# PART II

# CHAPTERS 600 – 1200

# POLICIES

# AND

# PROCEDURES

# FOR

# COMPREHENSIVE SUPPORTS WAIVER PROGRAM (COMP)

**FORMERLY COMMUNITY HABILITATION SUPPORTS SERVICES (CHSS)**

# AND

# NEW OPTIONS WAIVER PROGRAM (NOW)

**FORMELY MENTAL RETARDATION WAIVER (MRWP)**

# GENERAL MANUAL



**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAID**
**October 1, 2021**

**Policy Revision Record**
**October 1, 2021**

| NUMBER | REVISION DATE | SECTION | REVISION DESCRIPTION | REVISION TYPE | REASON FOR CHANGE |
|---|---|---|---|---|---|
| | | | | A=Added<br>D= Deleted<br>M= Modified | (Revision required by Regulation, Legislation, Etc. |
| 1 | 10/1/2021 | Manual Cover Page | Change date from July 1, 2021 to October 1, 2021 | M | N/A |
| 2 | 10/1/2021 | 606 J.6.iii | Clarification to prohibit training of prone manual restraints | M | The change is needed to provide clarification that training cannot be provided on the use of prone manual restraints |
| 3 | 10/1/2021 | 1205.ii | Deleted "face to face" requirement for Participant Direction training | D | The face to face requirement will no longer be required as of 10/1/2021 |
| 4 | 10/1/2021 | 1205.ii | Clarified the Participant Direction training is facilitated by DBHDD | M | The change is needed to provide clarification that DBHDD facilitates the training |
| 5 | 10/1/2021 | 1207 IV | Added for waiver program changes from NOW to COMP, services may only be initiated on the 1st of the month proceeding DBHDD approval of the conversion. | A | The change is needed in order to ensure seamless transition between NOW and COMP waiver programs |
| 6 | 10/1/2021 | 1210 C.11. | Deleted Support Coordination role to support family in filing a Live In Exemption and email to the DCH | D | This provision will be set forth in DBHDD policy as of 10.1.2021 |
| 7 | 10/1/2021 | 1217.E. | Added the requirement that the re-enrollment process requires the individual and designated representative to receive the mandatory training facilitated by DBHDD. | A | This provision is needed to ensure the individual and designated representative receive training when re-enrolling after a termination. |
| 8 | 10/1/2021 | 1217.G | Added the requirement if there is a substantiated finding | A | This provision is needed to ensure the health and safety of the individuals served. |

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| | | | by the appropriate investigative authority of abuse, neglect or exploitation committed by the individual's representative, the representative shall not be permitted to continue as the individual's designated representative. | | |

The following defines each column:

The following defines each column:

1. Num – This is the unique number of the comment.
2. Revision Date – the manual date of the change
3. Section. – The section of the document to which the comment applies.
4. Revision Description. – The paragraph for which the changes are occurring.
5. Revision Type
    a. A – The revision is an addition to the Policy
    b. D – The revision is a Deletion of the Policy
    c. M – The revision is modifying (changing) a portion of the Policy
6. Reason for the Change: Is the change needed because of a change in Regulation or Legislation, etc…..

**PART II, POLICIES AND PROCEDURES**
**FOR**
**COMPREHENSIVE SUPPORTS WAIVER PROGRAM**
**(COMP)**
**And**
**NEW OPTIONS WAIVER PROGRAM (NOW)**
**GENERAL MANUAL**

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**NOTE:**

Effective January 1, 2016, general policy for two waivers programs for individuals with intellectual and/or developmental disabilities I/DD, the **COMP** and **NOW Programs,** has been combined into one Manual. Differences in the two programs are described in greater detail in Part III policies, however, general provider requirements are consistent in both. The **COMP** waiver was designed for individuals with I/DD who need a full range of out-of-home services or intensive in-home services, as indicated in clinical assessments. The **COMP** waiver is also used for individuals transitioning out of institutions into community living. The **NOW** waiver provides supports to individuals with I/DD who do not need 24 hours care or who need less intensive services and supports, as indicated in clinical assessments. The **COMP** and **NOW** waivers each include specific services that are *only* available in that waiver and will be referenced as such throughout the document.

Services available in one but not both waiver programs include:

| COMP Waiver | NOW Waiver |
|---|---|
| Community Residential Alternative Services (CRA) | |
| Additional Staffing Services | |

## PART II - CHAPTER 600

## SPECIAL CONDITIONS OF PARTICIPATION

### 601. General

Rev 04 2017
Rev 01 2020

Following the value that services and supports for people with I/DD respect the vision of the individual, each agency or organization must incorporate this belief into their service delivery to support individuals with I/DD in living a meaningful life in the community. Specifically, the provider must ensure:

1. Person centered service planning and delivery that address what is important to and for individuals
2. Capacity and capabilities, including qualified and competent providers and staff
3. Individual safeguards
4. Satisfactory individual outcomes
5. Individuals rights and responsibilities
6. Individual access
7. System of care that offers the infrastructure necessary to provide coordinated services, supports, treatment and care

### 601.1 OUTCOMES FOR PERSONS SERVED

The Standards that follow are applicable to the organizations that provide I/DD services to individuals that are financially supported by funds authorized through DBHDD, regardless of the age or disability of the individual served.

Individual self-determination includes freedom, authority and responsibility and is considered key to achieving the vision of *a satisfying, independent life with dignity and respect for everyone.*

Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual and reflect person centered goal(s) of the individual. The purpose of the assessment is to determine the individual's wishes for their life and to determine how best to assist the individual in reaching those wishes including determining appropriate staff to deliver these services.

1. Assessments should include but are not limited to the following:
    a. The individual's:
        i. Wishes or personal life goal(s);
        ii. Perception of the issue(s) of concern;
        iii. Strengths;
        iv. Needs;
        v. Abilities; and
        vi. Preferences.
    b. Medical history;
    c. A current health history status report or examination in cases where:

i. Medications or other ongoing health interventions are required;
ii. Chronic or confounding health factors are present;
iii. Medication prescribed as part of DBHDD services has research indicating necessary surveillance of the emergence of diabetes, hypertension, and/or cardiovascular disease;
iv. Allergies or adverse reactions to medications have occurred; or
v. Withdrawal from a substance is an issue.

d. Appropriate diagnostic tools such as impairment indices, psychological testing or laboratory tests;
e. Social history;
f. Family history;
g. School records (for school-aged individuals);
h. Collateral history from family or persons significant to the individual if available.
NOTE: When collateral history is taken, information about the individual may not be shared with the person giving the collateral history unless the individual has given specific written consent; and
i. Review of legal concerns including
i. Advance Directives;
ii. Legal Competence;
iii. Legal Involvement of the courts; and
iv. Legal status as adjudicated by a court.

2. Additional assessments should be performed or obtained by the provider if required to fully inform the services, supports, care and treatment provided. These may include but are not limited to:
a. Assessment of trauma or abuse;
b. Suicide risk assessment;
c. Functional assessment;
d. Cognitive assessment;
e. Behavioral assessments;
f. Spiritual assessment;
g. Assessment of independent living skills;
h. Cultural assessment;
i. Recreational assessment;
j. Educational assessment;
k. Vocational assessment;
l. Nutritional assessment; and
m. Nursing assessment (Note: Required for nursing services to identify healthcare risks.)

The policies, procedures and the conditions related to participation in Georgia's Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) to provide home and community-based waiver services for persons with intellectual and developmental disabilities (I/DD) are authorized by an approved waiver from the Centers for Medicare and Medicaid Services (CMS) pursuant to

Section 2l76 of Public Law 97-35. The waiver provides for services to eligible individuals with I/DD who resides in or is at risk of an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) placement.

In addition to the policies and procedures in this manual, providers must adhere to the following:

1. Those conditions for participation in the Medical Assistance Program, which are, outlined in Part I Policies and Procedures for Medicaid/ PeachCare for Kids Manual applicable to all Medicaid providers;

2. Any policies and procedures specific to the COMP/NOW services rendered by the provider in the Part III COMP/NOW Manual; and

3. All applicable Standards for Department of Behavioral Health, Developmental Disabilities (DBHDD) in the DBHDD provider manual.

Rev 07 2020

The COMP/NOW Program provides the following services to individuals:

Adult Occupational Therapy Services
Adult Physical Therapy Services
Adult Speech and Language Therapy Services
Behavioral Supports Services, Level I and II
Community Access Services (Individual/Group)
Community Guide Services
Community Living Supports Services-Extended
Community Living Support Services in 15-minute increments (COMP/NOW)
Community Residential Alternative Services (COMP only)
Additional Staffing Services (COMP Only)
Environmental Accessibility Adaptation Services
Financial Support Services
Individual Directed Goods and Services
Rev 10 2019
Interpreter Services
Natural Support Training Services
Nutrition Services
Nursing Services
Prevocational Services
Respite Services
Specialized Medical Equipment Services
Specialized Medical Supplies Services
Support Coordination and Intensive Support Coordination Services
Supported Employment Services
Transportation Services
Vehicle Adaptation Services

See Chapter 900, Section 901 of this manual for a definition of each service.

## 602. Organization and Administration

Providers enrolled in the Comprehensive Supports Waiver Program (COMP) and New Options Waiver (NOW) services may be a local public or private agency or an individual provider that meets the Department of Community Health (DCH) and the Department of Behavioral Health and Developmental Disabilities (DBHDD) enrollment criteria.

Faith or Denominationally Based Organizations who receive Federal or State funds address issues specific to being a Faith or Denominationally Based Organization in their Policies and Practice must include the following information and how it is shared with individuals:

- Its religious character;
- The individual's freedom not to engage in religious activities;
- Their right to receive services from an alternative provider;
- The organization shall, within a reasonable time after the date of such objection, refer the individual to an alternative provider.
- If the organization provides employment that is associated with religious criteria, the individual must be informed.
- In no case may federal or state funds be used to support any inherently religious activities, such as but not limited to:
    - Inherently religious activities;
    - Religious instruction; or
    - Proselytization
- Organizations may use space in their facilities to provide services,
  support, care and treatment without removing religious art, icons, scriptures or other symbols.

In all cases, rules found at 42 CFR Parts 54, 54a and 45 CFR Parts 96, 260 and 1050 Charitable Choice Provisions and Regulations: Final Rules shall apply.

## 603. Other Provider Information

### 603.1 Core Requirements

Providers serving COMP/NOW Program individuals must be in compliance with **applicable DBHDD Community Services Standards and Policies.**

When Program Integrity or other focused audits are conducted by the Department of Community Health, the Department of Behavioral Health and Developmental Disabilities, and/or other regulatory agencies, and it is

determined that there are unmet standards under ANY of the 'critical function' areas, the Department of Community Health authorizes the Department of Behavioral Health and Developmental Disabilities (DBHDD) to recommend adverse action that requires enrolled providers to correct deficiencies. Health and Safety issues and /or individual's rights violation require an immediate corrective action plan by the provider and additional monitoring by Support Coordination Agency and/or Field Office staff will be implemented to verify compliance. Corrective Action Plans are tracked and monitored through the DBHDD Division of Accountability and Compliance which may recommend a suspension of new admissions, new services, or new sites or termination of the provider.

Noncompliance determinations in critical function areas may be cause for further adverse actions to be implemented, including suspension, recoupment of paid claims, and/or termination from the program. Additionally, failure to submit a Corrective Action Plan (CAP) will result in adverse action recommendations of suspension on new admissions, new services, new sites and /or recoupment of paid claims.

Critical function areas include:

- Violation of individual rights, responsibilities, and protections
- Inadequate behavioral support practices
- Violation of adequate and competent staff (including inadequate staff to individual ratios and service provision)
- Inadequate Medication and healthcare management
- Violation of respectful service environment (including environmental health and safety)
- Infection Control practices not evident.

**603.2 Provider Information Documentation Requirements**

Unless otherwise specified, materials cited below need not be submitted to the Department of Community Health (DCH), Division of Medicaid. They must be available for review at the agency or individual provider site.

- Disclosure of Ownership - If the provider organization is a corporation, information on all ownership interests of five percent or more (direct or indirect) must be available for review.

- Governing Body - The provider agency organization must have a governing body (or designated person(s) so functioning) which assumes full authority and responsibility for the operation of the COMP/NOW and for assuring compliance with all conditions of participation. A subdivision or subunit, which is required to meet independently the conditions of participation must have its own governing body.

- Bylaws - The provider agency must have written and dated bylaws which are periodically reviewed and updated, as appropriate, by its governing body.

- Reports - The provider shall furnish service reports to the Department of Behavioral Health and Developmental Disabilities in such form and at such times as may be specified, which accurately and fully disclose all COMP/NOW activities.

- Licensure - Licensure and other permits, when applicable, must be current and available at the agency or by the individual provider and open to view by the public.

- Records Management - All required records pertaining to the provision of COMP/NOW services shall be maintained in accordance with standards specified in this manual, in the Department of Behavioral Health and Developmental Disabilities Provider Manual, Part I Policies And Procedures For Medicaid/PeachCare For Kids, and with accepted professional standards and practices. Such records shall be subject to inspection and review by the Department and its agents, and must be made available during the provider's normal business hours (7:30 am – 5:00 pm).

Each provider must participate in the Department of Behavioral Health and Developmental Disabilities statewide individual data reporting system.

Each provider must participate in revenue and expenditure reporting on the Uniform Accounting System (UAS), maintenance of subsidiary expense ledgers, and specialized records for cost accounting purposes.

### 603.3 Provider Requirements for Accreditation and DBHDD Standards Quality Review

Rev. 04 2019
Rev. 10 2019

A. General Information:

1. Providers of COMP/NOW Services must meet Policy 02-703 Accreditation and Compliance Review Requirements for Providers of Intellectual and/or Developmental Disability (I/DD) Services in the DBHDD Provider Manual, Policy Section. The manual is accessed as follows: www.dbhdd.georgia.gov.
2. There are some I/DD services that are not required to be accredited or to complete the Standards Quality Review process. These include:
   a. Support Coordination

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   b. Specialized Services which include Specialized Medical Equipment, Specialized Medical Supplies, Environment Accessibility Adaptation, Transportation, and Vehicle

Adaptation when one or more of these specialized services are the only service (s) being delivered by the organization.

c. Professional Services to include Adult Physical Therapy, Adult Occupational Therapy, Adult Speech Therapy, Adult Nursing Services, Adult Nutrition Services, Behavioral Support Consultation Services/Level 1, Behavioral Support Services/ Level 2.

**B. Standards Quality Review for I/DD providers authorized to receive less than $250,000 annually**

**1. Standards Quality Review:** The DBHDD Provider Performance Unit conducts reviews regarding compliance with the Community Service Standards. Providers receive from DBHDD a Certificate of Standards Compliance for a period not to exceed five years. I/DD providers must maintain a current Certificate of Standards Compliance to provide services.

**2. Additional expectations related to demonstrating Standards Compliance:**

a. Compliance must be maintained for all DBHDD approved services.

b. Providers must be providing I/DD community services for a minimum of 12 months and have completed the DBHDD Standards review or be accredited to add new services/sites. If new services are approved, they will be included in the subsequent Standards Quality Review.

c. At any time, DBHDD may request a Special Standards Quality Review to assess a Provider's Compliance with the Community Service Standards.

d. Providers terminated due to failure to comply with the Standards Quality Review may not make application to become a provider for a period of one (1) year.

e. If during the standards quality review or a special standards quality review, critical function areas are identified, then the contracting Field Office(s) has the option to relocate the individual(s) immediately.

**C. Accreditation for DD Providers Authorized to Receive an Annual Amount Equal to or more than $250,000 annually**

1. General expectations regarding Accreditation:

(a) It is the responsibility of the Provider to select an accrediting

agency from the list listed in Appendix I and submit an Application for accreditation. This must occur within 30 days after the Provider has crossed the threshold and is authorized to receive funding in an amount more than $250,000 per year, regardless of expiration date of existing standards compliance certificate.

(b) The Provider is responsible for paying accreditation fees and providing to DBHDD Regional Services Administrator a copy of the Accrediting body's letter confirming the date of the survey.

(c) The Provider must be accredited within 12 months of application for accreditation.

(d) The provider must submit to DBHDD Regional Services Administrator results of accrediting body visit within seven (7) working days of receipt.

(e) The provider is expected to ensure that the specific services approved by DBHDD are properly accredited.

(f) If DBHDD approves the Provider to offer new service, the Provider must be accredited for the new category of service at the time of their next accreditation survey. If the provider's next accreditation survey is not due for longer than twelve (12) months from the time that the additional services are initiated by the provider, DBHDD may require the following:

i. that the Provider Performance Unit conducts a Special Standards Quality Review,

OR

ii. that the Provider verifies compliance with their accrediting body's requirements related to accrediting the new service.

2. Maintenance of Accreditation and Request for Waiver

If an accredited provider loses accreditation, fails to reapply for accreditation, or comes under a corrective action requirement with Accrediting body, the provider must notify DBDDD within 7 working days; this notification is done in writing via a letter sent to:

a. DBHDD Field Office
b. DBHDD Provider Network Management, Suite 23-247, 2 Peachtree Street, Atlanta GA 30303 AND
c. DBHDD Contracts Section, Suite 23-173, 2 Peachtree Street, Atlanta, GA 30303

3. Action related to each of the following situations

a. Loss of Accreditation: Loss of accreditation results in termination of the DBHDD relationship with the provider.

b. Failure to reapply will result in actions being taken against the provider. The provider will be given sixty (60)

calendar days, during which the agency makes application, payment and a scheduled visit date by accreditation body. Failure to meet this time frame results in termination of the DBHDD relationship with the provider.

## 604. Provider Enrollment

### 604.1 To Enroll to Become a New Provider

Rev 04 2019
Rev 01 2020

A. To enroll to become a provider agency or individual provider, you are required to attend a provider enrollment forum prior to completing a Letter of Intent and mailing it to:

GA Collaborative Enrollment
P.O. Box 56324
Atlanta, GA 30343

A registration link will be available when enrollment forums have been scheduled. The forum and open enrollment are located at the following website: www.georgiacollaborative.com.

The Letter of Intent can be found in *Recruitment and Application to Become a Provider of Developmental Disabilities Services Policy,* located at the following website: http://gadbhdd.policystat.com.

**Note: A Letter of Intent must be approved by GA Collaborative ASO before completion of the provider application as well as the Medicaid application. The application is to be completed upon notification of your Letter of Intent approval**.

- The Medicaid Provider Enrollment packet is obtained from the following website: www.mmis.georgia.gov or by calling (800) 766-4456 for assistance. The GA Collaborative ASO application can be found at www.georgiacollaborative.com. The Medicaid application should not be completed until directed by GA Collaborative ASO.

**Both applications are submitted to the address listed in the GA Collaborative ASO Agency application for new providers.**

**Note: 1. DBHDD submits the final DCH application and the DBHDD final Status Report to DCH for their final review. DCH reviews the information and approves or denies the provider request for enrollment.**

**2. Applicants may not re-apply as a COMP/NOW provider for one (1) year after date of denial by DCH of the enrollment application.**

**For existing providers wanting to add new services or locations, you may either mail your completed application to the above GA Collaborative Enrollment address or email it to GAEnrollment@beaconhealthoptions.com.** This application can be found at www.georgiacollaborative.com.

C. Questions regarding licensure requirements should be directed to the Department of Community Health, Healthcare Facility Regulation Division (HFR), formerly known as the Office of Regulatory Services, at 1-800-georgia or the website: www.dch.georgia.gov.

**1.** The Department requires proof of licensure or permit for the following services:

Adult Occupational Therapy Services
Adult Physical Therapy Services
Adult Speech Language Therapy Services
Community Living Support Services
Community Residential Alternative Services/Residential Training and Supervision
Nursing Services
Nutrition Services
Respite Services

Rev 4 2017

2. A proof of licensure is required from individual providers as defined for specific services in the Part III COMP/NOW Manual at the website: www.mmis.georgia.gov

D. Individual professionals making application to provide any of the following services should follow the information provided in Section 604.1 in submitting an individual provider application:

Adult Occupational Therapy Services
Adult Physical Therapy Services
Adult Speech and Language Therapy Services
Behavioral Supports Services Level 1and Level 2(Behavioral Management)

Community Living Support Services
Community Residential Alternative Services (Residential Training and Supervision)
Nursing Services
Rev 04 2017 Nutrition Services

Individuals applying to be enrolled Medicaid providers must have provided the waiver service for at least one year as an individual hired by a individual or representative through self-direction prior to submission of a provider application. The individual provider must provide evidence of satisfactory performance of self-directed waiver service through documentation from the support coordination agency (such as support coordination monitoring notes) and other sources (such as no evidence of substantiated critical incidents against the individual in the provision of self-directed services or required correction actions related to the provision of self-directed services by the individual). Policies and procedures related to self-direction are in Chapter 1200 of this manual.

E. Initial provider applications for Community Residential Alternative (CRA) Services (Residential Training and Supervision) are limited to three (3) residential sites (Community Living Arrangement) {COMP only}

F. Providers with approval to provide Community Residential Alternative Services (Residential Training and Supervision) at the initially approved one to three site(s) cannot apply to add additional sites or services, for one year and until the agency has completed the DBHDD Community Service Standards Quality Review or met accreditation. {COMP only}

G. Providers who apply to provide Community Residential Alternative Services (Residential Training and Supervision) in the host home/life sharing arrangement must be a currently approved agency provider of CRA/ Residential Training and Supervision services in a Personal Care Home or Community Living Arrangement or be an agency that only serves individuals under the age of 19 years and holds a Child Placing Agency license. {COMP only}

H. Provider agencies that apply or are enrolled to provide Financial Support Services (FSS) can not apply or be enrolled to provide any other waiver service. Application for enrollment for FSS are submitted directly to the Department of Community Health.

I. Provider agencies that apply or are enrolled to provide Support Coordination Services can not apply or be enrolled to provide any other waiver service.

J. The Georgia Department of Behavioral Health and Developmental Disabilities Field Office staff conducts preliminary site visits as required.

License(s) (as applicable)

1. **Community Living Arrangement License (**that serves exclusively two to four adults who are receiving services authorized or financed, in whole or in part, by the Georgia Department of Behavioral Health and Developmental Disabilities). {COMP only}

Or

**Child Placing Agency License** (for agency providing community residential alternative services provided in host home/life sharing arrangements for individuals under the age of 19 years)

2. **Private Home Care License** (for agency providing community living support and in-home respite services)

Or

**Home Health Agency License** (for home health agency providing adult therapy services)

Or

**Individual Professional Licenses** (for individuals and agencies for nursing, occupational therapy, physical therapy, speech and language therapy, and other professional services as required for specific COMP services).

**Personal Care Home Permit, Community Living Arrangement Permit, Child Caring Institutions for 4 beds and Child Placing Agencies** (for the provision of Respite Services only)

3. Personal Care Home (PCH) permits are not accepted for applications to provide Community Residential Alternative (CRA) Services. A CLA license is required for these applications. {COMP only}

K. Current Secretary of State Registration for all providers excluding community service boards

L. Current Business License or Permit for all providers

### 604.2 Approval of New Providers

1. Gainwell Technologies reviews and sends an approval letter with a provider number and corresponding approved service name(s) to the provider.

2. DBHDD issues a Letter of Agreement to agencies approved by DCH to provide COMP/NOW service.

## 605. Changes in Enrollment Information

Enrolled providers are required to provide written notice to the DCH, DBHDD, Healthcare Facility Regulation (as applicable), and Support Coordination.

A. Notification of Updated Information

Rev 10 2018
Rev 01/2020

1. Should the information submitted during enrollment (e.g. office location, the payee, voluntary termination, etc.) change, the provider must report those changes within ten (10) calendar days of the changes in writing to the following:

GA Collaborative Enrollment
P.O. Box 56324
Atlanta, GA 30343

OR
Email to GA_Enrollment@beaconhealthoptions.com

AND

Program Specialist, NOW/COMP Waivers
Department of Community Health (DCH)
2 Peachtree Street NW, 37th Floor
Atlanta, GA 30303

2. The Department of Community Health will verify information as needed and provide notification to Gainwell Technologies for claims system updates. Notice of a change of information is not accomplished by simply including the updated information on claims submitted for payment. These claims will be made to the payee on file. Checks returned to the Division by the Post Office will be voided.

Reported changes should include all of the following applicable items or any other pertinent information:

a. Address of the provider agency, administrative or business office
b. Address of the service location
c. Request to deactivate provider number
d. Request to reactivate suspended provider number
e. Request to terminate provider number
f. Telephone numbers
g. Changes in permit/license issued by Healthcare Facility Regulation
h. Other changes as outlined in Part I, Chapter 100, Section 105.7.

### 605.1 Process for Provider Enrollment Application for Facilities

Effective September 1, 2014, DCH will only accept online Medicaid enrollment applications for facilities, including additional locations. In extreme hardships cases, DCH may waive this requirement for the COMP/NOW providers; this request must be in writing and submitted to the Department of Behavioral Health and Developmental Disabilities (DBHDD) Office Provider Enrollment. DBHDD will submit the request to DCH Provider Enrollment for consideration. Facility applicants must enroll online by clicking on Provider Enrollment/Enrollment Wizard. The Enrollment Wizard will assist with the completion of an application. Facilities eligible to enroll using an additional Location must first log onto the web portal. A web base training module is located on the website @ www.mmis.georgia.gov. The training module is located under the Provider Information link.

## 606. Staffing Requirements

Individuals are provided Services and Supports by Staff who are properly Licensed, Credentialed, Trained and who are Competent.

606.1. Agency Staffing

A. Organizational policy and practice demonstrate that appropriate professional staff conducts the following services, supports, care and treatment including but not limited to:
1. Overseeing the services, supports, care and treatment provided to individuals;
2. Supervising the formulation of the individual service plan or individual recovery plan;
3. Conducting diagnostic, behavioral, functional and educational assessments;
4. Designing and writing behavior support plans
5. Implementing assessment, care and treatment activities as defined in professional practice acts; and

B. Supervising high intensity services such as screening or evaluation, assessment, residential behavioral support services. The type and number of professional staff and all other staff attached to the organization are:

1. Properly trained, licensed or credentialed in the professional field as required;
2. Present in numbers to provide adequate supervision to staff;
3. Present in numbers to provide services, supports, care and treatment to individuals as required;
4. Experienced and competent to provide services supports, care and treatment and/or supervision as required;
5. In all provider owner or operated settings, at least one staff trained in Basic Cardiac Life Support (BCLS) and first aid is on duty at all times on each shift;
6. DD Providers using Proxy Caregivers must receive training that includes knowledge and skills to perform any identified specialized health maintenance activity; and

C. The organization must have procedures and practices for verifying licenses, credentials, experience and competence of staff:

1. There is documentation of implementation of these procedures for all staff attached to the organization; and
2. Licenses and credentials are current as required by the field.

D. When medical and/or psychiatric services involving medication are provided, the organization receives direction for that service from a professional with experience in the field, such as medical director, physician consultant, or psychiatrist.

E. Federal law, state law, professional practice acts and in-field certification requirements are followed regarding:

1. Professional or non-professional qualifications required to provide the services offered. If it is determined that a service requiring licensure or certification by State Law is being provided by unlicensed staff, it is the responsibility of the organization to comply with DBHDD Policy 04-101 regarding Professional Licensing or Certification Requirements and the Reporting of Practice Act Violations;
2. Laws governing hours of work such as but not limited to the Fair Labor Standards Act.

F. Job descriptions are in place for all personnel that include:

1. Qualifications for the job;
2. Duties and responsibilities;
3. Competencies required;
4. Expectations regarding quality and quantity of work; and
5. Documentation that the individual staff has reviewed understands and is working under a job description specific to the work performed within the organization.

. G. Processes for managing personnel information and records which should include but not be limited to:
a. Criminal records check in accordance with Criminal History Records Checks for Contractors, DBHDD Policy 04-104 (including process
for reporting CRC status change);
b. Driver's license checks; and
c. Annual TB testing (for all staff providing direct support).

H. Provisions for and documentation of:
i. Timely orientation of personnel;
ii. Periodic assessment and development of training needs;
a) Development of activities responding to those needs; and
iii. Annual work performance evaluations.

b) Provisions for sanctioning and removal of staff when:
i. Staff is determined to have deficits in required competencies;
ii. Staff is accused of abuse, neglect or exploitation.

c) Administration of personnel policies without discrimination.

I. All staff, direct support volunteers, and direct support consultants shall be trained and show evidence of competence in the following;
a. Orientation requirements are specified for all staff and are provided prior to direct contact with individuals and are as follows:
i. The purpose, scope of services, supports, care and treatment offered including related policies and procedures;
ii. HIPAA and Confidentiality of individual information, both written and spoken;
iii. Rights and responsibilities of individuals;
iv. Requirements for recognizing and mandatory reporting suspected abuse, neglect or exploitation of any individual:
a) To the Georgia Department of Behavioral Health and Developmental Disabilities;
b) Within the organization;
c) To appropriate regulatory or licensing agencies (Healthcare Facility Regulation) and for in home services (Adult Protective Services); and
d) To law enforcement agencies.

J. Within the first (60) sixty days from date of hire, all staff having direct contact with individuals shall receive the training in the following which shall include, but not be limited to:
1. Person centered values, principles and approaches;
2. A Holistic approach for providing care, supports and services for the individual;
3. Medical, physical, behavioral and social needs and characteristics of the persons served;
4. Human rights and responsibilities (*);

5.Promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders;

6. The utilization of:
   i. Communication skills (*);
   ii Behavioral Support and Crisis Intervention techniques to de-escalate challenging and unsafe behaviors (*);
   iii Behavioral Support and Crisis Intervention techniques that are nationally benchmarked techniques for safe utilization of emergency interventions of last resort with the exception of the use of prone manual or mechanical restraint (*);
   iv. The Georgia Crisis Response Systems (GRCS)

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Rev 10/1/2021

7. Ethics, and Cultural Diversity Policies;
8. Fire safety (*);
9. Emergency and disaster plans and procedures (*);
10. Techniques of standard precautions, including:
    i. Preventative measures to minimize risk of HIV;
    ii. Current information as published by the Centers for Disease Control (CDC); and
    iii. Approaches to individual education.
11. BCLS including both written and hands on competency training is required;
12. First aid and safety;
13. Specific individual medications and their side effects (*);
14. Suicide Prevention Skills Training (such as AIM, QPRP); and
15. Ethics and Corporate Compliance is evident.
16. A minimum of 16 hours of training must be completed annually to include the trainings noted by asterisk (*) in items 4, 6, 8, 9, and 13 above.
17. The organization details in policy by job classification:
    i. Training that must be refreshed annually;
    ii. Additional training required for professional level staff;
    iii. Additional training/recertification (if applicable) required for all other staff.
18. Regular review and evaluation of the performance of all staff is documented at a minimum annually by managers who are clinically, administratively and experientially qualified to conduct evaluations on the staffs' knowledge, skills and abilities to deliver services using a person-centered approach.

19. It is evident that the organization demonstrates administration of personnel policies without discrimination.

Rev 04 2017

# PART II - CHAPTER 700

## INDIVIDUAL PARTICIPANT ELIGIBILITY CONDITIONS

### 701. Eligibility Criteria

Rev 04 2017

The Department of Behavioral Health and Developmental Disabilities and the Alliant Georgia Medical Care Foundation the criteria below to determine whether a individual is appropriate for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) services. Home and Community-Based services included under the waiver may be provided only to persons who are not inpatients of a hospital, Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Intermediate Care Facility for Persons with Intellectual Disability (ICF/ID with the exception of the personal assistance retainer for Community Living Support Services and who:

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A. Are categorically eligible Medicaid recipients; and

B. Have a diagnosis of an intellectual disability and/or a closely related condition (see Section 705); and

C. Are currently receiving the level of care provided in an ICF/ID which is reimbursable under the State Plan, and for whom home and community-based services are determined to be an appropriate alternative; or,

D. Are likely to require the level of care provided in an ICF/ID that would be reimbursable under the State Plan in the absence of home and community-based services that are determined to be an appropriate alternative.

### 702 Clinical Eligibility

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- A psychological assessment for intellectual functioning and/or adaptive behavior is required and must be based on an individually administered, comprehensive, age-appropriate, and standardized instrument(s) administered by a professional qualified to administer the particular assessment or test. The psychological assessment must document:

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◆ Diagnosis of an intellectual disability (see note below) defined by the following criteria:

(1) Age of Onset: Onset before the age of 18 years;
(2) Significantly Impaired Adaptive Functioning: Significant limitations in adaptive functioning (as defined by the testing instrument but typically at least two standard deviations below

the mean) in at least one of the following skill areas: conceptual skills (e.g., language; reading and writing; and money, time, and number concepts); social skills (e.g., interpersonal skills, social responsibility, self-esteem, gullibility, naiveté or wariness, follow rules/obeys laws, avoids being victimized, and social problem solving); and practical skills (e.g., activities of daily living or personal care, occupational skills, use of money, safety, health care, travel/transportation, scheduled/routines, and use of the telephone) OR an overall score on a standardized measure of conceptual, social, and practical skills; and

(3) Significantly Sub-average General Intellectual Functioning: Significantly sub-average general intellectual functioning defined as an intelligence quotient (IQ) of about 70 or below (approximately two standard deviations below the mean). Individuals with an IQ of 70 to 75 with appropriately measured, significant impairments to adaptive behavior that directly relate to issues of an intellectual disability may be considered as having an intellectual disability.

(4) The disability results in current substantial deficits in intellectual functioning and significant limitations in adaptive functioning (as defined by the testing instrument but typically at least two standard deviations below the mean) in at least one of the following skill areas: conceptual skills (e.g., language; reading and writing; and money, time, and number concepts); social skills (e.g., interpersonal skills, social responsibility, self-esteem, gullibility, naiveté or wariness, follow rules/obeys laws, avoids being victimized, and social problem solving); and practical skills (e.g., activities of daily living or personal care, occupational skills, use of money, safety, health care, travel/transportation, scheduled/routines, and use of the telephone) OR an overall score on a standardized measure of conceptual, social, and practical skills, and is likely to continue indefinitely.

