
POLICY TRANSMITTAL NO. 06-41	DATE: SEPTEMBER 22, 2006
OKLAHOMA HEALTH CARE AUTHORITY/DEVELOPMENTAL DISABILITIES SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS & POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:40-1-2; 40-5-55; 40-5-102; 40-5-103; 40-5-104; 40-5-110;
40-5-150; 40-5-152.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Developmental Disabilities Services rules are revised to establish guidelines to: (1) address situations in which Waiver-funded residential supports can be provided; and (2) govern the provision of specialized medical supplies. Revisions include: (1) Nutrition Service- to provide for persons who refuse nutrition services and specify requirements for nutrition services for persons not receiving residential supports; (2) Authorization for Habilitation Training Specialist Services- to specify requirements for authorization of Habilitation Training Specialist services; (3) Daily Living Supports- to clarify requirements for providers of Daily Living Supports services and criteria for a person receiving those services to receive additional staff supports; and (4) group home services for persons with mental retardation- to cite new rules governing alternative group homes established to implement Senate Bill 1583 and to remove the prohibition on serving persons with pending criminal charges in alternative group homes. Rules are also revised to allow providers of Specialized Foster Care services as well as some service recipients' family members to receive reimbursement for transporting the person they serve. While DDSD service recipients have transportation services authorized on their Plans of Care, under current rules neither Specialized Foster Care providers nor any family member are allowed to receive reimbursement for transporting the service recipient. These revisions will allow a family member other than the service recipient's spouse or the parent of a minor service recipient to contract to provide transportation services to work, medical appointments, or other activities identified in that person's Individual Plan.

Original signed on 9-19-06

James M. Nicholson, Director
Developmental Disabilities Services Division

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WF # 06-N (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-6392.

REMOVE

INSERT

317:40-1-2	317:40-1-2, pages 1-4, issued 6-1-06
317:40-5-55	317:40-5-55, pages 1-7, revised 6-1-06
317:40-5-102	317:40-5-102, pages 1-6, revised 6-1-06
317:40-5-103	317:40-5-103, pages 1-5, revised 6-7-06
317:40-5-104	317:40-5-104, pages 1-3, issued 6-1-06
317:40-5-110	317:40-5-110, pages 1-2, revised 6-1-06
317:40-5-150	317:40-5-150, pages 1-6, revised 6-1-06
317:40-5-152	317:40-5-152, pages 1-5, revised 6-1-06

317:40-1-2. Authorization for Residential Supports in the Community Waiver

(a) **Applicability.** The rules in this Section apply to services provided through the Community Waiver, specifically:

(1) those services identified in OAC 340:100-5-22.1, Community Residential Supports; and

(2) group home services.

(b) **General Information.** Waiver services are provided to supplement, and do not replace, existing non-Waiver, natural, or informal supports a service recipient receives. Waiver services support the service recipient to remain with his or her family and in the community. Service recipients and their Teams must examine all other service options prior to seeking residential supports. The criteria in subsection (c) of this Section are used to determine the necessity of residential supports.

(c) **Necessity of Residential Supports.** If the service recipient is unable to care for himself or herself, the Team may request residential supports if the supports requested comply with OAC 340:100-3-33.1, Criteria to establish service necessity, and:

(1) there is no caretaker to provide needed care to the service recipient;

(2) the service recipient's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:

(A) has moved into a nursing facility;

(B) is age 70 or older;

(C) is permanently incapacitated; or

(D) has died;

(3) there is a risk of abuse or neglect to a service recipient in the current home as evidenced by;

(A) recurrent involvement of the Oklahoma Department of Human Services Division of Children and Family Services (DCFS) or Adult Protective Services (APS) as documented by the case manager that indicates the service recipient's health and

safety cannot be assured and attempts to resolve the situation are not effective with DCFS or APS involvement; or

(B) removal from the home by DCFS or APS;

(4) direct support services required to enable a service recipient to remain in his or her current home exceed the cost of residential supports;

(5) the behavior of the service recipient is such that others are at risk of being seriously harmed by the service recipient, and sufficient supervision cannot be provided to ensure the safety of those in the home or community as evidenced by:

(A) documentation from DCFS or APS;

(B) medical records from previous injuries;

(C) incident reports or other documentation from service providers; or

(D) police reports;

(6) the service recipient's medical, psychiatric, or behavioral challenges are such that the service recipient is seriously injuring or harming himself or herself, or is in imminent danger of doing so as evidenced by any of the items listed in subparagraphs (A) through (D) of paragraph (5) of this subsection;

(7) the Legislature has appropriated special funds to serve a specific group or a specific class of individuals;

(8) as a temporary resolution to an emergency situation as defined in subsection (e) of this Section; or

(9) if residential supports are approved as part of a transition plan for a person leaving an ICF/MR.

(d) **Approval of Residential Supports.** When the Team requests residential supports, the case manager submits the documentation of relevant factors from subsection (c) of this Section to the Developmental Disabilities Services Division (DDSD) division director or designee. The director or designee approves or denies the request prior to the delivery of residential supports.

(e) **Emergency temporary residential supports.** Emergency temporary residential supports are authorized as described in this subsection.

(1) When an emergency situation exists in which temporary residential supports are requested by the Team, the case manager submits the justification for the services and a signed proposal developed by DDS and the caregiver to the DDS division director or designee. The proposal must include:

(A) criteria of what must occur for the service recipient to return to his or her home;

(B) a projected timeframe for the service recipient to return to his or her home; and

(C) an acknowledgment by the caregiver that residential services are temporary.

