
POLICY TRANSMITTAL NO. 09-30	DATE: JUNE 5, 2009
OKLAHOMA HEALTH CARE AUTHORITY/DEVELOPMENTAL DISABILITIES SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-410; 30-5-422; 30-5-1010; 30-5-1010.1; 35-9-5; 40-1-1; 40-5-1; 40-5-3; 40-5-5; 40-5-100; 40-7-6; 40-7-8; 40-7-11; and 40-7-13.

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

DDSD rules are revised to: (1) provide clarification relating to service utilization, provisions, authorizations, limitations, and eligibility requirements; (2) specify provider requirements and related activities of targeted case management to meet federal requirements; (3) clarify provider responsibilities and limitations in the agency companion program; (4) specify devices and services allowable through assistive technology; (5) clarify physical plant expectations for services provided in center-based settings; and (6) amend policy to reflect appropriate terminology.

Original signed on 5-21-09

James M. Nicholson, Director
Developmental Disabilities Services Division

Sandra Harrison, Coordinator
Office of Legislative Relations and Policy

WF # 09-M (NAP)

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 an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS 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, OKDHS 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, OKDHS: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 405-521-4326.

<u>REMOVE</u>	<u>INSERT</u>
317:30-5-410	317:30-5-410, 1 page only, revised 6-25-09
317:30-5-422	317:30-5-422, pages 1-2, revised 6-25-09
317:30-5-1010	317:30-5-1010, pages 1-2, revised 6-25-09
317:30-5-1010.1	317:30-5-1010.1, pages 1-3, revised 6-25-09
317:35-9-5	317:35-9-5, 1 page only, revised 6-25-09
317:40-1-1	317:40-1-1, pages 1-8, revised 6-25-09
317:40-5-1	-----
317:40-5-3	317:40-5-3, pages 1-4, revised 6-25-09
317:40-5-5	317:40-5-5, pages 1-3, revised 6-25-09
317:40-5-100	317:40-5-100, pages 1-7, revised 6-25-09
317:40-7-6	317:40-7-6, 1 page only, revised 6-25-09
317:40-7-8	317:40-7-8, pages 1-2, revised 6-25-09
317:40-7-11	317:40-7-11, 1 page only, revised 6-25-09
317:40-7-13	317:40-7-13, pages 1-2, revised 6-25-09

317:30-5-410. Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

(a) The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with mental retardation and certain persons with related conditions that are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Each waiver allows payment for family support services as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS).

Waiver services:

(1) when utilized with services normally covered by SoonerCare, other generic services, and natural supports provide for health and developmental needs of members who otherwise would not be able to live in a home or community setting;

(2) are provided with the goal of promoting independence through strengthening the member's capacity for self-care and self-sufficiency;

(3) are centered on the needs and preferences of the member and support the integration of the member within his/her community; and

(4) do not include room and board. The costs associated with room and board must be met by the member.

(b) The DDSD case manager develops the Individual Plan (IP) and Plan of Care (Plan) per OAC 340:100-5-53. The IP contains descriptions of the services provided, documentation of the amount, frequency and duration of the services, and types of service providers.

(1) Services:

(A) are authorized per OAC 340:100-3-33 and 100-3-33.1.

(B) provided prior to the development of the IP or not included in the IP are not compensable. The Plan may not be backdated;

(C) may be provided on an emergency basis when approved by the area manager or designee. The plan must be revised to reflect the additional services; and

(D) are provided by qualified provider entities contracted with the OHCA.

(2) Members have freedom of choice of providers and in the selection of HCBS or institutional services.

**MEDICAL PROVIDERS-FEE FOR SERVICE
AGENCY COMPANION, SPECIALIZED FOSTER CARE,
DAILY LIVING SUPPORTS, GROUP HOMES, AND
COMMUNITY TRANSITION SERVICES SPECIFIC**

OAC 317:30-5-422(p1)

317:30-5-422. Description of services

Residential supports include:

- (1) agency companion services (ACS) per OAC 317:40-5;
- (2) specialized foster care (SFC) per OAC 317:40-5;
- (3) daily living supports (DLS):
 - (A) Community Waiver per OAC 317:40-5-150; and
 - (B) Homeward Bound Waiver per OAC 317:40-5-153;
- (4) group home services provided per OAC 317:40-5-152; and
- (5) community transition services (CTS).

(A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide ACS, habilitation training specialist (HTS) services, or DLS, in addition to a contract to provide CTS.

(B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for the mentally retarded (ICF/MR) or provider-operated residential setting to the member's own home or apartment. The cost per member of Community Transition Services cannot exceed limitations set forth by OHCA. The member's name must be on the lease, deed or rental agreement. CTS:

(i) are furnished only when the member is unable to meet such expense and must be documented in the member's Individual Plan (IP);

(ii) include security deposits, essential furnishings such as major appliances, dining table/chairs, bedroom set, sofa, chair, window coverings, kitchen pots/pans, dishes, eating utensils, bed/bath linens, kitchen dish towel/potholders, one month supply of laundry/cleaning products, setup fees or deposits for initiating utility service, including phone, electricity, gas, and water . CTS also includes moving expenses, services/items necessary for the member's health and safety such as pest eradication, allergen control, one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, tempering valve or other anti-scald device when determined by the Team necessary to ensure the member's safety; and

(iii) does not include:

(I) recreational items, such as television, cable, satellite, internet, video cassette recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, or computer used primarily as diversion or recreation;

(II) monthly rental or mortgage expense;

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OAC 317:30-5-422(p2)

(III) food;

(IV) personal hygiene items;

(V) disposable items such as paper plates/napkins,
plastic utensils, disposable food storage bags,
aluminum foil, plastic wrap;

(VI) items that could be considered decorative such as
rugs, pictures, bread box, canisters, or more than one
basic clock;

(VII) any item not considered an essential basic one
time expense; or

(VIII) regular ongoing utility charges.