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Rev 04 2017

NOTE: Findings of the significant limitations in adaptive functioning and general intellectual functioning must be consistent with a diagnosis of intellectual disability and not solely the result of mental/emotional disorders, neurocognitive disorders, sensory impairments, substance abuse, personality disorder, specific learning disability, or attention-deficit/hyperactivity disorder.

Note: A diagnosis of intellectual disability according to correct diagnosis manuals is the same as a diagnosis of intellectual disability defined above (see Rosa's Law, Federal S. 2781, signed October 2010).

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- Eligibility through a "Related Condition" is defined as having a diagnosis of a condition found to be closely related to an intellectual disability and attributable to: (a) severe forms of cerebral palsy or epilepsy; or (b) any other condition, other than mental illness, found to be closely related to an intellectual disability because this condition results in substantial impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability and requires treatment or services similar to those required for these persons; and that meets the following criteria:

  (1) The individual must experience onset of the related condition and associated substantial adaptive functioning deficits before the age of 22 years;
  (2) The individual requires an ICF/ID level of care without home and community-based treatment or services similar to those required for individuals with a diagnosis of an intellectual disability;
  (3) The individual exhibits limitations in adaptive functioning (as defined by the testing instrument but typically at least two standard deviations below the mean) in three or more of the following areas of functioning: self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living; and the adaptive impairments must be directly related to the I/DD and cannot be primarily attributed to a solely physical abnormality/condition, mental/emotional disorders, sensory impairments, substance abuse, personality disorder, specific learning disability, or attention-deficit/hyperactivity disorder; and
  (4) The disability results in current substantial deficits in intellectual functioning or in three or more of the specified areas of adaptive behavior or functioning and is likely to continue indefinitely.

  **NOTE:** individual**s Aged 18 Years or Less:** Assessment findings meet the diagnostic criteria in the Pediatric Level of Care for individuals 18 years or less (see Appendix C).

The psychological assessment is completed, reviewed and updated as needed by a licensed psychologist. A psychological consultation report is acceptable when submitted with a copy of the referenced evaluation. Psychological consultation reports **must include a summary of the previous testing scores in the referenced evaluation (s) and must confirm an intellectual disability or other closely related condition.**

**Note**: Affidavits will be accepted for Individuals born prior to the age of 1970 in the documented absence of documentation from the

developmental period (prior to age 22). Affidavits will be accepted only from a family member, physician, or licensed psychologist who knew the individual during the developmental period. The affidavit must be consistent with evaluations and medical documentation in the record, and observations of a DBHDD psychologist during a face to face assessment. All individuals relying solely on an affidavit in place of a psychological evaluation during the developmental years must be seen for a face to face evaluation with a DBHDD psychologist prior to receiving a determination of pre-eligibility.

## 703. Eligibility Determination Process

1.Pre-eligibility Determinations

A. All persons requesting institutional or community services in the I/DD service system do so through the Department of Behavioral Health and Developmental Disabilities (DBHDD) Field Office. An individual or family participant applies for DD services by completing an Application for Developmental Disabilities Services (see Appendix B). The DBHDD Field Office requests the individual or family participant to provide copies of any previous psychological evaluations or adaptive behavior testing. The DBHDD Field Office will maintain copies of the application and related documentation.

B. The Intake and Evaluation (I&E) Team is responsible for the screening process. An I&E Team member from the DBHDD Field Office interviews the individual and/or his or her family member/representative to complete a screening assessment. Information gathered includes background information, functional abilities, developmental milestones, and behavioral and health issues.

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C. All supporting documentation is reviewed to determine whether the individual meets established eligibility criteria. To determine pre-eligibility, the Intake and Evaluation Team members review available copies of prior psychological evaluations and adaptive behavior testing and determine whether additional testing is required. The clinical eligibility criteria listed in section 702 governs pre-eligibility.

D. The DBHDD I&E psychologist reviews the available information and makes a recommendation regarding eligibility.

E. Upon a determination that an individual is pre-eligible for NOW/COMP waiver services, the individual is placed on the planning list.

F. If in individual is determined to be ineligible for services, a notice including the right to request a fair hearing will be provided to the individual by postal mail.

2.Initial Level of Care Determinations

A. When an individual is recommended by the DBHDD for enrollment onto the NOW/COMP waivers, DBHDD must conduct an initial level of care review. For an initial level of care review, the I&E psychologist reviews all psychological information and makes a recommendation regarding eligibility. The clinical eligibility criteria listed in section 702 governs initial level of care eligibility.
B. The recommendation and supporting documentation is then provided to the Alliant Georgia Medical Care Foundation (Alliant GMCF). Alliant GMCF makes the final determination regarding of initial level of care eligibility.

3.Level of Care Reevaluations

A. Level of care reevaluations are completed at a minimum of every 12 months but can occur a more frequent rate due to change in need or circumstance or due to a newly discovered information.
B. When an individual condition is being considered for reevaluation purposes, an updated psychological assessment or adaptive functioning assessment may be necessary. The clinical eligibility criteria listed in section 702 governs continued eligibility.
C. Upon reviewing all of the available and necessary information, a DBHDD psychologist will review the file and make a recommendation regarding continued eligibility.
D. Alliant GMCF will issue final ineligibility determinations.

## 704. Level of Care Approval Requirements

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- Each individual must have a current level of care (DMA-6/DMA-6A for initial level of care and DMA-7 form for level of care re-evaluations) approved by the DBHDD Field Office and with required signatures (see Appendix C). Level of care re-assessments are completed at a minimum of every 12 months. LOC service approval may not exceed 365 days.

- The DBHDD Field Office will not approve any level of care or re-evaluation until all required documents submitted for approval are complete. The initial date the completed Level of Care Re-Evaluation (DMA-7) form is received by the DBHDD Field Office with all additional required documentation for recertification will be the date that is entered into DBHDD Field Office system and will constitute the earliest re-certification date once approved. The annual date of the individuals current level of care is the date that the level of care is made effective.

- The signatures of the physician, nurse practitioner, or physician assistant on the DMA-6/DMA-6A form indicate concurrence with the medical

necessity decision that the waiver individual meets an ICF-ID level of care. The need for institutional care shall be considered to have been satisfied for persons who are currently receiving the level of care provided in an ICF/ID or SNF, unless otherwise indicated in the most recent utilization review of the individual.

- The approved initial level of care (DMA-6/DMA-6A) or re-certification of level of care (DMA-7) form is uploaded to a web-based system so that all providers have access. Initial service must begin within 60 days of DBHDD Field Office approval. In the event service does not begin within 60 days, the DMA-6/DMA-6A form and assessment will be reviewed by the clinicians and physician and updated as needed.

- No Medicaid reimbursement will be made for any service period of an individualized plan for which there is no valid and approved level of care (DMA-6/DMA-6A or DMA-7) in effect.

- The Level of Care Re-Evaluation form (DMA-7) must be signed by the field office RN, (see Appendix C for DMA-7 form and instructions).

- Each enrolled provider service type must maintain a copy of the current and approved DMA-6/DMA-6A or DMA-7 forms covering all periods of services rendered, in the individual 's record. Noncompliance to this program requirement will result in a request for refund from the Department.

## 705 Individual Service Plan (ISP) Development

Information is gathered from a variety of assessment tools to include the Health Risk Screening Tool (HRST), Supports Intensity Scale-A (SIS-A), and any assessments completed by the Intake and Evaluation Team. The ISP should also contain any known medical documentation and any documented health history as additional sources for health information.

A. HRST

1. The HRST assesses where the individual is likely to be most vulnerable in terms of potential health risks.
2. The I&E nurse completes the initial HRST.
3. The individual's service provider administers subsequent HRSTs.
4. Requests for adoption of updated HRST assessment
    a. Providers may request that an updated HRST assessment be adopted by DBHDD

b. A DBHDD employed registered nurse will review the HRST and all available documentation in the individual's record for consistency
c. If the registered nurse cannot validate the score on the HRST, the request to adopt the score will be denied
d. If a request to adopt an HRST assessment is denied, the individual will receive a notice affording the right to request a fair hearing by postal mail.

B. SIS-A

1. The SIS-A is administered by DBHDD employed assessors who have completed SIS training conducted by the American Association on Intellectual and Developmental Disabilities (AAIDD).
2. The SIS-A is only administered on individuals who are 16 years or older.
3. The SIS-A is only administered every 3 to 5 years unless:
    e. The individual graduates from high school
    f. The assessment administration significantly deviates from the requirements outlined by AAIDD (i.e. respondent had not known the individual for 3 months)
    g. The individual experiences a significant living change or a significant change in supports needs that necessitates an updated assessment (i.e. assessment conducted while the individual was in a crisis home with only crisis home staff and individual transitions to a host home)
4. Requests for SIS-A Re-administrations
    a. Individuals may request that a SIS-A be re-administered due to one of the reasons outlined above.
    b. If a request for re-administration is denied, the individual will receive a notice affording the right to request a fair hearing by postal mail.

The individual, his or her support network, and support coordinator as often as necessary, but no less frequently than annually will review each individual's ISP. Reevaluation and ISP reviews will also occur anytime there is a major life change for the individual. The ISP will be revised as needed or annually at a minimum to assure appropriate provision of services for the individual. All team members in attendance will sign the new ISP or ISP Version Change. The ISP version change will reflect the revised start date and services are effective as of the revised version change start date.

The ISP addresses what is important to and for the individual. This information includes the support need areas identified in the Supports Intensity Scale for individuals 16 years or older, and any health and safety issues identified in the screening process, SIS-A, or HRST. The Planning List Administrator or Support Coordinator, in conjunction with the individual, and his or her family and/or support network develop a written Individual Service Plan that includes the services to be provided, the frequency of services, and the type of provider to deliver the service.

All known medical conditions, allergies, diagnoses, behavioral health, physical health and medication summaries are also included in the ISP and/or Individual 360 of the individual's record. Diagnoses are indicated to ensure treatment of medical conditions such as obesity and diabetes. Behavioral Health conditions are noted and connections made to community mental health services as appropriate. Needed connections to primary care physicians and specialty medical providers are incorporated into the ISP. It is the responsibility of the primary care physician to ensure all appropriate health screenings and treatment.

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A service will not be reimbursed by DBHDD/DCH if it is not listed on the approved Individual Service Plan and Prior Authorization (PA). Special Authorization by DBHDD may be used to approve additional units of specialized medical supplies, equipment, or behavioral services. The rationale for approval along with specific description of the service delivery order is described in the DBHDD approval letter found in the individual case record and considered an extension of the ISP. Assurance is made that goods and services provided by the waiver are not covered under the Medicaid State Plan when applicable.

### 705.1 Additional Considerations in Development of the ISP

The individual or his or her representative is informed of the findings of the assessments in language he or she can understand.

The Support Coordinator or Planning List Administrator discusses service options with the individual, his/her support network and others as appropriate in order to identify social, education, and other needs, coordinating Medicaid-funded, non-Medicaid services, and natural supports.

Individuals direct decisions that impact their life.

An individualized service plan is developed with participation from the individual/representative, service providers and others, as requested by the individual/representative and should be:

- Driven by the individual and focused on outcomes the individual desires to achieve;

- Fully explained to the individual using language/communication he or she can understand and agreed to by the individual;
- Used to identify and prioritize the needs of the individual
- Include a page for signatures of the individual or guardian and other members to indicate who participated in the planning of services. Subsequent ISP version changes must also document individual/guardian's signature;
- Include information to identify social, educational and other needs that is important "To" the individual to make informed choice of service options and service providers;
- For individuals with coexisting, complex and confounding needs, cross disciplinary approaches to planning should be used.

For individuals with coexisting, complex and confounding needs, cross disciplinary approaches to planning should be used.

The ISP must list the services to be provided and the frequency of the services. No service will be reimbursed which is not listed on the ISP approved by the DBHDD Field Office. Assurance is made that goods and services provided by the waiver are not covered under the Medicaid State Plan when applicable.

Refer to definitions of service included in the DBHDD Provider Manual Part 1, Section 11: *DD Consumer Eligibility, Access and Planning list, Service Definitions and Service Guidelines* to determine who must authorize the plan;

A physician must review the plan when it authorizes medical services funded through the waiver program. When more than one physician is involved in the individual's care, an RN or MD/DO must review all pertinent information to assure there are no contradictions in the treatment orders or plan.

ISPs will include a statement of at minimum, one person-centered goal with objectives expressed by the individual. Services outlined on the ISP must directly correlate to the individual's assessed needs. Goal(s) should be described in the following format:

- **S**pecific to the desired outcomes;
- **M**easurable for progress;
- **A**chievable skills;
- **R**elevant to service provision;
- **R**ealistic to service provision; and
- **T**ime-limited with specified target dates.

**Documents Referenced in Individual Service Plan:**

Documents to be incorporated by reference into an individual service plan include, but are not limited to:

- Medical updates as indicated by physician orders or notes;
- A crisis plan which directs in advance the individual's desires/wishes/plans/objective(s) in the event of a crisis;
- A behavior support plan and/or a safety plan for individuals demonstrating challenging behaviors; and

A positive behavior support plan and safety plan for individuals who receive psychotropic medications for symptom management.

- Summaries of Progress towards person centered goal(s)
    - There is evidence that the individual data from tracking sheets and staff learning logs have been reviewed, analyzed for trends and summarized against progress toward goal(s) at least quarterly.
- Routine assessment such as annual physical examinations;
- Chronic medical issues;
-
- Acute and emergent needs;
- Medical;
- Psychiatric;
- Diagnostic testing such as psychological testing or labs; and
- Dental services.

E. **Behavior Support Practices**

1. In policies, procedures and practices, the organization outlines and defines the adaptive, supportive, medical protection devices and the restrictive interventions that are implemented or prohibited by the organization and licensure requirements. These devices include but are not limited to:
    a. Use of adaptive supportive devices or medical protective devices (devices which restrain movement but are applied for the protection of accidental injury, required for medical treatment or for corrective/supportive needs):
        i. May be used in any service, support, care and treatment environment;
        ii. Use is defined by a physician's order (order not to exceed twelve calendar months);
        iii. Written order to include rationale and instructions for the use of the device;
        iv. Authorized in the individual service plan (ISP); and
        v. Are used for medical and/or protection against injury and not for treatment of challenging behavior(s); and

vi. Renewal order of device requires documentation to justify continued use for a period not to exceed twelve (12) calendar months.

b. Time out (also known as withdrawal to a quiet area):
   i. Under no circumstance is egress physically or manually restricted;
   ii. Time out periods must be brief, not to exceed 15 minutes;
   iii. Procedure for time out utilization is incorporated in the behavior support plan; and
   iv. The justification for use and implementation details for time out utilization is documented.

c. Manual Hold/Restraint (also known as Personal Restraints): The application of physical force, without the use of any device, for the purpose of restricting the free movement of a person's body:
   i. May be used in all community settings except residential settings licensed as Personal Care Homes;
   ii. Circumstances of use must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
   iii. Brief handholding (less than 10 seconds) support for the purpose of providing safe crossing, safety or stabilization does not constitute a personal hold;
   iv. If permitted, Manual/Personal Restraint (ten seconds or more), shall not exceed five (5) minutes and use of personal restraint is documented;
   v. Use of manual/personal restraints must be outlined as an approved intervention in his/her safety plan; and
   vi. If manual/personal restraints are implemented more than three (3) times in a six (6) month period, there must be corresponding procedures to teach the individual skills that will decrease/eliminate the use of personal restraints.

d. Mechanical Restraint (also known as Physical Restraints): A device attached or adjacent to the individual's body that one cannot easily remove and that restricts freedom of movement or normal access to one's body or body parts. Mechanical/Physical restraints are prohibited in community settings.

e. Seclusion: The involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving, regardless of the purpose of the confinement. The practice of "restrictive time-out" (RTO) is seclusion and may not be utilized except in compliance with the requirement related to seclusion. The phrase "prevented from leaving" includes not only the use of a locked door, but also the use of physical control or verbal threats to prevent the individual from leaving. Seclusion is not permitted in COMP/NOW.

f. **Chemical restraint may never be used under any circumstance**. Chemical restraint is defined as a medication or drug that is:
   i. Not a standard treatment for the individual's medical or psychiatric condition;
   ii. Used to control behavior; and
   iii. Used to restrict the individual's freedom of movement.

   Examples of chemical restraint are the following:
   i. The use of over the counter medications such as Benadryl for the purpose of decreasing an individual's activity level during regular waking hours;
   ii. The use of an antipsychotic medication for a person who is not psychotic but simply 'pacing' or agitated.

g. PRN anti-psychotic medications for behavior control are not permitted. See Appendix I for a list of medications.

2. The approach to developing a positive behavior support plan (including a safety plan) and treatment for individuals demonstrating challenging behaviors should be consistent with the definitions and protocols in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings* and *Best Practice Standards for Behavioral Support Services* found in DBHDD Provider Manual for DD Providers. Behavior Support activities outlined in the PBSP is guided by an overall emphasis on not only decreasing target behaviors but also concurrently increasing skills in appropriate areas. The primary emphasis of the plan should be active skill building and prevention of challenging behaviors. Refer to service description for Behavior Support Services in COMP/NOW requirements
3. The PBSP and Safety Plan for challenging behaviors should be a collaborative effort among each provider providing services for the individual. The providers must work to develop and implement one plan that includes any modification for implementation for each service site and the modification must be addressed and approved prior to finalizing the plan. The final approved PBSP is incorporated by reference into the ISP. A copy of the individual's PBSP must be available at all service sites for implementation. The provider is responsible for training and coaching in the setting where the target behaviors occur. Behavioral Support Services may be included in the ISP to facilitate staff or family training of complex plans or those that address complex behaviors.
4. a) A positive behavior support plan should be developed and implemented for individuals with I/DD who receive psychotropic medications for symptom management of challenging behavior that continues to pose a significant risk to the individual, others, or the environment (e.g., self-injury, physical aggression, property destruction) and is not specifically related to mental illness or epilepsy

requiring treatment with psychotropic medications. The behavior support plan must minimally include:

1) An operationally defined behavior(s) for which the drug is intended to affect;
2) Measuring target behaviors which shall constitute the basis on which medication adjustments will be made; and
3) A focus on teaching replacement behaviors in an effort to replace the use of medication with behavioral programming.

b) A behavior support plan is not required for individuals receiving psychotropic medication to treat mental illness (e.g., schizophrenia, bi-polar disorder) or epilepsy when the record documents that the medication addresses the symptoms of the mental illness or epilepsy.

5. When positive behavior support plan is used to reduce challenging behaviors there must evidence that the following issues have been addressed. The plan is:
   a. Individualized (Person-Centered Planning);
   b. Based on a functional assessment;
   c. One that has addressed potential medical causes;
   d. Developed and overseen by a qualified professional (Refer to Appendix I for Developmental Disability Professional categories of Psychologist, Behavior Specialist, and Board Certified Behavior Analyst);
   e. Inclusive of methods outlined to teach alternative appropriate behaviors that will achieve the same results as the challenging behavior(s);
   f. Inclusive of rationale for the following:
      i. Use of identified approaches;
      ii. The time of their use;
      iii. An assessment of the impact on personal choice of the individual;
      iv. The targeted behavior; and
      v. How the targeted behavior will be recognized for success.
   g. Implemented by trained and competent staff as documented by individual who developed the BSP/Safety Plan and trained the staff.
   h. Has monitoring plans for review, analyzing trends, and summarizing the effectiveness of the plan and termination criteria. In addition, PBSP are routinely monitored to ensure provider compliance with prescribed data collection, staff training and interventions;
   i. Consent provided by the individual and his or her legal guardian;
   j. Discussed with the individual and family/natural supports (as permitted by the individual);
   k. Developed in accordance with *Best Practice Standards for Behavioral Support Services for Providers of Developmental Disabilities Services* (www.dbhdd.georgia.gov);

l. PBSP utilizes non-punitive, non-restrictive procedures and interventions; and
m. All behavioral services to include Behavior Support Consultants and Behavior Support Services adhere to the service description outlined in Part III COMP/NOW policy manuals.

6. Intrusive or restrictive procedures must be clearly justified through documentation of less restrictive procedures ineffectiveness and/or the need for more intrusive procedures due to the safety or health risks presented by the targeted behaviors. These procedures are authorized, incorporated into the BSP and/Safety Plan, approved by ISP interdisciplinary team, reviewed by organization's Rights Committee and supervised by qualified professional(s) and may not be in conflict with Federal or State Laws, Rules and Regulations, Clients Rights or Department standards to include but not limited to the document *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings* and the *Best Practice Standards for Behavioral Support* when developing a behavior support/safety plan.
7. Providers must have processes in place to implement crisis intervention as needed. The staff must be trained to respond to a crisis situation that occurs at the service site and have an agency's crisis plan, that at a minimum addresses:
   a. Approved interventions to be utilized by staff;
   b. Availability of additional resources to assist in diffusing the crisis;
   c. If the acute crisis presents a substantial risk of imminent harm to self and others, that community-based crisis services to include the Georgia Crisis Response System (GCRS) serves as an alternative to emergency room care, calling 911, institutional placement, and/or law enforcement involvement (including incarceration) is implemented;
   d. Protocols to access community-based crisis services to include the Georgia Crisis Response System must be included in agency's policy and procedures with staff trained to implement this protocol; and
   e. Notification process by Direct Support Staff that includes informing the designated on-call management staff and/or Director.
8. All organizations must have the capacity to address individual's behavioral needs. If the cause of the challenging behavior cannot be determined or satisfactorily addressed by the provider, there should be evidence of consultation with an outside professional who is licensed or qualified through education, supervised training and experience to address the behavior needs of the Individual. Those authoring such plans should minimally meet professional criteria as a Psychologist, Behavioral Specialist or a Board Certified Behavior Analyst (Refer to DBHDD Provider Manual for Community Developmental Disabilities Providers for professional qualifications);

9. If the need for behavior supports is identified, the individual or guardian is given a choice to select the qualified person to develop the BSP and /or Safety plan;10. Refer to NOW/COMP Part III policy manuals for full description of Behavioral Consultation/Level 1and Behavioral Support Services/Level 2 documentation requirements

## 706. Psychological/Behavioral, Social Work, and Nursing Assessment Updates

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**A. Psychological/Behavioral Assessment Updates:** The interdisciplinary team determines if there has been a change in the individual's condition and recommends a psychological/behavioral assessment update as follows:

- For individuals below 18 years of age, a psychological assessment (or psychological consultation report as indicated in Section 706) will be conducted every three (3) years for any individual whose initial level of care determination was not based on a diagnosis of moderate to profound intellectual disability or severe autism.

- For individuals over 18 years of age, a behavioral assessment update will be conducted when the individual scores a "2" and a total of 7 or greater on the SIS-A Exceptional Behavioral Supports Needs Section.

**B. Social Work Assessment Updates:** The interdisciplinary team determines if there have been major changes in a individual's home or family environment or other life circumstances, including but not limited to, loss or illness of caregiver, extended hospitalization (i.e., one month or more), or loss of home. Social work assessments are updated when the interdisciplinary team determines these changes have occurred.

- **Nursing Assessment Updates:**
  i. If the HRST Health Care Level is a 3 or greater or an individual score a "2" or two "1's" on the SIS-A Exceptional Medical Needs Section, a nursing assessment is completed as part of the initial level of care determination.

  ii. If the HRST Health Care Level of the individual is a 3 or greater or the individual scores a "2" (Extensive Support Needed) on Lifting and/or Transferring, Turning or Positioning, or Seizure Management or a total greater than 5 on the SIS-A Exceptional Medical Needs Section, the nursing assessment is updated.

E. The individual's support coordinator or service provider may request at any time technical assistance or re-evaluation from the DBHDD Field Office due to changing needs of a individual, including but not limited to, loss or illness of primary caregiver, extended

hospitalization, deteriorating neurological functioning, mental illness, severe aberrant behaviors, and significant decline in functioning.

F. The Support Coordinator submits to the DBHDD Field Office the individual's Level of Care Re-Evaluation form and Individual Service Plan, along with any required copies of updated psychological, social work, and/or nursing assessment(s) as indicated above.

**707** **Adverse Actions**

A individual denied service, involuntarily terminated from service, or has an involuntarily reduced service is notified in writing by DBHDD. The written notification provides the reason for the adverse action and outlines the procedure to appeal the decision and to request a hearing.

A. **Denial of Eligibility:** The individual and/or his/her representative (legal guardian) will receive written notice of the rights to appeal any COMP/NOW Waiver Program termination. The notice will outline the process for requesting a fair hearing. Eligibility for services under the waivers may be denied for the following reasons:

1. A individual fails to meet the eligibility criteria for NOW/COMP specified in this chapter.
2. The individual or his/her representative has not supplied information needed to complete the eligibility process.
3. The individual or his/her representative indicates a preference for institutional services through the Freedom of Choice document.
4. The individual or his/her representative refuses to sign the Freedom of Choice document, Individual Service Plan, or DMA 6/6-A/7 form.

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5. The individual does not meet the eligibility requirements for a specific service or a specific level of service
6. The Individual Service Plan costs are prohibitive because it increases the average cost of the NOW beyond the average ICF/ID costs and/or exceeds the NOW individual cost limit of $40,000 (Which does not include Support Coordination Services).

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NOTE: A 12 months approval of additional funding up to $6,000 above the NOW individual cost limit is permitted due to increase needs for services by the individual.

B. **Denial or Termination from the COMP/NOW Waiver Program due to Medicaid Eligibility Discontinuance:** COMP/NOW Waiver Program eligibility is dependent upon Medicaid eligibility, and discontinuance of Medicaid eligibility for an individual result in his or her denial or termination from the COMP/NOW Waiver Program. The individual and/or his/her representative will receive written notice of the rights to appeal

discontinuance of Medicaid eligibility from the local Department of Family and Children Services (DFCS) Office. The notice will outline the process for requesting a fair hearing. If the individual's Medicaid eligibility is reinstated, he or she can provide documentation of the reinstatement to initiate reenrollment onto the waiver.

C. **Termination from the COMP/NOW Waiver Program due to Department of Community Health Adverse Decision:** *Part I Policies and Procedures for Medicaid/Peachcare for Kids*, Chapter 500, Section 508 provides procedures for the request of a fair hearing should a decision of the Department of Community Health be adverse to a individual.

D. **Termination from the COMP/NOW Waiver Program due to DBHDD Adverse Decision:** The individual and/or his/her representative (legal guardian) will receive written notice of the rights to appeal any COMP/NOW Waiver Program termination. The notice will outline the process for requesting a fair hearing.

E. **Reduction of COMP/NOW Services:** The individual and/or his/her representative (legal guardian) will receive written notice of the rights to appeal any reduction of COMP/NOW services. The notice will outline the process for requesting a fair hearing.

## 708. **Outcomes for** individual**s**

### 708.1 <u>Respect for the Dignity of the Individual</u>

1. Access to appropriate services, supports, care and treatment is available regardless of:
   a. Age;
   b. Race, National Origin, Ethnicity;
   c. Gender;
   d. Religion;
   e. Social status;
   f. Physical disability;
   g. Mental disability;
   h. Gender identity; and Sexual orientation.
2. There are no barriers in accessing the services, supports, care and treatment offered by the organization, including but not limited to:
   a. Geographic;
   b. Architectural;
   c. Communication:
      i. Language access is provided to individuals with limited English proficiency or who are sensory impaired;
      ii. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed.
   d. Attitudinal;
   e. Procedural; and
   f. Organizational scheduling or availability

3. There is evidence of organizational person-centered planning and service delivery that demonstrates:
   a. Sensitivity to individual differences (including disabilities) and preferences is evident;
   b. Practices and activities that reduce stigma; and
   c. Interactions that is respectful, positive and supportive.
4. The organization must have written policies and procedures regarding the visitation rights of individuals, including a requirement that any reasonable restrictions must be based on the seriousness of the individual's mental or physical condition as ordered in writing by the attending physician. Such orders shall state the type and extent of the restriction. The order shall be reviewed for changes as needed and renewed at least annually. Additional orders shall follow the same procedure. The organization must meet the following requirements:
   a. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of his or her visitation rights, including any clinical restriction of such rights, when he or she is informed of his or her other rights under this section;
   b. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of the right, subject to his or her consent, to receive visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. However, the parent, guardian or custodian of a minor may restrict his or her visitation rights;
   c. Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identify, sexual orientation or disability;
   d. Ensure that all visitors enjoy full and equal visitation privileges consistent with the preferences of the individual;
   e. Not restrict visitation by an individual's attorney or personal physician on the basis of the individual's physical or mental condition;
   f. Visitors/guardians are also expected to adhere to any reasonable restrictions as ordered in writing by the attending physician in the area of diet; and
   g. If visitation facilitates/results in problematic behaviors, reasonable restrictions may be ordered and incorporated into the Safety Plan.

## 708.2 Human and Civil Rights

1. The organization has policies and promotes practices that:
   a. Do not discriminate;
   b. Promote receiving equitable supports from the organization;
   c. Provide services, supports, care and treatment in the least restrictive environment possible;

d. Emphasize the use of teaching functional communication, functional adaptive skills to increase independence, and using least restrictive interventions that are likely to be effective;
e. Incorporate DBHDD Clients Rights or Patients Rights Rules, as applicable to the organization; and
f. Delineates the rights and responsibilities of persons served.

2. In policy and practice the organization makes it clear that under no circumstances will the following occur:
   a. Threats of harm or mistreatment (overt or implied);
   b. Corporal punishment;
   c. Fear-eliciting procedures;
   d. Abuse or neglect of any kind;
   e. Exploitation including but not limited to unauthorized or coerced use of the individual's income or assets;
   f. Withholding basic nutrition or nutritional care; or
   g. Withholding of any basic necessity such as clothing, shelter, rest or sleep.

3. Federal and state laws and rules are evident in policy and practice including, but not limited to:
   a. For all community-based programs, practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9 are incorporated into the care of individuals served. Issues addressed include but are not limited to the right to:

      i. Care in the least restrictive environment;
      ii. Humane treatment or habilitation that affords protection from harm, exploitation or coercion.
      iii. Unless adjudicated incompetent by a court of law, be considered legally competent for any purpose without due process of law, including to maintain
         1. Civil;
         2. Political
         3. Personal; or
         4. Property rights.

4. There is evidence of the individual or legal guardian's signature on notification that all individuals are informed about their rights and responsibilities:
   a. At the onset of services, supports, care and treatment;
   b. At least annually during care;
   c. Through written information that is well prepared and in a language/format understandable by the individual; and

d. How confidentiality will be addressed including but not limited to who they wish to be informed about their services, supports, care and treatment.

### 708.3 Community Integration and Inclusion into the Larger Natural Community

Community integration and inclusion into the larger natural community is supported and evident. Terms "Integration and Inclusion" mean:

a. Use of community resources that are available to other citizens;
b. Providing the opportunity to actively participate in community activities and types of employment as citizens without disabilities;
c. The organization has community partnerships for capacity building and advocacy of activities to achieve this goal of integration;
d. The organization must provide supports and inclusion activities that show respect for the individual's dignity, personal preference and cultural differences;
e. There is documentation of individualized preferences, person-centered integration and inclusion in the community;
f. Building of community relationships (natural/paid/unpaid);
g. Supporting individual's choice as measured by the amount of control an individual has over his/her life; and
h. Supervised Apartment Living Arrangement such as scattered and cluster arrangements must meet all standards for integrated settings and comply with all state and local zoning regulations (such as setting attributes and choice). Refer to DBHDD Policy Community Integration & Residential Options & Supervised Apartment Living Arrangements for Individuals with DD, 02-601 for details.

### 708.4 Individual Rights and Responsibilities

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Providers must acknowledge that individuals have rights and responsibilities regarding participation in the COMP/NOW Waiver. At the time of admission the provider reviews individual rights and responsibilities with the individual and/or individual's representative. After the individual reads and signs a copy of the individual's rights and responsibilities, the provider gives a copy of the rights and responsibilities to the individual and the individual's representative if applicable. The provider places a copy in the individual's record.

Individual rights recognized by the provider include:

i. The right of access to accurate and easy-to-understand information

ii. The right to be treated with respect and to maintain one's dignity and individuality

iii. The right to voice grievances and complaints regarding services and supports that is furnished or not furnished, without fear of retaliation, discrimination, coercion, or reprisal

iv. The right to a choice of approved service provider(s)

v. The right to accept or refuse services

vi. The right to be informed of and participate in preparing the Individual Service Plan and any changes in the plan

vii. The right to be advised in advance of the provider(s) who will furnish services and the frequency and duration of services

viii. The right to confidential treatment of all information, including information in the individual's record

ix. The right to receive services in accordance with the current Individual Service Plan

x. The right to be informed of the name, business telephone number and business address of the person supervising the services and how to contact that person

xi. The right to have property and residence treated with respect

xii. The right to be fully and promptly informed of any cost share liability and the consequences if any cost share is not paid

xiii. The right to review individual's records on request

xiv. The right to receive adequate and appropriate services without discrimination.

xv. The right to be free from mental, verbal, sexual and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living

xvi. The right to be free from chemical or physical restraints

Individual responsibilities include:

i. compliance with all applicable policies, including but not limited to those found in the Parts II and III of the NOW and COMP General/Provider Manuals

ii. refraining from actions that endanger the health and safety of other waiver individuals and/or provider staff

iii. failure to comply with individual responsibilities may lead to termination of the waiver. Adverse actions will be issued in accordance with section 707(d) of this manual.

NOTE:

Providers must be aware of additional individual rights and responsibilities required under specific program licensure and must include signed copies of these rights and responsibilities in the individual's record.