(2) The division director or designee reviews the documentation and approves or denies the request prior to the delivery of emergency temporary residential supports.

(3) If an extension is required, the case manager submits additional information regarding the need for the extension and the new projected date for the service recipient to return to his or her home. Any extensions which are granted must also:

(A) be approved prior to service delivery;

(B) be time limited; and

(C) include criteria for return home.

(f) **Appeals.** The denial of a request for residential supports may be appealed through the hearing process described in OAC 340:2-5-61.

(g) **Options.** When community residential supports, as defined in OAC 340:100-5-22.1, are needed, as described in OAC 340:100-3-33.1, the service recipient or guardian selects a community residential option that meets the needs of the service recipient, taking into consideration the available resources.

(1) The options are:

(A) Specialized Foster, as described in OAC 317:40-5-50

through 40-5-76;

(B) Group Home services, as described in Oac 317:40-5-152;

(C) Agency Companion, as described in OAC 317:40-5-1 through 40-5-39;

(D) Daily Living Supports, as described in OAC 317:40-5-150 and OAC 317:40-5-152; and

(E) Prader-Willi services.

(2) The Team plans community residential supports to meet the service recipient's needs in accordance with:

(A) DDSD community residential supports rules found at OAC 340:100-5-22.1; and

(B) the program policy established for the specific community residential option cited in paragraph (1) of this subsection.

317:40-5-55. Specialized Foster Care provider responsibilities

(a) **General responsibilities.** The responsibilities of all Specialized Foster Care (SFC) providers are listed in this Subsection.

(1) Providers of Specialized Foster Care (SFC) are required to meet all applicable standards outlined in OAC 317:40-5-40.

(2) Providers of SFC are required to receive competency based training as outlined in OAC 340:100-3-38. The provider keeps all required training up to date and submits documentation to the SFC specialist at the time training is completed.

(3) The provider participates as a member of the service recipient's Team and assists in the development of the service recipient's Individual Plan, as described in OAC 340:100-5-50 through 100-5-58.

(4) The provider documents and notifies the case manager of any changes in behaviors or medical conditions of the service recipient within one working day. Incident reports are completed by the SFC provider and submitted to the DDSD case manager in accordance with OAC 340:100-3-34.

(5) The SFC provider is available to the service recipient at any time.

(6) The primary employment of the SFC provider is to provide SFC services to the service recipient. The SFC provider does not have other employment unless the other employment has been pre-approved by the supervisor of the DDSD foster care unit.

(A) Generally, providers are not approved for other employment because the provider must be available before and after school or vocational programs and often during the day due to holidays or illnesses.

(B) If, after receiving approval for other employment, it is found that the SFC provider's employment interferes with the care, training, or supervision needed by the service recipient, the provider must determine if he or she wants to terminate the other employment or have the service recipient moved from the home.

(C) The DDSD does not authorize Homemaker, Habilitation

Training Specialist, or respite services in order for the SFC provider to perform other employment.

(7) The provider does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals With Disabilities Education Act (IDEA-B).

(8) The provider allows the service recipient to have experiences, both in and out of the home, to enhance the service recipient's development, learning, growth, independence, community inclusion, and well-being, while assisting the service recipient to achieve his or her maximum level of independence.

(9) The provider ensures confidentiality is maintained regarding the service recipient in accordance with the DDSO confidentiality policy, OAC 340:100-3-2.

(10) The provider is sensitive to and assists the service recipient in participating in the service recipient's choice of religious faith. No service recipient is expected to attend any religious service against his or her wishes.

(11) The provider has a valid driver's license, maintains a motor vehicle in working order, and complies with requirements of OAC 317:40-5-103, Transportation.

(12) The provider arranges, and ensures that the service recipient obtains, a medical and a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed.

(13) The provider transports or arranges transportation, using adapted transportation when appropriate, for the service recipient to and from school, employment, church, recreational activities, and medical or therapy appointments.

(A) SFC providers may sign a transportation contract.

(B) The provider must assure availability and use of an approved and appropriate child auto restraint system as required by law in transporting children and, in cases of adults receiving services, any additional restraints identified as necessary in the Plan.

(14) The provider assures the person receiving services is

clean, appropriately dressed, and on time for activities and appointments.

(15) The provider ensures no other adult or child is served in the home on a regular or part-time basis without prior approval from the DDS area manager or designee.

(16) The provider does not provide services to more than three individuals regardless of the type of service provided, including SFC, DCFS foster care, respite, baby-sitting, or other such services. Any exception to this paragraph must be approved in writing by the director of DDS or designee prior to authorization or service delivery.

(17) The provider permits visitation and monitoring of the home by authorized DDS staff. In order to assure maintenance of standards, some visits are unannounced. The visits occur at least monthly and are not intended to be intrusive but to ensure the safety and well-being of the service recipient.

(18) The provider encourages and cooperates in planning visits in the SFC home by relatives, guardians, or friends of the service recipient. Visits by the service recipient to the home of friends or relatives must be approved by the service recipient's legally authorized representative.

(19) The provider abides by the policies of DDS found at OAC 340:100-3-12, Prohibition of client abuse, and OAC 340:100-5-58, Prohibited procedures. The provider is prohibited from signing an authorization for school personnel to use physical discipline or corporal punishment.

(20) The provider notifies the DDS case manager when the need arises for substitute supervision in the event of an emergency, in accordance with the Backup Plan, as specified in OAC 317:40-5-59.

(21) The provider provides written 30-day notice to the service recipient and DDS case manager when it is necessary for a service recipient to be moved from the home.