(iv) prior approval for exceptions and/or questions
regarding eligible items and/or expenditures are directed
to the program manager for community transition services
at OKDHS/DDSD state office.

**MEDICAL PROVIDERS-FEE FOR SERVICE
TARGETED CASE MANAGEMENT SERVICES
FOR PERSONS WITH MENTAL RETARDATION
AND/OR RELATED CONDITIONS**

OAC 317:30-5-1010(p1)

317:30-5-1010. Eligible providers

(a) **Eligible providers.** Services are provided by Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case managers.

(1) **Certification requirements.** SoonerCare Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services must be made available to all eligible members and must be delivered on a statewide basis with procedures that assure 24 hour availability, the protection and safety of members, continuity of services without duplication, and compliance with federal and State mandates and regulations related to servicing the targeted population are met in a uniform and consistent manner. A DDSDTCM case manager must:

- (A) be employed by the OKDHS, DDSD.
- (B) possess knowledge of:
 - (i) case management methods, principles and techniques;
 - (ii) types of developmental disabilities represented within the caseload;
 - (iii) types of providers and services available for members;
 - (iv) the behavioral sciences and allied disciplines involved in the evaluation, care and training of persons with developmental disabilities;
 - (v) interviewing principles and techniques;
 - (vi) counseling principles and techniques; and
 - (vii) adaptive communication techniques and non-verbal communication.
- (C) possess skill in:
 - (i) managing a caseload;
 - (ii) effectively intervening in crisis situations;
 - (iii) working cooperatively and effectively with other professionals in a team situation;
 - (iv) collecting and analyzing information;
 - (v) making decisions relating to services provided to members;
 - (vi) developing a logical and practical plan of treatment for members with developmental disabilities;
 - (vii) evaluating the progress of members and the quality of their habilitation programs;
 - (viii) communicating effectively; and
 - (ix) mediating with providers and agencies to resolve problems.

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OAC 317:30-5-1010(p2)

(b) **Provider agreement.** A Provider Agreement between the Oklahoma Health Care Authority and the provider for DDS/TCM services must be in effect before reimbursement can be made for compensable services.

(c) **Provider selection.** Target group consists of eligible members with developmental disabilities. Providers are limited to providers of case management services capable of ensuring that members with developmental disabilities receive needed services.

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TARGETED CASE MANAGEMENT SERVICES
FOR PERSONS WITH MENTAL RETARDATION
AND/OR RELATED CONDITIONS**

OAC 317:30-5-1010.1(p1)

317:30-5-1010.1. Scope of service

(a) Description of targeted case management services.

(1) Case management services are services furnished to assist members, eligible under the Medicaid State Plan, in gaining access to needed medical, social, educational and other services. Case management includes the following assistance:

(A) assessment of a member to determine the need for medical, educational, social, or other services. Assessment activities include:

(i) taking member history;

(ii) identifying the member's needs and completing related documentation; and

(iii) gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the member.

(B) development of an individual plan and a specific plan of care that:

(i) are based on the information collected through the assessment;

(ii) specify the goals and actions to address medical, social, educational, and other services needed by the member;

(iii) include activities such as ensuring the active participation of the eligible member; and work with the member or member's authorized health care decision maker, and others to develop the goals; and

(iv) identify a course of action to respond to the assessed needs of the eligible member.

(C) referral and related activities to help an eligible member obtain needed services including activities that help link a member with:

(i) medical, social, educational providers; or

(ii) other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the member.

(D) monitoring and follow-up activities include activities and contact necessary to ensure the individual plan and the plan of care are implemented and adequately address the member's needs. Activities and contact may be with the member, his or her family members, providers, other entities or individuals, and may be conducted as frequently as necessary including at least one annual monitoring to assure

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the following conditions are met:

- (i) services are being furnished in accordance with the member's plan of care;
- (ii) services in the plan of care are adequate; and
- (iii) if there are changes in the needs or status of the member, necessary adjustments are made to the plan of care, and to service arrangements with providers.

(2) Case management may include contact with individuals who are directly related to identifying the needs and supports for helping the eligible member to access services.

(b) Targeted Case Management Service Requirements. DDSD assures that:

(1) case management services are provided in a manner consistent with the best interest of members and are not used to restrict a member's access to other services under the plan;

(2) members are not compelled to receive case management services, condition receipt of case management services on the receipt of other SoonerCare services, or condition receipt of other SoonerCare services on receipt of case management services;

(3) case management conducts activities to ensure the health and welfare of HCBS waiver members. For members who refuse case management services, these activities are completed as follows:

(A) the member develops an Individual Plan (IP) per OAC 340:100-5-50 through 340:100-5-58.

(B) the member develops a plan of care requesting authorization for services and submits it with the IP to the Developmental Disabilities Services Division (DDSD) plan of care reviewer for review and approval per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(C) monthly progress reports, incident reports, OKDHS form 06HM005E, OKDHS form 06HM006E, and other documentation required to be submitted to case management are submitted to the DDSD state office program manager for case management for monitoring and follow-up per OAC 340:100-3-27.

(D) monitoring visits required by OAC 340:100-3-27 are conducted by DDSD Quality Assurance staff.

(E) the DDSD state office program manager assigns staff responsibility for maintaining the record in Client Contact Manager (CCM), obtaining necessary documents from the member and others for continuing service eligibility, providing information regarding available HCBS Waiver providers, making referrals to other programs and identifying training

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OAC 317:30-5-1010.1(p3)

available to assist the member in completing the required tasks.

(4) providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

(c) **Non-Duplication of services.** To the extent any eligible members in the identified target population are receiving case management services from another provider agency as a result of being members of other covered target groups, the provider assures that case management activities are coordinated to avoid unnecessary duplication of service.