**709. Eligibility Determination for Medical Assistance Only (MAO)**

Individuals who receive SSI are eligible for Medicaid. Individual whose income exceeds SSI eligibility may be considered to be Medicaid eligible as a result of a Medical Assistance Only (MAO) determination. The county Division of Family & Children Services determines eligibility and cost share responsibility. The MAO determination will indicate a monthly cost share amount (if any) calculated from the individual's income as the individual's cost share or individual liability for services being rendered. The cost share is reassessed no less than annually, sometimes more frequently.

The Intake and Evaluation Team is responsible for initiating the eligibility process as follows:

- completion of the initial MAO Communicator
- sending and or delivering to the local county DFCS office in the county of individual's residence the following documents: MAO Communicator, copy of the DMA-6/6A with Alliant GMCF approval, Medicaid application (unless the family/representative has already submitted).
- the individual/representative and or family member will assist the individual in setting an appointment at the local DFCS office following level of care determination
- the Support Coordinator is responsible for assisting providers in the timely completion of subsequent MAO renewals annually using the MAO Communicator to indicate continuation of level of care. A DMA-7 document must accompany the Communicator form.

The process for a individual transferring from an ICF/ID or SNF and receiving Medicaid reimbursed services follows the following process:

- Upon determination of level of care eligibility by Alliant Georgia Medical Care Foundation (through a DMA-6/DMA-6A) and availability of funds for admission, the Intake and Evaluation Team follows the process outlined above with the following exceptions:
- If the individual is an SSI recipient, Social Security must be notified of discharge from the institution. Notification is accomplished through submission of a DMA-59 from the facility indicating discharge and date of discharge.
- If the individual's Medicaid eligibility is directly linked to institutional category of eligibility, outlined above for determination of initial eligibility but must submit the institutional discharge notice (DMA-59) with the DMA-6/6A and MAO Communicator.

- The DHS Division of Family and Children Services (DFCS) is responsible for determining eligibility and the amount of cost share (if applicable).

- MAO status must be reviewed annually according to DFCS guidelines. The Support Coordinator is responsible for this process. In advance of Medicaid eligibility redetermination DFCS sends a notice of recertification date and required documentation to the waiver individual's/representative's address on file.

### 710. Other Medicaid Eligibility Types and Programs

TEFRA/Katie Beckett is an eligibility category that is defined as a Medicaid service made available to certain children with disabilities. It allows states to make Medicaid services available to these children who would not ordinarily be eligible for Social Security Income (SSI) benefits because of their parents' income.

### 711. Georgia Pediatric Program (GAPP)

The Georgia Pediatric Program (GAPP) is designed to serve eligible members under the age of 20 years 11 months based on medical necessity determination(s). Eligible pediatric members age out of the GAPP program on their 21st birthday. Members must be medically fragile with multiple systems diagnoses and require continuous skilled nursing care or skilled nursing care in shifts in order to be considered for services in the Georgia Pediatric Program. This pediatric program allows the Department of Community Health to use Title XIX funds to provide approved services to medically fragile children in their homes and communities as well as in a 'medical' daycare setting as an alternative to placing children in a nursing care facility. Members served by the GAPP are required to meet the same level of care as for admission to a hospital or nursing facility and must be Medicaid eligible.

The Georgia Pediatric Program (GAPP) offers the following services:

A. In-Home Skilled Nursing Services

There are services that a person cannot receive through GAPP while receiving those same services through the DD waivers. Those services as follows:

- Community Living Supports Services (CLS)
- Nursing Services
- Natural Support Training Services

If the DD provider bills a claim for services that are provided by GAPP, the claim will deny for duplication. Claims that deny as a result of apparent duplication of services may be reviewed on a case-by-case basis. When the claim denies the providers may submit for review the denied TCN's and address all submittals related to the TCN's to the New Options Waiver and Comprehensive Supports Waiver (NOW/COMP) Program Specialist at the Department of Community Health at the following address:

Department of Community Health
New Options Waiver/Comprehensive Supports Waiver (NOW/COMP)
Program Specialist
2 Peachtree Street, NW, 37th Floor
Atlanta, Georgia 30303

# PART II - CHAPTER 800

# PRIOR APPROVAL

## 801. General

The Department requires that all COMP/NOW services are approved prior to reimbursement being rendered. Prior approval does not guarantee reimbursement or individual eligibility. In order for an enrolled provider to be reimbursed for prior approved services, the individual must be Medicaid eligible at the time services are rendered and with a valid and current level of care determination.

**802.**

## 802. Obtaining Prior Approval

The DBHDD Field offices authorize reimbursement for services described in the Individual Support Plan through Prior Authorization. Prior Authorization is required for payment of all claims submitted for reimbursement of services in the NOW and COMP Programs. The Prior Authorization request is submitted for approval to the DBHDD Field Office prior to service delivery. Authorization by DBHDD transmits electronically to the DCH claims system for reimbursement and contains the following elements: date spans for service delivery, the selected provider of each service, the procedure codes, and amount of each service. The prior authorization for service can be accessed by service providers in the Medicaid Management Information System (www.mmis.georgia.gov).

The enrolled provider's COMP/NOW individual record must include a copy of the approved Prior Authorization forms. Noncompliance with this program requirement will result in a request for refund from the Department.

# PART II - CHAPTER 900
# GENERAL SERVICE REQUIREMENTS

## 901. Services Overview

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Note: Individuals have the option to self-direct COMP/NOW services listed in section 1208 of this manual. The Co-Employer Participant-Direction Option is available for the services listed in section 1209 of this manual. For details on participant-direction, refer to *Part II Policies and Procedures for COMP, Chapter 1200*.

All services provided under the Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) are based on the clinically assessed need of the individual that includes consideration of what is important to and for the person, person-centered planning/thinking, and the use of person-centered tools (see COMP/NOW Part II for information on person-centered planning). These reimbursable services include the following and are as specified in the approved ISP:

a. Adult Occupational Therapy Services – these services address the occupational therapy needs of the adult individual that result from his or her developmental disabilities.

b. Adult Physical Therapy Services – these services address the physical therapy needs of the adult individual that result from his or her I/DD developmental disabilities.

c. Adult Speech and Language Therapy Services – these services address the speech and language therapy needs of the adult individual that results from his or her I/DD.

d. Behavioral Supports Services Level 2 – these services are the professional level services that assist the individual with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations.

e. Behavioral Supports Services Level 1 – these services are the professional level services that assist the individual with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations through offering direct training and assistance to formal and informal care providers;

f. Community Access Services – these services are designed to assist the individual in acquiring, retaining, or improving self-help, socialization,

and adaptive skills required for active participation and independent functioning outside the individual's place of residence.

g. Community Guide Services – these services are only for individuals who opt for participant direction and assist these individual s with defining and directing their own services and supports and meeting the responsibilities of participant direction.

h. Community Living Support Services – these services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to an individual's continued residence in his or her family home.

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Providers of Community Living Services must utilize either the DCH approved EVV vendor or a third party vendor that is approved by DCH

i. Community Residential Alternative Services– these services are targeted for people who require intense levels of residential support in small group settings of four or less, foster homes, or host home/life sharing arrangements and include a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time.(COMP only)

j. Environmental Accessibility Adaptation Services– these services consist of physical adaptations to the individual 's of family's home which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home.

k. Financial Support Services – these services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended.

l. Individual Directed Goods and Services – these services are not otherwise provided through the COMP or Medicaid State Plan but are services, equipment or supplies identified by the individual who opts for participant direction and his or her Support Coordinator or interdisciplinary team.

m. Interpreter Services – (COMP only) - Interpreter Services provide sign language interpretation support services to qualified individuals s in conjunction with DBHDD authorized services.

n. Natural Support Training Services – these services provide training and education to individuals who provide unpaid support, training, companionship or supervision to individuals.

o. Nursing Services - Clinical nursing services are indicated when the individual has a clinical diagnosis which requires ongoing complex assessment and intervention for the purpose of health restoration or prevention of further deterioration of the health of the individual. Nursing care is the assessment and treatment of human responses to actual or potential health problems as identified through the nursing process. Thusly, nursing services is the provision of this level of care via the process of assessment, assignment of nursing diagnosis, planning, implementation/intervention and continued evaluations directed by the Georgia Nurse Practice Act and generally accepted standards of practice.

Rev 04 2017

p. Nutrition services - evaluation and dietary intervention services that are not otherwise covered by Medicaid State Plan Services. Adult Nutrition Services include nutrition evaluation, education of individual, family, and support staff, and periodic monitoring and dietary intervention to improve nutrition-related health conditions.

q. Prevocational Services – these services prepare a individual for paid or unpaid employment and include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

Rev. 10 2011
Rev. 01 2012

r. Respite Services – these services provide brief periods of support or relief for caregivers or individuals with disabilities and include maintenance respite for planned or scheduled relief or emergency respite for a individual requiring a short period of structured support (typically due to behavioral support needs) or due to a family emergency.

s. Specialized Medical Equipment Services – this equipment consists of devices, controls or appliances specified in the Individual Service plan, which enable individual s to increase their abilities to perform activities of daily living and to interact more independently with their environment.

t. Specialized Medical Supplies Services – these supplies consist of food supplements, special clothing, diapers, bed wetting protective chunks, and other authorized supplies that are specified in the Individual Service Plan.

u. Support Coordination Services – these services are a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services with the objective of protecting the health and safety of individual s while ensuring access to needed waiver and other services.

v. Supported Employment Services– these services are supports that enable individual s, for whom competitive employment at or above the minimum wage, is unlikely absent the provision of supports, and who, because of their disabilities, need supports to work in a regular work setting.

w. Transportation Services – these services enable individual s to gain access to waiver and other community services, activities, resources, and organizations typically utilized by the general population but do not include transportation available through Medicaid non-emergency transportation or as an element of another waiver service; and

x. Vehicle Adaptation Services – these services include adaptations to the individual 's or family's vehicle approved in the Individual Service Plan, such as a hydraulic lift, ramps, special seats and other modifications to allow for access into and out of the vehicle as well as safety while moving.

Part III, Policies and Procedures for the Comprehensive Supports Waiver (COMP) Program and New Options Waiver (NOW) Program provides the service requirements specific to the individual COMP/NOW Services. Description of each service is discussed more fully in *Part III Policies and Procedures for COMP/NOW*. The general service requirements for the COMP/NOW Program are specified in the section to follow.

## 902. Exclusions and Special Conditions

Payment directly or indirectly for any waiver services provided to individual s by legally responsible relatives, such as spouses, parents of minor children, or legal guardians, when the services are those that these persons are already legally obligated to provide is prohibited in this waiver. Direct payment is defined as a payment made to the legally responsible individual without any diversion. Indirect payments occur when a payment is made to a recipient, a provider, or a third party, and then transferred to the legally responsible individual or approved family paid caregiver. Other individual s' family members, by blood or marriage, who are aged 18 years or older, may be reimbursed for providing services when there are extenuating circumstances (family is defined as a person who is related by blood within the third degree of consanguinity by blood, adoption, or marriage. Third degree of consanguinity include mother, father, grandmother, grandfather, great grandfather, great grandmother, sister, brother, daughter, son, granddaughter, grandson, great granddaughter, great grandson, aunt, uncle, niece, or nephew. Please see chapter 1200 for additional information regarding extenuating circumstances.

**B. Medical, home health, dental, and pharmacy services that are provided under the Medicaid State Plan are not included as**

**COMP/NOW services; however, the provider along with the Support Coordinator is expected to ensure the member is linked with all needed and appropriate services.**

## 903. Duplication of Services

A. Waiver Programs include:

- New Options Waiver (NOW)
- Comprehensive Supports Waiver (COMP)
- Community Care Services Program (CCSP)
- Independent Care Waiver Program (ICWP)
- Service Options Using Resources in Community Environments (SOURCE)
- GAPP (see service duplication in Section 713)
- NOW/COMP and other Waiver clients are not eligible to enroll in Medicaid HMOs.

**A** individual **may receive more than one service within a single waiver program, but an** individual **may not participate in more than one waiver program at any given time. Claims submitted for services rendered to the same** individual **under more than one Waiver Program will be denied.**

## 904. Hospice and Home Health Services

If an individual enrolled in the Comprehensive Supports Waiver Program/New Options Waiver Program is diagnosed with a terminal illness, he or she may elect to enroll in the Hospice program. He or she may continue to receive the following waiver services that are not duplicative of the hospice services:

- Community Access Services
- Prevocational Services
- Community Residential Alternative Services {COMP only}
- Natural Support Training Services
- Additional Staffing Services {COMP only}

Request or claims for other waiver services while enrolled in the Hospice program will be denied.

When a COMP/NOW individual elects to enroll in the Hospice program, the hospice agency assumes full responsibility for the professional management of the individual's **hospice** care in accordance with the hospice Conditions of Participation. When an individual enrolled in a waiver program elects hospice, the hospice agency, the waiver individual and the waiver individual case manager

**must** communicate, establish, and agree upon a coordinated plan of care for both providers that reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation. The Hospice provider must coordinate care of the individual enrolled in other Medicaid programs, i.e., Home and Community-Based Waivers and Nursing Facilities, as evidenced in the individual's hospice plan of care.

A. When a COMP/NOW individual elects Hospice services, a plan of care must be written and is consistent with the hospice philosophy of care. The plan of care must be written in accordance with the Code of Federal Regulations (CFR) and include the individual's current medical, physical, psychosocial, and spiritual needs. The hospice must designate an RN from the hospice to coordinate the implementation of the plan of care.
B. Evidence of the coordinated plan of care must be in the clinical records of both providers. The waiver provider and the hospice must communicate with each other when any changes are indicated to the plan of care and each provider must be aware of the other's responsibilities in implementing the plan of care.

C. All **hospice services must** be provided directly by hospice employees and cannot be delegated. The hospice may involve the waiver provider staff in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of the patient's family/caregiver in implementing the plan of care.

   The waiver provider **must** offer the same service to its individual who has elected the hospice benefit as it furnishes to its individual s who have not elected the hospice benefit. The individual receiving hospice services should not experience any lack of these services because of his or her status as a hospice program member.

**Home Health Services**

Rev 10 2018

As noted in Home Health policy 602 "A member may receive Home Health services while enrolled in a Waiver as allowed by the Waiver service policy. Typically, waiver policy prohibits waiver services that would be considered duplicative of Home Health Services." Support coordinators and providers must coordinate waiver services with Home Health services referred by the individual's physician.

COMP and NOW individual s receiving waiver-funded adult nursing or therapy services are not eligible to receive the same service on the same day through the Home Health program. Coordination between the home health agency, support coordination, and waiver provider staff will determine which program best meets the needs of the individual. This coordination should

involve contacting the physician's office for specific orders that would have been carried out by the home health provider.

Individuals receiving other, non-skilled waiver services will be able to use skilled services provided through the Home Health program but coordination of services must take place to assure continuity of care.

## 905 Transportation Requirements

A. Individual and agency providers that provide transportation as a part of a waiver service specified in the COMP/NOW Part III manuals must meet the following requirements:

1) Be legally licensed in the State of Georgia with the class of license appropriate to the vehicle operated if transporting individual s as follows:

i. Have a valid, Class C license as defined by the Georgia Department of Driver Services for any single vehicle with a gross vehicle weight rating not in excess of 26,000 pounds.

ii. Have valid, Commercial Driver's License (CDL) as defined by the Georgia Department of Driver Services if the vehicle operated falls into one of the following two classes:

1. If the vehicle has a gross vehicle weight of 26,001 or more; or
2. If the vehicle is designated to transport 15 or more passengers, including the driver.

2) Have no more than two chargeable accidents, moving violations, or any DUIs in a three (3) year period within the last five (5) years of the seven (7) year Motor Vehicle Record (MVR) period if transporting individual s.

**NOTE**: The Department will allow an exception to Out-of-State Driver's License and MVP record under the following circumstances: (1) the individual is on active duty in Georgia; (2) the individual is a college student enrolled at a Georgia college or university; or (3) the individual's place of residence is a neighboring state on the border of Georgia. For individual to be granted this exception, he or she must:

a. Have a valid, Class C license
b. Have no convictions for substance abuse, sexual crime or crime of violence for five (5) years prior to providing the service
c. Have current, valid insurance

**906 Day Services Requirements**

The delivery of day services to include Community Access, Prevocational, and Supported Employment services must be based on the individual 's needs and outlined in the Individual Services Plan. Any variation from the Individual Service Plan should be considered noncompliance and will be reported as such.

**907 Developmental Disability Professional (DDP):**

All DDP services rendered by a provider agency must be provided by an individual qualified to be a DDP. The DDP may be employed by or be under professional contract with the provider agency. Qualifications, including a listing of eligible professional types, are found in Section G in the DBHDD Provider Manual for Community Developmental Disabilities Providers, Part 11, Section 1 of Community Service Standards.

At least one Agency employee or Professional under contract with the agency must:

- Be a Developmental Disability Professional (DDP), and
- Have the responsibility for overseeing the delivery of waiver services to individual s with the focus on overall quality of service delivery by the provider agency.

The same individual may serve as the Agency Director and DDP provided the staff member meets the professional qualifications of each position. The duties of each role must be delivered documented separately. Documentation related to particular activities will be delineated by the use of either professional designation following the staff member's signature.

Rev 07 2018

**Note: This requirement is waived for agencies or individual providers delivering the following professional services: nursing, therapy services, behavioral support services, behavioral supports consultation, nutrition, services, and for those providing only** Environmental Accessibility Adaptation, Specialized Medical Equipment, Specialized Medical Supplies, Transportation and/or Vehicle Adaptation.

**907.1 Developmental Disability Professional (DDP) Job Functions:** Each Development Disability Professional (DDP) has a specified schedule with sufficient hours to meet the oversight role required by the level of need for individual(s) supported, which includes but is not limited to:

- Overseeing the services and supports provided to individual for general guidance to the provider agency in areas of compliance and quality improvement;
- Assuring that the supports provided are within the scope of the agency's service enrollment and experience to assure effective delivery;
- Assuring that services address the individual 's needs and adhere to the application of person-centered values, choice and individual 's rights;

- Providing, arranging or overseeing curricula used in staff training and directed to service delivery in the context of individual goal(s) and objective(s);
- Recommending other needed services /supports or changes to the delivery model using a continuous quality improvement approach;
- Providing consultation to the provider agency in ISP implementation strategies that support the goal(s) of the individual;
- Assess areas of risk either individually or overall risk to persons served through agency practice, policy or lack of policy and/or procedures. Providing risk mitigation strategies to the provider agency;
- Reviewing that functional assessments are in place to support development of the individual 's plan for delivery of all waiver services to include:
    a. The Health Risk Screening Tool;
    b. The Supports Intensity Scale;
    c. Functional Behavioral evaluation; and
    d. Additional Assessment (E.g.; Nursing, OT, PT) as needed or required.

- Overseeing high intensity services if applicable that address health and safety risks for the individual s that includes:
    - The implementation and effectiveness of Behavior Support Plans;
    - The implementation and effectiveness of the individual 's Crisis Plan; and
    - Identifying ongoing supports as needed (medical and/or behavioral) in collaboration with agency personnel, staff of other agencies providing support to individual s mutually served, or other members of the healthcare team.

**907.2 Developmental Disability Professional (DDP) Requirements:**

The provision of DDP oversight and service provision must be documented in the individual 's record when DDP services are needed for a specific individual.

**The DDP personnel file must include the following documents:**

a. A signed DDP job description or contract that meets the DDP requirements for oversight and professional consultation;
b. A specified schedule for each site and sufficient contract hours (not a PRN staff) to meet the agency's need for general oversight and quality improvement activities as well as consultation and/or evaluation of individuals as needed.
c. There is documentation of attestation by the DDP that the scheduled or contracted hours do not conflict with his/her work with another provider agency;
d. A copy of diploma, license or certification to verify qualifications for performing DDP job functions is maintained in the personnel file; and
e. Annual evaluation of DDP deliverables relative to the agency's functions and needs as part of QI activities.

**Note:** A DDP is not scheduled to work only on a PRN (pro re nata) basis.

**Documentation Requirements for DDP:**

Agencies will identify for the DDP's ongoing review any individual receiving clinical services (nursing, therapy(s), behavioral services) and any individual with changes in functional, medical, behavioral or social status.

Rev 07 2016

There is documentation to verify all necessary face-to-face individual visits, other contact, or communication with or on behalf of the individual in the individual 's record. (Documentation will contain the purpose of the visit or contact, assessment or evaluation, training, plan for intervention, and any changes in service delivery such as change in staff recommendations.)

DDP documentation must meet documentation requirements to include date, location of service delivery, signature (title), beginning and ending time when the service was provided.

**Required Training for Developmental Disabilities Professionals:**

In addition to the initial orientation requirements for new employees listed in the Waiver manuals Chapter 600, Section 606, other required trainings for DDPs' in their first year of employment include:

- Individual Service Planning (Person-Centered);
- Supports Intensity Scale Overview;
- Health Risk Screening Tool on line training overview.
- The provider agency must also show participation and document the participation of each DDP in a **minimum of eight (8) hours per year** of DBHDD sponsored or other training in the area of I/DD in the DDP employee's file or require and maintain the documentation of participation in such training on an annual basis from any DDP independent contractors.

**Developmental Disability Professional (DDP) Competency:**

The provider will be responsible for monitoring and ensuring the DDP meets his/her above assigned responsibilities utilizing the below performance indicators.
Performance indicators of the responsibilities listed are as follows:

1. Consulted with, supervised, trained and/or provided guidance to direct support staff regarding implementation of service to comply with person-centered values and techniques. Documentation of consultation may be maintained in the form of training agenda, staff meetings, etc. This documentation shall include the signature, title/credentials, time (beginning and end time of delivery of training or in-service support) date, and staff attendance verified by signature sheet or other attendance record. Copy maintained by the provider agency.
2. Assist and provide feedback to the provider in reviewing the quality of the services delivered.
3. Provide technical assistance to the provider agency in corrective action requirements and participate in response regardless of the origin of the Corrective Action Plan requirement.
4. Participate in the agency's Quality Improvement Plan and Risk Management reviews based on qualifications and training background, provide medical and behavioral recommendations and guidance as needed.

**908. Termination of** Individual **Services Requirements**

The provider must provide a minimum of a 30 days' notice when terminating COMP/NOW services to an individual. The provider must agree to be a part of the transition process with the support coordinator and DBHDD Field Office and continue to provide COMP/NOW services until a new provider is identified and transition to this provider occurs in order to assure continuity of care and maintenance of health and safety for the individual.

909 Proxy Caregivers and Health Maintenance Activities

Licensed provider agencies, including co-employer agencies, must abide by the Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100. Proxy caregivers may be used under the following licensure categories:

- Private Homecare
- Personal Care Homes
- Community Living Arrangements
- Assisted Living Communities
- Residential Drug Abuse Treatment Programs
- Traumatic Brain Injury Facilities

Rev. 07 2020

**State's Response during State and National Emergencies**

The guidance contained within this document relates to services rendered and billed during normal circumstances. In the event of an officially declared National or State emergency guidance may be modified to address members and providers' needs. Providers are asked to refer to the most current Banner Messages and Providers Notices as to any policy updates.

## PART II - CHAPTER 1000

## BASIS FOR REIMBURSEMENT

### 1001. General

Reimbursement for COMP/NOW services is made by the Division of Medicaid to providers who have completed the enrollment process and rendered services to eligible individual s with a current level of care and valid prior authorization subsequent to the screening and assessment by the Intake and Evaluation Team. Reimbursement is made only for services contained in the Individual Service Plan and authorized by the DBHDD Field Office (See Appendix A). Failure to adhere to any provision of the COMP/NOW Program will require that the provider repay all funds collected for services, including funds collected for services for which required documentation was not prepared and completed. In addition, if a provider is judged to have provided inadequate justification for services rendered, the Department will review all relevant documentation before authorizing payments.

### 1002. Reimbursement Methodology

Rev 04 2017

The rates for COMP/NOW services are prospective rates based on historical costs where available and based on State Plan costs for comparable services for new services where historical cost was not available.

### 1003. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will edit claims for the presence of an ordering, referring or prescribing provider as required by program policy.

Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Please refer to the Medicaid and PeachCare for Kids Part I Policies and Procedures manual, Section 112, for more information."

**For the NEW CMS-1500 claim form:**

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

**For claims entered via the web:**

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

**For claims transmitted via EDI:**

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications

- Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx

Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

## 1004. Limitations on Billing of Case Management

Case Management Services means services which will assist Medicaid eligible individuals to gain access to needed medical, social, educational and other services. Such services include but are not limited to, the following:

1) Assessment of eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical educational, social or other services.

2) Development of a specific care plan based on the information collected through assessment; that specifies the goal(s) and actions to address the medical, social, educational and other services needed by eligible individuals.
3) Referral and related activities to help and individual obtain needed services.
4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the individual.

Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for case management services to more than one agency or Medicaid provider that renders case management services to an individual. This policy is set forth according the federal Requirements and Limits Applicable to Specific Services defined in the State Medicaid Manual, section 4302.

It is the responsibility of the case manager to ensure that the member is not receiving case management services from any other agency. The case manager must obtain from the member information regarding any and all other services that he/she may be receiving prior to enrolling the member in a case management program. If the case manager should learn that the member is enrolled in another case management program, the case manager is advised not to render any case management services until it is verified that his/her case management services are primary. This may require termination of the member from another case management provider before case management from the new provider can be billed. It is the case manager's responsibility to advise the member of the various case management choices available to the member and to allow the member to make an affirmative choice among them.

Basis for Reimbursement

DCH will reimburse only one provider agency for case management services. The Department has established the case management hierarchy below to define which case management is primary and will be reimbursed. The Department's billing system has been modified to include edits to ensure the hierarchy is followed in the case of billing from more than one case management provider. The case management provider highest on the hierarchy will be reimbursed if 2 case managers should submit claims for the same month of service.

1) COS 830 – (Case Management Organization –CMO)
2) COS 851 - (SOURCE Case Management)
   COS 930 – (SOURCE Case Management) When the procedure is T2022 and the modifier is SE alone or with any other modifier

3) COS 660 – (Independent Care Waiver)
COS 680/681 – (New Options Waiver/Comprehensive Supports Waiver)
4) COS 442 – (C-Bay)
5) COS 764 - (Child Protective Services Targeted Case Management)
6) COS 800 - (Early Intervention Case Management)
7) COS 765 - (Adult Protective Services Targeted Case Management)
8) COS 763 - (At Risk of Incarceration Targeted Case Management)
9) COS 762 - (Adults with AIDS Targeted Case Management)
10) COS 790 - (Rehab Services/DSPS)
11) COS 960 - (Children Intervention School Services)

**NOTES: Persons enrolled in hospice have case managers who manage all of their care and may not receive case management from any other program while enrolled in hospice. The Department's hospice lock-in system will automatically cause any other claims for case management to be denied.**

**1005. CMS 1500 Claim Form**

Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Please refer to the Medicaid and PeachCare for Kids Part I Policies and Procedures manual, Section 112, for more information."

Rev 04 2021

1006. Community Living Support Services

Effective July 1, 2021 a DCH approved EVV vendor must be used to submit all Community Living Support Services claims to be eligible for reimbursement.

# PART II - CHAPTER 1100

# DOCUMENTATION AND RECORDS

## 1101. General

This chapter specifies the general requirements for documentation and records for COMP/NOW providers. The Part III Services Manual for the Comprehensive Supports Waiver (COMP) and the New Options Waiver (NOW) specifies documentation and record requirements specific to individual waiver services. Chapter 700 of this manual includes any documentation and record requirements for screening, and the initial and reevaluations regarding level of care.

## 1102. Individualized Service Planning and Implementation

The intent of the development of the Individual Service Plan (ISP) is a process that focuses on the individual's person-centered goal(s) and wishes of a "life well-lived". Information included within this individualized plan should be presented as a single plan describing the individual's service/support needs within a daily life versus a daily service. Support networks should work closely together to identify issues of risk and needed supports to address those risks while never losing sight that the individual is at the center of the planning process and included in all discussions. Individualized service planning produces an organized statement of the proposed services to guide the provider(s) and individual throughout the duration of service. Chapter 700 of this manual covers the process of development of the initial Individual Service Plan. This section describes the process for updating subsequent Individual Service Plans.

**A. Annual Individual Service Plan Document:** After the initial Individual Service Plan (ISP), the individual 's support coordinator is responsible for the development of the annual ISP document. It is the responsibility of the support coordinator to discuss service options with the individual, his/her family and others as appropriate over the course of the year. Annual ISP meetings will use the individual 's date of birth as a guide to annual review.

**B. Choice of Service Options and Providers:** The ongoing discussion on the range of service options is repeated at the annual review At this time, it is the Support Coordinator's responsibility to discuss service options based on the individual 's assessed support needs, with the individual , their family and others as appropriate in order to identify social, education, and other needs. These needs may indicate Medicaid and non-Medicaid covered services. The support coordinator works with the individual and/or family/representative to determine their choices among the service options for the individual and available providers prior to the formal Individual Service Plan meeting with the chosen provider(s).

C. **ISP Meeting** Individual **s and Documentation:** The individual 's support coordinator facilitates the ISP development. The support coordinator works with the individual (and their representative) to determine whom he or she wants to include in the ISP development meetings and the formal ISP meeting and invites those identified. Individuals participating in these meetings should include people who best know the individual outside the service system and from other agencies and resources as deemed appropriate, with the individual or legal representative's consent. The support coordinator informs the individual that he or she can have a representative to help with the ISP development process. The support coordinator documents the occurrence of all ISP development meetings with the individual, his/her family and others as appropriate.

D. **ISP and Individual 360** The Individual Service Plan (ISP) and Individual 360 are based on what is important to/for the individual and includes the following:

a. Desired outcomes of the individual (goal

b. The services to be provided, including the frequency and amount

c. Known medical conditions, allergies and medication summaries

d. Behavioral Health conditions and connections to community mental health services as appropriate.

e. Needed connections to primary care physicians and specialty medical providers.

f. The provider responsible for each service or the name of the service element and type of professional staff that is responsible for service (e.g., Registered Nurse);

g. Consideration of the following:

1) The individual 's support systems; and

2) The community resources available to be used

i. Wellness of individuals is facilitated through:
1) Advocacy
2) Individual care practices
3) Education
4) Sensitivity to issues affecting wellness including, but not limited to:

- Gender
- Culture; and
- Age
- 5) Incorporation of wellness goal(s) within the individual plan6) The intent of the development of the ISP is a process that focuses on the individual's person- centered goal(s) and wishes of a "life well-lived." Information included within this individualized plan should be presented as a single plan that addresses residential and all other paid supports that the individual receives. The Support networks should work closely together to identify issues of risk and needed supports to address those risks while never losing sight that the individual is at the center of the planning process and included in all discussions. If the individual receives residential services, the residential provider has the primary responsibility in conjunction with the support coordinator or state services coordinator to assure a holistic (i.e., integrated) support plan for all services identified as a need for the individual.

Rev 01 2013

**E.** Individual **'s Involvement and Acceptance in Developing ISP Document:** The individual 's involvement and acceptance, if applicable, in developing the ISP must be documented.

1. The individual 's signature on the ISP Signature page signifies this acceptance.
2. If a individual declines a service or is unable to sign the ISP, it is documented in the individual 's record.

**F. Family Involvement:** Unless clinically or programmatically contraindicated, individual s are asked to consent to the family's involvement in the service planning and service delivery processes. Contraindications, if present, and the individual 's refusal, if permission is not given, are documented in the support notes of the individual's record.

**G. ISP Annual Review and Version Changes:** Circumstances warranting more frequent reviews would include, but are not limited to, significant changes in individual functioning, increases or decreases in services, change of provider(s), changes in medical, social or behavioral statuses, family crisis, and reduction in funding.

Rev 01 2013

Individualized service plans or portions of the plan must be reassessed as indicated by the following:

a.. Changing needs, circumstances and responses of the individual, including but not limited to:

i. Any life change
ii. Change in services
iii. Change of address
iv. Change in frequency of service.

b. As requested by the individual;
c. As required for re-authorization;
d. At least annually;
e. When goal(s) are not being met; and
f. ISP annual review and/or version changes: Each ISP must be reviewed and /or
updated annually or more often as needed to reflect all life changes, progress
or lack of progress to identify changes in outcome, review changes in medical/psychological or social services and to identify new problems or goal(s).

**H. The Organization Maintains a System of Information Management that Protects Individual Information and that is Secure, Organized, and Confidential**

1. The organization has clear policies, procedures, and practices that support secure, organized and confidential management of information, to include electronic individual records if applicable.

2. All individuals determine how their right to confidentiality will be addressed including but not limited to who they wish to be informed about their services, supports and treatment. Maintenance and transfer of both written and spoken information is addressed:
    a. Personal individual information;
    b. Billing information; and
    c. All service related information.