(22) The SFC provider does not serve as representative payee for the service recipient.

(23) The provider ensures the service recipient's funds are properly safeguarded.

(24) The provider assists the service recipient in accessing and using entitlement programs for which the service recipient may be eligible.

(25) The provider must use the room and board reimbursement payment to meet the service recipient's needs, as specified in the room and board contract.

(A) The provider retains a copy of the current room and board contract in the home at all times.

(B) Items purchased with the room and board reimbursement include, but are not limited to:

(i) housing;

(ii) food;

(iii) clothing;

(iv) care; and

(v) incidental expenses such as:

(I) birthday and Christmas gifts;

(II) haircuts;

(III) personal grooming equipment;

(IV) allowances;

(V) toys;

(VI) school supplies and lunches;

(VII) school pictures;

(VIII) costs of recreational activities;

(IX) special clothing items required for dress occasions and school classes such as gym shorts and shirts;

(X) extracurricular athletic and other equipment,

including uniforms, needed for the service recipient to pursue his or her particular interests or job;

(XI) prom and graduation expenses including caps, gowns, rings, pictures, and announcements;

(XII) routine transportation expenses involved in meeting the service recipient's medical, educational, or recreational needs, unless the provider has a transportation contract;

(XIII) non-prescription medication; and

(XIV) other maintenance supplies required by the service recipient.

(C) All items purchased for the service recipient with the room and board payment are the property of the service recipient and are given by the provider to the service recipient when a change of residence occurs.

(D) The room and board payment is made on a monthly basis and is prorated based on the actual days the service recipient is in the home on the initial and final months of residence.

(26) The provider maintains a Personal Possession Inventory (DDS-22) for each service recipient living in the home.

(27) The provider maintains the service recipient's home record in accordance with OAC 340:100-3-40.

(28) The provider immediately reports to the DDS SFC staff all changes in the household including, but not limited to:

(A) telephone number;

(B) address;

(C) marriage or divorce;

(D) persons moving into or out of the home;

(E) provider's health status;

(F) provider's employment; and

(G) provider's income.

(29) The provider maintains home owner's or renter's insurance, including applicable liability coverages, and provides a copy to the SFC Specialist.

(30) The provider serves as the Health Care Coordinator and follows the Health Care Coordinator policy outlined in OAC 340:100-5-26.

(31) Each SFC provider follows all applicable rules of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority, promotes the independence of the service recipient, and follows recommendations of the service recipient's Team.

(b) Responsibilities specific to SFC providers serving children.

The provider is charged with the same general legal responsibility any parent has to exercise reasonable and prudent behavior in his or her actions and in the supervision and support of the child.

(1) The provider works with the DDS case manager and Division of Children and Family Services (DCFS) staff when the provider needs respite for a child in custody.

(2) The provider participates in the development of the Individual Education Plan (IEP) and may serve as surrogate parent when appropriate.

(3) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDS case manager prior to traveling out of state for an overnight visit. If the child is in the custody of the OKDHS, the permission of the DCFS specialist is also secured.

(4) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDS case manager prior to involvement of the child in any publicity. If the child is in OKDHS custody, the permission of the DCFS specialist is also secured.

(c) Responsibilities specific to SFC providers serving adults.

Additional SFC provider responsibilities for serving adults are given in this Subsection.

(1) The provider obtains permission from the service recipient's

legal guardian, when applicable, and notifies the DDS case manager, prior to:

(A) traveling out of state for an overnight visit.

(B) involvement of the service recipient in any publicity.

(2) When the service recipient is his or her own payee or has a representative payee, the provider ensures the monthly contribution for services as identified in a written agreement between the service recipient and the provider, is used toward the cost of food, rent, and household expenses.

(A) The service recipient's minimum monthly contribution is \$250.00 per month.

(B) Changes in the service recipient's monthly contribution are developed on an individualized basis by the service recipient's Team.

317:40-5-102. Nutrition Services

(a) **Purpose.** The rules in this Section are established to ensure that nutrition services to sustain quality of life and ensure optimal nutritional status are provided to individuals with developmental disabilities who receive Home and Community-Based Waiver services.

(b) **General information.** Nutrition services are based on the individual's need as specified by the Individual Plan and include evaluation of the service recipient's nutritional status.

(1) If nutrition services from funding sources other than Waiver services are available to the service recipient, the service recipient uses those services before using Waiver services. In order for the service recipient to receive Waiver-funded nutrition services, the requirements in this Section must be fulfilled.

(2) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services.

(A) Refusal of nutrition services must be documented in the Individual Plan.

(B) If the service recipient has been receiving nutrition services and nutritional status is currently stable, the Team may specify that nutrition services are not needed. The Team specifies individual risk factors for the service recipient that would necessitate resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the service recipient's status regarding these factors.

(3) Staff of the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) and contract agents implement procedures for nutritional risk identification, implementation of needed services, and nutritional risk monitoring to maintain and improve the nutritional health status of each person served.

(c) **Services for persons not receiving residential supports.** If the service recipient does not receive residential supports as defined in OAC 340:100-5-22.1, or group home services:

(1) the Individual Plan must justify the need for nutrition services as described in OAC 340:100-3-33.1, Criteria to establish service necessity; and

(2) procedures described in subsections (e) through (j) are followed unless other procedures are approved in writing by the DDS area manager or designee.