317:35-9-5. Home and Community - Based Waiver Services for persons with mental retardation or certain persons with related conditions

(a) Services provided through Home and Community - Based Services (HCBS) Waivers are outside the normal scope of SoonerCare services. HCBS Waivers are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Oklahoma's Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of waiver administration. HCBS Waivers allow the OHCA to offer certain home and community based services to categorically needy members who, without such services, would be eligible for care in a facility for persons with mental retardation.

(b) Individuals with mental retardation are eligible for SoonerCare as categorically needy under the HCBS Waiver program when eligibility conditions in (1) through (5) are met:

(1) The individual is determined financially eligible per OAC 317:35-9-68;

(2) The individual meets the Social Security Administration (SSA) definition of disabled;

(3) The individual requires a level of care provided in a public or private intermediate care facility for persons with mental retardation (ICF/MR) and has a diagnosis of mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability;

(4) It is appropriate to provide care outside the ICF/MR; and

(5) The average cost of providing care outside the ICF/MR does not exceed the cost of providing institutional care.

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with mental retardation or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers as defined in Section 1915(c) of the Social Security Act and administered by the Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD). The specific waivers are the In-Home Supports Waiver (IHSW) for Adults, the In-Home Supports Waiver (IHSW) for Children, the Community Waiver, and the Homeward Bound Waiver.

(b) **Program Administration.** Services funded through a HCBS Waiver for persons with mental retardation or for certain persons with related conditions are administered by DDSD, under the oversight of the Oklahoma Health Care Authority (OHCA), the State Medicaid agency. The rules in this subsection do not limit the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.

(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.

(2) DDSD must limit the utilization of the HCBS Waiver services based on:

(A) the federally-approved member capacity for the individual HCBS Waivers;

(B) the cost-effectiveness of the individual HCBS Waivers as determined according to federal requirements; and

(C) State appropriations.

(3) DDSD must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.

(c) **Program provisions.** Each individual requesting HCBS Waiver services and his or her family or guardian are responsible for:

(1) accessing, with the assistance of OKDHS staff, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under a HCBS Waiver program;

(2) cooperating in the determination of medical and financial eligibility, including prompt reporting of changes in income or resources; and

(3) choosing between HCBS Waiver services and institutional care.

(d) **Waiver Eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in paragraph (1) of this Subsection and the criteria for one of the Waivers established in Subparagraph (A), (B), or (C) of this Subsection.

(1) HCBS Waiver services are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in subsection (a) of this Section, a person must first be determined financially eligible for SoonerCare through the OKDHS Family Support Services Division per OAC 317:35-9-68. The SoonerCare eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility as described in Section 1-819 of Title 63 of Oklahoma Statutes, or Intermediate Care facility for persons with mental retardation (ICF/MR). The individual may not be receiving DDS state-funded services such as the Family Support Assistance Payment, sheltered workshop services, community integrated employment services, or assisted living without waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

(A) **In-Home Supports Waivers.** To be eligible for services funded through the In-Home Supports Waiver (IHSW), a person must:

- (i) meet all criteria for HCBS Waiver services given in subsection (d) of this Section;
- (ii) be determined to have a disability, with a diagnosis of mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability, by:
 - (I) the Social Security Administration; or
 - (II) the OHCA, Level of Care Evaluation Unit (LOCEU);
- (iii) be three years of age or older;
- (iv) be determined by the OHCA/LOCEU to meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122;
- (v) reside in:
 - (I) the home of a family member or friend;
 - (II) his or her own home;
 - (III) an OKDHS Children and Family Services Division (CFSD) foster home; or
 - (IV) a CFSD group home; and
- (vi) have critical support needs that can be met through a combination of non-paid, non-Waiver, and State Plan resources available to the individual, and with HCBS Waiver resources that are within the annual per capita Waiver limit agreed between the State of Oklahoma and the

Centers for Medicare and Medicaid Services (CMS).

(B) **Community Waiver.** To be eligible for services funded through the Community Waiver, the person must:

(i) meet all criteria given in subsection (d) of this Section;

(ii) be age three or older;

(iii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDSD Division Director or designee;

(iv) be determined, in accordance with either subunit I or both subunits II and III of this unit:

(I) to have mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorder in Persons with Intellectual Disability or a related condition by the DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(II) to have a disability, with a diagnosis of mental retardation, by the Social Security Administration or the OHCA/LOCEU; and

(III) to meet the ICF/MR Institutional Level of Care requirements by the OHCA/LOCEU.

(C) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the person must:

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBS Waiver services given in subsection (d) of this Section; and

(iii) be determined to:

(I) have mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability or a related condition by DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(II) meet the ICF/MR Institutional Level of Care requirements by the OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in subsection (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, current within one year, that includes:

- (i) a functional assessment; and
- (ii) a statement of age of onset of the disability;

(B) a social service summary, current within one year, that includes a developmental history; and

(C) a medical evaluation current within 90 days.

(3) The OHCA reviews the diagnostic reports listed in paragraph (2) of this subsection and makes a determination of eligibility for DDS services and ICF/MR level of care for the services funded through an IHSW or the Community Waiver.

(4) For individuals who are determined to have mental retardation or a related condition by DDSD in accordance with the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDSD reviews the diagnostic reports listed in paragraph (2) of this subsection and, on behalf of the OHCA, makes a determination of eligibility for DDS services and ICF/MR level of care.

(5) A determination of need for ICF/MR Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(e) **Waiting list.** When State DDSD resources are unavailable for new persons to be added to services funded through a HCBS Waiver, persons are placed on a statewide waiting list for services.

(1) The waiting list is maintained in chronological order based on the date of receipt of a written request for services.

(2) The waiting list for persons requesting HCBS Waiver services is administered by DDSD uniformly throughout the state.