3. The organization has a Confidentiality and HIPAA Privacy Policy that clearly addresses state and federal confidentiality laws and regulations, including but not limited to federal regulations on "Confidentiality of Alcohol and Drug Abuse Patient Records" at 42 C.F.R. Part 2 (as applicable) and state laws at O.C.G.A. §§ 37-3-166 (MH), 37-4-125 (DD) and 37-7-166 (AD) as applicable. The organization has a Notice of Privacy Practices that gives the individual adequate notice of the organization's policies and practices regarding use and disclosure of their Protected Health Information (PHI). The notice should contain mandatory elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II). In addition, the organization should address:

    1) HIPAA Privacy and Security Rules, as outlined at 45 CFR Parts 160 and 164 are specifically reviewed with staff and individuals;
    2) Appointment of the Privacy Officer;
    3) Training to be provided to all staff;
    4) Posting of the Notice of Privacy Practices in a prominent place; and

5) Maintenance of the individual's signed acknowledgement of receipt of Privacy Notice in their record;
6) Provision of the rights of individuals regarding their PHI as defined in federal and state laws and in HIPAA, including but not limited to:
   i. Right to access to one's own record.
   ii. Right to request an amendment.
   iii. Right to request communications by alternative means.
   iv. Right to request restriction of access by others.
7) Identification of its Business Associates, and obtaining Business Associate agreements with Business Associates, in compliance with HIPAA requirements.
8) Identification of violations of confidentiality or HIPAA and follow up to include compliance with all requirements of HIPAA at 45 C.F.R. sections 164.400 through 164.414:
   i. Reporting of violations to the Privacy Officer.
   ii. Risk assessment of the violation as required by HIPAA provisions.
   iii. Determination of whether the violation constitutes a "breach" as defined by HIPAA.
   iv. Notifications of breaches to the individual(s) affected, to the Secretary of Health and Human Services, and if necessary to the media, in compliance with HIPAA requirements.
9) Corrective Actions for sanctions of employee(s) as necessary, mitigation of harm to any individual and preventing risks to PHI

4. A record of all disclosure of Protected Health Information (PHI) should be kept in the medical record, so that the organization can provide an accounting of disclosures to the individual for 6 years from the current date. The record must include:
   1) Date of disclosure;
   2) Name of entity or person who received the Protected Health Information;
   3) A brief description of the Protected Health Information disclosed;
   4) A copy of any written request for disclosure; and
   5) Written authorization from the individual or legal guardian to disclose PHI, where applicable.

5. Authorization for release of information is obtained when Protected Health Information of an individual is to be released or shared between organizations or with others outside the organization. All applicable DBHDD policies and procedures and HIPAA Privacy Rules (45 CFR parts 160 and 164) related to disclosure and authorization of Protected Health Information are followed. Information contained in each release of information must include:

a. Specific information to be released or obtained;
b. The purpose for the authorization for release of information;
c. To whom the information may be released or given;
d. The time period that the release authorization remains in effect (reasonable based on the topic of information, generally not to exceed a year); and,
e. A statement that authorization may be revoked at any time by the individual, to the extent that the organization has not already acted upon the authorization.

6. Exceptions to use of an authorization for release of information are clear in policy:
   a. Disclosures may be made if required or permitted by law;
   b. Disclosure is authorized as a valid exception to the law;
   c. A valid court order or subpoena are required for mental health or I/DD records;
   d. A valid court order and subpoena are required for alcohol or drug abuse records;
   e. When required to share individual information with the DBHDD or any provider of treatment or services for the individual under contract or LOA with the DBHDD; or
   f. In the case of an emergency treatment situation as determined by the individual's physician, the chief clinical officer can release Protected Health Information (PHI) to the treating physician or psychologist.
7. The organization has written operational procedures, consistent with legal requirements governing the retention, maintenance and purging of records.
   a. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of their creation or the date when last in effect (whichever is later).
   b. Protocol for all records to be returned to or disposed of as directed by the contracting regions after specified retention period or termination of contract/agreement; and
   c. Compliance with HIPAA Security Rule provisions to the degree mandated by or appropriate under the Security Rule to protect the security, integrity and availability of records.

I. The organization has written policy, protocols, and documented practice of how information in the record is transferred when an individual is relocated or discharged from service to include but not be limited to:
   a. A complete certified copy of the record to DBHDD or the provider who will assume service provision, that includes individual's Protected Health Information, billing information, service related information such as current medical orders, medications, behavior plans as deemed

necessary for the purposes of the individual's continuity of care and treatment;

b. Unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts; and

c. The time frames by which transfer of documents and personal belongings will be completed.

9. Assessments, ISPs, and documentation required by Medicaid are to be retained in the individual's records for six years.

**J. Medication Oversight and Monitoring**

1. A current copy of the physician(s) order or current prescription dated and signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:
   a. Regular, on-going medications;
   b. Controlled substances;
   c. PRN (as needed) Over-the-counter (OTC) medications;
   d. PRN medications (does not include standing orders for psychotropic medications for symptom management of behavior); or
   e. Discontinuance order.
2. Anti-psychotic medications must be prescribed by a psychiatrist or psychiatric nurse practitioner unless the medication is prescribed for epilepsy or dementia and there is documentation that includes:
   a. Informed consent for the medication is obtained and a signed copy is maintained in the clinical record. It is the responsibility of the physician/designee to complete the informed consent;
   b. The treating psychiatrist or psychiatric nurse personally examines the individual to determine whether this person has the capacity to understand to consent for herself or himself;
   c. If the individual does not have the capacity to consent for herself or himself, an appropriate substitute decision maker is identified based on the Order of Priority outlined in Georgia Medical Consent Law;
   d. The risks/benefits is explained in language the individual can understand;
   e. Medication education provided by the organization's staff should be documented in the clinical record; and
   f. Education regarding the risks and benefits of the medication is documented.
3. The organization has written policies, procedures, and practices specific to the type of services for all aspects of medication management including, but not limited to:
   a. Prescribing:
      i. The physician's order or current prescription is defined as a prescription signed by one authorized to prescribe in Georgia; and
      ii. Electronic prescriptions (E-scripts and Sure scripts), if practiced

b. Authenticating orders: Describes the required time frame for obtaining the actual or faxed physician's signature for telephone or verbal orders accepted by a licensed nurse.
c. Ordering and Procuring medication and refills: Procuring initial prescription medication and over-the-counter drugs within twenty-four hours of prescription receipt, and refills before twenty-four hours of the exhaustion of current drug supply.
d. Medication Labeling: Describes that all medications must have a label affixed by a licensed professional with the authority to do so. This includes sample medications.
e. Storing: Includes prescribed medications, floor stock drugs, refrigerated drugs, and controlled substances.
f. Security: Requires safe storage of medication as required by law including single and double locks, shift counting of the medications, individual dose sign-out recording, documented planned destruction, and refrigeration and daily temperature logs. All controlled substances are double locked and there is documented accountability of controlled substances at all stages of possession.
g. Dispensing: Describes the process allowed for pharmacists and/or physicians only. Includes the verification of the individual's medications from other agencies and provides a documentation log with the pharmacist's or physician's signature and date when the drug was verified. Only physicians or pharmacists may re-package or dispense medications:
    i. This includes the re-packaging of medications into containers such as "day minders" and medications that are sent with the individual when the individual is away from his residence.
    ii. Note that an individual capable of independent self-administration of medication may be coached in setting up their personal "day minder".
h. Supervision of individual self-administration: Includes all steps in the process from verifying the physician's medication order to documentation and observation of the individual for the medication's effects each time supervision of individual self-administration occurs. Makes clear that staff members may not administer medications unless licensed to do so, and the methods staff members may use to supervise or assist, such as via hand-over-hand technique, when an individual self-administers his/her medications. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication.
i. Administration of medications: Administration of medications may be done only by those who are licensed in this state to do so.
j. Recording: Includes the guidelines for documentation of all aspects of medication management. This includes adding and discontinuing medication, charting scheduled and as needed medications, observations regarding the effects of drugs, refused and missing doses,

making corrections, and a legend for recording. The legend includes initials, signature and title of staff member.

k. Disposal of discontinued or out-of-date medication: Includes via an environmentally friendly method of disposal by pharmacy.

l. Education to the individual and family (as approved by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record.

m. All PRN or "as needed" medications will be accessible for each individual as per his/her prescriber(s) order(s) and as defined in the individual's ISP. Additionally, the organization must have written protocols and documented practice that ensures safe and timely accessibility that includes, at a minimum, how medication will be stored, secured or refrigerated when transported to different programs and home visits.

n. Timeliness of medication administration/supervision: Organizations must adopt medication administration/supervision policies following standards of practice that meet the individual safety needs, the nature of the prescribed medication and its specific clinical use. Provider policy must address protocols for obtaining medication on a timely basis and educating organizational staff in the specific medication information from the individual's primary physician, a prescribing practitioner or pharmacy for the importance of timeliness of medication administration/supervision of medications.

4. Organizational policy, procedures and documented practices stipulate that:
   a. The use of Proxy Caregivers for Health Maintenance Activities must be in accordance with requirements as specified in Chapter 900, Section 909 of this manual.
   b. There are safeguards utilized for medications known to have substantial risk or undesirable effects, to include:
      i. Obtaining and maintaining copies of appropriate lab testing and assessment tools that accompany the use of the medications prescribed from the individual's physician for the individual's clinical record, or at a minimum, documenting in the clinical record the requests for the copies of these tests and assessments, and follow-up appointments with the individual's physician for any further actions needed;
      ii. For individual in residential services, there is documentation of a review of polypharmacy usage in order to ensure that intra-class and inter-class polypharmacy use for psychiatric reasons are justifiable, if applicable, using the following monitoring criteria:
         a) Intra-class Polypharmacy monitoring reports includes individuals who are on more than one psychotropic medication in the same single class of medications (2 or more

antipsychotics, antidepressants, mood stabilizers), e.g., the use of 2 anti-depressants to treat depression.

b) Inter-class Polypharmacy monitoring reports include individuals who are on 3 or more different classes of medications (antipsychotics, antidepressants, mood stabilizers), e.g., the use of an antipsychotic, an antidepressant and mood stabilizer to treat someone with Schizoaffective Disorder.

c. There are protocols for the handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.
d. The organization defines requirements for timely notification to the prescribing professional regarding:
   i. Medication errors;
   ii. Medication problems;
   iii. Drug reactions;
   iv. Refusal of medication by the individual; and
   v. Failure to administer/supervise on time medications.
e. There are practices for regular and ongoing physician review of prescribed medications including, but not limited to:
   i. Appropriateness of the medication;
   ii. Documented need for continued use of the medication;
   iii. Monitoring the presence of side effects. (Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS) testing.);
   iv. Monitoring of therapeutic blood levels, if required by the medication such as Blood Glucose testing, Dilantin blood levels and Depakote blood levels.
   v. Ordering specific monitoring and treatment protocols for Diabetic, hypertensive, seizure disorder, and cardiac individuals, especially related to medications prescribed and required vital sign parameters for administration;
   vi. Maintain individualized medication protocols for specific individuals receiving health maintenance activities.
   vi. Monitoring of other associated laboratory studies.
f. For organizations that secure their medications from retail pharmacies, there is a biennial assessment of agency practice of management of medications at all sites housing medications. An independent licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
   i. A written report of findings, including corrections required;
   ii. A photocopy of the pharmacist's license or a photocopy of the license of the Registered Nurse; and

iii. A statement of attestation from the independent licensed pharmacist or licensed Registered Nurse that all issues have been corrected.

g. The organization needs to have policy which describes the process for developing individualized healthcare protocols, monitoring, reporting and, if applicable, preventative healthcare maintenance, to include but not limited to the healthcare needs:
   i. Bowel Elimination (Constipation and Diarrhea);
   ii. Hypertension;
   iii. Weight;
   iv. Skin Care;
   v. Seizures;
   vi. Fluid Intake (Hydration);
   vii. Aspirations;
   viii. Falls;
   ix. Diabetes; and
   x. Protocols for medication schedule for critical and non-critical timings.

5. The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right:
   a. Right person: Check the name on the order and the individual and include the use of at least two identifiers.
   b. Right medication: Check the medication label against the order.
   c. Right time: Check the frequency and time to be given of the ordered medication and double check that the ordered dose is given at the correct time. Confirm when last dose was given.
   d. Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record document to ensure all are the same.
   e. Right route: Check the order and appropriateness of route ordered and confirm that the individual can take or receive the medication by the ordered route.
   f. Right position: The correct anatomical position for the medication method or route to ensure its proper effect, instillation and retention. If needed, individual should be assisted to assume the correct position.
   g. Right Documentation: Document the administration/supervision after the ordered medication is given on the MAR; and
   h. Right to Refuse Medication: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
6. A Medication Administration Record is in place for each calendar month that an individual takes or receives medication(s):
   a. Documentation of routine, ongoing medications occur in one discreet portion of the MAR and include but may not be limited to:
      i. Documentation by calendar month that is sequential according to the days of the month;

ii. A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication:
    a) Name of the medication;
    b) Dose as ordered;
    c) Route as ordered;
    d) Time of day as ordered; and
    e) Special instructions accompanying the order, if any, such as but not limited to:
        1. Must be taken with meals;
        2. Must be taken with fruit juice;
        3. May not be taken with milk or milk products.

iii. If the individual is to take or receive the medication more than one time during one calendar day:
    a) Each time of day must have a corresponding line that permits as many entries as there are days in the month;

iv. All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;

v. When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing discontinuation; followed by a mark through of all lines representing days and times that were discontinued.

b. Documentation of medications that are taken or received on a periodic basis, including over the counter medications, occur in a separate discreet portion of the MAR and include but may not be limited to:
    i. Documentation by calendar month that is sequential according to the days of the month;
    ii. A listing of each medication taken or received on a periodic basis during that month including a full replication of information in the physician's order for each medication:
        a) Name of medication;
        b) Dose as ordered;
        c) Route as ordered;
        d) Purpose of the medication; and
        e) Frequency that the medication may be taken.
    iii. The date and time the medication is taken or received is documented for each use.
    iv. When 'PRN' or 'as needed' medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.

c. Each MAR shall include the legend that clarifies:
    i. The identity of the authorized staff's initials using full signature and title;

ii. The reasons that a medication may not be given, is held or otherwise note received by the individual, such as but not limited to:

"H" = Hospital
"R" = Refused
"NPO" Nothing by mouth
"HM" Home Visit
"DS"= Day Service

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K. **Service Environment**

Respectful Service Environment (To include Host Homes and Day Services Sites)

1. Services, supports, care or treatment approaches support the individual in:
   a. Living in the most integrated community setting appropriate to the individual's requirement, preferences and level of independence;
   b. Exercising meaningful choices about living environments, providers of services received, the types of supports, and the manner by which services are provided;
   c. Obtaining quality services in a manner as consistent as possible with community living preferences and priorities; and
   d. Inclusion and active community integration is supported and evident in documentation.
2. Services are provided in an appropriate environment that is respectful and ensures the privacy of individuals supported or served. (For Host Homes and Community Access Services Sites refer to DBHDD Operational Standards for Host Homes/Life Sharing Policy 02-704 and for Community Access Services Physical Environment refer to NOW/COMP Part III). The environment is:
   a. Clean;
   b. Age appropriate;
   c. Accessible (individuals who need assistance with ambulation shall be provided bedrooms that have access to a ground level exit to the outside or have access to exits with easily negotiable ramps or accessible lifts. The home shall provide at least two (2) exits, remote from each other that are accessible to the individuals served);
   d. Individual's rooms are personalized;
   e. Adequately lighted, ventilated, and temperature controlled;
   f. There is sufficient space, equipment and privacy to accommodate;
   g. An area/room for visitation;
   h. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported; and
   i. The American with Disabilities Act of 1990 requiring facilities to be readily accessible to and usable by people with disabilities is addressed, if applicable. Refer to 2010 Standard ADA Compliance for accessible design.

3. The environment is safe:
    a. All local and state ordinances are addressed:
        i. Copies of inspection reports are available;
        ii. Licenses or certificates are current and available as required by the site or the service;
        iii. An automatic extinguishing system (sprinkler) shall be installed per city/county requirements for residential settings excluding host homes not governed by other federal, state and county rules and regulations, if applicable; and
        iv. Approved smoke alarm shall be installed in all sleeping rooms, hallways and in all normally occupied areas on all levels of the residences per safety code. Smoke alarms especially in the bedrooms shall be tested monthly and practice documented. The facility shall be inspected annually to meet fire safety code and copies of inspection maintained.
    b. Installation of Fire alarm system and inspection of equipment meets safety code.
    c. Fire drills are conducted for individuals and staff:
        i. Once a month at alternative times; including
        ii. Twice a year during sleeping hours if residential services;
        iii. All fire drills shall be documented with staffing involved;
        iv. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit.
4. Food guidelines are in place for safe food consumption and storage of food in refrigerator, freezer and cupboards to maintain temperature, expiration dates on food items to include open items and the prevention of foodborne illnesses. When food service is utilized, required certifications related to health, safety and sanitation are available. A three day supply of non-perishable emergency food and water is available for all individuals supported in residences. A residence shall arrange for and serve special diets as prescribed.
5. Policies, plans and procedures are in place that addresses Emergency Evacuation, Relocation, Preparedness and Disaster Response. Supplies needed for emergency evacuation are maintained in a readily accessible manner, including individuals' information, family contact information and current copies of physician's orders for all individual's medications.
    a. Plans include detailed information regarding evacuating, transporting and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:
        i. Medical emergencies;
        ii. Missing persons;
            a) Georgia's Mattie's Call Act provides for an alert system when an individual with developmental disabilities, dementia, or other cognitive impairment is missing. Law requires residences licensed as Personal Care Homes to notify law enforcement within 30 minutes of discovering a missing individual.
        iii. Natural and man-made disasters;
        iv. Power failures;

v. Continuity of medical care as required;
vi. Notifications to families or designees; and
vii. Continuity of Operation Planning (COOP) to include identifying locations and providing a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided. COOP must also include plans for sheltering in place (for more information go to: http://www.georgiadisaster.info/PersonsWithDisabilities/disasterpreparedness.html ; and http://www.fema.gov/about/org/ncp/coop/templates.shtm).

b. Emergency preparedness notice and plans are:
i. Reviewed annually;
ii. Tested at least quarterly for emergencies that occur locally on a less frequent basis such as, but not limited to flood, tornado or hurricane; and
iii. Drilled with more frequency if there is a greater potential for the emergency.

6. Residential living support service options:
a. Are integrated and established within residential neighborhoods;
b. Are single family dwellings;
c. Have space for informal gatherings;
d. Have personal space and privacy for persons supported; and
e. **Are understood to be the "home" of the person supported or served.**

7. Video/ cameras monitoring **may not be used** in the following instances:
a. In an individual's personal residence as it is an invasion of privacy and is strictly prohibited; and
b. In lieu of staff presence.

8. There are policies, procedures, and practices for transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place:
a. Policies and procedures apply to all vehicles used, including:
i. Those owned or leased by the organization;
ii. Those owned or lease by subcontractors; and
iii. Use of personal vehicles of staff.
b. Policies and procedures include, but are not limited to:
i. Authenticating licenses of drivers;
ii. Proof of insurance;
iii. Routine maintenance;
iv. Requirements for evidence of driver training;
v. Safe transport of persons served;
vi. Requirements for maintaining an attendance log of persons while in vehicles;
vii. Safe use of lift;
viii. Availability of first aid kits;
ix. Fire suppression equipment; and
x. Emergency preparedness.

9. Locks on exterior doors in **ALL** community settings (including, but not limited to, Personal Care Homes, Host Home/Life-Sharing sites, and Day Services sites) must comply with the following provisions:
   a. **ALL** locks used on any exterior door must be capable of being unlocked from the inside by the individuals receiving services in that setting, without the need for obtaining assistance from provider staff or any other person.
   b. Neither the lock nor any mechanism or control for operating the lock may be placed in a location that is inaccessible to or concealed from any individual receiving services in the setting.
   c. No exterior door may be fitted with any lock that requires a key, key card, badge, combination, or passcode to unlock it from the inside.

## L. Infection Control Practices are Evident in Service Settings:

1. The organization, at a minimum, has a basic Infection Control Plan which is reviewed bi-annually for effectiveness and revision, if needed. The Plan addresses:
   a. Standard Precautions;
   b. Hand Washing Guidelines;
   c. Proper storage of Personal Hygiene items; and
   d. Specific common illnesses/infectious diseases likely to be emergent in the particular service setting.
2. The organization has policies, procedures and practices for controlling and preventing infections in the service setting. There is evidence of:
   a. Guidelines for environmental cleaning and sanitizing;
   b. Guidelines for safe food handling and storage;
   c. Guidelines for laundry; and
   d. Guidelines for food preparation.
3. Procedures for the prevention of infestation by insects, rodents or pests shall be maintained and conducted continually to protect the health of individuals served.
4. No vicious/dangerous animals shall be kept. Any pets living in the service setting must be healthy and not pose a health risk to the individual supported. All pets must meet the local, state, and federal requirements to include the following:
   a. All animals that require rabies vaccinations annually must have current documentation of the rabies inoculation;
   b. Exotic animals must be obtained from federally approved sources; and
   c. Parrots and Psittacine family birds must be USDA inspected and banded.

## M. Oversight of Contracted/Subcontracted Providers/Professionals by the Organization

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1. The organization is responsible for the Contracted/Subcontracted Provider/Professional compliance with:

a. Contract/Agreement requirements, documented and maintained for review;
b. Standards of practice and specified requirements in the Provider manual for the Department of BHDD, including *Community Service Standards for All Providers;*
c. Licensure requirements;
d. Accreditation or Community Service Standards Quality Review requirements; and
e. Quality improvement and risk reduction activities.

2. There is documented evidence of active oversight of the Contracted/Subcontracted Provider/Professional capacity and compliance to provide quality care to include monitoring of:
    a. Financial oversight and management of individual funds;
    b. Staff competency and training;
    c. Mechanisms that assure care is provided according to the plan of care for each individual served; and
    d. The requirement for a Host Home Study when contracting with a Host Home provider, to provide updating and meeting home study requirements for new members to include general health examinations, screening for communicable disease, criminal records check/clearance, character references and training compliance.
3. A report shall be made quarterly to the agency's Board of Directors regarding:
    a. Services provided by Contracted/Subcontracted Provider/Professional; and
    b. Quality of performance of the Contracted/Subcontracted Provider/Professional.
4. A report shall be made to the DBHDD Field Office prior to the end of the first quarter and third quarter of the fiscal year that includes:
    a. Name and contact information of all contracted providers;
    b. The specific services provided by each contracted provider;
    c. The number and location of individual supported by each contracted provider; and
    d. Annualized amount paid to each contracted provider.

## 1103. Provider Intake

Service providers, except for providers of participant-directed services, conduct an intake for individuals at the beginning of waiver services. This section specifies requirements related to that intake. Requirements for providers of participant-directed services are covered in Chapter 1200 of this manual.

A. The service provider intake consists of basic identifying information, including information that the Georgia Department of Behavioral Health and Developmental Disabilities requests for the statewide individual data reporting system, appropriate consents to service, and other standardized agency forms. A release of information form will be obtained as needed, and will be time, agency, and event specific.

B. The individual is to be informed of projected duration of service, hours of service, rules of conduct, involvement of family members and individual rights and responsibilities.

## 1104. Individual Service Plan (ISP) Goal Progress Documentation

Providers are required to document progress towards moving the Individual towards independence by meeting the individual's ISP, which includes person-centered goal(s), desired outcomes in the individual's action plan, and the amount/type of assistance/support in the ISP. This section covers ISP progress documentation for providers, except for providers of participant-directed services. The Part III, Policies and Procedure Manual for the Comprehensive Supports Waiver and New Options Waiver specifies documentation and record requirements specific to individual waiver services. Chapter 1200 of this policy manual specifies documentation requirements for providers of participant-directed services.

A. Activity Notes/Learning Logs are formulated to document provision of services and document progress or lack of progress.

B. Activity Notes/Learning Logs document the actual implementation of the planned services, strategies or interventions and reflect the course of service received by the individual and individual 's response to the service provided.

1. Activity Notes/Learning Logs (which may include charts, tracking sheets, narratives, etc.) are a chronological record that reflects the direct contact, other direct and indirect services rendered to attain the expected individual outcomes. Justification for ISP modifications and reviews must be documented in the activity notes.

    a. Activity Notes/Learning Logs must be dated and signed by the provider staff making the entries on the date of the occurrence/service.
    b. Notation of communications from family, significant others and other community agencies that address the condition or needs of individual s must be entered in the record.
    c. Appointments missed or canceled by the individual or staff is to be documented along with appropriate follow-up attempts to reschedule.
    d. Services for which Medicaid is billed must be accurately reflected in the services documented in the individual 's record.
    e. Activity Notes/Learning Logs must be kept readily available for review by the Department for purposes of audit or monitoring.

2. Other than as noted above for providers of participant-directed services, there are no exceptions to activity note documentation in detailing service delivery to the COMP/NOW individual. Failure to adequately record service documentation to justify reimbursement claims may result in a request for refund by the Department when Utilization Review or other focused audits are conducted.

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Provider staff must document the service provided to a individual each time service is delivered (See Appendix S of this manual for examples of documentation). If any form is used that includes staff initials, a key for the initials must be in the individual 's record. A daily service, such as Community Residential Alternative Services, must be documented each day the service is provided. The daily documentation must include the required elements listed below. Except for providers of participant-directed services, all providers must document the following in the record of each individual each time a waiver service is delivered:

- Specific activity, training, or assistance provided;
- Date and the beginning and ending time when the service was provided;
- Location where the service was delivered;
- Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
- Progress towards moving the individual in the direction of independence by completing the individual 's ISP, which includes person-centered goal(s), desired outcomes in the individual 's action plan, and the amount/type of assistance/support in the ISP.

## 1105. Maintenance of Records

Providers, with the exception of providers of participant-directed services, must maintain written documentation of all level of care evaluations and reevaluations in the individual's case record for a period of six (6) years. Copies of these evaluations must be made available to the State upon request. Maintenance of records requirements for providers of participant-directed services are covered in Chapter 1200 of this manual.

The organization has written operational procedures, consistent with legal requirements governing the retention, maintenance and purging of records. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of its creation or the date when last in effect (whichever is later).

### 1105.1 Documentation

1. The individual record is a legal document, information in the record should be:
    a. Organized;
    b. Complete;
    c. Current;
    d. Meaningful;
    e. Succinct; and
    f. Essential to:
        i. Protect the individual; their rights; and
        ii. Comply with legal regulation.
    g. Dated, timed, and authenticated with the authors identified by name, credential and by title:
        i. Notes entered retroactively into the record after an event or a shift must be identified as a "late entry";
        ii. Documentation is to be done each shift or service contact by staff providing the service;
        iii. If notes are voice recorded and typed or a computer is used to write notes that are printed, each entry must be dated and the physical documentation must be signed and dated by the staff writing the note. Notes should then be placed in the individual's record; and
        iv. If handwritten notes are transcribed electronically at a later date, the former should be kept to demonstrate that documentation occurred on the day billed.
    h. Written in black or blue ink;
    i. Red ink may be used to denote allergies or special precautions;
    j. Corrected as legally prescribed by:
        i. Drawing a single line through the error;
        ii. Labeling the change with the word "error";
        iii. Inserting the corrected information; and
        iv. Initialing and dating the correction.
2. At a minimum, the individual's information shall include:
    a. The name of the individual, precautions, allergies (or no known allergies – NKA) and "volume #x of #y" on the front of the record;
        i. Note that the individual's name, allergies and precautions must be flagged on the medication administration record.
    b. Individual's identification and emergency contract information;
    c. Financial information;
    d. Rights, consent and legal information including but not limited to:
        i. Consent for service;
        ii. Release of information documentation;
        iii. Any psychiatric or other advanced directive;
        iv. Legal documentation establishing guardianship;
        v. Evidence that individual rights are reviewed at least one time a year; and
        vi. Evidence that individual responsibilities are reviewed at least one time a year.

e. Pertinent medical information;
f. Screening information and assessments, including but not limited to:
i. Functional, psychological and diagnostic assessments.
g. Individual service plan
h. Discharge summary information provided to the individual and new service provider, if applicable, at the time of discharge includes:
i. Strengths, needs, preferences and abilities of the individual;
ii. Services, supports, care and treatment provided;
iii. Achievements;
iv. Necessary plans for referral; and
v. A dictated or hand-written summary of the course of services, supports, care and treatment incorporating the discharge summary information provided to the individual and new service provider, if applicable, must be placed in the record within 30 days of discharge.

i. The organization must have policy, procedures and practices for Discharge/Transfer/ immediate transfer due to medical or behavioral needs of individuals in all cases. Agency employees, subcontractors and their employees and volunteers who abandon an individual are subject to administrative review by the contracting Field Office(s) representing DBHDD to evaluate for recommendations to the Department of Community Health concerning increasing new admission capacity further or continuing the relationship with the provider agency.

j. All relocation/discharge of individuals within or outside the agency must have prior approval from the DBHDD Field Office. A copy of the approval must be maintained in the individual record.

k. Progress notes or Learning Logs (for DD individuals) describing progress toward goal(s), including:
i. Implementation of interventions specified in the plan;
ii. The individual's response to the intervention or activity based on data; and
iii. Date, location and the beginning and ending time when the service was provided.

l. Event notes documenting:
i. Issues, situations or events occurring in the life of the individual;
ii. The individual's response to the issues, situations or events;
iii. Relationships and interactions with family and friends, if applicable;
iv. Missed appointments including:
a) Findings of follow-up; and
b) Strategies to avoid future missed appointments.

m. Records or reports from previous or other current providers; and
n. Correspondence.

3. The individual's response to the services, supports, care and treatment is a consistent theme in documentation.
a. Frequency and style of documentation are appropriate to the frequency and intensity of services, supports, care and treatment; and
b. Documentation includes record of contacts with persons involved in other

aspects of the individual's care, including but not limited to internal or external referrals.

4. There is a process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts.
5. A provider must ensure that DBHDD, DCH, Healthcare Facility Regulation (as applicable) and Support Coordination are provided updated, accurate information which includes but is not limited to the following:
   a) Correct address of the agency/business location;
   b) Correct street address of the service location, if different from above;
   c) Current phone number(s)
   d) Name of contact person (s)
   e) Data on subcontractors providing direct member care
   f) Enrolled providers are required to furnish written notice to the DBHDD Provider Enrollment Unit, DCH, the Support Coordination agency and individual supported within 10 calendar days change in provider data. Changes requiring written notice include, but are not limited to the following:
      i. Address of the provider agency administrative business office;
      ii. Address of the service location;
      iii. Payee changes;
      iv. Change in permit/license issued by Healthcare Facility Regulation Section;
      v. If the contact person for the administrative or service location changes, the provider must notify the DBHDD applicable Field Office within 30 calendar days of the change.
6. The provider must maintain on file a copy of all approved waiver requests and/or exceptional rate approval documents and have such waiver(s) and/or rate documents available for review by the State. The original letter may be maintained at the provider office location but a copy of the exceptional rate/additional staffing request and all supporting documentation relevant to service delivery must be maintained in the individual record at the service delivery site(s). The provider must notify the Regional Services Administer or designee when there is any change to services and/or exceptional rate for which the exceptional rate/additional staffing was requested. For waivers of standards for services that are audited/monitored by DBHDD or Department of Community Health contracted entities, the provider must produce a copy of the waiver letter at the time of the audit in order for the DBHDD reviewer, External Review Organization or other contracted entity to appropriately incorporate the approved waiver into the audit/monitoring activity.

## 1106. Management and Protection of Individual Funds

The personal funds of an individual are managed by the individual and are protected.

Policies and clear accountability practices regarding individual valuables and finances comply with all applicable DBHDD policies (Policy 02-702) and Social Security Guidelines for Organizational and /or Representative Payees regarding management of personal need spending accounts for individuals served. Providers are encouraged to utilize persons outside the organization to serve as "representative payee" such as, but not limited to:

- Family
- Other person of significance to the individual
- Other persons in the community not associated with the agency

The agency is able to demonstrate documented effort to secure a qualified, independent party to manage the individual's valuables and finances when the person served is unable to manage funds and there is no other person in the life of the individual who is able to assist in the management of individual valuables or funds. Individual funds cannot be co-mingled with the agency's funds or other individuals' funds.

## 1107. Monitoring

All ISPs for recipients of services under the COMP/NOW Waiver will be reviewed and monitored by the State through the DBHDD Field Office, the DCH Program Integrity Unit's Utilization Review Team, and through desk reviews of the services provided. When DCH utilization reviews result in deficiencies, the provider must submit a Corrective Action (CAP) to the Department of Community Health within fifteen (15) calendar days of the date of utilization review reports. Failure to comply with the request for a corrective action plan may result in adverse action, including suspension of referrals or termination from the program.

Each Community Living Support (CLS) provider agency under COMP/NOW must provide a current Private Home Care Provider License from the Department of Community Health, Healthcare Facility Regulation Division (HFR), to the DBHDD Field Office if providing covered PHC services as defined by HFR.

It will be the responsibility of the DBHDD Field Office to assure that all CLS provider agencies providing PHC covered services as defined by HFR have and maintain a current PHC license. In the event that HFR should take action to change the provider license/permit from a permanent licensure or permit to a provisional status, the COMP/NOW CLS provider agency is at risk of being discharged as a Medicaid provider. Failure to adhere to maintaining a current PHC license will require that the agency repay all funds collected for CLS services rendered by a non-licensed CLS provider agency providing PHC covered services as defined by HFR.

**1108. Multi-Purpose Information Consumer Profile**

The Georgia Department of Behavioral Health and Developmental Disabilities is implementing a new comprehensive data collection and utilization management system titled the Multi-Purpose Information Consumer Profile (MICP). The MICP will be used to capture data regarding basic consumer demographics and service detail on all individuals served by the Division. This new form is being implemented in order to streamline and consolidate multiple data collection processes for registration, authorization, and reporting of publicly funded services.

The Division sponsors individual satisfaction surveys for all adult populations. These surveys generally require no direct action from service providers. However, providers are expected to make their facilities and individuals available to teams who gather the survey responses.

**NOTE: This is meant to cover access to consumers and facilities for the NCI Consumer Surveys (currently completed by the Support Coordination Agencies).**

Providers of I/DD services who serve ten or more waiver or state funded adults in residential, day or employment services (including subcontractors) are expected to complete – on an annual basis -- the National Core Indicators Provider Staff Turnover and Board Membership Survey. The survey instrument and instructions for completion will be sent directly to providers.

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# PART II

## CHAPTER 1200

## PARTICIPANT-DIRECTION

### 1201. General

Rev. 04 2019

The Comprehensive Supports Waiver (COMP) Program and the New Options Waiver (NOW) Program promote personal choice and control over the delivery of waiver services by affording opportunities for use of the participant-direction model for those individuals who live in their own private residence or the home of a family member.