(d) **Services for persons receiving residential supports.** If the service recipient receives residential supports as defined in OAC 340:100-5-22.1, or group home services:

(1) the service recipient must have an updated OKDHS Form DDS-7, Physical Status Review (PSR), in accordance with OAC 340:100-5-26, identifying an eating problem or nutritional risk indicated by a score of 3 or 4 on Eating, 4 on Gastrointestinal, 4 on Skin Breakdown, 4 on bowel Function, or 3 or 4 on the Nutrition section of the PSR. The Team must address these risks in the Individual Plan and identify appropriate professional oversight; and

(2) the requirements in subsections (e) through (j) of this Section are followed.

(e) **Assessment.** The nutrition therapist evaluates the service recipient's nutritional status and completes OKDHS Form DDS-40, Level of Nutritional Risk Assessment.

(1) The assessment must include, but is not limited to:

(A) health, diet, and behavioral history impacting on nutrition;

(B) clinical measures including body composition and physical assessment.

(C) dietary assessment, including:

(i) nutrient needs;

(ii) eating skills;

(iii) nutritional intake; and

(iv) drug-nutrient interactions; and

(D) recommendations to address nutritional risk needs, including:

(i) outcomes;

(ii) strategies;

(iii) staff training; and

(iv) program monitoring and evaluation.

(2) The nutrition therapist and other involved professionals make recommendations for achieving positive nutritional outcomes based on the risks identified on the OKDHS form DDS-40.

(3) The nutrition therapist sends a copy of the DDS-40 to the case manager within ten working days of the authorization.

(4) If the assessment shows the service recipient rated as "High Nutritional Risk", the nutrition therapist sends a copy of the DDS-40 to the DDSD area nutrition therapist or DDSD area professional support services designee as well as the case manager within 10 working days of the authorization.

(f) Planning. The DDSD case manager, in conjunction with the Team, reviews the identified nutritional issues that impact the service recipient's life.

(1) Any service recipient with a PSR score of 3 or above on Section A, Eating, must have an individualized mealtime assistance plan developed and reviewed at least annually by the Team member(s) identified responsible in the Individual Plan. The mealtime assistance plan includes but is not limited to:

(A) a diet or meal plan;

(B) positioning needs;

(C) adaptive equipment needs;

(D) communication needs;

(E) food presentation;

(F) documentation requirements;

(G) monitoring requirements; and

(H) training and assistance requirements.

(2) In accordance with OAC 340:100-5-26, the Team:

(A) discusses any gastrostomy or jejunostomy tube placement, including discussion of less intrusive alternatives, prior to implementation of the proposed procedure; or

(B) reviews emergency placement of any gastrostomy or jejunostomy tube within five working days after placement.

(3) The Team annually develops, and documents in the Individual Plan a review of, a plan for return to oral intake, in accordance with individual needs, for each service recipient who receives nutrition through a tube.

(4) Desired nutritional outcomes are developed and integrated into the Individual Plan using the least restrictive, least intrusive, most normalizing measures that can be carried out across environments.

(5) The Team member(s) identified responsible in the Individual Plan develops methods to support the nutritional outcomes, which include:

(A) implementation strategies;

(B) staff training; and

(C) program monitoring.

(g) **Implementation.** Strategies are implemented by the assigned person within a designated time frame established by the Team based on individual need(s).

(1) Direct support staff members are trained in accordance with the Individual Plan and OAC 340:100-3-38.

(2) All special diets, nutritional supplements, and aids to digestion and elimination must be prescribed and reviewed at least annually by a physician.

(h) **Documentation.** Program documentation as determined necessary by the Team is maintained in the service recipient's home record

for the purpose of evaluation and monitoring. The professional provider(s) sends documentation regarding the service recipient's progress on the nutrition outcomes, program concerns, and recommendations for remediation of any problem area to the case manager each month, or as often as deemed necessary by the Team.

(i) Evaluation and monitoring. A review to evaluate the success of the program is performed at least once each month or as deemed necessary in the Individual Plan by the professional(s) designated by the Team. The area manager or designee may require a specified schedule for service recipients with a high nutritional risk.

(1) The designated professional(s) reviews the program data submitted for:

- (A) completeness;
- (B) consistency of implementation; and
- (C) positive outcomes.

(2) DDSD professional support services personnel provide administrative oversight and quality assurance monitoring on an ongoing basis to service recipients with eating risk or nutritional risk identified through the PSR using:

- (A) on-site visits; and
- (B) record reviews.

(3) When a service recipient is identified by the DDS-40 to be at high nutritional risk, he or she receives increased monitoring by:

- (A) the nutrition therapist and health care coordinator, as determined necessary by the Team; and
- (B) the DDSD area nutrition therapist or DDSD area professional support services designee.

(4) Significant changes in nutritional status must be reported to the case manager by the health care coordinator.

(5) The DDS-40:

- (A) is used by the contract nutrition provider to reassess

service recipients at high risk on a quarterly basis; and

(B) must be submitted by the contract nutrition provider to the DDSD area nutrition therapist or DDSD area professional support services designee within 15 days following the end of each quarter (March, June, September, December).

(6) The DDSD area nutrition therapist or designee, in conjunction with DDSD support services professionals, provides technical assistance to resolve individual nutrition issues and makes recommendations for additional technical assistance if needed.

(j) **Technical Assistance.** Professional contract providers serving as management consultants provide technical assistance as authorized. Technical assistance may be requested using OKDHS form DDS-41, Physical-Nutritional Management Consultation Request, by the Team or DDSD support services staff to address:

- (1) unresolved nutritional management issues;
- (2) gastrostomy or jejunostomy tube placement or removal;
- (3) individualized mealtime assistance plan development; or
- (4) any aspect of assessment, planning, implementation, evaluation, or monitoring of nutrition services.