(3) An individual is removed from the waiting list if the individual:

- (A) is found to be ineligible for services;
- (B) cannot be located by OKDHS;
- (C) does not provide required information to OKDHS;
- (D) is not a resident of the state of Oklahoma; or
- (E) is offered Waiver services through either an IHSW or the Community Waiver and declines services.

(f) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDSD ensures action regarding a request for services occurs within 45 days. If action is not taken within the required 45 days, the applicant may seek resolution as described in OAC 340:2-5.

(1) Applicants are allowed 60 days to provide information requested by DDSD to determine eligibility for services.

(2) If requested information is not provided within 60 days, the

applicant is notified that the request has been denied, and the individual is removed from the waiting list.

(g) **Admission protocol.** Initiation of services funded through a HCBS Waiver occurs in chronological order from the waiting list in accordance with subsection (e) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or his or her legal guardian, and upon determination of eligibility, in accordance with subsection (d) of this Section. Exceptions to the chronological requirement may be made when:

(1) an emergency situation exists in which the health or safety of the person needing services, or of others, is endangered, and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself and:

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

(I) is hospitalized;

(II) has moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) has died; and

(ii) there is no caretaker to provide needed care to the individual; or

(iii) an eligible person is living at a homeless shelter or on the street;

(B) the OKDHS finds that the person needs protective services due to experiencing ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.

(2) the Legislature has appropriated special funds with which to serve a specific group or a specific class of individuals under the provisions of a HCBS Waiver;

(3) Waiver services are required for people who transition to the community from a public ICF/MR or who are children in the

State's custody receiving services from OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/MR and enters the Waiver;

(4) individuals residing in nursing facilities prior to January 1, 1989, who are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted pursuant to the provisions of 42 CFR 483.100 et seq to have mental retardation or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community Waiver.

(h) **Movement between DDS HCBS Waiver programs.** A person's movement from services funded through one HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults become effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a member has critical support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS Director or designee; and

(B) funding is available in accordance with subsection (b) of this Section.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization has been within the per capita allowance of the IHSW.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(i) **Continued eligibility for HCBS Waiver services.** Eligibility for children receiving HCBS Waiver services is re-determined if a determination of disability due to mental retardation has not been made by the Social Security Administration when the OHCA/LOCEU determines categorical relationship to the SoonerCare program according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:35-9-5. DDS may require a new diagnostic evaluation in accordance with paragraph (d)(2) of this subsection and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph (d)(2) of this

Section has been noted.

(j) **HCBS Waiver services case closure.** HCBS Waiver services are terminated:

(1) when a member or the member's legal guardian chooses to no longer receive Waiver services;

(2) when a member is incarcerated;

(3) when a member is financially ineligible to receive Waiver services;

(4) when a member is determined by the Social Security Administration to no longer have a disability qualifying the individual for services under these Waivers;

(5) when a member is determined by the OHCA/LOCEU to no longer be eligible;

(6) when a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;

(7) when a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive days;

(8) when the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process as described in OAC 340:100-5-50 through 340:100-5-58;

(9) when the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of OKDHS policy or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective;

(10) when the member is determined to no longer be SoonerCare eligible;

(11) when there is sufficient evidence that the member or his/her legal representative has engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) when the member or his/her legal representative either cannot be located, has not responded to, or has not allowed case management to complete plan development or monitoring activities as required by policy and the member or his/her legal representative:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits case management (the case manager) from being able to complete plan development or monitoring activities as required by policy;

(13) when the member or his/her legal representative fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) when it is determined that HCBS Waiver services are no longer necessary to meet the member's needs and professional documentation provides assurance that the member's health, safety, and welfare can be maintained without Waiver supports;

(15) when the member or his/her legal representative fails to cooperate with service delivery;

(16) when a family member, authorized representative, other individual in the member's household or persons who routinely visit, pose a threat of harm or injury to provider staff or official representatives of OKDHS; or

(17) when a member no longer receives a minimum of one Waiver service per month and DDSD is unable to monitor member on a monthly basis.

(k) **Reinstatement of services.** Waiver services are reinstated when:

(1) the situation resulting in case closure of a Hissom class member is resolved;

(2) a member is incarcerated for 90 days or less;

(3) a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 days or less; or

(4) a member's SoonerCare eligibility is re-established within 90 days of the date of SoonerCare ineligibility.

317:40-5-3. Agency companion services

- (a) Agency companion services (ACS):
- (1) are provided by agencies contracted with the Oklahoma Health Care Authority (OHCA);
 - (2) provide a living arrangement developed to meet the specific needs of the member that includes a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;
 - (3) are available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under the age of 18 years may be served with approval from the DDS D director or designee;
 - (4) are based on the member's need for residential services per OAC 340:100-5-22 and support as described in the member's Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58.
- (b) An agency companion:
- (1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDS D);
 - (2) may provide companion services for one member . Exceptions to serve as companion for two members may be granted only upon approved by the DDS D director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;
 - (3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the DDS D director or designee;
 - (4) may not provide companion services to more than two members at any time;
 - (5) household may not serve more than three members through any combination of companion or respite services;
 - (6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.
 - (A) Employment as an agency companion is the companion's primary employment.
 - (B) The companion may not have other employment when:
 - (i) the member(s) require enhanced or pervasive level of support;
 - (ii) approved to serve two members regardless of the

levels of support required by the members.

(C) The companion may have other employment when:

(i) the member requires intermittent or close levels of support;

(ii) the personal support Team documents and addresses all related concerns in the member's IP; and

(iii) the other employment is approved in advance by the DDS area manager or designee;

(7) approved for other employment may not be employed in another position that requires on-call duties.

(A) If, after receiving approval for other employment, authorized DDS staff determines the other employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 days:

(i) the other employment; or

(ii) his or her employment as an agency companion.

(B) Homemaker, habilitation training specialist, and respite services are not provided in order for the companion to perform other employment.

(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's salary.