The Participant or his or her designated Representative (Participant/Representative), assisted by the Support Coordinator, chooses services that meet their needs from among the allowable under the participant-directed service delivery model. The Participant/Representative exercises Employer Authority and has decision-making authority over the support workers who provide waiver services. The Participant/Representative may function as the employer of record (common law employer) of support workers or may be the co-employer with a traditional provider agency, which functions as the employer of record.

The Participant/Representative also has decision- making authority over the annually approved budget for specified services provided through the participant-directed waiver service delivery model as determined through assessed need.

### 1202. Participant Eligibility

Rev. 04 2019

The COMP/NOW provides every Participant/Representative, the opportunity to elect to direct waiver services outlined in section 1208. Should the Participant/Representative choose to participant direct allowable waiver services, the election must be specified in the Individual Service Plan (ISP).

The participant enrolled in Participant-Directed service delivery model may receive other COMP/NOW waiver services through Traditional Agency Providers except for the exclusions specified in the Part III, Policies and Procedures Manual for the COMP/NOW Program. Traditional Agency Provider services must be specified in the Individual Service Plan (ISP) in accordance with provider requirements and qualifications specified for each respective service in the Part III, Policies and Procedures for the COMP/NOW Program.

A participant may choose to represent oneself to direct services if they have the ability to complete criteria outlined in sections 1204, 1205, and 1209. The participant may choose a person to represent them if they are not capable of completing duties of a representative.

## 1203. Participant-Direction by a Representative

Waiver services may be directed by:

1) A legal representative of the participant, or
2) A non-legal representative freely chosen by an *adult* participant.

A representative volunteers as an unpaid person to assist with participant-direction responsibilities on behalf of the participant. Representatives must follow all requirements related to the direction of waiver services, including signed documentation (Participant Directed Terms and Conditions, known as the Memorandum of Understanding) of their understanding of their role and responsibilities as a representative.

When an adult waiver participant chooses a non-legal representative, his or her Support Coordinator, DBHDD staff may review whether the continued direction of waiver services by the non-legal representative is in the best interests of the adult waiver participant at any time.

Under no circumstances may a representative for an individual in Participant-Direction be approved to be the provider of the participant directed Medicaid waiver services.

The representative must be someone committed to representing the individual and their best interests and serves a natural support or unpaid role in the life of the individual. The representative can choose a co-representative or back up representative to place on file with the fiscal agent. The co-representative or backup representative prior to his or her designation must also complete mandatory training. At no time can this co-representative or back up representative be a paid worker through Participant-Directed services.

## 1204. Eligibility Criteria

Refer to Section 700 related to eligibility criteria for the NOW and COMP Waiver Programs. The participant-directed service model outlined in this chapter represents a specific method of service delivery and ongoing management following admission to one of the Waiver Programs. The Participant-directed service delivery model is available to individuals who:

A. Meet the annual level of care eligibility criteria as outlined in chapter 700 of this manual

B. Are enrolled in or eligible for COMP/NOW Services and are capable of demonstrating that he/she is able to direct his or her COMP/NOW services, follow all policies and procedures for the participant-direction option applicable to the Participant, and abide by all Medicaid fraud and misuse rules and regulations, or has a designated Representative with the demonstrated ability to assist with the above responsibilities; and,

C. Are able to communicate effectively with the Support Coordinator and, if applicable, any caregiver of COMP/NOW services eligible for Participant- Direction, or has a designated representative with the demonstrated ability to assist with this responsibility; and,

D. Are able to understand and perform, if applicable, the tasks required to employ providers of COMP/NOW services (including recruitment, hiring, scheduling, training, supervision, and termination) or has a designated representative with the demonstrated ability to assist with this responsibility; and,

E. Are able to complete and submit all required timesheets/invoices and manage the individual budget through the COMP/NOW participant-directed service delivery model or has a designated representative with the demonstrated ability to assist with this responsibility; and,

F. Must possess the ability to access, obtain, read, and understand waiver manuals without assistance from hired employees (with the exception of a community guide).

**NOTE: Refer to section 701 related to eligibility criteria for COMP and NOW Waiver Programs. The participant-directed service model outlined in this chapter represent specific method of service delivery and on-going management following admission of one of the Waiver Programs.**

## 1205. Enrollment process for Participant Direction

Prior to enrollment in the Participant Direction service delivery model, the participant/representative will complete the following:

i. The participant must identify who he or she is designating as her participant direction representative. This designation must be documented in the ISP meeting minutes in the box titled "describe discussion around continuing current services or choosing new waiver options including participant directed.";

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ii. Attend a mandatory training facilitated by DBHDD. A Certificate of Attendance will be issued by DBHDD staff after the completion of training. A copy of the Certificate of Attendance should be provided to the Support Coordinator to initiate services into the Participant Direct service delivery model. Training attendance certificates are only valid for 90 days following training. If the representative does not complete the Participant Direct enrollment process within 90 days of completion of the required training, he/she must attend training again.

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iii. Anyone enrolled in Participant Direction before implementation of this provision's training requirement must complete the aforementioned training to continue to be enrolled in Participant Direction.

iv. Sign the Participant Direction Terms and Conditions for participation, also known as the Memorandum of Understanding (MOU). This must be signed by the individual themselves, if they are self-representing, or by the Representative who has attended training. The MOU will be uploaded into the IDD Case management system and entitled "PD training MOU";

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1. The individual, or their designated representative, must sign an updated MOU each year during the individual's annual ISP renewal meeting to demonstrate understanding of and compliance with all Participant Direction policies and procedures and should be uploaded by the Support Coordinator, AND

v. Choose and enroll with an approved fiscal agent. The fiscal agent will verify that mandatory training has been completed by the applicant prior to enrollment.

1. The representative on file with the fiscal agent cannot be changed or added as a backup representative without proof of training.

## 1206. Evaluation of Eligibility for Participant Direction

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Participants/representatives may be deemed ineligible to self-direct COMP/NOW Services for failure to meet the criteria outlined in chapter 1200 or for failure to identify an eligible representative or employee per the requirements of this manual.

A period of 12 months must lapse upon termination from participant-direction prior to reconsideration of eligibility to return to the participant direction service delivery model. Participants/Representatives will be notified of a denial in writing by DBHDD.

An individual participant's/representative's ability to participant-direct COMP/NOW services may be assessed/reassessed at any time, as determined by the Support Coordinator or DBHDD staff, due to changes in capacity or supports.

## 1207. Requirements for Enrollment in Participant-Direction

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Once a participant or representative meets the eligibility criteria for the Participant-Direction of COMP/NOW services, completes the mandatory training, and completes enrollment process, the Support Coordinator or Planning List Administrator must provide the following to initiate enrollment of the participant:

I. Submit an ISP addendum with participant direction as the chosen service-delivery model. The addendum must include who the designated representative will be;

II. Documentation with the ISP addendum of a viable individualized emergency back-up plan to include names of natural supports, description of how health and safety or crisis issues will be addressed, and safety plans;
   - This plan is for use if the staff person is unavailable to provide services.

III. Provision of a minimum of thirty (30) days written notice by the Support Coordinator to the current COMP/NOW provider(s); AND ; For new waiver participants' or for individuals transitioning from a traditional provider, a plan to include potential staff/vendors, schedules, frequency of services, and timeframe for start of staff/vendor should be included in the ISP.

IV. For new enrollees, Participant-Directed COMP/NOW Services may only be initiated on the 1st of the month after attending the mandatory training. For waiver program changes from NOW to COMP, services may only be initiated on the 1st of the month proceeding DBHDD approval of the conversion.

**1208. Eligible Waiver Services**

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**The participant-directed service model may be selected for the service types listed below.** Details of service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP/NOW Policies and Procedures. Each service is described in a distinct chapter with service definition as well as a list of non-covered items. Individuals and/or their representatives who choose the participant-directed service delivery model are responsible for review and adherence to all service requirements as defined in Part III of the COMP and NOW Manuals.

1. Community Access Individual
2. Community Access Group
3. Community Living Support
4. Community living Support – Shared
5. Community Living Support – Extended
6. Community Living Support – Personal Assistance Retainer
7. Respite – Hourly
8. Respite – Daily
9. Transportation
10. Environmental Accessibility Adaptation
11. Community Guide
12. Individual Directed Goods and Services
13. Natural Support Training
14. Adult Physical Therapy
15. Adult Occupational Therapy
16. Adult Speech Language Therapy
17. Vehicle Adaptation
18. Behavioral Supports Consultation
19. Behavioral Supports Services
20. Supported Employment
21. Specialized Medical Supplies
22. Specialized Medical Equipment

**1209. Participant-Direction Authority**

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All waiver services eligible for the participant-direction service model provide the following decision-making authorities for participants/representatives:

A. **Participant – Budget Authority**

The participant or the participant's representative has decision-making authority over the annual budget for waiver services. The Participant-Budget Authority Responsibilities are:

a. Determine the amount paid for services within the State's established annual limits;
b. Schedule the provision of services as outlined in the ISP for frequency,
c. Authorize payment for waiver goods and services through work with fiscal agent;
d. Review and approve provider and/or employees invoices for services rendered.
e. Monitor service utilization to ensure annual service allocations are not exceeded

B. **Participant – Employer Authority**

The Participant/Representative has decision-making authority over employees who provide waiver services. The Participant/Representative may function as the common law employer or the co-employer of workers.

1. **Participant/Common Law Employer Model**

The Participant/Representative is the common law employer of workers who provide waiver services. Financial Support Services (FSS) are mandatory and the FSS functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.

The cost of the FSS is included in the individual budget. FSS services are not eligible to be Participant-Directed. A FSS or fiscal agent must be selected from the Department of Community Health's enrolled providers.

The Participant-employer Authority Responsibilities for this model include:

a. Recruit staff in accordance with specific service requirements as specified in the Part III, Policies and Procedures Manual for the COMP/NOW Program.
b. Verify staff qualifications.
c. Hire staff (common law employer).
d. Obtain criminal history and/or background investigation of staff.
e. The Financial Support Services conducts criminal records checks of support workers hired by the participant or representative acting as the employer of recorder.
f. Determine staff duties consistent with service specifications in the ISP.
g. Determine staff wages, within budget and benefits subject to applicable State limits.
h. Schedule staff.
i. Orient and instruct staff in duties.
j. Supervise staff.
k. Evaluate staff performance within 90 days of employment and on an annual basis moving forward.
l. Verify time worked by staff and approve time sheets within 30 days

of the date of service.

m. Select vendors in accordance with specific service requirements as specified in the Part III, Policies and Procedures Manual for the COMP/NOW Program.

n. Establish a sustainable emergency backup plan
    i. emergency back-up plan to include names of natural supports, description of how health and safety or crisis issues will be addressed, and safety plans;
        This plan is for use if/ when staff person is unavailable to provide services as hired for and to meet the needs of the individual

2. Participant/Co-Employer Model

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The participant (or the participant's representative) functions as the co- employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant- selected/recruited staff and performs necessary payroll and human resources functions.

The types of agencies that serve as co-employers of participant-selected staff are limited to enrolled co-employer providers of the following waiver services:

a. Community Access
b. Community Guide
c. Community Living Support
d. Supported Employment
e. Respite
f. Transportation

The Participant/Representative and the Agency share the follow Co-Employer Responsibilities:

A. Recruit staff:
B. Determine staff duties consistent with service specifications:
C. Determine staff wages and benefits subject to applicable State limits:
D. Schedule staff:
E. Orient and instruct staff in duties:
F. Supervise staff:
G. Evaluate staff performance within first 90 days of employment and on an annual basis moving forward:

The Participant/Representative Co-Employer Responsibilities, in addition to the responsibilities shared with the Agency, are:

a. Verify staff qualifications
b. Obtain criminal history/background investigations of co-employees
c. Conduct criminal background checks for co-employees
d. Hire staff
e. Process payroll, withholding, filing and payment of applicable federal, state

and local employment-related taxes and insurance for co-employees:
f. Conducts skills training and provides technical assistance to participants and/or their representatives on employer-related responsibilities:
g. Process and bill for services approved in the service plan.

## 1210. Support Requirements for Participant-Direction

The Participant-direction service model requires two (2) distinct support services for participants who elect to direct their own services and manage the budget allocated for their support needs. These support services are designed to assist participants in assuming their management responsibilities:

A. Financial Support Services (Fiscal agent)
B. Support Coordination (Case Management) Services, and

NOTE: The Financial Support Service only pays for services specified in the Individual Service Plan. Support Coordinators additionally must monitor the provision of all services in relation to ISP goal(s), the health and safety of the waiver participant.

### Financial Support Services

#### A. Services Overview:

Financial Support Services are designed to perform fiscal and related finance functions for the participant or representative who elects the participant-direction service delivery model. Financial Support Services are provided by a Fiscal Intermediary Agency (FIA) established as a legally recognized entity in the United States, qualified and registered to do business in the state of Georgia and approved as a Medicaid provider by the Department of Community Health (DCH.).

Financial Support Services are covered as a distinct waiver service entitled Financial Support Services (FSS) as specified in the COMP Part III, Policies and Procedures Manual.. FSS are mandatory for Participants who elect to direct their eligible waiver services, and to exercise the Participant-Budget Authority. Costs for FSS are included in and paid from the Participant's individual budget.

Financial Support Services (FSS) assist the participant or representative who elects Participant Direction by performing customer-friendly, fiscal support functions or accounting services.
FSS also assures that funds to provide services through the participant-directed service delivery model and supports outlined in the ISP are managed and distributed as authorized.

The Department of Community Health is responsible for monitoring the performance of Financial Support Services (FSS) providers. DCH monitors, reviews and evaluates participants' expenditure activity to ensure the integrity of

the financial transactions performed by FSS providers. DCH utilizes reports from Participants, their Representatives, Support Coordinators, Community Guides, and DBHDD agency staff to identify any issues with the adequacy of supports provided by FSS providers to participants exercising the employer and/or budget authority.

Financial Support Services are not available to participants or representatives who choose the Co-Employer model for self-directed service delivery and supports. The Co-Employer provider agency processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance for co-employees. This agency also processes and bills for services approved in the service plan.

B. **Responsibilities of FSS Providers:**

1. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance for participants or representatives who elect to be the employer of record of support workers.

2. Provides technical assistance to participants and/or their representatives on submission of all required employer-related documents.

3. Track and report on income, disbursements and balances of participant funds. Provides technical assistance to participants and their representative on process of reviewing the reports of expenditures and budget status.

4. Process and pay invoices for goods and services approved in the service plan

5. Provide the participant or representative with once a month reports of expenditures and the status of the participant-directed budget for Participant/Representative who elects to exercise the Budget Authority.

6. Report suspicious account activity including but not limited to excessive billing or inappropriate billing to the Participant Direction Manager

C. **Employment/Vendor Enrollment and Financial Reporting Requirements:**

1) A participant or representative acting as a common law employer must complete the employer enrollment process;

2) All new employees must complete the employment enrollment process prior to receiving any paychecks. There are no exceptions to this policy;

3) All invoices for vendor payments and employee timesheets must be completed accurately and timely, and accordance with the approved Individual Service Plan

4) Any vendors must complete the vendor enrollment process prior to receiving any payment;

5) DBHDD, DCH and FSS provider are not responsible for delays in payment caused by late submissions, incomplete or illegible forms, neglect of the participant or his or her representative or employee, or failure to inform the FSS provider of changes in address, etc.;

6) Timesheets and invoices may be returned to the participant or representative due to error. The participant or representative must complete or correct the identified error and re-submit the timesheet and/or invoice to the FSS provider. The timesheet and/or invoice will be processed and paid in the next pay period following receipt of the corrected timesheet or invoice by the FSS provider;

7) Other reasons an employee may not get paid include: late time sheets, lack of or incomplete employer enrollment forms, lack of an authorized Individual Service Plan or Prior Authorization, insufficient funds in budget for billed services, or billing at an unreasonable rate;

8) The FSS provider will generate paychecks and invoices at least twice per month and, according to the established payment schedule;

9) Information on unemployment benefits, workers' compensation coverage, and tax withholding is available from the FSS provider;

10) Participant/Representative and their employees should first attempt to resolve payroll problems by directing contacting the FSS provider. If problems persist, the participant or representative may contact the Support Coordinator for assistance;

11) Participants, representatives and their employees should be knowledgeable about Medicaid fraud. Medicaid fraud is committed when an employer or employee is not truthful regarding services provided to Medicaid Waiver participants in order to obtain improper payment.

12) Vendors cannot be enrolled to provide Community Living Supports, Community Guide, Respite, or Supportive Employment services. These services may only be provided by an employee.

**D. Support Coordination (Case Management) Services**

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Support Coordination (Case Management) Services are performed by Support Coordinators. Case Management Services are covered as distinct waiver services entitled Support Coordination Services and Intensive Support Coordination

Services as specified in the Part III, Policies and Procedures Manual for Support Coordination Services and Intensive Support Coordination Services.

An individual has the right to choose which support coordination agency they want to render case management services. This is a required service within the participant-direction model.

C. **Responsibilities of Support Coordinators**

1. Prior to enrollment, inform the participant and/or representative of the benefits, risks and responsibilities of Participant-Direction.

2. Inform the participant that a representative may assist him or her with participant direction.

3. Inform the participant or representative about freedom of choice of providers, individual rights, and the grievance process.

4. Support the participant or representative with the development of the individual emergency back-up plan and safety plan by discussing at the ISP meeting and writing plan in the ISP.

5. Complete an ISP/addendum in accordance with applicable policy upon request of the individual/representative to avoid lapse in services or payments to employees.

6. Provide the participant or representative with the process for changing the Individual Service Plan, as well as and the reassessment and review schedules.

7. Include frequency of services and plan of use of services within meeting minutes of the ISP. Confirm that all items are covered under services selected on the budget prior to writing them in the ISP/addendum.

8. Assist the participant or representative with recognizing and reporting critical events and with identifying and managing known and/or potential risk.

9. Evaluate the quality and outcome of services provided through the participant-directed model, such that services are delivered in a manner that protects the health and safety and promotes quality of life of the participant.

10. Provide a copy of the MOU terms each year at the ISP and obtain a signature of the representative and the individual on the MOU. Upload the signed MOU into the Case Management Information System- IDD Connects.

11. Give written notice to fiscal agents when there is a change from one fiscal agent to another or transition from fiscal agent to a traditional provider.

12. Submit documentation to the Field Office up including: family hire request form, Service Change/Technical Assistance Request Form, supplemental waiver application, critical incident reports for suspected abuse/neglect, and reports of suspected fraud and/or misuse of waiver funds.

14. A referral to the appropriate investigative agencies and/or law enforcement will be made for all incidents involving fraud, misuse of funds, abuse, or neglect.

## Community Guide Services

Community Guide Services provide information and assistance in support of participant-direction and are provided through the distinct waiver service called Community Guide Services as specified in the COMP Part III, Policies and Procedures Manual.

Community Guide Services are individualized services designed to assist participants in meeting their responsibilities in the participant-direction option for service delivery. Information provided by the Community Guide helps the participant's understanding of provider qualifications, record keeping, and other participant-direction responsibilities. The intended outcome of these services is to improve the participant's knowledge and skills for Participant-Direction.

Community guides cannot be hired as an employee or vendor for the individual to provide any other services while employed as a community guide.

## Responsibilities of Community Guides

Based on the assessed need of the participant and as specified in the approved ISP, Community Guides provide the following information and assistance services:

1. Assist these participants with defining and directing their own services and supports as well as meeting the responsibilities of Participant-direction service delivery model;

2. Provide information, direct assistance, and training to participants on service delivery;

3. Assist and train participants and their representatives to build the skills required for Participant Direction, to include, but not limited to;

    a. exploring and brokering available community resources;

    b. meeting their participant- direction responsibilities;

    c. Information and assistance that helps the participant in problem solving and decision-making;

d. developing supportive community relationships and other resources that promotes implementation of the Individual Service Plan;

e. developing and managing the individual budget;

f. recruiting, hiring, training, managing, evaluating, and changing employees;

g. scheduling and outlining the duties of employees;

h. effective employer of support workers;

i. understanding provider qualifications, record keeping and other participant-direction requirements.

**1211. <u>Employee Eligibility</u>**

Participants/Representatives who opt to participant-direct Community Guide are the common law employer or co-employer of employees who provide these services. Community Guide employees must meet the following, in addition to the specific provider requirements, in addition to specified provider requirements for these services in the Part II and Part III, Policies and Procedures Manual for the NOW/COMP Program:

A. Are at least 18 years of age or older.

B. Are U.S citizens or legally authorized to work in the United States.

C. Have a valid Social Security Number;

D. Are legally eligible for employment under state and federal laws;

E. Have a minimum of a bachelor's degree in a human service field and experience in providing direct assistance to individuals with disabilities to network within a local community or comparable training, education or skills;

F. Agree to provide required documentation of a criminal records check, prior to providing Community Guide Services;

G. Attend all mandatory, DBHDD training;

H. Be knowledgeable about resources in any local community in which the provider is a Community Guide;

I. Have demonstrated connections to the informal structures of any local community in which the provider is a Community Guide;

J. Have an understanding of Community Guide services, DD waiver participant-direction service delivery requirements, and strategies for working effectively and communicating clearly with individuals with DD and their families/representatives;

K. Sign affidavits regarding: incident reporting, abuse/neglect/exploitation; confidentiality; person-centered planning; and respect and rights.

L. Understand and agree to comply with the Participant-Direction Option requirements, including confidentiality requirements.

## 1212. Hiring Family/Relatives to Provide Participant-Directed Waiver Services

Payment directly or indirectly for waiver services provided to participants in the NOW/COMP Participant-Direction model by legally responsible relatives, such as spouses, parents to minor children, or court-appointed legal guardians, is prohibited.

Other family members (as defined in section 902) of the participant may be compensated for providing participant-directed NOW/COMP services if the family member is granted **prior approval** by demonstrating the presence of *at least two documented extenuating circumstances* as defined below.

Under these circumstances, family members may be considered to provide the following participant-directed NOW/COMP services: Community Access, Community Living Support, Supported Employment, or Transportation Services.

A family member or relative who is serving as the participant's representative or back-up to representative may not be approved to provide NOW/COMP services for the participant under any circumstances. Individuals/Representatives must reapply for each family hire to the regional field office staff on an annual basis at least 60 days before the ISP start date. Additionally, all individuals transferring to a different DBHDD field office must re-apply for all family hires prior to the initiation of services in the new region.

Prior approval to hire a participant's family member must be obtained from the Department of Behavioral Health and Developmental Disabilities, in accordance with the protocol outlined below. Extenuating circumstances include:

A. A lack of qualified employees in the area in which the individual lives in. There must be documentation of attempts to hire employees and/or how they failed to provide services. There must be documentation of why other employees in the area cannot be utilized for services; and/or

B. The presence of extraordinary and specialized skills, education, or knowledge by approvable family/relatives written in the request for approval. The proposed family hire must have documented proof of skills and/or education of ability or experience working in the area of the population served; and/or

C. A clear demonstration of the use and compensation of family/relatives being the most cost effective and efficient means to provide the services in comparison to the cost of service if provided by a traditional provider of the same service.

**Steps for Approval of Extenuating Circumstances**

A. The individual or representative must work with his or her Support Coordinator to complete the family hire request form and provide documentation of extenuating circumstances.

B. Requests for consideration of extenuating circumstances are to be made and submitted to the designated DBHDD Field Office Intake and Evaluation Manager.

C. The regional Intake and Evaluation Manager reviews the request and notifies the individual and/ or representative of the decision in writing. The family hire request form will then be uploaded in CIS entitled "family hire request form."

**Appeals of Denials of Requests**

If the initial request for family hire approval is denied, the individual/representative may appeal the decision. The individual/representative will notify his or her support coordinator of the desire to appeal. The support coordinator will notify the Intake and Evaluation Manager in the appropriate field office of the appeal by email and include any additional relevant information for consideration. The Intake and Evaluation manager will notify the Regional Services Administrator. The Regional Services Administrator will review the family hire request form uploaded by the Intake and Evaluation Manager and any additional relevant information provided by the support coordinator and then notify the individual/representative of his or her decision by postal mail and upload the updated family hire request form in CIS entitled "family hire request form" If the request is denied at second level review, the individual may appeal the decision to the Participant Direction Manager through his or her support coordinator. The Support Coordinator will notify the Participant Direction Manager of the appeal by email and include any additional relevant information for consideration. The Participant Direction staff will review the family hire request form and any additional relevant information provided by the support coordinator prior to making his or her decision. The Participant Direction Manager will notify the individual or representative of his or her decision via postal mail and upload the family hire request form in CIS entitled "family hire request form.

**1213. Special Requirements and Conditions of Participation of Employees**

**A.** An individual who is employed to provide services through the NOW/COMP participant-directed service delivery model for the participant and paid by the FSS provider may not also serve as the participant's participant direction service delivery model representative;

**B.** A participant's spouse or parent, if the participant is a minor, may not be paid as an employee through the COMP/NOW participant-directed service delivery model;

C. A Participant's legal guardian may not be paid to provide services under the participant-directed service delivery model;

**D.** Employees are not paid to provide services while the individual is admitted to a hospital or skilled nursing facility, except where approved with the provision of a personal assistance retainer for Community Living Services (see COMP/NOW Part III, Policies and Procedures for Personal Assistance Retainer details). Employees reimbursed under the personal assistance retainer may not provide services within the institutional setting or be reassigned to the care of another waiver participant during the individual's institutional service span in a hospital or skilled nursing facility;

The utilization of other family members/relatives of the Participant as providers of services through the COMP participant-directed service delivery model must be approved by the Department of Behavioral Health and Developmental Disabilities and documented in the ISP;

E. Persons with a history of abuse, neglect, or exploitation substantiated by DBHDD office of incident management or adult protective services may not be paid to provide any services under the participant direction service delivery option;

F. Persons with a history of felony conviction as evidenced in the criminal records check may not be hired as an employee.

G. Individuals convicted of child, client, or patient abuse, neglect or mistreatment, regardless of date, may not be hired as an employee.

H. Employees are not paid for vacation time or any other services not rendered according to NOW/COMP policies and procedures.

## 1214. Service Documentation and other Requirements

Key documentation required for services provided through the participant-directed service delivery model consist of:

1) All documentation, receipts, invoices, timesheets, case notes, etc. MUST be kept on site for a minimum of six (6) years after the date of service.
2) Employee timesheets must be submitted within 30 days of service delivery in order to be paid for service by fiscal agent;
3) Vendor payments;
4) Written summaries of the participant's progress on ISP goal(s);
5) Anyone receiving a gift card to pay for SMS or IDGS items, must submit final receipts of purchase to Participant Direction Staff within 30 calendar days of receiving a gift card. Receipts must be mailed to:
   DBHDD
   Attn: Participant Direction Staff

2 Peachtree St NW, 22nd Floor
Atlanta GA 30303

a) Items purchased must be covered under SMS and/or IDGS services as written in NOW/COMP Manual Part III.
b) Receipts must total within 5% of the total amount of the gift card issued.
c) Receipts must be maintained in the Participant's records for 6 years.

**Participant-Direction through a FSS Provider**

The participant or representative who utilizes a FSS provider for participant-direction must:

1. Maintain copies of timesheets and vendor payments for documentation of date and time of service delivery for a minimum of six (6) years after the date of service
2. Maintain copies of CLS Personal Assistance Retainer Timesheet for any claims of this retainer for Community Living Support Services for 6 years after the date of service;

3. Require employees to provide a written summary of the participant's progress on the ISP goal(s) and daily service notes within 24 hours of each service date;

4. Require professional vendors of goal related services, to provide written summary of the participant's progress on the ISP goal(s) and service notes within 14 days of each service date.

**Participant-Direction through a Co-Employer Agency**

The Co-Employer agency of any participant or representative who opts for participant-direction through a Co-Employer Agency must:

1) Maintain copies of timesheets and vendor payments for documentation of date and time of service delivery for a period of six (6) years following the date of service;
2) Document the following in the record of each participant for whom a personal assistance retainer is a component of Community Living Support Services:
    1. Beginning and end date of absence;
    2. Reason for absence; and
    3. Scheduled "leave" days and units per day for Community Living Support Services as specified in the ISP and reimbursed using the PAR guidelines for claims submission.
3) Require employees and professional vendors to provide a written summary of the participant's progress on the daily service notes within the 24 hours of each service date.
4) Meet all documentation requirements for any co-employer service that

requires a license in accordance with the specified documentation requirements of the license.

## 1215. Maintenance of Records

### A. Co-Employer Agency Requirements

Co-employer agency providers must maintain written documentation of all level of care evaluations and reevaluations in the individual's case record for a period of six (6) years. Copies of these evaluations must be made available to the Department upon request.

### B. Requirements for Participant-Direction through a FSS Provider

Level of care evaluations and reevaluations for participants/representatives who opt for participant-direction through a FSS provider are maintained in the IDD case management system for a period of six (6) years from the date of service. Copies of these evaluations must be made available to the Department upon request.

## 1216. Exclusions and Special Conditions

A. An individual serving as a representative for a waiver participant in the self-directed service delivery model is not eligible to be a participant-directed provider of eligible services.

B. Payment directly or indirectly for NOW/COMP services provided to recipients in the Participant-direction model by legally responsible relatives such as spouses, parents to minor children, or court-appointed legal guardians is prohibited in this waiver. Other family members or relatives of the participant may be compensated for some NOW/COMP services as indicated in Section 1212 of this manual.

C. Services provided by approved family hires, except as noted above, may be covered only if:
   - The family member meets the provider qualifications and training standards specified in the waiver for that service (see COMP Part III, Policies and Procedures for these requirements);
   - The family member or friend meets the training qualifications prior to rendering services to a NOW/COMP participant;
   - An agreement documenting rate of pay and hours of service is in place between the participant or representative and employee before services are rendered;
   - The participant or representative pays the employee at a rate that does not exceed that which would otherwise be paid to a traditional provider of a similar service;
   - The service is not an activity that the family would ordinarily perform or is responsible to perform;
   - An individual employee may not provide more than 40 hours of paid NOW/COMP services in a seven-day period.

- The employee maintains and submits timesheets and other required documentation for hours paid.

D. Provider agencies enrolled to provide NOW/COMP services cannot be vendors for services provided through the participant-directed model.

## 1217. Termination from Participant-Direction Model

A. A participant or representative may voluntarily decide to terminate Participant-Direction and return to provider-managed services.

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- The individual must notify his or her assigned support coordinator of the desire to discontinue services through the participant-direction service delivery model.

B. Involuntary termination of Participant-Direction can occur due to any of the following reasons:

- Failure of the participant or representative to meet the responsibilities of Participant Direction as indicated in section 1202 and 1204.
- Identified health and safety issues for the participant. Health and safety issues include but are not limited to: maltreatment of the participant, use of funds in a manner that lead to a depletion of allocated funds prior to the end of the ISP year and other circumstances that can result in high-risk situations.
- Fraud and/or misuse of funds, such as the attempted purchase of non-covered items, will also result in involuntary termination of participant direction.
- For SMS or IDGS funds used to purchase gift cards, the first failure to submit receipts within 30 days of receiving a gift card or a balance on the gift card in excess of 5% of the total value of the gift card will lead to written warning. The second failure to comply with this policy will lead to termination of the participation direction service delivery model for one calendar year.
- For individuals using transportation funds to purchase credits, the first failure to submit receipts within 60 days of receiving a gift card will lead to written warning. The second failure to comply with this policy will lead to termination of the participation direction service delivery model for one calendar year.

C. A referral to the appropriate investigative agencies and/or law enforcement will be made for all incidents involving fraud, misuse of funds, abuse, neglect, or exploitation.

D. When notified of a pending termination of the participant directed service model, the support coordinator is responsible for a timely revision of the ISP, ensuring continuity in services by linking the participant to traditional waiver providers, and assuring the participant's health and welfare during the transition period.

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E. A period of twelve (12) months must elapse prior to consideration for re- enrollment in the participant-directed service delivery model if for violation of policy. The re-enrollment process requires the individual and designated representative to receive the mandatory training facilitated by DBHDD. See Section 1205 for more information.

F. If a participant or representative's fraudulent actions are substantiated by the appropriate investigative authority, the participant will not be permitted to reenroll in Participant Directed service model.

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G. If there is a substantiated finding by the appropriate investigative authority of abuse, neglect or exploitation committed by the individual's representative, the representative shall not be permitted to continue as the individual's designated representative.