317:40-5-103. Transportation

(a) **General Information.** Transportation services include acquisition of, and payment for the use of, adapted, non-adapted, and public transportation.

(1) Transportation is provided to promote inclusion in the community, access to programs and services, and participation in activities to enhance community living skills.

(2) Services include, but are not limited to, transportation to and from medical appointments, work or employment services, recreational activities, and other community activities within the number of miles authorized in the Plan of Care.

(A) Adapted or non-adapted transportation is provided for each eligible person; or

(B) Public transportation is provided up to a maximum of \$5,000 per Plan of Care year. The director of DDS or designee may approve requests for public transportation services totaling more than \$5,000 per year if public transportation is the most cost-effective alternative. For the purposes of this Section, public transportation is defined as:

(i) public transportation services, such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) a transportation program operated by the service recipient's employment services or day services provider.

(3) Services are provided to eligible service recipients in accordance with the service recipient's Plan of Care.

(4) Authorization of Transportation Services is based on:

(A) Team consideration, in accordance with OAC 340:100-5-52, of the unique needs of the person and the most cost effective type of transportation services that meets the service recipient's need, in accordance with subsection (d) of this Section;

(B) the service recipient's participation in Waiver services; and

(C) the scope of the transportation program as explained in this section.

(b) **Standards for transportation providers.** All drivers must have a valid and current Oklahoma drivers license, and the vehicle(s) must meet applicable local and state requirements for vehicle licensure, inspection, insurance, and capacity.

(1) The provider must ensure that any vehicle used to transport service recipients:

(A) meets the needs of the service recipient;

(B) is maintained in a safe condition;

(C) has a current vehicle tag; and

(D) is operated in accordance with local, state, and federal law, regulation, and ordinance.

(2) The provider maintains liability insurance in an amount sufficient to pay for injuries or loss to persons or property occasioned by negligence or malfeasance by the agency, its agents, or employees.

(3) The transportation provider must adequately maintain equipment installed to provide supports for service recipients.

(4) Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(A) the service date;

(B) the odometer mileage reading;

(C) the name of the service recipient transported;

(D) the purpose of the trip; and

(E) the starting point and destination.

(5) A family member, including a family member living in the same household, of an adult service recipient may establish a contract to provide transportation services to:

(A) work or employment services;

(B) medical appointments; and

(C) other activities identified in the Individual Plan as necessary to meet the needs of the service recipient, as defined in OAC 340:100-3-33.1.

(c) **Services not covered.** Services that cannot be claimed as transportation services include:

- (1) services not approved by the Team;
- (2) services not authorized by the Plan of Care;
- (3) trips that have no specified purpose or destination;
- (4) trips for family, provider, or staff convenience;
- (5) transportation provided by the person receiving services, the service recipient's spouse, or the mother or father of the service recipient, if the service recipient is a minor;
- (6) trips when the service recipient is not in the vehicle;
- (7) transportation claimed for more than one service recipient per vehicle at the same time or for the same miles, except public transportation;
- (8) transportation outside the State of Oklahoma unless:
 - (A) the transportation is provided to access the nearest available medical or therapeutic service; or
 - (B) advance written approval is given by the DDS Area Manager or designee;
- (9) services which are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;
- (10) transportation that occurs during the performance of the service recipient's paid employment, even if the employer is a contract provider.

(d) **Assessment and Team process.** At least annually, the Team addresses the service recipient's transportation needs. The Team

determines the most appropriate means of transportation based on the:

(1) present needs of the person receiving services. When addressing the possible need for adapted transportation, the Team considers the needs of the service recipient only. The needs of other individuals living in the same household are considered separately;

(2) service recipient's ability to access public transportation services; and

(3) the availability of other transportation resources including family, neighbors, friends, and community agencies.

(e) **Adapted Transportation.** Adapted transportation provides transportation in modified vehicles or vehicles specifically procured to meet medical or behavioral needs of the service recipient which cannot be met with the use of a standard passenger vehicle. Vehicle modifications that may be needed include, but are not limited to, wheelchair safe travel systems, wheelchair lifts, raised roofs and doors, and exterior mounted wheelchair or scooter carriers.

(1) The Team determines if the service recipient needs adapted transportation according to:

(A) the service recipient's need for physical support when sitting;

(B) the service recipient's need for physical assistance during transfers from one surface to another;

(C) the portability of the service recipient's wheelchair;

(D) associated health problems the service recipient may have; and

(E) behavioral issues related to vehicle travel.

(2) The transportation provider and the equipment vendor ensure that requirements of the Americans with Disabilities Act are met when Team-recommended vehicle modifications are installed.

(3) The transportation provider ensures that all staff assisting with transportation have been trained according to the

requirements specified by the Team and the equipment manufacturer.

(4) The adapted transportation rate is not paid when a vehicle has been adapted with funds from the HCBWS program.

(f) **Authorization of transportation services.** The authorization limitations given in this subsection include the total of all transportation units on the Plan of Care, not just the units authorized for the residential setting identified.

(1) Up to 12,000 units of transportation services may be authorized in a service recipient's plan of care in accordance with OAC 340:100-3-33 and OAC 340:100-3-33.1.

(2) The Area Manager or designee may approve up to 14,400 miles per Plan of Care year for people who have extensive needs for transportation services.