(1) Therapeutic leave:

(A) is a SoonerCare payment made to the contract provider to enable the member to retain services; and

(B) is claimed when:

(i) the member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless of whether the companion is present; or

(ii) the companion uses authorized respite time;

(C) is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year; and

(D) cannot be accrued from one Plan of Care year to the next

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate which is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the salary that he or she would earn if the member were not on therapeutic leave.

(d) Levels of support for the member and corresponding payment are:

- (1) determined by authorized DDSD staff in accordance with levels described in (A) through (D); and
- (2) re-evaluated when the member has a change in agency companion providers which includes a change in agencies or individual companion providers.

(A) **Intermittent level of support.** Intermittent level of support is authorized when the member:

- (i) requires minimal assistance with basic daily living skills, such as bathing, dressing, and eating;
- (ii) communicates needs and wants;
- (iii) is able to spend short periods of time unsupervised inside and outside the home;
- (iv) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and
- (v) has stable or no ongoing medical or behavioral difficulties.

(B) **Close level of support.** Close level of support is authorized when the member:

- (i) requires regular, frequent and sometimes constant assistance and support or is totally dependent on others to complete daily living skills, such as bathing, dressing, eating, and toileting;
- (ii) has difficulty or is unable to communicate basic needs and wants;
- (iii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and
- (iv) requires regular monitoring and assistance with health, medication, or behavior interventions, and may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is authorized when the member:

- (i) is totally dependent on others for:
 - (I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and
 - (II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;
- (ii) demonstrates ongoing complex medical or behavioral

issues requiring specialized training courses per OAC 340:100-3-38.3; and

(iii) has medical support needs that are rated at Level 4, 5, or 6 on the Physical Status Review (PSR), per OAC 340:100-5-26. In cases where complex medical needs are not adequately characterized by the PSR, exceptions may be granted only upon review by the DDS director or designee; or

(iv) requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14;

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, and

(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system. The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

317:40-5-5. Agency Companion Services provider responsibilities

(a) Providers of Agency Companion Services (ACS) are required to meet all applicable standards outlined in this subchapter and competency-based training described in OAC 340:100-3-38. The provider agency ensures that all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, as described in subsection (b) of OAC 340:100-3-27, for the companion, and if warranted, revocation of approval of the companion.

(c) In addition to the criteria given in OAC 317:40-5-4, the companion:

(1) ensures no other adult or child is cared for in the home on a regular or part-time basis including other Oklahoma Department of Human Services (OKDHS) placements, family members, and friends without prior written authorization from the OKDHS Developmental Disabilities Services Division (DDSD) area manager or designee;

(2) meets the requirements of OAC 317:40-5-103, Transportation. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the member's enhanced independence, self sufficiency, community inclusion, and well-being;

(5) participates as a member of the member's Team and assists in the development of the member's Individual Plan for service provision;

(6) with assistance from the DDSD case manager and the provider agency program coordination staff, develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Individual Plan;

(A) The companion documents and provides monthly data and health care summaries to the provider agency program coordination staff.

(B) The agency staff provides monthly reports to the DDSD case manager or nurse.

(7) delivers services at appropriate times as directed in the Individual Plan;

(8) 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);

(9) is sensitive to and assists the member in participating in

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the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;

(10) participates in and supports visitation and contact with the member's natural family, guardian, and friends, provided this visitation is desired by the member;

(11) obtains permission from the member's legal guardian, if a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) traveling out of state;

(B) overnight visits; or

(C) involvement of the member in any publicity;

(12) serves as the member's health care coordinator in accordance with OAC 340:100-5-26;

(13) ensures the monthly room and board contribution received from the member as reflected on OKDHS Form 06AC074E, Service Authorization Budget (SAB), is used toward the cost of operating the household;

(14) assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;

(15) works closely with the provider agency program coordination staff and the DDS case manager to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;

(16) assists the member in achieving the member's maximum level of independence;

(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;

(18) ensures that the member's confidentiality is maintained in accordance with OAC 340:100-3-2;

(19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;

(20) implements training and provides supports that enable the member to actively join in community life;

(21) does not serve as representative payee for the member without a written exception approval from the DDS area manager or designee;

(A) The written approval is retained in the member's home record.

(B) When serving as payee, the companion complies with the requirements of OAC 340:100-3-4.

(22) ensures the member's funds are properly safeguarded.

(23) must obtain prior approval from the provider agency when making a purchase of over \$50.00 with the member's funds;

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- (24) allows the provider agency staff and DDS staff to make announced and unannounced visits to the home;
- (25) develops an Evacuation Plan, OKDHS Form 06AC020E, for the home and conducts training with the member;
- (26) conducts fire and weather drills at least quarterly and maintains the Fire and Weather Drill Record, OKDHS Form 06AC021E, available for review;
- (27) develops and maintains a Personal Possession Inventory, OKDHS Form 06AC022E, documenting the member's possessions and adaptive equipment;
- (28) supports the member's employment program by:
 - (A) assisting the member to wear appropriate work attire; and
 - (B) contacting the member's employer only as outlined by the Team and in the Individual Plan; and
- (29) follows all applicable rules promulgated by the Oklahoma Health Care Authority or DDS, including:
 - (A) OAC 340:100-3-40;
 - (B) OAC 340:100-5-50 through 100-5-58;
 - (C) OAC 340:100-5-26;
 - (D) OAC 340:100-5-34;
 - (E) OAC 340:100-5-32;
 - (F) OAC 340:100-5-22.1;
 - (G) OAC 340:100-3-24; and
 - (H) OAC 340:100-3-38.