## Appendix A

## DBHDD FIELD OFFICE CONTACT LIST

| DBHDD Region 1 | DBHDD Region 2 | DBHDD Region 3 |
|---|---|---|
| | | |
| Regional Services Administrator – D | Regional Services Administrator – DD | Regional Services Administrator – DD |
| Elise Beumer | Josie Baker | Vivia Black |
| Elise.Beumer@dbhdd.ga.gov | Josie.Baker@dbhdd.ga.gov | Vivia.Black@dbhdd.ga.gov |
| 1230 Bald Ridge Marina Road | 3405 Mike Padgett Highway | 3073 Panthersville Rd |
| Suite 800 | Building 3 | Building 10 |
| Cumming, Georgia 30041 | Augusta, Georgia 30906 | Decatur, Georgia 30034 |
| Phone: (678) 947-2818 | Phone: (706) 792-7741 | Phone: (404) 244-5050 or |
| Fax: (678) 947-2817 | Fax: (706) 792-7740 | Phone: (404) 244-5056 |
| Toll Free: 1 (877) 217-4462 | Toll Free: 1 (877) 551-4897 | Fax: (404) 414-3048 |

| DBHDD Region 4 | DBHDD Region 5 | DBHDD Region 6 |
|---|---|---|
| | | |
| Regional Services Administrator - DD | Regional Services Administrator - DD | Regional Services Administrator – DD |
| Timothy Hester | Ramona Pullin | Valona Baldwin |
| Timothy.Hester@dbhdd.ga.gov | Ramona.Pullin@dbhdd.ga.gov | Valona.Baldwin@dbhdd.ga.gov |
| | | |
| 400 South Pinetree Rd | 1915 Eisenhower Dr., Building 7 | 3000 Shatulga Rd., Building 4 |
| P.O. Box 1378 | Savannah, GA 31406 | P.O. Box 12435 |
| Thomasville, Georgia 31799-1378 | Phone: (912) 303-6309 | Columbus, Georgia 31907-2435 |
| Phone: (229) 225-5099 | Fax: (678) 947-2817 | Phone: (706) 565-7835 |
| Fax: (229) 227-2918 | Toll Free: 1 (800) 348-3503 | Fax: (706) 565-3565 |
| Toll Free: 1 (877) 683-8557 | | Toll Free: 1 (877) 565-8040 |

## Appendix B

## DBHDD SERVICES APPLICATION



# Georgia Department of Behavioral Health and Developmental Disabilities

### Application for Intellectual/Developmental Disabilities Services

**Personal Details** — All fields marked * are required

First Name * | M.I. | Last Name *

Suffix (select one): ☐ JR. ☐ SR. ☐ II ☐ III

Maiden or Birth Surname | Preferred Name

Date of Birth (MMDDYYYY) *

Gender (select one) *: ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Other/Unknown

Marital Status (select one) *: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed ☐ Unknown/Refused

Race (select one) *: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White/Caucasian ☐ Asian ☐ Multiracial ☐ Other Single Race ☐ Unknown/Refused

Hispanic/Latino Origin (select one) *: ☐ Yes ☐ No ☐ Unknown/Refused

SSN * | ☐ SSN Not Available | ☐ Medicare # | Medicaid # or Application Date

Current Living Situation _____

Primary Phone Number * | Secondary Phone Number

Email Address | Confirm Email Address

Street Address * | Apt/Unit/Suite or Other Address | City *

State * | Zip * | County of Residence *

Is the Applicant Lawfully Present in the United States?
☐ Yes ☐ No ☐ N/A (e.g. individual is under 18) ☐ Unknown/Refused

Is the Applicant a Veteran?
☐ Yes ☐ No ☐ Unknown/Refused

☐ Check here if mailing Address is same as above

Mailing Street Address or PO Box | Mailing Apt/Unit/Suite or Other Address | Mailing City

Mailing State | Mailing Zip | County of Residence

**PRIMARY CONTACT DETAILS**

Primary Contact First Name | M.I. | Primary Contact Last Name | Suffix (select one) ☐ JR. ☐ SR. ☐ II ☐ III

Relation to Applicant | Primary Contact Age | Email Address

Primary Phone Number | Secondary Phone Number

Street Address | Apt/Suite or Other Address Info

City | State | Zip | County of Residence

# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Legal Status and Guardian

All fields marked * are required

**What is the legal status of the Applicant?**

- ☐ Competent
- ☐ Emancipated
- ☐ Legally Incompetent: Documentation Required*
- ☐ Minor
- ☐ Unknown

**It is mandatory to fill in Legal Guardian details for individuals with a Court appointed guardian.*
***Note: Guardianship Order from a Georgia Probate Court must be attached***

**Is Legal Guardian a ***

☐ Person ☐ Agency

**Legal Guardian or Caseworker First Name ***

**Legal Guardian Caseworker Last Name ***

**Suffix** (select one)
☐ JR. ☐ SR. ☐ II ☐ III

**M.I.**

**Legal Guardian Email**

**Relationship to Applicant (select one) ***

- ☐ Case Worker
- ☐ Child
- ☐ Counselor/Teacher
- ☐ Friend
- ☐ Grandparent
- ☐ In-Law Relative
- ☐ Neighbor
- ☐ Other Family Member
- ☐ Parent
- ☐ Roommate
- ☐ School
- ☐ Sibling
- ☐ Spouse/Significant Other
- ☐ Substitute Decision-Maker
- ☐ Other

| Legal Guardian Phone Number * | | Legal Guardian Phone Extension |
|---|---|---|
| | | |

☐ Check here if Legal Guardian's Address is the same as the Applicant

**Legal Guardian Street Address or PO Box**

**Apt/Unit/Suite or Other Address**

**City**

**State**

**Zip**

**County of Residence**

# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Communication

All fields marked * are required

**English Proficiency (select one)**

- ☐ Very Well
- ☐ Well
- ☐ Not Well
- ☐ Not at All
- ☐ Unknown/Refused

**Does the Applicant prefer to speak or use a language other than English? ***

☐ Yes ☐ No ☐ Unknown/Refused | Preferred Language _____

**What mode of communication does the Applicant utilize? (select all that apply) ***

- ☐ Communicates verbally (regardless of proficiency)
- ☐ Communication Aids (any type of device used for communication)
- ☐ American Sign Language (ASL)
- ☐ Other Manual Communication (cued speech; gestures; signed exact English; other signed languages; etc.)
- ☐ Other Communication

**Preferred Mode of Communication (select an option) ***

- ☐ Communicates verbally (regardless of proficiency)
- ☐ Communication Aids (any type of device used for communication)
- ☐ American Sign Language (ASL)
- ☐ Other Manual Communication (cued speech; gestures; signed exact English; other signed languages; etc.)
- ☐ Other Communication

### Hearing

**Is the Applicant deaf or does the Applicant have serious difficulty hearing? ***

☐ Yes ☐ No ☐ Unknown/Refused

**Is there indication from sources other than the Applicant (e.g. third-party report; interviewer's observation; medical records, etc.) that the Applicant has hearing loss?**

☐ Yes ☐ No ☐ Unknown/Refused

### Vision

**Is the Applicant blind or does the Applicant have serious difficulty seeing, even when wearing glasses/contacts? ***

☐ Yes ☐ No ☐ Unknown/Refused

# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### IDD Diagnosis

All fields marked * are required

**Does the Applicant have a confirmed Intellectual and/or Developmental Disability Diagnosis?**

☐ Yes ☐ No ☐ Unknown/Refused

### Referral/Resources

**Select Applicant Referral Source ***

**Referral Source Name ***

**Current Resources Selection ***

| | | |
|---|---|---|
| ☐ Adoption Assistance | ☐ HIPP (Health Insurance Premium Payment Prog) | ☐ Railroad Benefits |
| ☐ CAPS (Subsidized Child Care Assist) | ☐ Housing Assistance (Section 8, HPRP) | ☐ SOURCE (Source Options Using Resources in a Comm Environment |
| ☐ CBAY (Comm Based Alternatives for Youth | ☐ ICWP (Independent Care Waiver Prog) | ☐ SSDI |
| ☐ CCSP (Comm Care Services Prog) | ☐ MAO (Medical Assistance Only) | ☐ SSI |
| ☐ Deeming Waiver (Katie Beckett) | ☐ Medicaid | ☐ TANF (Temp Assist for Needy Families) |
| ☐ Employment | ☐ Medicare | ☐ Ticket to Work |
| ☐ Food Stamps (SNAP) | ☐ PASS (Plan for Achieving Self Sup) | ☐ Veterans Assistance/Benefits |
| ☐ FQHC (Federally Qualified Health Ctr) | ☐ PeachCare for Kids | ☐ Vocational Rehabilitation |
| ☐ GAPP (Georgia Pediatric Prog Waiver) | ☐ Private Insurance | ☐ Other |

**Applicant's Monthly Gross Income ***

### Physician Details

All fields marked * are required

**Physician Name**

**Email**

**Street Address/PO Box**

**Apt/Unit/Suite or Other Address Info**

**City** **State** **Zip**

**Phone Number** **Phone Extension** **Fax Number**

# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Application Supporting Documents

All fields marked * are required

Please ATTACH supporting documentation to verify Medicaid eligibility, lawful presence, and a qualifying diagnosis or condition. An application is complete for DBHDD review when required documents are received by mail or documents are attached to accompany the web application.

Document Type

- ☐ Birth Certificate or Permanent Resident Card *
- ☐ Developmental Evaluation
- ☐ Medicaid *
- ☐ Medicare Card (if applicable) *
- ☐ Other Medical or Diagnostic Reports
- ☐ Psychological Evaluation *
- ☐ School IEP Report *
- ☐ School Transcript
- ☐ Social Security Benefit Letter *
- ☐ Social Security Card *
- ☐ Vocational/Support Employment Records
- ☐ Release of Information and/or Guardianship Documents

*If the applicant does not have social security card, Medicaid or Medicare, documentation of lawful presence can include: a birth certificate or unexpired permanent resident card. A description of documentation of lawful presence can be found at: http://www.mmis.georgia.gov. To access this information, please point to the 'provider information' menu and select 'provider manuals'. The criteria can be found in the 'Comprehensive Supports Waiver Program Part II manual.'*

### Application Signature

All fields marked * are required

Last Name | First Name | M.I. | Date

Application Completed By

☐ Applicant ☐ Guardian ☐ Family Member ☐ Other (agency, etc.) _____

Printed Name

_____

Please indicate the preferred method of contact

☐ Email Address ☐ Phone

Email Address _____ Primary Phone Number _____

## LIST OF INFORMATION TO BRING TO YOUR SCREENING APPOINTMENT

***Remember to bring the following information with you to your screening appointment.***

1. ***Social Security card or Social Security number***
2. ***Medicaid/Medicare card***
3. ***Social Security benefit information***
4. ***If you are working, your most recent check stub or most recent tax records***
5. ***Your most recent bank statement***
6. ***If you are under eighteen, the annual income information for your family or legal guardian***
7. ***Insurance information***
8. ***A doctor or psychologist completed copies of medical, diagnostic or testing reports you may have that.***
9. ***Copies of reports describing your abilities that may have been completed by schools you attended or by other service agencies.***
10. ***Current Doctors name, address and phone number***
11. ***School records, particularly school psychological reports***
12. ***Guardianship documents (if applicable)***

***You will be asked to sign a release of information like the one enclosed with the application so that we may obtain copies of previous testing, medical evaluations or diagnostic work ups.***

***It will be important to bring with you the names and addresses of your doctor, your school and any person or agency that you have received services from in the past.***

*ENCLOSURES*

***Sample release of information to be signed by the applicant or legal guardian***
***A Guide to Georgia's Services for Persons with Mental Retardation***

# APPENDIX C

**Section A – Identifying Information**

| 1. Applicant's Name/Address: | 2. Medicaid Number: | 3. Social Security Number | |
|---|---|---|---|
| | | 4. Sex / Age / 4A. Birthdate | |
| | 7. Patient's Name (Last, First, Middle Initial) | | |

| 5. Type of Facility (Check One) | 6. Type of Recommendation | 8. Date of Nursing Facility Admission | 9. Patient Transferring From (Check One): |
|---|---|---|---|
| 1. ϒ Nursing Facility<br>2. ϒ ICF/MR | 1. ϒ Nursing Facility<br>2. ϒ ICF/MR | / / | ϒ Hospital ϒ Home ϒ Another Nursing home |

| Recipient's Home Address:<br>Recipient's Telephone Number: | Date of Medicaid Application / / | 9A. State Authority (MH & ID Screening) Level I/II |
|---|---|---|
| This is to certify that the facility of attending physician is hereby authorized to provider the Department of Community Health, Division of Medical Assistance and the Division of Family and Children Services, Department of Human Resources with necessary information including Medical Data. | | Restricted Auth Code Date<br>9B. This is not a re-admission for OBRA purposes<br>Restricted Auth Code Date |

**Section B – Physician's Report and Recommendation**

| 12. Diagnosis on admission to the facility (hospital transfer report may be attached) 1. Primary 2. Secondary 3. Other | 1. ICD-9 | 2. ICD-9 | 3. ICD-9 |
|---|---|---|---|
| 12A. Diagnosis on admission to the facility (hospital transfer report may be attached) 1. Primary _____ 2. Secondary _____ 3. Other | 1. ICD-10 | 2. ICD-10 | 3. ICD-10 |

13. Treatment Plan (Attach copy of order sheet if more convenient) Hospital Dates: _____ to

| Medications | | | | 16 Diagnostic and Treatment Procedures | |
|---|---|---|---|---|---|
| N | Dosage | Rou | Frequenc | Type | Frequency |
| | | | | | |

| 14. Recommendation Regarding Level of Care Considered Necessary<br>1. ϒ Skilled 2. ϒ Intermediate 3. ϒ Intermediate Care for | 15. Length of Time Care Needed Months<br>1. ϒ Permanent 2. ϒ Temporary _____ estimated | 16. Is Patient free of communicable diseases?<br>1. ϒ Yes 2. ϒ No |
|---|---|---|
| 17. This patient's condition ϒ could ϒ could not be managed by provisions of ϒ community care or ϒ home health services.<br>18. I certify that the patient requires the level of care provide by a nursing facility or an Intermediate care facility for the mentally retarded. | 19. Physician's Name (Print)<br>Physician's Address (Print)<br>20. Date Signed by Physician / / | 21. Physician's License Number<br>Physician's Phone Number ( ) |

**Section C– Evaluation of Nursing Care Needed (check appropriate box only)**

| 22. Diet | 23. Bowel | 24. Overall | 25. Restorative Potential | 26. Mental & Behavioral Status | | |
|---|---|---|---|---|---|---|
| ϒ Regular<br>ϒ Diabetic<br>ϒ Formula<br>ϒ Low Sodium<br>ϒ Tube feeding | ϒ Continent<br>ϒ Occas. Incontinent<br>ϒ Incontinent<br>ϒ Colostomy | ϒ Improving<br>ϒ Stable<br>ϒ Fluctuating<br>ϒ Deteriorating<br>ϒ Critical | ϒ Good<br>ϒ Fair<br>ϒ Poor<br>ϒ Questionable<br>ϒ None | ϒ Agitated<br>ϒ Confused<br>ϒ Cooperative<br>ϒ Depressed<br>ϒ Forgetful | ϒ Noisy<br>ϒ Nonresponsive<br>ϒ Vacillating<br>ϒ Violent<br>ϒ Wanders | ϒ Dependent<br>ϒ Independent<br>ϒ Anxious<br>ϒ Well Adjusted<br>ϒ Disoriented |

| 27. Decubitus | 28. Bladder | 30. Indicate Frequency Per Week | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ϒ Yes ϒ Surgery<br>ϒ No Date:<br>ϒ Infected<br>ϒ On Admission | ϒ Continent<br>ϒ Occas. Incontinent<br>ϒ Incontinent<br>ϒ Catheter | | Physical Therapy | Occupational Therapy | Remotive Therapy | Reality Orientation | Speech Therapy | Bowel and Bladder Retrain | Activities Program |
| | | Received | | | | | | | |
| 29. Hours Out of Bed Per Day _____ Care ϒ Catheter Care ϒ Colostomy | | Needed | | | | | | | |

31. Record Appropriate Legend

| IMPAIRMENTS | ACTIVITIES OF DAILY LIVING |
|---|---|
| 1. Severe<br>2. Moderate<br>3. Mild<br>4. None<br>Sight Hear Speech Ltd Motion Paralysis | 1. Dependent<br>2. Needs Asst.<br>3. Independent<br>4. Not App<br>Eats Wheelchair Transfer Bath Ambulation Dressing |

32. Remarks

| 33. Pre-Admission Certification Number | 34. Signed | 35. Date Signed / / |
|---|---|---|

**DO NOT WRITE**

Continued Stay Review Date: _____ Payment Date _____ Approved for _____ Days

| 36. Level of Care Recommended by GMCF | LOS | 37. Signature (GMCF) | Date: / / | 38. Attachments (GMCF) 1. ϒ Yes 2. ϒ No |
|---|---|---|---|---|
| | | | | |

## PHYSICIAN'S RECOMMENDATION CONCERNING NURSING FACILITY CARE OR INTERMEDIATE CARE FOR THE INTELLECTUALLY DISABLED

### Form DMA-6 Instructions

This section provides detailed instructions for completion of the Form DMA-6. Before payment can be made, a Form DMA-6 must be completed and signed by the admitting physician.

### Section A - Identifying Information

**Item 1**: **Applicant's Name and Address**
Enter the complete name and address of the applicant including the city and zip code.

**Item 2**: **Medicaid Number**
Enter the Medicaid number exactly as it appears on the Medical Assistance Eligibility Certification (this number may change so it is imperative that you review the Certification during each month of service.). A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;
b. If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or
c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

**The entire number must be placed on the form correctly.** In exceptional instances, it may be necessary to contact the caseworker in the DFCS office for the Medicaid number.

**Item 3: Social Security Number**
Enter the applicant's nine-digit Social Security number.

**Item 4: Sex &Age**
Enter the applicant's sex, whether male or female and age.

**Item 4A: Date of birth**
Enter applicant date of birth.

**Item 5: Type of Facility**
Enter a check in the box corresponding to the type of facility.

**Item 6: Type of Recommendation**
Enter a check in the box corresponding to the type of recommendation being made. If the recommendation is for a recipient's initial admission or readmission to the facility, the box corresponding to initial should be checked. If the recommendation is for continued placement, the box corresponding to continued placement should be checked on the subsequent recommendation form.

**Item 7: Patient's Name (Last, First, Middle Initial)**
Enter the patient's full name, first name, and middle initial in that order.

**Item 8: Date of Nursing Facility Admission**
Enter the date of the recipient's admission to the nursing facility.

**Item 9: Patient Transferred From:**
Enter a check in the box corresponding to either hospital, private pay, home, another nursing facility, or Medicare, according to the recipient's status immediately preceding admission to the facility.
Enter the recipient's home address, mother's maiden name, and the date of Medicaid application.

**Item 9A: State Authority (MH & MR Screening)**
Please enter the restricted authorization code and date assigned by the Contractor. This field is for new admissions only.

**Item 9B: State Authority (MH & MR Screening)**
Please enter the restricted authorization code and date assigned by the Contractor originally (new admission PA). This field should be used for a readmission or transfer to another nursing facility.

**Item 10 & 11: Signature**
Authorization for Facility or Attending Physician to provide the Department of Community Health, Division of Medical Assistance and the Division of Family and chi1dren Services, Department of Human Resources with necessary information including Medical Data.
Have the patient, his/her spouse, parents or other relative or legal representative sign and date (Item 11) the authorization.

**Section B - Physician's Examination Report and Recommendation**
**Item 12: ICD-9 Diagnosis (Add attachment(s) for additional diagnoses)**
Describe the primary, secondary, and any third ICD-9 diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.

**Item 12A: ICD-10 Diagnosis Code (Add attachment(s) for additional diagnoses)**
Describe the primary, secondary, and any third ICD-10 diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.

**Item 13: Treatment Plan (Attach a Copy of the Order Sheet if More Convenient), Hospital Dates, Hospital Diagnosis**
The admitting diagnoses (primary, secondary and other) and dates of admission and discharge must be recorded. The treatment plan also should include all medications the recipient is to receive. Names of drugs with dosages, routes, and frequencies of administration are to be included. Any diagnostic or treatment procedures and frequencies should be indicated.

**Item 14: Recommendation Regarding Level of Care Considered Necessary**
Enter a check in the correct box for Skilled or Intermediate Care for Mentally Retarded. The Skilled box is appropriated as the nursing facility level of care.

**Item 15: Length of time is Needed**
Enter the length of time as permanent

**Item 16: Is Patient free of communicable disease?**
Enter a check in the appropriate box (Yes or No)

**Item 17: Alternatives to Nursing Home Placement**
The admitting or attending physician must indicate whether the patient's condition could be managed by provision of Community Care or Home Health Services. Enter a check in the box corresponding to "could" and either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not " if neither is appropriate.

**Item 18: Certification Statement of the Physician and Signature**
The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. Signature stamps are not acceptable. If the physician does not agree that institutional care is appropriate, enter N/A and sign.

**Item 19: Physician's Name and Address (Print)**
Print the admitting or attending physician's name and address in the spaces provided.

**Item 20: Date signed by the physician**
Enter the date the physician signs the form.

**Item 21: Physician's Licensure Number and Physician's Telephone Number**
Enter the Georgia license number for the attending or admitting physician.
Enter the attending or admitting physician's telephone number including area code.

---

**Section C - Evaluation of Nursing Care Needed (Check Appropriate box only)**

All items in Section C of this form must be completed by Licensed personnel involved in the care of the applicant.

**Item 22: Diet**
Enter the appropriate diet for the recipient. If "other" is checked, please specify type of diet.

**Item 23: Bowel**
Check the appropriate box to indicate the bowel and bladder habits of the recipient.

**Item 24: Overall Condition**
Check the appropriate box to indicate the recipient's overall condition.

**Item 25: Restorative**
Check the appropriate box to indicate the recipient's restorative potential.

**Item 26: Mental & Behavioral Status**
Check all appropriate boxes to indicate the recipient's mental and behavioral status.

**Item 27: Decubiti**
Check the appropriate box to indicate if the recipient has decubiti. If "yes" is checked and "surgery" is also checked, the date of surgery should be included in the space provided.

**Item 28: Bladder**
Check the appropriate box to indicate bladder habits of the recipient.

**Item 29: Hours Out of Bed Per Day**
Indicate the number of hours the recipient is to be out of bed per day in the space provided. Check other treatment procedures the recipient requires.

**Item 30: Indicate Frequency Per Week**
If applicable, indicate the number of treatment or therapy sessions per week the recipient receives or needs.

**Item 31: Record Appropriate Legend**
Enter appropriate number indicating the level of impairment or level of assistance needed in the boxes provided.

**Item 32: Remarks**
Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form.

**Item 33: Pre-admission Certification Number**
Indicate the pre-admission certification number (if applicable).

**Item 34: Signed**
The person completing Section C should sign in this space.

**Item 35: Date Signed**
Enter the date this section of the form is completed.

**Item 43**: **Print Name of MD or RN**
The individual completing Section C should print their name and sign the DMA-6.

**Do Not Write Below This Line**
Items 44 through 52

## Protocol for Physicians Signature

**A physician's review of the ISP is considered if:-**

- The HRST indicates a level 3 or above. When the CMC screening tool indicates a level 3 or above. If the CMC screening tool indicates a level 2, then the nurse will use their judgment to determine the need for physician review of the ISP.

**The nurse will-**

- The comprehensive assessment will be uploaded into Miscellaneous Docs section.
- The nurse will then check the physician review box in Section 1 of the ISP if a review is indicated.

**Personal Information**

| **Consumer Name:** | **Allergies:** | **Physician's Review Required** |
|---|---|---|
| First Name: MI: Last Name:<br>Preferred Name: | NKA | ☐ |

**Physician will –**

- Complete and sign the Physician Review form if indicated in the electronic ISP and **check the physician's review button**.
- If the I&E physician identifies any issues that need any special prompt attention the RN will be contacted by phone/email in addition to the physician writing the recommendations in the physician's review section
- The R.N will be responsible for contacting the Support Coordinator and provider to ensure follow up.
- A revision or addendum to the goal(s)/ action plan and or risk protection page may be recommended
- **OA's will approve the ISP**

**Type of Program:** ☐ **Nursing Facility** ☐ **GAPP** ☐ **TEFRA/Katie Beckett** ☐ **MR/DD**

## PEDIATRIC DMA 6(A)
## PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

**Section A – Identifying Information**

| | | | | |
|---|---|---|---|---|
| 1. Applicant's Name/Address:<br><br>DFCS County_ | 2. Medicaid Number: | 3. Social Security Number | | |
| | | 4. Sex | Age | 4A. Birthdate |
| | 5. Primary Care Physician | | | |
| | 6. Applicant's Telephone # | | | |
| 7. In the caretaker's opinion, would the child require institutionalization if | 8. Does child attend school? | 9. Date of Medicaid | | |

Name of Caregiver #1: Name of Caregiver #2:

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Department of Community Health and the Department of Human Resources, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when

**Section B – Physician's Report and Recommendation**

12. History: *(attach additional sheet if needed)*

| | 1. ICD- | 2. ICD- | 3. ICD-9 |
|---|---|---|---|
| 13. I C D - 9 Diagnosis 1) 2) 3) | | | |
| 13A. I C D - 1 0 Diagnosis 1) 2) 3) | 1. ICD-10 | 2. ICD-10 | 3. ICD-10 |

| 15. Medications N | Dosage | R | Frequenc | 16. Diagnostic and Treatment Type |
|---|---|---|---|---|
| | | | | |

17. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations:_____ Rehabilitative/Habilitative Services:_____

| | | | |
|---|---|---|---|
| 18. Anticipated Dates of Hospitalization: | 19. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ ICAMR Facility | | |
| 20. Type of Recommendation: ☐ Initial | 21. Patient Transferred from (check one): ☐ Hospital ☐ Another NF | 22. Length of Time Care Needed Months | 23. Is patient free of communicable diseases? |
| 24. This patient's condition ☐ could ☐ could not be managed by | 25. Physician's Name (Print):<br>Physician's Address (Print): | | |
| 26. I certify that this patient requires the level of care provided | 27. Date signed by Physician | 28. Physician's Licensure No. | 28. Physician's Telephone #: |

**Section C– Evaluation of Nursing Care Needed (check appropriate box only)**

| 29. Nutrition | 30. Bowel | 31. Cardiopulmonary | 32. Mobility | 33. Behavioral Status |
|---|---|---|---|---|
| ☐ Regular<br>☐ Diabetic Shots<br>☐ Formula-Special<br>☐ Tube feeding<br>☐ N/G-tube/G-tube<br>☐ Slow Feeder<br>☐ FTT or Premature<br>☐ Hyperal | ☐ Age Dependent Incontinence<br>☐ Incontinent - Age > 3<br>☐ Colostomy<br>☐ Continent | ☐ Monitoring<br>☐ CPAP/Bi-PAP)<br>☐ CP Monitor<br>☐ Pulse Ox<br>☐ Vital signs > 2/day<br>☐ Therapy<br>☐ Oxygen<br>☐ Home Vent<br>☐ Trach | ☐ Prosthesis<br>☐ Splints<br>☐ Unable to ambulate > 18 months old whe | ☐ Agitated<br>☐ Cooperative<br>☐ Alert<br>☐ Developmental Delay<br>☐ Intellectual Disability<br>☐ Behavioral Problems (please describe, if checked)<br>☐ Suicidal |
| **34. Integument** | **35. Urogenital** | **36. Surgery** | **37. Therapy/Visits** | **38. Neurological Status** |
| ☐ Burn Care<br>☐ Sterile Dressings<br>☐ Decubiti<br>☐ Bedridden<br>☐ Eczema-severe | ☐ Dialysis in home<br>☐ Ostomy<br>☐ Incontinent – Age > 3<br>☐ Catheterization | ☐ Level 1 (5 or > surgeries)<br>☐ Level II (< 5 surgeries)<br>☐ None | Day care Services<br>☐ High Tech - 4 or more times per week | ☐ Deaf<br>☐ Blind<br>☐ Seizures<br>☐ Neurological Deficits<br>☐ Paralysis |

| 39. Other Therapy Visits | 40. Remarks |
|---|---|
| ☐ Five days per week ☐ Less than 5 | |

| 41. Pre-Admission Certification Number | 42. Date Signed | 43. Print Name of MD or RN: |
|---|---|---|
| | | |

**D**

44. Continued Stay Review Date: _____ Admission Date _____Approved for

| | |
|---|---|
| 45. Are nursing services, rehabilitative/habilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes | 46A. State Authority MH & MR Screening) Level I/II<br>Restricted Auth. Code Date<br>46B. This is not a re-admission for OBRA purposes |
| 47. Hospitalization Precertification ☐ Met ☐ Not Met | Restricted Auth. Code Date |
| 48. Level of Care Recommended by Contractor | |

| 49. Approval Period | 50. Signature (Contractor) | 51. Date / / | 52. Attachments (Contractor) | |
|---|---|---|---|---|

## ***PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE***

## ***INSTRUCTIONS FOR COMPLETING THE PEDIATRIC CARE FORM DMA-6(A)***

This section provides detailed instructions for completion of the *Form **DMA-6 (A)***. Before payment can be made, a ***Form DMA-6 (A)*** must be completed by the ***Primary Care Physician (PCP) and the parent or legal representative*** and signed by the PCP. The Form DMA-6 (A) is considered valid only if it is signed by the ***Primary Care Physician*** and dated.

**Section A - Identifying Information**
It is the responsibility of the responsible party to see that Section A of the form is completed with the applicant's name and address.

**Item 1**: **Applicant's Name and Address**
Enter the complete name and address of the applicant including the city and zip code.

The caseworker in the Department of Family and Children Services (DFCS) will complete the mailing address and county of the originating application.

**Item 2**: **Medicaid Number**
Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

**The entire number must be placed on the form correctly.** In exceptional instances, it may be necessary to contact the caseworker in the DFCS office for the Medicaid number.

**Item 3: Social Security Number**
Enter the applicant's nine-digit Social Security number.

**Item 4 & 4A: Sex, Age and Date of birth**
Enter the applicant's sex, age, and date of birth.

**Item 5: Primary Care Physician**
Enter the entire name of the Primary Care Physician (PCP).

**Item 6: Telephone Number**
Enter the telephone number including area code of the applicant's parent or the legal representative.

**Item 7: Does the child meet the Level of Care (LOC) criteria? (Refer to the DCH's website for the LOC definitions.) Statement being asked to caregiver to support LOC.** Please check the appropriate box.

**Item 8: Does the child attend school?**
Please check the appropriate box if the member attends school.

**Item 9: Date of Medicaid Application**
Enter the date the family made application for Medicaid services.

**Fields below Item 9:**
Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, please indicate the name of the caregiver.

**Read the statement below the name(s) of the caregiver(s) and then**;
**Item 10: Signature**
The parent or legal representative for the applicant should sign the DMA-6 (A).

**Item 11: Date**
Please include the date the DMA-6 (A) was signed by the parent or the legal representative.

**Section B - Physician's Examination Report and Recommendation**

**Item 12: History (attach additional sheet(s) if needed)**
Describe the applicant's medical history (Hospital records may be attached).

**Item 13: Diagnosis (Add attachment(s) for additional diagnoses)**
Describe the primary, secondary, and any third ICD-9 diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.

**Item 13A: Diagnosis (Add attachment(s) for additional diagnoses)**
Describe the primary, secondary, and any third ICD-10 diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.

**Item 14: Medications (Add attachment(s) for additional medication(s)**
The name of all medications the applicant is to receive should be listed. Name of drugs with dosages, routes, and frequencies of administration are to be included.

**Item 15: Diagnostic and Treatment Procedures**
Any diagnostic or treatment procedures and frequencies should be indicated.

**Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)**
List previous hospitalization dates, as well as rehabilitative/habilitative, and other health care services the applicant has received or currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

**Item 17: Anticipated Dates of Hospitalization**
List any dates the applicant may be hospitalized in the near future for services. Enter N/A if not applicable.

**Item 18: Level of Care Recommended**
Recommendation regarding the level of care considered necessary. Enter a check in the correct box for hospital, nursing facility, or an intermediate care facility for the mentally retarded. Enter N/A if institutional care is not applicable.

**Item 19: Type of Recommendation**
Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.

**Item: 20: Patient Transferred from (Check one)**
Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

**Item 21: Length of Time Care Needed**
Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box on the length of time care is needed either permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

**Item 22: Is Patient Free of Communicable Diseases?**
Enter a check in the appropriate box.

**Item 23: Alternatives to Nursing Facility Placement**
The admitting or attending physician must indicate whether the applicant's condition could or could not be managed by provision of the Community Care or Home Health Care Services Programs. Enter a check in the box corresponding to "could" and either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not" if neither is appropriate.

**Item 24: Physician's Name and Address**
Print the admitting or attending physician's name and address in the spaces provided.

**Item 25: Certification Statement of the Physician and Signature**
The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. Signature stamps are not acceptable. If the physician does not agree that institutional care is appropriate, enter N/A and sign.

**Item 26: Date signed by the physician**
Enter the date the physician signs the form.

**Item 27: Physician's Licensure Number**
Enter the Georgia license number for the attending or admitting physician.

**Item 28: Physician's Telephone Number**
Enter the attending or admitting physician's telephone number including area code.

---

**Section C - Evaluation of Nursing Care Needed (Check Appropriate box only)**

Licensed personnel involved in the care of the applicant should complete Section C of this form.

**Item 29: Nutrition**
Check the appropriate box(es) regarding the nutritional needs of the applicant.

**Item 30: Bowel**
Check the appropriate box(es) to indicate the bowel and bladder habits of the applicant.

**Item 31: Cardiopulmonary Status**
Check the appropriate box(es) to indicate the cardiopulmonary status of the applicant. Enter N/A, if not applicable.

**Item 32: Mobility**
Check the appropriate box(es) to indicate the mobility of the applicant.

**Item 33: Behavioral Status**
Check all appropriate box(es) to indicate the applicant's mental and behavioral status.

**Item 34: Integument System**
Check the appropriate box(es) to indicate the integument system of the applicant.

**Item 35: Urogenital**
Check the appropriate box(es) for the urogenital functioning of the applicant.

**Item 36: Surgery**
Check the appropriate box regarding the number of surgeries the applicant has had to your knowledge or obtain this information from the parent or other legal representative.

**Item 37: Therapy/Visits**
Check the appropriate box to indicate the amount of therapy visits the applicant receives.

**Item 38: Neurological Status**
Check the appropriate box (es) regarding the neurological status of the applicant.

**Item 39: Other Therapy Visits**
If applicable, indicate the number of treatment or therapy sessions per week the applicant receives or needs. Enter N/A, if not applicable.

**Item 40: Remarks**
Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form or any additional comments.
**Item 41: Pre-admission Certification Number**
Indicate the pre-admission certification number (if applicable).

**Item 42: Date Signed**
Enter the date this section of the form is completed.

**Item 43**: **Print Name of MD or RN**
The individual completing Section C should print their name and sign the DMA-6 (A).