(3) The Division Director or designee may approve:

(A) transportation services in excess of 14,400 miles per Plan of Care year in extenuating situations when person-centered planning has identified specific needs which require additional transportation for a limited period; or

(B) any combination of public transportation services with adapted or non-adapted transportation; or

(C) public transportation services in excess of \$5000 when this is the most cost effective service option for necessary transportation.

317:40-5-104. Specialized medical supplies

(a) General requirements. Specialized medical supplies include supplies specified in the plan of care that meet the criteria given in this Section.

(1) Specialized medical supplies include the purchase of ancillary supplies not available under the Medicaid State Plan. Items reimbursed with Home and Community Based Waiver (HCBW) funds are in addition to any supplies furnished under the Medicaid State Plan.

(2) Specialized medical supplies meet the criteria for service necessity given in OAC 340:100-3-33.1.

(3) All items meet applicable standards of manufacture, design, and installation.

(4) Specialized medical supplies providers must hold a current Durable Medical Equipment (DME) contract with the Oklahoma Health Care Authority.

(5) Items that can be purchased as specialized medical supplies include:

(A) incontinence supplies, as described in subsection (b) of this Section;

(B) nutritional supplements;

(C) supplies for respirator or ventilator care;

(D) decubitus care supplies;

(E) supplies for catheterization; and

(F) supplies needed for health conditions.

(6) Items that cannot be purchased as specialized medical supplies include:

(A) over the counter medications(s);

(B) personal hygiene items;

(C) medicine cups;

(D) items that are not medically necessary;

(E) prescription medication(s); and

(F) items available through the Medicaid State Plan. Items available through the Medicaid State Plan must be exhausted before waiver-funded services can be accessed.

(7) Specialized medical supplies must be:

(A) necessary to address a medical condition;

(B) of direct medical or remedial benefit to the service recipient;

(C) medical in nature; and

(D) consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

(b) **Limited coverage.** Items available in limited quantities through specialized medical supplies include:

(1) incontinence wipes, 300 wipes per month;

(2) non-sterile gloves, as approved by the Team;

(3) disposable underpads, 60 pads per month; and

(4) incontinence briefs, 180 briefs per month.

(A) Adult briefs are purchased only in accordance with the implementation of elimination guidelines developed by the Team.

(B) Exceptions to the requirement for implementation of elimination guidelines may be approved by the DDS nurse when the service recipient has a medical condition that precludes implementation of elimination guidelines, such as atonic bladder, neurogenic bladder, or following a surgical procedure.

(c) **Exceptions.** Exceptions to the requirements of this Section are explained in this subsection.

(1) When a service recipient's Team determines that the service recipient needs medical supplies that:

(A) are not available under the Medicaid State Plan and for which no Health Care Procedure Code exists, the case manager e-mails pertinent information regarding the service recipient's medical supply need to the programs manager responsible for Specialized Medical Supplies. The e-mail includes all pertinent information that supports the need for the supply, including but not limited to, quantity and purpose; or

(B) exceed the limits stated in subsection (b) of this Section, the case manager submits the request for additional supplies to the DDSD area manager.

(2) Approval or denial of exception requests is made on a case by case basis and does not override the general applicability of this Section.

(3) Approval of a specialized medical supplies exception does not exceed one plan of care year.

317:40-5-110. Authorization for Habilitation Training Specialist Services

(a) Habilitation Training Specialist (HTS) Services are:

(1) authorized as a result of needs identified by the team and informed selection by the service recipient;

(2) shared among service recipients who are members of the same household; and

(3) authorized only during periods when staff are engaged in purposeful activity which directly or indirectly benefits the service recipient. Staff must be physically able and mentally alert to carry out the duties of the job. At no time are HTS services authorized for periods during which the staff are allowed to sleep.

(b) HTS Services may be provided in community residential service settings defined in OAC 340:100-5-22.1 including:

(1) agency companion services as described in OAC 317:40-5-1 through 40-5-39;

(2) as provided in accordance with Daily Living Supports policy at OAC 317:40-5-150; and,

(3) as provided in accordance with Specialized Foster Care Policy at OAC 317:40-5-50 through 40-5-76; or

(4) services for people with Prader Willi syndrome.

(c) HTS Services are based on need and limited to no more than 12 hours per day per household in any setting other than settings described in OAC 340:100-5-22.1, Community Residential Supports, except with approval in accordance with OAC 340:100-3-33, Service authorization, that the increased services are necessary to avoid institutional placement due to:

(1) the complexity of the family or caregiver support needs. Consideration must be given to:

(A) the age and health of the caregiver;

(B) the number of household members requiring the caregiver's time; and

(C) the accessibility of needed resources; and

(2) the resources of the family, caregiver, or household members that are available to the service recipient. Consideration must be given to the number of family members able to assist the caregiver and available community supports; and

(3) the resources of other agencies or programs available to the service recipient or family. Consideration must be given to services available from:

(A) the public schools;

(B) the Oklahoma Health Care Authority;

(C) the Oklahoma Department of Rehabilitative Services;

(D) other OKDHS programs; and

(E) services provided by other local, state, or federal resources.

(d) When it appears that approval of an exception is needed to prevent institutional placement, the case manager submits the request which identifies the circumstances supporting the need for an exception to the area manager.

(e) The DDS area manager or designee must approve, deny, or notify the case manager of issues preventing approval within 10 working days.

317:40-5-150. Daily Living Supports

(a) **Introduction.** Daily Living Supports (DLS) are provided by an agency, approved by the Developmental Disabilities Services Division (DDSD), that has a valid Oklahoma Health Care Authority contract for the service.