317:40-5-100. Assistive technology devices and services

(a) **Applicability.** The rules in this Section apply to assistive technology (AT) services and devices authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.**

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:

- (A) visual alarms;
- (B) telecommunication devices (TDDS);
- (C) telephone amplifying devices;
- (D) other devices for protection of health and safety of members who are deaf or hard of hearing;
- (E) tape recorders;
- (F) talking calculators;
- (G) specialized lamps;
- (H) magnifiers;
- (I) braille writers;
- (J) braille paper;
- (K) talking computerized devices;
- (L) other devices for protection of health and safety of members who are blind or visually impaired;
- (M) augmentative and alternative communication devices including language board and electronic communication devices;
- (N) competence based cause and effect systems such as switches;
- (O) mobility and positioning devices including:
 - (i) wheelchairs;
 - (ii) travel chairs;
 - (iii) walkers;
 - (iv) positioning systems;
 - (v) ramps;
 - (vi) seating systems;
 - (vii) standers;
 - (viii) lifts;
 - (ix) bathing equipment;
 - (x) specialized beds;
 - (xi) specialized chairs; and
- (P) orthotic and prosthetic devices, including:
 - (i) braces;

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- (ii) prescribed modified shoes;
 - (iii) splints; and
 - (Q) environmental controls or devices;
 - (R) items necessary for life support and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare.
- (2) AT services include:
 - (A) sign language interpreter services for members who are deaf;
 - (B) reader services;
 - (C) auxiliary aids;
 - (D) training the member and provider in the use and maintenance of equipment and auxiliary aids;
 - (E) repair of AT devices; and
 - (F) evaluation of the AT needs of a member.
- (3) AT devices and services must be included in the member's Individual Plan (IP) and arrangements for this HCBS service must be made through the member's case manager.
- (4) AT devices are provided by vendors with a Durable Medical Equipment (DME) contract with the Oklahoma Health Care Authority (OHCA).
- (5) AT devices and services are authorized in accordance with requirements of The Oklahoma Central Purchasing Act, other applicable statutory provisions, OAC 580:15 and OKDHS approved purchasing procedures.
- (6) AT devices or services may be authorized when the device or service:
 - (A) has no utility apart from the needs of the person receiving services ;
 - (B) is not otherwise available through SoonerCare, Department of Rehabilitative Services, or any other third party or known community resource;
 - (C) has no less expensive equivalent that meets the member's needs ;
 - (D) is not solely for family or staff convenience or preference;
 - (E) is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;
 - (F) is of direct medical or remedial benefit to the member;
 - (G) enables the member to maintain, increase, or improve functional capabilities;

(H) is supported by objective documentation included in a professional assessment except as specified per OAC 317:40-5-100;

(I) is within the scope of assistive technology per OAC 317:40-5-100; and

(J) is the most appropriate and cost effective bid if applicable.

(c) **Assessments.** Assessments for AT devices or services are performed by a licensed professional service provider(s) and reviewed by other providers whose services may be affected by the type of device selected. A licensed professional must:

(1) determine whether the person's identified outcome can be accomplished through the creative use of other resources such as:

(A) household items or toys;

(B) equipment loan programs;

(C) low-technology devices or other less intrusive options;
or

(D) a similar, more cost-effective device.

(2) recommend the most appropriate AT based on the member's:

(A) present and future needs, especially for members with degenerative conditions;

(B) history of use of similar AT, and ability to use the device currently and for at least the foreseeable future (no less than 5 years); and

(C) outcomes.

(3) complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device.

Supporting documentation must include:

(A) review of device considered;

(B) availability of device rental with discussion of advantages and disadvantages;

(C) how frequently and in what situations device will be used in daily activities and routines;

(D) how the member and caregiver(s) will be trained to use the AT device; and

(E) features and specifications of the device that are necessary for the member, including rationale for why other alternatives are not available to meet the member's needs.

(4) provide a current, unedited videotape or pictures of the person member using the device, including the time frames of the trials recorded, upon request by DDS staff.

(d) Authorization of repairs, or replacement of parts. Repairs to AT devices, or replacement of device parts, do not require a professional assessment or recommendation. DDSD area office resource development staff with assistive technology experience may authorize repairs and replacement of parts for previously recommended assistive technology.

(e) Retrieval of assistive technology devices. When devices are no longer needed by a member, OKDHS/DDSD staff may retrieve the device.

(f) Team decision-making process. The member's Personal Support Team reviews the licensed professional's assessment and decision making review. The Team ensures the recommended AT:

(1) is needed by the member to achieve a specific, identified functional outcome;

(A) A functional outcome, in this Section, means the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the activity independently, such as self-care, assistance with eating, or transfers.

(B) Functional outcomes must be reasonable and necessary given a member's age the diagnosis and abilities.

(2) allows the member receiving services to:

(A) improve or maintain health and safety;

(B) participate in community life;

(C) express choices; or

(D) participate in vocational training or employment;

(3) will be used frequently or in a variety of situations;

(4) will fit easily into the member's lifestyle and work place;

(5) is specific to the member's unique needs; and

(6) is not authorized solely for family or staff convenience.

(g) Requirements and standards for AT devices and service providers.

(1) Providers guarantee devices, work, and materials for one year, and supply necessary follow-up evaluation to ensure optimum usability.

(2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluate the need for AT and individually customize AT devices as needed.