**Do Not Write Below This Line**
Items 44 through 52

## Protocol for Physicians Signature

**A physician's signature is required on the ISP if-**

- When the completed HRST indicates a level 3 and/or the CMC screening tool indicates a level 2 than the nurse will use their judgment to determine the need for physician review of the ISP.

**The nurse will-**

- **Bold** the need for physician's review as the first recommendation in the nursing assessment (annual or comprehensive).
- The comprehensive assessment will be uploaded into Miscellaneous Docs section. *** Note- if a comprehensive assessment is uploaded, a note will be placed in the blank built-in nursing assessment to see comprehensive assessment in misc. docs and the nurse will electronically sign the built in assessment**.
- The nurse will then check the physician review box in Section 1 of the ISP.

**Personal Information**

| **Consumer Name:** | **Allergies:** | **Physician's Review Required** |
|---|---|---|
| First Name: MI: Last Name:<br>Preferred Name: | NKA | ☐ |

**Physician will**

- Complete and sign the Physician Review form, uploaded the form into the Misc. Docs section and **uncheck the physician's review button**.
- If the I&E physician identifies any issues that need any special prompt attention the RN will be contacted by phone/email in addition to the physician writing the recommendations in the physician's review section
- The R.N will be responsible for contacting the Support Coordinator and provider to ensure follow up.
- A revision or addendum to the goal(s)/ action plan and or risk protection page will be recommended accordingly
- **OA's will approve the ISP**

DMA-7 Level of Care Re-Evaluation Form for ICF/ID

| NAME: | DOB: | Region: |
|---|---|---|
| **Support Plan Effective Date:** | | |

**Level of Care Eligibility**: The individual meets one of the following criteria. Check the criteria that are met.

- ☐ The individual's disability is intellectual disability; or
- ☐ The individual is eligible under the category of Other Closely Related Condition.

**Please check all that Apply:**

| | Disability Conditions | ✓ | Major Life Activities |
|---|---|---|---|
| ☐ | Autism | | Self Care |
| ☐ | Cerebral Palsy | | Understanding and Use of Language |
| ☐ | Epilepsy | | Learning |
| ☐ | Other _____ | | Mobility |
| ☐ | Intellectual Disability | | Self Direction |
| ☐ | | | Capacity for Independent Living |
| ☐ | | | Conceptual Skills |
| ☐ | | | Social Skills |
| ☐ | | | Practical Skills |
| ☐ | | | Overall score on a standardized measure of conceptual, social, and practical skills |

**Medicaid Eligibility:**

Individual has a current Medicaid Number. Medicaid # is _____

**Eligibility Determination: Check the correct statement:**

- ☐ Individual has met Level of Care Eligibility (1) has a Medicaid number (2) and is eligible for Waiver Services.
- ☐ Individual has not met the Level of Care Eligibility and is not eligible for Waiver Services.
- ☐ Individual is in an ICF-ID and was referred for Medicaid eligibility on _____ (Date)

  The result was: Eligible ____ Ineligible ____ Date of Determination _____

**Home and Community Based Waiver Level of Care Re-Evaluation (if applicable)**

- ✓ Field Office Nurse with the Field Intake and Evaluation Team signs the Level of Care Re-Evaluation

**Regional Clinical Reviewer Signature:** **Date:**

**Approval Period:**

**ICF-ID Facility Level of Care Re-Evaluation (if applicable)**

- ✓ Facility RN and Field Office RN sign the Level of Care Re-Evaluation

**Facility RN Signature:** **Date:**

**Field Office RN Signature:** **Date:**

**Approval Period:**

DMA-7 (Rev 4/13; 10/19)

## ***INSTRUCTIONS FOR COMPLETING THE LEVEL OF CARE RE-EVALUATION FOR ICF/ID (DMA-7)***

This document provides detailed instructions for completion of the Level of Care (LOC) Re-Evaluation Form. Before payment can be made, the LOC Re-Evaluation form must be approved by the DBHDD Field Office.

**Item 1**: **Participant's Name**
Enter the complete name beginning with the Last Name then the First Name of the participant

**Item 2**: Date of Birth
Enter the participant's date of birth.

**Item 3: Region**
Enter the participant's DBHDD Region

**Item 4: Support Plan Effective Date**
Enter the start date of the most current ISP

**Item 5**: **Level of Care Eligibility:** The individual meets one of the following criteria and is eligible to receive the services provided in an ICF/ID. Check the criteria that are met.

1. Check that the individual's disability is an intellectual disability if the individual's waiver eligibility determination indicated eligibility by diagnosis of an intellectual disability.

2. Check that the individual is eligible under the category of "Other Related Condition" if the individual's waiver eligibility determination indicated eligibility by diagnosis of a condition found to be closely related to an intellectual disability and attributable to: (a) cerebral palsy or epilepsy; or (b) any other condition, other than mental illness, which results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability.

**Item 6a**: Please check all Disability Conditions that apply to the individual:

| **Disability Conditions** |
|---|
| |
| |
| |
| Autism |
| Cerebral Palsy |
| Epilepsy |
| |
| |
| Other: _____ (Specify any other disability conditions) |
| Intellectual Disability _____ |

**Item 6b**: Please check all Major Life Activities that apply to the LOC Re-Evaluation:

| **Major Life Activities**: Check all areas in which the individual has substantial deficits. Note: To meet ICF/ID Level of Care the individual must have substantial deficits in at least two areas if the individual's disability is intellectual disability and in at least three areas if the individual is eligible under the category of Other Closely Related Condition. |
|---|
| **Self Care** - Basic Activities of Daily Living include:<br>• Bathing and showering (washing the body)<br>• Bowel and bladder management (recognizing the need to relieve oneself)<br>• Dressing<br>• Personal hygiene and grooming (including washing hair)<br>• Eating (including chewing and swallowing)<br>• Feeding (setting up food and bringing it to the mouth)<br>• Toilet hygiene (completing the act of relieving oneself) |
| **Understanding and Use of Language** – Impairments in receptive and/or expressive language. This major life activity includes ability to understand others and to fully express oneself in own language (including sign language) with adaptive communication devices if used by individual. |
| **Learning** – Limitations in practical and functional academics, such as reading, computation, and telling time. This major life activity includes the ability to apply reasoning and problem solving, learn new tasks, apply to new situations, or adapt to change |
| **Mobility** – limitation in one's ability to move the body or one or more extremities independently. This major life activity includes physical movement of one's body from place to place, with adaptive aids if used by individual, and consists of the ability to transfer, to walk, or to be reliant on a wheelchair or scooter for mobility. It does not include vehicle transportation. |
| **Self-Direction** – limitation in making decisions and setting and carrying out goal(s) independently. This major life activity includes the ability to make decisions that match one's own values and desires. |
| **Capacity for Independent Living** – limitation in age appropriate behaviors for the individual to live independently. This major life activity includes ability to prepare food, manage money, clean house, do laundry, work independently or use the telephone with assistive devices if uses them. |
| **Conceptual skills** – significant limitations in the following areas- language; reading and writing; and money, time, and number concepts |
| **Social skills** – significant limitations in following areas- interpersonal skills, social responsibility, self-esteem, gullibility, naiveté or wariness, follow rules/obeys laws, avoids being victimized, and social problem solving |
| **Practical skills** -significant limitations in following areas- activities of daily living or personal care, occupational skills, use of money, safety, health care, travel/transportation, scheduled/routines, and use of the telephone |
| **Overall score on a standardized measure of conceptual, social, and practical skills** |

**Item 7**: **Medicaid Eligibility**

Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

**c.** If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

**Item 8**: **Eligibility Determination:** Check the correct statement:

| | |
|---|---|
| | Individual has met Level of Care Eligibility (1) has a Medicaid number and is (2) eligible for waiver services. |
| | Individual has not met the Level of Care Eligibility and is not eligible for Waiver Services |
| | Individual is in an ICF-ID and was referred for Medicaid Eligibility on (enter the date).<br>The result was ___Eligible ____Ineligible Date of Determination: _____ |

**Item 8: Home and Community Based Waiver LOC Re-Evaluation (if applicable)**

The Field Office RN reviews the LOC Re-Evaluation form, the ISP, and any accompanying assessment updates to determine whether the person continues to meet the level of care requirement. The Field Office RN will sign and date this document after that review.

**Item 9: Approval Period**

This section is completed by the Field Office RN and is the time period for which the LOC has been re-certified for Home and Community Based Waiver services. The initial date the completed LOC Re-evaluation form is received by the DBHDD Field Office with all additional required documentation for recertification will constitute the earliest re-certification date once approved.

**Item 10: ICF-ID Facility Level of Care Re-Evaluation (if applicable)**

The facility RN completes the Level of Care Re-Evaluation Form, signs and forwards the completed form, the current individualized program plan, and any accompanying assessment updates to the Field Office RN for review. The Field Office RN signs and dates this section.

Approval Period: This section is completed by the Field Office RN and is the time period for which the LOC has been re-certified for ICF/ID Facility based services. The initial date the completed LOC Re-evaluation form is received by the DBHDD Field Office with all additional required documentation for recertification will constitute the earliest re-certification date once approved.

## Appendix D-

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APPENDIX E

# New Options Waiver Program and Comprehensive Supports Waiver Program

## FREEDOM OF CHOICE

## (Statement of Informed Consent)

It is the policy of the State of Georgia that services are delivered in the least restrictive manner that addresses the service needs of the individual while enhancing the promotion of social integration. Further, it is the policy of the State to recognize the recipient's full citizenship and individual dignity; providing safeguards to protect rights, health and the welfare of recipients.

Based on these beliefs the State of Georgia assures that potential recipients and their authorized representative(s) will be afforded an opportunity to make an informed choice concerning services and providers.

Once a recipient is determined to be likely to require the level of care provided in an SNF, ICF or ICF/ID the recipient and his/her authorized representative will be informed of any feasible alternative available under the waiver and given the choice of either institutional or home and community-based services. This choice of care is documented.

Recipients may request through the regional office that a different support coordinator be assigned. Recipients have the choice of qualified providers in all areas of care and may request a change in providers through the region.

The substance of the information provided will make one reasonably familiar with service options, provider options, their alternatives, and possible benefits and hazards, and the disclosure of said information is designed to be fully understood and appears to be fully understood.

**Verification**

I have verified that the recipient and his/her authorized representative have been informed about their choices in the manner outlined above. The recipient has received a copy of this signed form.

_____ _____

Planning List Administrator/Support Coordinator or Authorized Designee — Date

**Acceptance**

I and/or my authorized representative have been informed of my choices and have chosen to accept the program and providers described in the attached Individualized Service Plan.

_____ _____

Recipient — Date

_____ _____

Authorized Representative — Date

_____ _____

**Witness** — **Date**

**Refusal**

I and/or my authorized representative have been informed of my choices and have chosen to refuse waiver services.

_____ _____

Recipient — Date

_____ _____

Authorized Representative — Date

_____ _____

Witness — Date

New Options Waiver Program and Comprehensive Supports Waiver Program

FREEDOM OF CHOICE FORM INSTRUCTIONS

Purpose

The intent of this form is to assure that the participants and their representatives will be:

(1) Informed of any alternatives available under the waiver and
(2) Given the choice of either institutional or home and community-based services.

This process assures that recipients and their representatives can make an informed choice concerning service options(s). The presumption of the law is that a person may consent for him/herself. This presumption should be abandoned only when it is evident that the individual is not capable of doing so. The very nature of a diagnosed condition of an intellectual/developmental disability confirms that the individual who is diagnosed with an intellectual/developmental disability lacks capacity. The recognized reality and trend in the law is that individuals with intellectual/developmental disabilities are often neither wholly competent nor wholly incompetent. The New Options Waiver Program has chosen to involve and recognize the rights of all recipients while at the same time protecting the rights of recipients through the request of concurrent consent by recipients' authorized representatives.

Whoever is selected as authorized representative must meet the three tests for effect consent: that is, he/she must be competent, adequately informed about the factors involved in the decision and be knowledgeable about the person for whom consent is sought, and voluntary (free from coercion or conflict of interest). The authorized representative must act on the basis of the best interest of the person for whom his or her consent is sought. A suggested list of potential candidates for authorized representatives includes, but is not limited to the following: guardian or conservator, parent, participant's spouse, adult child, adult next-of-kin, any responsible relative, and attorney(s). In the absence of an available, suitable candidate an advocate appointed by the Georgia Advocacy Office may serve as the designated representative.

Process

Step (1) Provide an overview of service options, noting pro's and con's related to each option; this includes inherent and potential risks, benefits, and stigmas.

A) The content of the overview should make one reasonably familiar with service options.
B) The presentation of information should be designed to match the recipient's and/or his/her representative's level of comprehension.
C) Evidence of participant/representative's understanding of information should be evidenced in the discussion of the same.

Step (2) Once information has been provided and appears to be understood, the Planning List Administrator/Support Coordinator (or designee) should verify that this information has been provided appropriately and is understood. Once verified, the form should be signed at the designated sign-off under verification statement.

Step (3) Informed participant/representative chooses a service option. The Informed participant/representative should sign under the appropriate statement that reflects their choice. In cases where the individual participant is a minor, and/or unable due to physical and/or mental causes to sign his/her name, and/or unable to legibly write his/her name, the participant's name should be printed, above his/her signature or mark, if any, and be initialed by the

participant's authorized representative.

A witness should sign verifying both the participant's and authorized representative's signature. The witness may be the Planning List Administrator/Support Coordinator or his/her authorized designee.

Step (4) Once the form is completed (with signatures under appropriate statements), it should be placed in the participant's record.

Rev. 01 2009

APPENDIX F

# MR/DD WAIVER PROGRAM COMMUNICATOR
# MAO DETERMINATION

| | | |
|---|---|---|
| Participant Name | County | MHID # |
| Address | Soc. Sec. # | Medicaid # |
| City State Zip Code | Date of Birth | (Area Code) Phone # |

Provider _____ Phone # _____

**SECTION I COMPLETED BY PLANNING LIST ADMIN/SUPPORT COORDINATOR**

_____ Date participant was determined eligible for New Options Waiver (NOW)/Comprehensive Supports Waiver (COMP)

Signature: _____ Date _____

**SECTION II COMPLETED BY PLANNING LIST ADMIN/SUPPORT COORDINATOR (check those which apply)**

_____ Participant currently resides in an ICF-MR which receives Medicaid reimbursement for his/her services. Please compute cost share. Discharge Date: _____
NOW/COMP Enrollment Date: _____

_____ Participant currently resides in the community and does not receive Medicaid. Please determine eligibility and cost share. Date services begin: _

_____ Participant is currently receiving MAO. Please compute cost share.

_____ Participant needs annual re-determination of MAO status and cost share.

_____ Participant requires a home visit for application. (Reason in Remarks)

Signature: _____ Phone No. _____ Date _____

**SECTION III COMPLETED BY DFACS CASEWORKER**

_____ Date participant applied for MAO ELIGIBILITY DATE: _____

$ _____ Participant's cost share Effective Date: _____

$ _____ Participant's cost share due to liability change Effective Date: _____

_____ Date participant was determined INELIGIBLE. (Reason in Remarks)

Signature: _____ Phone No. _____ Date _____

**SECTION IV COMPLETED BY NOW/COMP PLANNING LIST ADMIN/SUPPORT COORDINATOR**

This member has been released from the NOW/COMP effective _____, for the following reason.

Signature: _____ Phone No. _____ Date _____

**SECTION V COMPLETED BY NOW/COMP SUPPORT COORDINATOR OR DFACS CASEWORKER**

**REMARKS:**

# APPENDIX G
# Prior Authorization Form

**State of Georgia DHR -- Prior Authorization Request**

| | |
|---|---|
| **Last Name, First Name**<br><br>**MHN Number: 111111111111**<br>**Medicaid Number:**<br>Gender: F<br>Date of Birth: 12/02/1945 | **Prior Auth. Number: 504000000000**<br>**Fiscal Year: 2005**<br><br>**Address:**<br>3136 Friendly Street<br>SNELLVILLE , GA 30078 |

**Intake Provider**

Columbus Community Services - Atlanta
2300 Henderson Mill Road
Suite 100
Atlanta, GA 30345
Office: 770-938-5310 (24 hrs.)
Toll Free: 800-579-7609

**Diagnosis**

*A minimum of one ICD-9 Code is required.

| ICD-9 | Date of Diagnosis | Primary | Date of Change |
|---|---|---|---|
| 317 | 06/01/1954 | yes | 05/24/2004 |

**Services**

| Service | Provider | Start Date | End Date | Number of Units | Rate Per Unit | Max Units Per Day | Max Units Per Month | Annualized Units |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| T2021 | GWINNETT CO ARC, INC , 000000000B | 07/01/2004 | 06/30/2005 | 5760 | $3.04 | 24 | 0 | 5760 |
| T2025 - U5 | GWINNETT CO ARC, INC - 000000000A | 07/01/2004 | 06/30/2005 | 365 | $122.99 | 1 | 0 | 365 |

**Program Information**

Check if this is Retroactive Request due to MAO Eligibility: ☐

| Status | Effective Date | Notes |
|---|---|---|
| Flipped | 5/3/2004 1:25:40 AM | Flipped |
| Saved | 5/24/2004 7:25:35 AM | Saved |
| Approved | 5/27/2004 8:30:21 AM | Approved |
| Accepted | 5/28/2004 5:10>14 AM | Accepted |

Rev 10
2019

# Appendix H
# Enhanced Supports Services Delivery

**Purpose: Defines eligibility requirements, documentation of need, available services and documentation of service delivery for the following:**

- **Request for additional units of service for Specialized Medical Supplies and Specialized Medical Equipment**
- **Request for Additional Staffing in Community Residential Alternative, Community Access Group and Community Living Supports Services**

In extraordinary circumstances related to transition of an individual from an institution or imminent risk of institutionalization of an individual, providers may request the payment for enhanced supports service delivery due to person's extreme medical and behavior needs that exceeds the established maximum rate for the New Options Waiver (NOW) service and Comprehensive Supports Waiver (COMP) service.
The enhanced supports delivery requests are subject to the Department of Behavioral Health and Developmental Disabilities approval with notification of approval to the Department of Community Health. Providers must be authorized by the DBHDD Regional Office and the Division of Developmental Disabilities to receive reimbursement for additional units of service or enhanced supports for eligible waiver services. Any enhanced supports services (additional units or additional staffing) delivery requires prior approval before delivery of services and is time limited as indicated in the approval notice.

## NOW and COMP Services Eligible to Receive Additional Units

| Additional Units |
|---|
| Specialized Medical Supplies |
| Specialized Medical Equipment |

*Note: Only services provided by traditional providers are eligible for approval of additional units

## COMP Services Eligible for Additional Staffing

| *Additional Staffing/Hours |
|---|
| Community Access Group Services |
| Community Living Support Services |
| Community Residential Alternative Services |

**Note: Only the services provided by traditional providers are eligible. Participant-directed and services provided through the co-employer model are not eligible to receive Additional Staffing*.

**Eligibility Criteria for Enhanced Services Delivery:**
To be considered for enhanced supports services, additional staffing, or to exceed maximum

allowable units, extraordinary circumstances must be demonstrated by the following:

**1. Extraordinary Placement Circumstances:**

Extraordinary circumstances related to the placement or continued stay of the participant in the community must be documented by:

| | | |
|---|---|---|
| The individual is currently in an institution and unable to move to the least restrictive alternative in the community because health and safety needs require enhanced service delivery, | OR | The extent of an participant's needs presents imminent risk of institutionalization (i.e., the only options are institutionalization or enhanced service delivery beyond that provided by the established Medicaid maximum rate); |

2. **Assessed Extraordinary Needs of the Participant:** extraordinary needs of the participant must be documented by at least one of the following assessment findings:
   a. the Health Risk Screening Tool
   b. a validated Supports Intensity Scale with or without SIS Supplemental Questions
   c. a Communication Assessment for Deaf Services or Nursing Assessment for enhanced supports:

| **Health Risk Screening Tool (HRST)** | **<u>Supports Intensity Scale (SIS)</u>** |
|---|---|
| a. A rating of 4 on Eating or Toileting in the HRST Category I – Functional Status, with Georgia licensed Registered Nurse review and signature, OR<br><br>b. A rating of 4 on Self Abuse or Aggression Toward Others and Property in the HRST Category II – Behaviors, with Georgia licensed Registered Nurse review, signature, and documented consultation of RN with Qualified Developmental Disability Professional (QDDP) level psychology professional, OR<br><br>c. Any rating of 4 on Treatments in the HRST Category III – Physiological, with Georgia licensed Registered Nurse review with signature and supported by a professional, OR<br><br>d. Four or more ratings of 4 overall on the HSRT, with Georgia licensed Registered Nurse review and signature, | a. A rating of 2 (Extensive Support Needed) on Lifting and/or Transferring, Turning or Positioning, or Seizure Management in the Supports Intensity Scale (SIS) Section 3A: Exceptional Medical Supports Needed, with Georgia licensed Registered Nurse review and signature, OR<br><br>b A rating of 2 (Extensive Support Needed) on at least one of the following:<br>-Prevention of Assaults/Injuries to Others<br>-Prevention of Property Destruction<br>-Prevention of Sexual Aggression<br>-Prevention of Self-Injurious Behavior<br>-Prevention of Pica, or<br>-Prevention of Suicide Attempts<br>…in the SIS Section **1b.** Exceptional Behavioral Supports Needed with Georgia licensed Registered Nurse review, signature, and documented consultation of RN with Qualified Intellectual Disability Professional (QIDP) level psychology professional, OR<br><br>c. A Total Score rating of at least 7 on the SIS Section 1b: Exceptional Behavioral Supports Needed, with Georgia licensed |

| | |
|---|---|
| | Registered Nurse review and signature, and documented consultation of RN with Qualified Intellectual Disability Professional (QIDP) level psychology professional if the extraordinary supports/additional residential staffing request relates to exceptional behavior support needs;<br>d. SIS Supplemental Questions 2, 3, or 4 indicating extraordinary circumstances which verify the need for Additional Staffing. |
| **c. Communication Assessment for Deaf Services** A Communication Assessment performed by the Department of Behavioral Health and Developmental Disabilities Office of Deaf Services indicating the need for additional or a specialized staff proficient in communication with deaf individuals, or. | **d. Nursing Assessments**<br>A Nursing Assessment performed by the Department of Behavior Health and Developmental Disabilities Field Office registered Nurse indicating the need for specialized medical supplies or specialized medical equipment. |

*Please note: For special eligibility criteria for additional staffing review COMP Part III Additional Staffing

3. **DBHDD Clinical Assessment.** A clinical based review and specification of the enhanced supports additional units, and/or additional staffing required will be conducted by a DBHDD Field Office Clinician for individuals currently on the waivers or entering the waivers from the community. A Transition Triage Team will conduct the clinically based review and specification of the enhanced service supports (additional units and/or additional staffing required by individuals transitioning to the community from a hospital or ICF/IDD setting.

The following checklist represents examples of but not limited to supporting documentation that may provide evidence of need:

| **CHECKLIST: PERTINENT RECORD DOCUMENTATION** | | | |
|---|---|---|---|
| ____ | Current service plan | ____ | Recent progress notes (case management, residential) |
| ____ | BSP, Behavior data tracking, etc. | ____ | Relevant legal documentation |
| ____ | Safety/Crisis Plan | ____ | Recent incident reports |
| ____ | Medical support plan, Healthcare Plans/protocols | ____ | Additional information: school records, IEPs, personal statement from past caregivers, proof of home modifications, doctor's notes, hospitalizations etc. |

**AND**

**4. <u>Individual Support Plan</u>**

Enhanced Supports Service Delivery Requirements must be written in the Individual Support Plan that describes the direct service need required for the care of the participant. The enhanced service delivery specific to the extraordinary needs of the participant may include one or more of the following:

- **Additional Staffing Requirements: Enhanced staff (additional paraprofessional, or specialized staff for direct care duties for support).** Specialized direct care staff skills, which include, but are not limited to, lawfully delegated medically related tasks, and implementation of behavioral support plans for severe aggressive behavior, intensive self-injurious behavior, major property destruction and/or other significant challenging behaviors:

- **A medical diagnosis or condition, reflected in the nursing evaluation, HRST or SIS, requiring use of the specialized equipment, and/or specialized supplies as described below:**

    - **Specialized Medical Supplies Requirements:** Additional frequency of use of medical supplies, which results in an exceptional quantity of medical supplies, or requirements for multiple types of medical supplies on a frequent basis.

    - **Specialized Medical Equipment Requirements:** Extraordinary medical equipment requirements, which result in need for a one-time purchase at the lifetime maximum.

**Documentation Request for Enhanced Supports Service Delivery Requests**
**Documentation for Enhanced Supports Service Delivery requests must be filed on site at the providers site and/or the family home and uploaded in the Case Management System (IDD CONNECTS)**

- Crisis/Safety Plan submission is required for all Extraordinary Supports Requests and Additional Staffing requests. Crisis/Safety Plan for any crisis is defined as an occurrence that poses a health and safety risk to the participant and/or others as a result of the enhanced support needs of the participant; the Crisis/Safety Plan, as applicable to the enhanced service delivery request, includes, but is not limited to, the following:
    - Back up plans when critical staff are absent for all additional staffing supports requests;
    - Behavior Support Plan is required for all requests related to behavior. The components include comprehensive functional and diagnostic assessment of challenging behavior, plan development, staff competency-based training, observation, intervention and ongoing assessment. Behavior data analysis and graphing are used to evaluate outcomes and update the behavior plan.

    - Crisis/Safety interventions when behaviors occur that pose health and safety risks to the participant and/or others both in the home, the community, or in transit; and/or
    - Support protocol for any participant at risk of elopement in the event of an elopement for Additional Staffing Requests.

- If the request is related to a behavioral need, the supporting documentation should include <u>at least 3 months</u> of behavioral data presented in a clear and decipherable summary graphic format. The submitted documentation/data must be comprehensive and accurately reflect multiple types of data to support the request which may include but is not limited to the following:

- Monthly Frequency (the number of days during the month during which behavior occurs);
- Daily Episodic Rate (the number of times behavior occurs within a day);
- Duration (length of time behavior occurs before ceasing or de-escalating to a manageable level);
- Time of Day (times of day behavior occurs to the nearest hour);
- Setting (location or environment in which behavior occurs, e.g. in/around home, at doctors office, etc.);
- Severity (extent of injury or damage resulting when behavior occurs);
- Intensity (extent of intervention needed for behavior to cease or de-escalate to a manageable level, e.g., verbal/gestural prompt, remove from area, physical blocking, brief manual restraint, multiple staff, crisis intervention, mobile crisis team, law enforcement, hospitalization, arrest); and
- Level of staff support (ratio of staff [e.g., 1:2, 1:1] and type of supervision [e.g., line of sight, within arm's reach] support provided throughout the day during the time period under review)

**Documentation Request for Additional Staffing**

- Provider completes the Enhanced Supports Services Request template section for Additional Staffing Template and submits it to the DBHDD Regional Field Office (templates available in the Provider Toolkit at www.dbhdd.georgia.gov).
- Justification of additional hours or additional staff which includes current utilization of hours within assigned tier categories and plan to use the additional hours requested.

- Providers in community group settings must list all participants served in the setting, the participants' assessment level and direct support hours provided to each. Please refer to the Enhanced Supports Services Request template available in the Provider Toolkit at www.dbhdd.georgia.gov.

**Documentation Request to Exceed Maximum Allowable Units**

- Provider completes the Extraordinary Request Template and the Budget Template and submits the completed documents to the DBHDD Regional Field Office (templates available in the Provider Toolkit at www.dbhdd.georgia.gov).

**Enhanced Supports Service requests for Additional Staffing and/ or Additional Units to Exceed Maximum Allowable Units Request Review:**

**Process:**

DBHDD, Division of Developmental Disabilities conducts a clinical/programmatic review of the basis for the request as follows:

- **Clinical/Programmatic Review:** The Division of DD will deny any enhanced service delivery request if it:
  a. Does not meet or adequately document the need for extraordinary supports, additional staffing, or additional units, OR

b. Does not meet or adequately document the utilization of available services, OR
c. Does not adequately link the Enhanced Supports Service Delivery Requirements to the assessed needs of the individual participant.

- **Enhanced Supports Service Delivery Requirements Review:** The Division of DD does not approve enhanced units, supports, or staffing delivery requests that are inconsistent with the service definition of the service requested. Please see the NOW and COMP Part III Manuals for a list of service definitions.

**Administrative Cost for Specialized Medical Supplies:**
The administrative cost for Specialized Medical Supplies (SMS). The administrative costs for SMS includes ordering, billing, handling, delivery, processing, and documenting. The administrative costs are based on the unique items ordered. For example, formula is one unique item, and 12 cases of formula are regarded as one unique item.

**NOTE:** Any supplies in the category of over-the-counter medications are counted as one unique item for all supplies in this category. Also, any supplies in the category of herbal supplements, nutritional oils, other non-nutritional supplements and vitamins are counted as one unique item for all supplies in this category. Items not primarily and customarily used for a prescribed medical purpose or that are not medical in nature are generally excluded from coverage.
.

Administrative costs for SMS Additional Units are based on unique items as defined above. The administrative costs are as follows:

| Number of Unique Items | Annual Administrative Costs |
|---|---|
| 1 to 4 | $250 |
| 5 to 8 | $335 |
| 9 to 12 | $449 |
| 13 to 16 | $602 |
| Above 16 | $807 |

**Accountability and Program Integrity**
Delivery of services must be documented based upon the enhanced service delivery requirements for the participant due to his or her exceptional needs and in accordance with Medicaid guidelines. All additional supports services, (additional staffing and additional units) approvals are subject to DCH Program Integrity audits and quality and compliance reviews by the DBHDD State and Regional Field Offices. DBHDD State and Regional Field Offices make referrals to DCH Program Integrity if reviews indicate failure by the provider to deliver services as approved.

**ANY ANNUAL ENHANCED SUPPORTS (ADDITIONAL UNITS, OR ADDITIONAL STAFFING) AUTHORIZATION THAT EXPIRES WITHOUT A REQUEST FOR CONTINUATION AND APPROVAL FOR CONTINUATION BY THE DIVISION OF DD WILL BE TERMINATED ON THE DATE OF THE EXPIRATION.**

## APPENDIX I
## Glossary of Terms

**Approved Accrediting Bodies**
National accrediting organizations approved and recognized by the Georgia Department of Behavioral Health and Developmental Disabilities are the following:

1. CARF – the Rehabilitation Accreditation Commission
2. JCAHO – The Joint Commission on Accreditation of Healthcare Organizations
3. The Council – The Council on Quality and Leadership
4. COA – Council on Accreditation of Services for Families and Children
5. ACHC – The Accreditation Council for Health Care for Community Residential Alternative (CRA) and Community Living Support (CLS) Nursing Services only.

**Accreditation**
A review process conducted by a nationally recognized and approved accrediting body of a person or agency that is a direct service provider for people with mental illness, developmental disabilities or addictive diseases, focusing on prescribed standards as they relate to services and supports for those individuals.

Standards Quality Review - A review process conducted by the Provider Performance Unit of the Georgia Department of Behavioral Health and Developmental Disabilities of a person or agency that is a direct service provider for people with mental illness, developmental disabilities or addictive diseases, focusing on standards found in the "DBHDD Provider Manual for Community DD Providers Part 11, Section 1

**Certified Nurse Aide**
An individual who has completed a State approved Nursing Home Facility based or non-Nursing Home Facility based program offering training to become eligible for certification as a certified nurse aide. The individual must take and pass the competency evaluation examination to be included on the Georgia Nurse Aide registry. Candidates must renew their certification every two years to stay active on the Georgia Nurse Aide registry.

**COMP – Comprehensive Supports Waiver Program**
A home and community-based services waiver developed to serve individuals with intellectual/developmental disabilities that have been transferred to the community from an institution or are living in the community and require comprehensive and intensive services. In home and community-based services, waiver developed to serve individuals with intellectual/developmental disabilities that have been transferred to the community from an institution or are living in the community and require comprehensive and intensive services.

**Core Requirements for All Providers**
Core standards or requirements of the Georgia Department of Behavioral Health and Developmental Disabilities that are applicable to all individual and organizational providers who receive funds authorized by the division through contract, sub-contract or letter of agreement,

regardless of the accreditation or certification status of the provider.

**Delegation**

Delegation is the process wherein a Registered Professional Nurse transfers to an individual deemed competent the authority and responsibility for the performance of selected nursing tasks in selected situations. The Registered Professional Nurse retains accountability for the outcome. Assessment prior to delegation must occur to determine

1. The required practice is within the scope of nursing
2. Complexity of task and the predictability of outcome
3. Evaluates the performance of staff to whom the task is delegated
4. Confirms competence of individual responsible for performance of task
5. Establishes a schedule of supervision and re-evaluation

**Direct Care**

Direct care refers to activities that assist the patient to meet their basic needs.

**Direct Support Staff (DSP)**

Direct Support Staff are individuals who work directly with individuals with physical and/or intellectual disabilities with the aim of assisting the individual to become integrated into his/her community in the least restrictive environment. A DSP also acts as an advocate for the disabled individual, in communicating their needs, self-expression and goals.

**Developmental Disability Professional (DDP)**

All intellectual/developmental disabilities services are provided by or under the direct supervision of a **Developmental Disability Professional**. Refer to DBHDD Provider Manual for Community DD Providers Community Service Standards Part 11, Section G for a list of Professionals who qualify to be a DDP..

**DBHDD – Department of Behavioral Health and Developmental Disabilities**

The Department of Behavioral Health and Developmental Disabilities is responsible for the administration of the DD waiver programs. This is done through DBHDD's Division of Developmental Disabilities.

**DMA - Division of Medicaid**

The Division of Medicaid is responsible for the final approval of all services and claims reimbursed to providers. DMA contracts with the Department of Behavioral Health and Developmental Disabilities for the overall coordination and daily administration of the waiver programs.