(1) Daily Living Supports require meeting the daily support needs of the service recipients living in the home.

(A) In accordance with the needs of the service recipient, Daily Living Supports include hands-on assistance, supervision, or prompting so that the service recipient performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports also include assistance with cognitive tasks or provision of services, in accordance with OAC 340:100-5-57, to prevent a service recipient from harming self or others.

(C) Daily Living Supports also include:

(i) the provision of staff training in accordance with OAC 340:100-3-38, to meet the specific needs of the service recipient;

(ii) program supervision that includes the 24-hour availability of response staff to meet schedules and unpredictable needs;

(iii) program oversight;

(iv) assisting the service recipient in obtaining services and supplies;

(v) developing and assuring emergency plans are in place;
and

(vi) coordinating overall safety and supports in the home.

(D) Direct support services are coordinated and shared among household members receiving services to meet identified needs.

(2) DLS include an average of eight hours daily of direct support services. Service recipients needing direct support services exceeding an average of eight hours per day identify, with case manager assistance, roommates willing to share Daily Living Supports services. Additional direct support services are considered in accordance with subsection (f) of this Section.

(b) **Eligibility.** Daily Living Supports are provided to individuals who:

(1) are eighteen years of age or older, unless approved by the Director of OKDHS or designee;

(2) need an average of at least eight hours of direct support services daily;

(3) are participants in the DDSD Community waiver, described in OAC 317:40-1-1;

(4) need community residential services outside the family home; and

(5) do not simultaneously receive any other community residential or group home services.

(c) **Service requirements.** Daily Living Supports must be:

(1) included in the service recipient's Individual Plan in accordance with OAC 340:100-5-51, including a description of the type(s) and intensity of supervision and assistance that must be provided to the service recipient;

(2) authorized in the service recipient's Plan of Care;

(3) provided by the contracted provider agency chosen by the service recipient or guardian;

(4) delivered in accordance with DDSD Community Residential Supports rules at OAC 340:100-5-22.1; and

(5) provided directly to the service recipient.

(d) **Home Requirements.** Daily Living Supports are provided to

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eligible service recipients living outside their family's home in a home that:

(1) is leased or owned by the service recipient(s) or the service recipient's legal guardian; and

(2) houses no more than three individuals living together. Exceptions for homes shared by four service recipients may be granted in writing by the DDS director or designee.

(e) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

(1) ensure ongoing supports as needed when the service recipient is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) ensure compliance with all applicable DDS policy found at OAC 340:100; and

(3) provide for the welfare of all service recipients living in the home.

(f) **Criteria for direct support staff services beyond eight hours per day.** Additional direct support services including Habilitation Training Specialist(HTS), Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section must be approved by the DDS area manager or designee.

(1) In order to receive additional direct support staff services, the service recipients living together must have insufficient supports including hourly nursing services to meet their needs for support.

(A) Additional direct support staffing may be authorized if the service recipient is living with two roommates but still has medical or behavior support needs beyond the capacity of staff shared with the other roommates, including participation by staff providing hourly nursing services.

(B) Additional direct support staffing is only provided to a service recipient who has one or no roommates if:

(i) the area manager or designee documents that behavior

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support issues make it impossible for the service recipient to have a roommate; or

(ii) in accordance with paragraph (2) of this subsection.

(C) If a service recipient lives with one or no roommates or requires a second support staff to meet his or her intensive behavior support needs, the Team must provide clear documentation that the service recipient has difficulty establishing compatible relations with others as evidenced by:

(i) severe and persistent emotional and behavioral disturbances; or

(ii) a history of difficulty sharing a home with others.

(2) The area manager or designee may grant conditional approvals for staff beyond an average of eight hours per day per service recipient:

(A) due to the temporary or permanent departure of a roommate while another roommate is being identified; or

(B) to facilitate emergency residential placement of a person needing services while roommates are being identified.

(3) As part of the annual review, the case manager must:

(A) re-evaluate the service recipient's need for additional direct support services; and

(B) implement any alternative solutions that would promote independence and reduce intrusion by paid workers as much as possible. Documentation of such evaluations and the implementation of alternative solutions is included in the case manager's record.

(g) **Daily Living Supports claims.** No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each service recipient.

(1) The provider agency claims one unit of service for each day during which the service recipient receives Daily Living Supports. A day is defined as the period between 12:00 a.m. and

11:59 p.m.

(2) Claims must not be based on budgeted amounts.

(3) When a service recipient changes provider agencies, only the outgoing service provider agency claims for the day that the service recipient moves.

(h) **Billing for other support services.** Additional support services such as HTS, Intensive Personal Supports, or Homemaker Services may be provided to a service recipient receiving Daily Living Supports, if:

(1) the additional support services have been authorized in the service recipient's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the service recipient. The direct support staffing is averaged across the week when the needs of the service recipients in the household vary from day to day; and

(2) an average of eight hours of DLS has already been provided to the service recipient each day that week.

(A) The provider cannot bill for additional support services unless 56 hours of DLS have been provided during the week to the service recipient.

(B) If support services are provided to multiple service recipients residing in the same household at the same time, the provider agency cannot count these hours toward each service recipient's 8-hour minimum. For example, three hours of service provided simultaneously by a single direct contact staff to three residents in the same household may only be counted as three hours of service for one of the service recipients, not three hours for each resident.

(i) **Therapeutic leave.** Therapeutic leave is a Medicaid payment made to the Daily Living Supports contract provider to enable the service recipient to retain personal care services.