(h) Services not covered through AT devices and services. Assistive technology devices and services do not include;

(1) trampolines;

(2) hot tubs;

(3) bean bag chairs;

- (4) recliners with lift capabilities;
 - (5) computers except as adapted for individual needs as a primary means of oral communication and approved per OAC 317:40-5-100;
 - (6) massage tables; and
 - (7) educational games and toys.
- (i) **Approval or denial of AT.** DDSD approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease/purchase of the AT is determined per OAC 317:40-5-100.
- (1) The DDSD case manager sends the AT request to designated DDSD area office resource development staff with AT experience. The request must include:
- (A) the licensed professional's assessment and decision making review;
 - (B) a copy of the Plan of Care;
 - (C) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-100; and
 - (D) all additional documentation to support the need for the assistive technology device or service.
- (2) The designated area office resource development staff, with AT experience, approves or denies the AT request when there is no fixed rate for the device and the device has a cost less than \$2500 based on:
- (A) the criteria given in subsection (d) of this Section;
 - (B) the scope of the program, as explained in subsection (a) of this Section; and
 - (C) the cost effectiveness of the AT, as explained in subsection (a) of this Section.
- (3) Authorization for purchase or a written denial is provided within ten working days of receipt of a complete request.
- (A) If the AT is approved, a letter of authorization is issued.
 - (B) If additional documentation is required by the area office resource development staff with AT experience, to authorize the recommended AT, the request packet is returned to the case manager for completion.
 - (C) If necessary, the case manager will contact the licensed professional to request the additional documentation and the licensed professional will supply further documentation upon request of the area office resource development staff with AT experience.
 - (D) The authorization of AT that has no fixed rate and is \$2,500 or more is performed as in paragraph (2) of this

subsection, except that the area office resource development staff with AT experience:

- (i) solicits three bids for the AT;
- (ii) submits the AT request, bids, and other relevant information to the DDS State Office AT programs manager within five working days of receipt of the required bids; and
- (iii) the State Office AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five working days of receipt of all required documentation for AT.

(j) Approval of vehicle adaptations. Vehicle adaptations are assessed and approved per OAC 317:40-5-100. In addition, the requirements in this paragraph must be met.

(1) The vehicle to be adapted must be owned or in the process of being purchased by the member receiving services or his or her family.

(2) The AT request must include a certified mechanic's statement that the vehicle and adaptations are mechanically sound.

(3) Vehicle adaptations are limited to one vehicle in a ten year period per member. Authorization for more than one vehicle adaptation in a 10-year period must be approved by the DDS division administrator or designee.

(k) Denial. Procedures for denial of an AT device or service are described in this paragraph.

(1) The person denying the AT request provides a written denial to the case manager citing the reason for denial per policy.

(2) The case manager sends the Notice of Action, OKDHS form 06MP004E, to the member and his or her family or guardian.

(3) Denial of assistive technology services may be appealed through the OKDHS hearing process per OAC 340:2-5.

(l) Return of an AT device. If, during a trial use period or rental of a device, the therapist or Team including the licensed professional if available, who recommended the AT, determines the device is not appropriate, the licensed professional sends a brief report describing the reason(s) for the change of device recommendation to the DDS case manager. The case manager forwards the report to the designated area office resource development staff, who arranges for the return of the equipment to the vendor or manufacturer.

(m) Rental of AT devices. AT devices are rented when the licensed professional or area office resource development staff with AT experience determines rental of the device is more cost effective

than purchase of the device or the licensed professional recommends a trial period to determine if the device meets the needs of the member.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.

(2) Area office resource development staff with AT experience monitor use of equipment during the rental agreement for:

(A) cost effectiveness of the rental time frames;

(B) conditions of renewal; and

(C) the Team's re-evaluation of the member's need for the device per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device whenever such option is available from the manufacturer or vendor.

(4) If a device is rented for a trial use period, the Team decides within 90 days whether:

(A) the equipment meets the member's needs; and

(B) to purchase the equipment or return it.

(n) Assistive Technology Committee. The committee reviews equipment requests when deemed necessary by the OKDHS/DDSD state office assistive technology programs manager.

(1) The AT committee is comprised of:

(A) DDS professional staff members of the appropriate therapy;

(B) DDS AT state office programs manager;

(C) the DDS area manager or designee; and

(D) an AT expert not employed by OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria given in this Section. Any endorsement or denial includes a written rationale for the decision and, if necessary, an alternative solution(s), directed to the case manager within 20 working days of receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified in OAC 317:40-5-100.

317:40-7-6. Center-Based Services

(a) Center-Based Services are provided in segregated settings, where the majority of people served have a disability. Any employment service provided where a majority of the people at the site are persons with a disability is billed as Center-Based Services.

(b) Center-Based Services are pre-planned, documented activities that relate to the member's identified employment outcomes.

(c) Examples of Center-Based Services are active participation in:

(1) paid contract work which occurs in a workshop or other center-based setting.

(2) Team-prescribed therapy programs such as speech, physical therapy, or switch activation which are implemented by employment provider staff in the workshop or other center-based setting.

(3) unpaid training or paid work experience which occurs in a setting without opportunities for regular daily interactions with co-workers without disabilities or the general public.

(4) computer classes, GED preparation, job club, interviewing skills, or other classes whose participants all have disabilities, even if the location is in the community.

(d) Paid contract work is usually subcontracted, and the persons receiving services earn commensurate wage according to Department of Labor regulations.

(e) For SoonerCare reimbursement in Center-Based Services, a member's pay cannot exceed 50% of minimum wage.

(f) Participation in Center-Based Services is limited to 15 hours per week for persons receiving services through the Homeward Bound Waiver, unless approved through the exception process explained in OAC 317:40-7-21.

(g) Agency must meet physical plant expectations of OAC 340:100-17-13.

(h) During periods in which no paid work is available for members, despite the documented good faith efforts of the provider to secure such work, the employment provider agency ensures that each member participates in training activities that are age appropriate, work related, and consistent with the IP. Such activities may include, but are not limited to:

(1) resume development and application writing;

(2) work attire selection;

(3) job interview training and practice;

(4) job safety and evacuation training;

(5) personal or social skills training; and

(6) stamina and wellness classes.

317:40-7-8. Employment training specialist services

Employment training specialist (ETS) services include evaluation, training, and supportive assistance that allow the member to obtain and engage in remunerative employment. ETS services are:

- (1) provided by a certified job coach;
- (2) not available when subcontracting;
- (3) used to help a member with a new job in a generic employment setting.

