

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - Monitoring	Month	200	11.00	1205.42		
Remote Support Services - Assessment	Hour	200	2.00	46.07	18428.00	
Self-Directed Support Services Total:						537500.00
Self-Directed Support Services	Hour	215	50.00	50.00	537500.00	
Skilled Nursing Total:						12300740.11
Licensed Vocational Nurse	Hour	695	364.59	38.20	9679499.91	
Registered Nurse	Hour	1000	43.07	60.86	2621240.20	
Specialized Medical Equipment and Supplies Total:						6427742.84
Specialized Medical Equipment and Supplies	Piece	3842	1.00	1673.02	6427742.84	
Transition/Set Up Expenses Total:						17970.80
Transition/Set Up Expenses	Transition	4	1.00	4492.70	17970.80	
Vehicle Modifications and Adaptations Total:						7254820.54
Vehicle Modifications and Adaptations	Modification	506	1.00	14337.59	7254820.54	

GRAND TOTAL: 7749303830.75

Total Estimated Unduplicated Participants: 179000

Factor D (Divide total by number of participants): 43292.20

Average Length of Stay on the Waiver: 343