(1) Therapeutic leave is claimed when the service recipient does not receive Daily Living Supports services for 24 consecutive hours from 12:00 a.m. to 11:59 p.m. because of:

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(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. Daily living supports staff are present with the service recipient in the hospital as approved by the service recipient's Team in the Individual Plan.

(2) A service recipient may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) To promote continuity of direct support staff in the service recipient's absence, the provider pays the staff member the salary that he or she would have earned if the service recipient were not on therapeutic leave if the provider is unable to provide an alternative work opportunity.

317:40-5-152. Group home services for persons with mental retardation

(a) **General Information.** Group homes provide a congregate living arrangement offering up to 24-hour per day supervision, supportive assistance, and training in daily living skills to eligible individuals eighteen years of age and older. Upon approval of the director of the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services or designee, persons younger than eighteen may be served.

(1) Group homes ensure that persons reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.

(2) Group homes must be licensed by DDSD in accordance with 10 O.S. § 1430.1.

(3) Persons receiving group home services receive no other form of residential supports.

(4) Habilitation training specialist services or Homemaker services for persons receiving group home services may be approved only by the director of DDSD or designee to resolve a temporary emergency when no other resolution exists.

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide Home and Community-Based Waiver Services for the Mentally Retarded.

(1) Group home providers must have a completed and approved Application for Provider Agency from DDSD.

(2) Provider's staff must:

(A) complete the DDSD-sanctioned training curriculum in accordance with OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening given at OAC 340:100-3-39.

(c) **Description of services.** Group home services are provided in accordance with this subsection.

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(1) Services to each individual are provided in accordance with the Individual Plan developed in accordance with OAC 340:100-5-50 through 100-5-54.

(2) Health care services are secured in accordance with OAC 340:100-5-26.

(3) Group homes follow protective intervention practices described in OAC 340:100-5-57 and 100-5-58.

(4) Individuals are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(5) Group home services meet all applicable requirements of OAC 340:100.

(6) In addition to the documentation required by OAC 340:100-3-40, the provider agency must maintain:

(A) staff time sheets which document the hours each staff member was present and on duty in the group home; and

(B) documentation of each service recipient's presence or absence on the daily attendance form provided by DDS.

(7) The provider agency ensures that program coordination staff (PCS) supervise, guide, and oversee all aspects of group home services.

(A) The PCS must:

(i) get to know each person receiving services and his or her needs;

(ii) make announced and unannounced visits to the group home. The PCS makes a minimum of three unannounced monitoring visits per month. Of the unannounced visits:

(I) at least one unannounced visit each month must occur on Saturday or Sunday; and

(II) another must occur between 8:00 p.m. and 7:00 a.m. on a weekday;

(iii) provide support and assistance to any person receiving services who is experiencing an emotional, behavioral, or medical crisis;

(iv) be accessible to direct service staff 24 hours per day and available to respond, in person if necessary, to an emergency;

(v) supervise direct contact staff to promote achievement of outcomes in the Plan;

(vi) assist the case manager as requested to prepare for and implement the Plan and its revisions in accordance with OAC 340:100-5-50 through 340:100-5-58;

(vii) ensure rules of OKDHS and OHCA are followed; and

(viii) complete necessary training as specified in OAC 340:100-3-38.

(B) Each person filling this role in a provider agency must have a minimum of four years of any combination of college level education and full-time equivalent experience in serving persons with disabilities, unless this requirement is waived in writing by the DDS director or designee.

(8) Staff who assist an individual with bathing or showering have the responsibility to ensure the water temperature is safe and comfortable for the individual being bathed. The requirements of this paragraph are enforced even if an anti-scald device is in use.

(d) **Coverage limitations.** Services are provided up to 366 days per year.

(e) **Types of group home services.** There are three types of group home services provided through Home and Community-Based Waiver Services.

(1) **Traditional group homes.** Traditional group homes serve no more than 12 persons.

(A) Homes opened after the effective date of these rules serve no more than six individuals.

(B) Traditional group home services may also be provided through DDS state funds.

(2) **Community living homes.** Community living homes serve up to six individuals.

(A) Persons who receive community living home services have needs that cannot be met in a less structured setting. These include people with:

(i) a diagnosis of severe or profound mental retardation requiring frequent assistance in the performance of activities necessary for daily living or continual supervision to ensure the individual's health and safety;

(ii) complex needs requiring frequent assistance in the performance of activities necessary for daily living, such as the frequent assistance of staff for positioning, bathing, or other necessary movement; or

(iii) complex needs requiring frequent supervision and training in appropriate social and interactive skills in order to remain included in the community.

(B) Services offered in a community living home include:

(i) 24-hour awake supervision;

(ii) program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building and training.

(3) **Alternative group homes.** Alternative group homes serve up to four individuals who have evidence of behavioral or emotional challenges in addition to mental retardation and require extensive supervision and assistance in order to remain in the community.

(A) To be eligible for alternative group homes services an individual must meet criteria given in OAC 340:100-5-22.6.

(B) Services are provided in accordance with OAC 340:100-5-22.6 to meet the needs of the service recipient including:

(i) supports to assist the service recipient in acquiring, retaining, and improving self-care, daily living, social, adaptive, and leisure skills needed to reside successfully within the community;

(ii) 24-hour awake staff;

(iii) specialized training developed to meet the specific needs of each service recipient; and

(iv) program supervision and oversight including 24-hour availability of response staff to meet individual schedules or unpredictable needs.

(C) A determination must be made by the Developmental Disabilities Services Division Community Services Unit that the alternative group home is appropriate and all other community residential services are not appropriate.