(A) ETS services are:

(i) not available if the member held the same job for the same employer in the past;

(ii) available when the member requires 100% on-site intervention for up to the number of hours the member works per week for six weeks per Plan of Care year; and

(iii) used in training members employed in individual placements on new jobs when the:

(I) member receives at least minimum wage; and

(II) employer is not the employment services provider.

(B) If the member does not use all of the training units on the first job placement in the Plan of Care year, the balance of training units may be used on a subsequent job placement with the current provider, or with a new provider;

(4) used in assessment and outcome development for members residing in the community who are new to the provider agency, when determined necessary by the Personal Support Team (Team).

The provider:

(A) may claim a documented maximum of 20 hours per member for initial assessment. The projected units for the assessment and outcome development must:

(i) be approved in advance by the Team; and

(ii) relate to the member's desired outcomes; and

(B) cannot claim the same period of time for more than one type of service;

(5) used in Team meetings, when the case manager has requested participation of direct service employment staff in accordance with OAC 340:100-5-52, up to 20 hours per Plan of Care year;

(6) used in job development for a member on an individual job site upon the member's completion of three consecutive months on the job.

(A) Up to 40 hours may be used during a Plan of Care year after documentation of job development activities is submitted to the case manager.

(B) The job must:

(i) pay at least minimum wage;

(ii) employ each member at least 15 hours per week; and

(iii) be provided by an employer who is not the member's

contract provider;

(7) used in development of a Plan for Achieving Self-Support (PASS) up to 40 hours per Plan of Care year after documentation of PASS development, if not developed by a Community Work Incentives Coordinator or the Department of Rehabilitation Services, and implementation of an approved PASS after documentation has been submitted to the case manager;

(8) used in development of an Impairment Related Work Expense (IRWE) up to 20 hours per Plan of Care year after documentation of IRWE development, if not developed by a Community Work Incentives Coordinator or Oklahoma Department of Rehabilitation, and implementation of an approved IRWE after documentation is submitted to the case manager; and

(9) used in interviewing for a job that is eligible for ETS services.

(10) If the member needs job coach services after expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan. The plan should include the process for fading as the member's independence increases and progress documented on OKDHS form 06WP066E.

317:40-7-11. Stabilization Services

Stabilization Services are ongoing support services needed to maintain a member in an integrated competitive employment site. Stabilization Services are provided for up to two years per job. Stabilization Services continue until the next Plan of Care following the end of two years of Stabilization Services.

(1) Stabilization Services are provided when the job coach intervention time required at the job site is 20% or less of the member's total work hours for four consecutive weeks or when the member moved from Department of Rehabilitation Services (DRS) services.

(A) If, after the member moves to Stabilization, the Team determines that support is needed above 20% for longer than two weeks, the Team may revise the member's Plan of Care to reflect the need for Job Coaching Services.

(B) A member receiving services from DRS moves to services funded by DDS upon completion of the Job Stabilization milestone. The employment provider agency submits the request for transfer of funding during the Job Stabilization milestone as described in the DRS Supported Employment contract.

(2) Stabilization Services must:

(A) identify the supports needed, including development of natural supports;

(B) specify, in a measurable manner, the services to be provided.

(3) Reimbursement for Stabilization Services is based upon the number of hours the member is employed at a rate of minimum wage or above.

(4) If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan.

317:40-7-13. Supplemental Supports for Center-Based Services

(a) In those instances when a member receiving Center-Based Services needs additional supports, the provider assigns staff in patterns that most effectively meet the needs of each member as indicated by a personal care and/or a risk assessment and defined in the Individual Plan (IP) or Protective Intervention Plan.

(b) If re-arranging staff patterns is not sufficient to meet the member's needs, the provider may file a request and plan for Supplemental Supports utilizing Vocational Habilitation Training Specialist Services. Supplemental Supports can be claimed only if provided by a staff member who has completed all specialized training and individual-specific training prescribed by the Team in accordance with OAC 340:100-3-38.

(c) Supplemental Supports for Center-Based Services include two types of services, behavioral continuous support, and personal care intermittent support.

(1) **Continuous Supplemental Supports.** Continuous Supplemental Supports cannot exceed 15 hours per week for persons receiving services through the Homeward Bound waiver unless specifically approved through the exception process described in OAC 317:40-7-21.

(A) To be eligible for continuous supplemental supports, the member must have:

(i) a protective intervention plan that:

(I) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(II) has been submitted to the Human Rights Committee (HRC) per OAC 340:100-3-6; and

(III) has been approved by the State Behavior Review Committee (SBRC) per OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff per OAC 340:100-5-57; or

(ii) procedures included in the protective intervention plan which address dangerous behavior that places the member or others at risk of serious physical harm. The Team submits documentation of this risk and the procedures to the DDSD positive support field specialist to assure that positive approaches are being used to manage dangerous behavior.

(B) The Team documents discussion of the need for continuous Supplemental Supports.

(2) **Intermittent Supplemental Supports.** To receive personal care intermittent support, a member must have a personal care need that requires staffing of at least one-to-one during that time frame when the support is needed.

(A) If a member needs intermittent personal care support

during Center-Based Services, the Team documents discussion of:

(i) the specific support need(s) of the member, such as staff-assisted repositioning, lifting, transferring, individualized bathroom assistance, or nutritional support; and

(ii) the calculations that combine the time increments of support to determine the total number of units needed on the Plan of Care.

(B) The case manager sends the documentation to the case management supervisor for approval.

(C) The case management supervisor signs and forwards a copy of the approval, denial, or recommended modifications to the case manager within two working days of receipt.

(D) A member may receive Center-Based Services and Intermittent Supplemental Supports at the same time.

(d) Supplemental Support for Center-Based Services described in this Section cannot be accessed in Community-Based Services.

(e) Sufficient staff must be available in the center-based facility to provide the supplemental support in order for a provider to claim the units.