**Family**

35Family is defined as a person who is related by blood within the third degree of consanguinity by blood, adoption, or marriage. Third degree of consanguinity includes mother, father, grandmother, grandfather, great grandfather, great grandmother, sister, brother, daughter, son, granddaughter, grandson, great granddaughter, great grandson, aunt, uncle, niece, or nephew.

**Funding through Authorization**
Cumulative monies received by providers including any combination of funds through contract(s) or letter(s) of agreement with the department through the division:

1. State Dollars
2. Medicaid Waiver Funds

**Facility**
A provider owned or operated building or place.

**Georgia Board of Nursing Policy Statement: Assignment to Unlicensed Assistive Personnel.** OCGA 43-26-12 (5) provides an exemption to licensure for the performance of auxiliary services in the care of patients when such care and activities do not require the knowledge and skills required of a person practicing nursing as a registered professional nurse and when such care and activities are performed under orders or direction of a licensed physician, licensed dentist, licensed podiatrist, or person licensed to practice nursing as a registered professional nurse. Therefore, if the care and activities meet all the above criteria for the exemption, it is an unlicensed activity and can be assigned.

**Georgia Board of Nursing Policy Statement: Medication Administration.** The administration of medication is the process whereby a prescribed medication or medication ordered under a nurse protocol, O.C.G.A. 43-34-26-1, is given to a patient/client by one of several routes to include but not be limited to, oral, inhalation, topical, rectal, or parenteral. The registered nurse verifies the medication order and the properly prescribed medication, gives the medication in accordance with current standards of practice and accepted principles and procedures as taught in nursing education. These include verification that the right medication is being given to the right patient/client in the right dose, by the right route at the right time as well as the assessment of the patient/client following administration of the medication for expected effects and possible untoward side effects. Administration of medication is a complex nursing responsibility which requires knowledge of anatomy, physiology, pathophysiology and pharmacology. Registered nurses may administer medications prescribed by authorized health care providers which may include protocols as defined in O.C.G.A. 43-34-26.1.

**Georgia Board of Nursing Scope of Practice Decision Tree**
A one-page document designed to assist in decision making regarding use of Unlicensed Assistive Personnel.
http://sos.ga.gov/PLB/acrobat/Forms/38%20Reference%20-%20Scope%20of%20Practice%20Decision%20Tree.pdf

**GHP - Georgia Health Partnership**
DMA contracts with GHP to process all Provider Enrollment Applications, assign provider enrollment numbers, and process provider claims.

**Health Risk Screening Tool (HRST)**
The Health Risk Screening Tool (HRST) is an online instrument offered by Health Risk Screening, Inc., that is completed by professional and other trained individuals identified in DBHDD Policy 02-803, Health Risk Screening Tool (HRST).

**Indirect Care** Services that are related to patient care but do not require interaction between the provider and the patient. Indirect focuses on review and documentation of care activities as well as maintaining the environment in which patient care is delivered.

**Individual Service Plan - ISP**
An ISP is a written comprehensive plan that identifies in measurable terms the expected outcomes of all services to be provided to the participant. The ISP is directed toward achieving self-sufficiency and community integration.

**Intake and Evaluation Team (I&E)**
The Intake and Evaluation Regional Office staff who evaluate applicant's eligibility for waiver-funded services. The team includes a physician, nurse, social worker, and a psychologist or behavioral specialist. Other disciplines that provide services to the applicant must also be a part of the team (Occupational Therapist, Speech Therapist, Physical Therapist and others which may provide services). A team of professionals with clinical expertise located in each DBHDD regional field office that provides screening to determine if individuals with developmental disabilities are eligible for services. Identified Intake and Evaluation (I & E) staff also execute tasks, which support ongoing assessment of individuals currently receiving services, such as the initial completion of the HRST tool by the I&E Team RN.

**Interdisciplinary Team**
The interdisciplinary team is a group of individuals representing various disciplines that work together to develop the Individual Service Plan for a participant. The interdisciplinary team must include a social worker, nurse, and behavior specialist or psychologist. Additionally, if a participant receives services from an occupational therapist, physical therapist, and/or speech therapist, that professional(s) also must be part of the interdisciplinary team. Similarly, the physician also must be part of the interdisciplinary team if a participant receives services from a physician (beyond the annual physical and acute care).

**License or Certificate**
Proof of legal authority to operate. Examples of agencies that are required to be licensed or certified to provide direct care to consumers are (but are not limited to) the following:

1. Personal Care Homes
2. Private Home Care Providers
3. Freestanding Residential Detoxification Services
4. Nursing Homes
1. Crisis Stabilization Programs
2. Community Living Arrangements

**NOW – New Options Waiver Program**
A home and community based services waiver developed to serve individuals with intellectual/developmental disabilities who live in their own or family home.

**Private Homecare (Authority O.C.G.A. §§ 31-7-2.2, 31-9-2 and 43-26-12(a) (9)**

111-8-65-.11 Service Plans.

(1) Service Plan Content. A Provider shall establish and implement written policies and procedures for service planning. A written plan of services shall be established in collaboration with the client and the responsible party, if applicable, and the client's personal physician if the services to be provided are nursing services and the client has a personal physician.

(a) The service plan shall include the functional limitations of the client, types of service required, the expected times and frequency of service delivery in the client's residence, the expected duration of services that will be provided, the stated goals and objectives of the services, and discharge plans.

(b) When applicable to the condition of the client and the services to be provided, the [service] plan shall also include pertinent diagnoses, medications and treatments, equipment needs, and diet and nutritional needs.

(2) Service plans shall be completed by the service supervisor within seven working days after services are initially provided in the residence. Service plans for nursing services shall be reviewed and updated at least every sixty two days. Other service plans shall be reviewed and updated at the time of each supervisory visit. Parts of the plans must be revised whenever there are changes in the items listed in the rules .11(l) (a) and (b), above.

Authority: O.C.G.A. §§ 31-2-5, 31-2-7 and 31-7-300 et seq

**Proxy Caregiver OCGA** 43-26-12 (9) (A-C) et seq., provides for the performance of health maintenance activities by a proxy caregiver pursuant to a written plan of care for a disabled individual.
OCGA 43-26-12 (9) (C) For purposes of this paragraph, the term:

a. "Disabled individual" means an individual who has a physical or mental impairment that substantially limits one or more major life activities and who meets the criteria for a disability under state or federal law.
b. "Health maintenance activities" are limited to those activities that, but for a disability, a person could reasonably be expected to do for himself or herself. Such activities are typically taught by a registered professional nurse, but may be taught by an attending physician, advanced practice registered nurse, physician assistant, or directly to a patient

and are part of ongoing care. Health maintenance activities are those activities that do not include complex care such as administration of intravenous medications, central line maintenance, and complex wound care; do not require complex observations or critical decisions; can be safely performed and have reasonably precise, unchanging directions; and have outcomes or results that are reasonably predictable. Health maintenance activities conducted pursuant to this paragraph shall not be considered the practice of nursing.

c. "Proxy caregiver" means an unlicensed person who has been selected by a disabled individual or a person legally authorized to act on behalf of such individual to serve as such individual's proxy caregiver and indicated through informed consent, provided that such person shall receive training and shall demonstrate the necessary knowledge and skills to perform documented health maintenance activities, including identified specialized procedures, for such individual.

d. "Training" means teaching proxy caregivers the necessary knowledge and skills to perform health maintenance activities for disabled individuals. Good faith efforts by an attending physician, advanced practice registered nurse, physician assistant, or registered professional nurse to provide training to a proxy caregiver to perform health maintenance activities shall not be construed to be professional delegation.

**DBHDD Regional Field Offices**
The DBHDD Regional Field Office coordinates and monitors the waiver as well as funding for other services and resources for Georgia's IDD population. The state is currently divided into 6 (six) regions. Individuals seeking /IDD services should apply through the Regional Field Office that serves their county.

**Registered Professional Nurse [RN]**
A person who is authorized by a license issued under Article 1, Georgia Registered Professional Nurse Practice Act, to practice nursing as a registered professional nurse

**Supervision**

Supervision is the provision of guidance and oversight of a delegated nursing task. Supervision may be direct or indirect through various means of written and verbal communication.

**Waiver of Accreditation**
A letter stating that a person or agency may have an extension of a period of time during which to complete their accreditation process.

**Waiver of Certification**
A letter stating that a person or agency may have an extension of a period of time during which to complete their certification process.

## Gainwell Technologies Formerly DXC Technology

Provider and Member Services
P.O. Box 105200
Tucker, GA 30085-5200

## Electronic Data Interchange (EDI)

1-877-261-8785

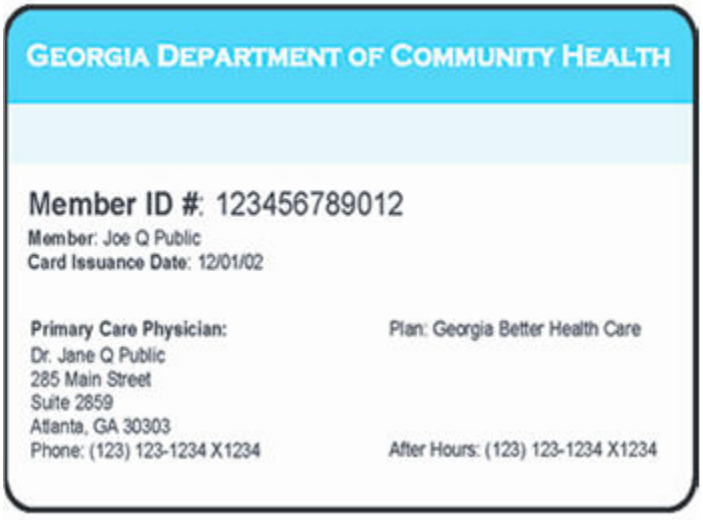
1. Asynchronous
2. Web portal
3. Physical media
4. Network Data Mover (NDM)
5. Systems Network Architecture (SNA)
6. Transmission Control Protocol/
7. Internet Protocol (TCP/IP)

## Provider Inquiry Numbers:

~ 800-766-4456 (Toll free)

The web contact address is www.mmis.georgia.gov

APPENDIX K


GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Member ID #: 123456789012
Member: Joe Q Public
Card Issuance Date: 12/01/02
Primary Care Physician:
Dr. Jane Q Public
285 Main Street
Suite 2859
Atlanta, GA 30303
Phone: (123) 123-1234 X1234
Plan: Georgia Better Health Care
After Hours: (123) 123-1234 X1234


Verify eligibility at www.mmis.georgia.gov
300 OERSTED
If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.
Payor: For Non-Managed Care Members
Customer Service: 1-800-766-4456 (Toll Free)
HP Enterprise Services
Member: Box 105200
Provider: Box 105201
Tucker, GA 30085
Prior Authorization: GMCF
1455 Lincoln Parkway, Suite 800
Atlanta, GA 30346
SXC, Inc.
Rx BIN-001553
Rx PCN-GAM
SXC Rx Prior Auth
1-866-525-5827
Mail RX Drug Claims to:
SXC Health Solutions, Inc.
P.O. Box 3214
Lisle, IL 60532-8214
Rx Provider Help Line
1-866-525-5826
This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.
HP75

**APPENDIX L**
**Medicaid Provider Application Process for DBHDD Services**

## Provider Enrollment

### To Enroll to Become a New Provider

A. To enroll to become a provider agency or individual provider, you are required to attend a provider enrollment forum prior to completing a Letter of Intent and mailing it to:

GA Collaborative Enrollment
240 Corporate Blvd, Suite 100
Norfolk, VA 23502

A registration link will be available when enrollment forums have been scheduled. The forum and open enrollment is located at the following website: www.georgiacollaborative.com.

The Letter of Intent can be found in *Recruitment and Application to Become a Provider of Developmental Disabilities Services Policy,* located at the following website: http://gadbhdd.policystat.com.

**Note: A Letter of Intent must be approved by GA Collaborative ASO before completion of the provider application as well as the Medicaid application. The application is to be completed upon notification of your Letter of Intent approval**.

A. The Medicaid Provider Enrollment packet is obtained from the following website: www.mmis.georgia.gov or by calling (800) 766-4456 for assistance. The GA Collaborative ASO application can be found at www.georgiacollaborative.com. The Medicaid application should not be completed until directed by GA Collaborative ASO.

**Both applications are submitted to the address listed in the GA Collaborative ASO Agency application for new providers.**

**Note: 1. DBHDD submits the final DCH application and the DBHDD final Status Report to DCH for their final review. DCH reviews the information and approves or denies the provider request for enrollment.**

**2. Applicants may not re-apply as a COMP/NOW provider for one (1) year after date of denial by DCH of the enrollment application.**

**For existing providers wanting to add new services or locations, you may either mail your completed application to the above GA Collaborative Enrollment address or email it to GAEnrollment@beaconhealthoptions.com.** This application can be found at www.georgiacollaborative.com.

July 2021

# Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

| | | |
|---|---|---|
| Amerigroup Community Care<br>1-800-454-3730<br>www.amerigroup.com | Peach State Health Plan<br>866-874-0633<br>www.pshpgeorgia.com | CareSource<br>1-855-202-1058<br>www.caresource.com |

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

| Included Populations | Excluded Populations |
|---|---|
| Parent/Caretaker with Children | Aged, Blind and Disabled |
| Transitional Medicaid | Nursing home |
| Pregnant Women (Right from the Start Medicaid – RSM) | Long-term care (Waivers, SOURCE) |
| Children (Right from the Start Medicaid – RSM) | Federally Recognized Indian Tribe |
| Children (newborn) | Georgia Pediatric Program (GAPP) |
| Women Eligible Due to Breast and Cervical Cancer | Hospice |
| PeachCare for Kids® | Children's Medical Services program |
| Parent/Caretaker with Children | Medicare Eligible |
| Children under 19 | Supplemental Security Income (SSI) Medicaid |
| Women's Health Medicaid (WHM) | Medically Needy |
| Refugees | Recipients enrolled under group health plans |
| Planning for Healthy Babies® | Individuals enrolled in a Community Based Alternatives for Youths (CBAY) |
| Resource Mothers Outreach | |

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services

they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All three CMOs are State-wide.**

The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

**Included Categories of Eligibility (COE):**

| COE | DESCRIPTION |
|---|---|
| 104 | LIM – Adult |
| 105 | LIM – Child |
| 118 | LIM – 1st Yr Trans Med Ast Adult |
| 119 | LIM – 1st Yr Trans Med Ast Child |
| 122 | CS Adult 4 Month Extended |
| 123 | CS Child 4 Month Extended |
| 135 | Newborn Child |
| 170 | RSM Pregnant Women |
| 171 | RSM Child |
| 180 | P4HB Inter Pregnancy Care |
| 181 | P4HB Family Planning Only |
| 182 | P4HB ROMC - LIM |
| 183 | P4HB ROMC - ABD |
| 194 | RSM Expansion Pregnant Women |
| 195 | RSM Expansion Child < 1 Yr |
| 196 | RSM Expn Child w/DOB < = 10/1/83 |
| 197 | RSM Preg Women Income < 185 FPL |
| 245 | Women's Health Medicaid |
| 471 | RSM Child |
| 506 | Refugee (DMP) – Adult |
| 507 | Refugee (DMP) – Child |
| 508 | Post Ref Extended Med – Adult |
| 509 | Post Ref Extended Med – Child |
| 510 | Refugee MAO – Adult |

| | |
|---|---|
| 511 | Refugee MAO – Child |
| 571 | Refugee RSM - Child |
| 595 | Refugee RSM Exp. Child < 1 |
| 596 | Refugee RSM Exp Child DOB </= 10/01/83 |
| 790 | Peachcare < 150% FPL |
| 791 | Peachcare 150 – 200% FPL |
| 792 | Peachcare 201 – 235% FPL |
| 793 | Peachcare > 235% FPL |
| 835 | Newborn |
| 836 | Newborn (DFACS) |
| 871 | RSM (DHACS) |
| 876 | RSM Pregnant Women (DHACS) |
| 894 | RSM Exp Pregnant Women (DHACS) |
| 895 | RSM Exp Child < 1 (DHACS) |
| 897 | RSM Pregnant Women Income > 185% FPL (DHACS) |
| 898 | RSM Child < 1 Mother has Aid = 897 (DHACS) |
| 918 | LIM Adult |
| 919 | LIM Child |
| 920 | Refugee Adult |
| 921 | Refugee Child |

**Excluded Categories of Eligibility (COE):**

| COE | DESCRIPTION |
|---|---|
| 124 | Standard Filing Unit – Adult |
| 125 | Standard Filing Unit – Child |
| 131 | Child Welfare Foster Care |
| 132 | State Funded Adoption Assistance |
| 147 | Family Medically Needy Spend down |
| 148 | Pregnant Women Medical Needy Spend down |
| 172 | RSM 150% Expansion |
| 180 | Interconceptional Waiver |
| 210 | Nursing Home – Aged |
| 211 | Nursing Home – Blind |
| 212 | Nursing Home – Disabled |
| 215 | 30 Day Hospital – Aged |
| 216 | 30 Day Hospital – Blind |
| 217 | 30 Day Hospital – Disabled |
| 218 | Protected Med/1972 Cola - Aged |
| 219 | Protected Med/1972 Cola – Blind |
| 220 | Protected Med/1972 Cola - Disabled |
| 221 | Disabled Widower 1984 Cola - Aged |
| 222 | Disabled Widower 1984 Cola – Blind |
| 223 | Disabled Widower 1984 Cola – Disabled |
| 224 | Pickle - Aged |

| | |
|---|---|
| 225 | Pickle – Blind |
| 226 | Pickle – Disabled |
| 227 | Disabled Adult Child - Aged |
| 227 | Disabled Adult Child - Aged |
| 229 | Disabled Adult Child – Disabled |
| 230 | Disabled Widower Age 50-59 – Aged |
| 231 | Disabled Widower Age 50-59 – Blind |
| 232 | Disabled Widower Age 50-59 – Disabled |
| 233 | Widower Age 60-64 – Aged |
| 234 | Widower Age 60-64 – Blind |
| 235 | Widower Age 60-64 – Disabled |
| 236 | 3 Mo. Prior Medicaid – Aged |
| 237 | 3 Mo. Prior Medicaid – Blind |
| 238 | 3 Mo. Prior Medicaid – Disabled |
| 239 | Abd Med. Needy Defacto – Aged |
| 240 | Abd Med. Needy Defacto – Blind |
| 241 | Abd Med. Needy Defacto – Disabled |
| 242 | Abd Med Spend down – Aged |
| 243 | Abd Med Spend down – Blind |
| 244 | Abd Med Spend down – Disabled |
| 246 | Ticket to Work |
| 247 | Disabled Child – 1996 |
| 250 | Deeming Waiver |
| 251 | Independent Waiver |
| 252 | Mental Retardation Waiver |
| 253 | Laurens Co. Waiver |
| 254 | HIV Waiver |
| 255 | Cystic Fibrosis Waiver |
| 259 | Community Care Waiver |
| 280 | Hospice – Aged |
| 281 | Hospice – Blind |
| 282 | Hospice – Disabled |
| 283 | LTC Med. Needy Defacto – Aged |
| 284 | LTC Med. Needy Defacto –Blind |
| 285 | LTC Med. Needy Defacto – Disabled |
| 286 | LTC Med. Needy Spend down – Aged |
| 287 | LTC Med. Needy Spend down – Blind |
| 288 | LTC Med. Needy Spend down – Disabled |
| 289 | Institutional Hospice – Aged |
| 290 | Institutional Hospice – Blind |
| 291 | Institutional Hospice – Disabled |
| 301 | SSI – Aged |
| 302 | SSI – Blind |
| 303 | SSI – Disabled |
| 304 | SSI Appeal – Aged |
| 305 | SSI Appeal – Blind |
| 306 | SSI Appeal – Disabled |

| | |
|---|---|
| 307 | SSI Work Continuance – Aged |
| 309 | SSI Work Continuance – Disabled |
| 308 | SSI Work Continuance – Blind |
| 315 | SSI Zebley Child |
| 321 | SSI E02 Month – Aged |
| 322 | SSI E02 Month – Blind |
| 323 | SSI E02 Month – Disabled |
| 387 | SSI Trans. Medicaid – Aged |
| 388 | SSI Trans. Medicaid – Blind |
| 389 | SSI Trans. Medicaid – Disabled |
| 410 | Nursing Home – Aged |
| 411 | Nursing Home – Blind |
| 412 | Nursing Home – Disabled |
| 424 | Pickle – Aged |
| 425 | Pickle – Blind |
| 426 | Pickle – Disabled |
| 427 | Disabled Adult Child – Aged |
| 428 | Disabled Adult Child – Blind |
| 429 | Disabled Adult Child – Disabled |
| 445 | N07 Child |
| 446 | Widower – Aged |
| 447 | Widower – Blind |
| 448 | Widower – Disabled |
| 460 | Qualified Medicare Beneficiary |
| 466 | Spec. Low Inc. Medicare Beneficiary |
| 575 | Refugee Med. Needy Spend down |
| 660 | Qualified Medicare Beneficiary |
| 661 | Spec. Low Income Medicare Beneficiary |
| 662 | Q11 Beneficiary |
| 663 | Q12 Beneficiary |
| 664 | Qua. Working Disabled Individual |
| 815 | Aged Inmate |
| 817 | Disabled Inmate |
| 870 | Emergency Alien – Adult |
| 873 | Emergency Alien – Child |
| 874 | Pregnant Adult Inmate |
| 915 | Aged MAO |
| 916 | Blind MAO |
| 917 | Disabled MAO |
| 983 | Aged Medically Needy |
| 984 | Blind Medically Needy |
| 985 | Disabled Medically Needy |

**HEALTH CARE PROVIDERS**

For information regarding the participating health plans (enrollment, rates, and procedures), please

call the numbers listed below.
Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 800-454-3730<br>(general information)<br>www.amerigroup.com | 1-855-202-1058<br>www.careSource.com/GeorgiaMedicaid | 866-874-0633 (general information)<br>866-874-0633 (claims)<br>800-704-1483 (medical management)<br>www.pshpgeorgia.com |

**Registering immunizations with GRITS:**
If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.
**Important tips for the provider to know/do when a member comes in:**
Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.
You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.
**Use of the Medicaid Management Information System (MMIS) web portal:**

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.
**Participating in a Georgia Families' health plan:**
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.
**Billing the health plans for services provided:**
For members who are in Georgia Families, you should file claims with the member's health plan.
**If a claim is submitted to GAINWELL TECHNOLOGIES in error:**
GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.
**Credentialing**
Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.
Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.
This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple

times.
The CVO's one-source application process:

- •Saves time
- •Increases efficiency
- •Eliminates duplication of data needed for multiple CMOs
- •Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.
GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

**Assignment of separate provider numbers by all of the health plans:**
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

**Billing the health plans for services provided:**
For members who are in Georgia Families, you should file claims with the member's health plan.

**If a claim is submitted to GAINWELL TECHNOLOGIES in error:**
GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

**Receiving payment:**
Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

**Health plans payment of clean claims:**
Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|

| | | |
|---|---|---|
| Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated.<br>Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday.<br>Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday.<br>**Dental:** Checks are mailed weekly on Thursday for **clean** claims.<br>**Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th)<br><br>**Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day) | CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated.<br><br>Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays. | Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual. |

**How often can a patient change his/her PCP?**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| Anytime | Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as:<br>• Member requests to be assigned to a family member's PCP<br>• PCP does not provide the covered services a member seeks due to moral or religious objections<br>• PCP moves, retires, etc. | Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change. |

**Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| Next business day | PCP selections are updated in CareSource's systems daily. | PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month. |

**PHARMACY**

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 800-454-3730<br>https://providers.amerigroup.com/pages/ga-2012.aspx | 844-441-8024<br>https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod | 866-874-0633<br>www.pshpgeorgia.com |

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

**The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:**

| Health Plan | PBM | BIN # | PCN # | GROUP # | Helpdesk |
|---|---|---|---|---|---|
| **Amerigroup Community Care** | IngenioRx | 020107 | HL | WKJA | 1-833-235-2031 |
| **CareSource** | Express Scripts (ESI) | 003858 | MA | RXINN01 | 1-800-416-3630 |
| **Peach State Health Plan** | RxAdvance | 020545 | RXA379 | RXGMCGA01 | 1-800-518-5973 |
| | CVS | 004336 | MCAIDADV | RX5439 | 1-844-297-0513 |

**If a patient does not have an identification card:**

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at

www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.
Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| No, you will need the member's health plan ID number | Yes, you may also use the health plan ID number. | Yes |

**Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:**

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

**Will Medicaid cover prescriptions for members that the health plans do not?**

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

**Who to call to request a PA:**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 1 (800) 454-3730 | 1 (855) 202-1058<br>1 (866) 930-0019 (fax) | 1 (866) 399-0929 |

# APPENDIX N

## Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) services are defined as medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.

**How do I get NEMT services?**

If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling. Urgent care or same day reservations may require verification from your direct provider of service confirming you must be seen that day. Each broker has a toll-free telephone number to schedule transportation services, and available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.

All counties in Georgia are grouped into five regions for NEMT services. A NEMT Broker covers each region. If you need NEMT services, **you must contact the NEMT Broker serving the county you live in** to ask for Non-Emergency Medical Transportation. Contact Southeastrans for Atlanta and North Regions and ModivCare, formerly LogistiCare, for Central, East and Southwest See the chart below to determine which broker serves your county and call the broker's telephone number for that region.

**What if I have problems with a NEMT provider or broker?**

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. If you have a question, comment, or complaint about a NEMT provider or broker that has not been resolved with the broker, you may contact the Georgia Department of Community Health, NEMT unit.

**NEMT REGIONS & COUNTIES SERVED**

| Region | NEMT Broker & Phone Number | Counties Served |
|---|---|---|

| | | |
|---|---|---|
| North | **Southeastrans**<br><br>*Toll free*<br>1-866-388-9844<br><br>*Local*<br>678-510-4555 | Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield |
| Atlanta | **Southeastrans**<br>404-209-4000<br><br>*Note: For Georgia Families 360°*<br><br>1-866-991-6701 | Fulton, DeKalb, and Gwinnett |
| Central | **ModivCare**<br>***(formerly LogistiCare)***<br><br>*Toll free*<br>1-888-224-7981 | Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson |
| East | **ModivCare**<br>***(formerly LogistiCare)***<br><br>Toll free<br>1-888-224-7988<br><br>*Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities*<br><br>1-800-486-7642 Ext. 461 or 436 | Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes |
| | | |

## APPENDIX O

## Person Centered Planning

Person Centered Organizations: Creating Transformational Change

Basics of Person Centered Thinking (PCT):

(1) What is it?

- Set of tools that convey the core belief that all people are valued
- A common language, easily communicated, that activate the agency's values
- A set of skills that result in teams keeping the focus on the person who needs support – not agency or turf issues
- A way to describe the desired lifestyle of the person who is supported, not the lifestyle desired by the agency
- Creates a blueprint for critical thinking skills for frontline staff, supervisors and managers that is consistent

(2) How does it benefit an Organization?

- Aligns the agency's approach towards its employees with its approach towards people supported
- Creates a focus on the preferences of the customer, resulting in context necessary to address issues of health, safety and valued social roles.
- Replaces jargon with a common language
- Uses a set of tools, easily taught, that build critical thinking skills for employees
- Tools are interrelated –one supports the next
- Initial Two-Day Training builds knowledge, followed by structured practice to develop skill
- Same tools used to develop and support the people served are used to develop and support the abilities of all employees throughout the agency.

How does PCT do this?

- Person Centered Planning-> PC Plan (many people involved, one person's plan)
- Person Centered Thinking (changes in our language)
- Person Centered Practices–(changes in our Tools and documents)
- Person Centered Organizations–(changes in our Processes-business and program)
- Person Centered Systems–(changes in our Relationships with external agencies)

The Evolution of the Efforts

Training in Person Centered Planning 1990

Training in Person Centered Thinking 2001

Training + the Development and Support of Coaches 2002

Training and Coaches + the Sustained Engagement of Organizational Leadership – 2005

Training, Coaches, Organizational Leadership + Sustained Engagement of System Leadership – 2006

- Teaching person centered thinking skills
- Developing and supporting coaches to spread the skills
- Creating structured ways for leadership to listen to coaches
- Building local capacity/creating sustainability
    - 
    - Person centered thinking trainers
    - Teaching leadership/quality management skills

1. Intentionally building better partnerships between all of the key stakeholders

The structure of the effort -

2. Transactional Dynamics –the everyday interactions and exchanges that create the working climate; changes in these interactions can change the climate of the workplace; structure, roles, reporting, tasks, management practice, supervisory activities etc.

3. Transformative Change –change within an organization that creates a shift in values

or culture; generally requires "entirely new behavior sets on the part of organization members"

Transactional vs. Transformative*

*From W. Warner Burke, Diagnosis for Organizational Change

- 

Culture Change permeates the full organization:

a. Leadership

b. Employees

c. Service Delivery/Programs

d. Business Departments –Finance, Information Technology, HR

e. Mission/Vision/Values and Strategy

f. Relationships with external organizations and partners

Transformative Change

- Customer Focus clearly defines expectations, and ties to the M/V/V and strategy of the organization

- Leaders demonstrate through their own language, and clear messages that labels are not acceptable

➢

a. People are referred to respectfully throughout the organization

b. Really effective leaders realize that their job is not to have all the answers, but rather to understand what questions they should ask to help their employees discover the answers

i. Customer desired outcomes drive service delivery approach

➢

a. I am listened to

b. What is important to me is recognized and present every day

ii. Focus on becoming a learning organization –continuous quality improvement

➢ Dedicated to learning from all engagements, alleviating blame culture, and building strong partnerships internally and externally

iii. Full organization is focused on how to move beyond simply meeting standards –

➢ Recognizing compliance as the floor, not the ceiling, of high quality service/performance.

- 

iv. What should be shared?

a. With others in the organization

b. With others outside of the organization

ii. What should be celebrated?

iii. What should be changed?

a. Is this story typical practice or is it exceptional practice?

b. What organizational issues of structure, practice, rules or communication are getting in the way of implementing person centered practice? (Level 2)

c. What system-wide issues (as above) exist? (Level 3)

d. What did you hear in the story?

5. What methods/strategies will you use? Is it repeatable?

a. What is the sequence of activity?

b. Which departments will be included? Which areas, offices or locations? Which service sector?

c. Who will need to know, and how will they be informed?

d. How will you make sure it is uniform?

e. How will you determine that your approach is effective?

f. How will you know it is working? What is your strategy for learning from your approach?

g. What measures will you use?

6. Where does the change need to occur?

Answers to the QUESTION: What do you think you are doing differently because of your efforts at creating Person Centered Organizations?

From long term services organizations–July 2009

1. "This project made me look at people in a different way"

2. "I have gained the ability to listen to people better and more carefully and ask better questions as I try to get to know them" (regulator)

3. "This program has (helped) us to become team players."

4. "Whenever situations arise, we come together as a team."

Answers to the QUESTION: What do you think you are doing differently because of your work?

From Developmental Disability Services:

i. "Opens up communication"

j. "The tools are versatile; you can use them with everyone"

k. "This effort has brought common sense into supporting people"

l. "Results in better lives and a better workplace"

m. "Keeps our organization focused" (from CEO)

n. "Makes our job easier"

o. "Helps us focus on the people and not just the regulations"

p. "I have been in the field for 19 years and this is so much better, not just collecting data, but learning about a better life"

q. "It brings people together and unifies them for the right purpose"

**APPENDIX P**
**LETTER OF INTENT TO PROVIDE SERVICES FORM**

**GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES**
***Division of Developmental Disabilities***

**SERVICE SITE**
(Legal name and address must be registered with the Georgia Secretary of State's office)

| | | | |
|---|---|---|---|
| **Legal Name**: | | | |
| Tax ID #: | | | |
| Corporate Street Address: | | | |
| City: | County: | State: | Zip Code: |
| **Service Site Name**: | | | |
| Service Site Address: | | | |
| City: | County: | State: | Zip Code: |
| Mailing Address (if different): | | | |
| City: | County: | State: | Zip Code: |
| **Owner:** | | | |
| Telephone: | | Fax: | |
| Email Address: | | Website: | |
| **Director:** | | | |
| Telephone: | | Fax: | |
| Email Address: | | Website: | |
| **Nurse:** | | | |
| Telephone: | | Fax: | |
| Email Address: | | Website: | |
| **Developmental Disabilities Professional:** | | | |
| Telephone: | | Fax: | |
| Email Address: | | Website: | |

***EMAIL ADDRESSES MUST BE CURRENT AND CORRECT AS ALL FUTURE CORRESPONDENCE FROM DBHDD WILL BE CONDUCTED VIA EMAIL. IT IS THE RESPONSIBILITY OF THE POTENTIAL PROVIDER TO ENSURE THAT EMAILS FROM DBHDD ARE ACCEPTED BY YOUR EMAIL SYSTEM AND DO NOT GO TO THE "SPAM" MAILBOX.***

**List below the Waiver Services that you are applying to provide and the number of individuals to be served in each Service.**

| Waiver Service *Such as CRA, CLS, SE etc.* | Number of Individuals to be Served In Each Service | County of Service Provision | Region of Service Provision | Licensed Service Y/N? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**In accordance with Department of Community Health (DCH) Healthcare Facility Regulation Division (HFR) [which was formerly known as Office of Regulatory Services or ORS], please indicate all applicable license(s) that you possess:**

❒ Child Placing Agency (CPA) license
❒ Community Living Arrangement (CLA) license
❒ Home Health Agency (HHA) license
❒ Personal Care Home (PCH) license
❒ Private Home Care (PHC) license

**Please list any services that the organization has delivered to citizens with developmental disabilities within the past five years.**

| Name of Service | Location of Service | Length Of Service |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Please list any previous Contracts, Letters of Agreement (LOA) or Provider Agreements (PA) issued to the organization within the last five years by any of the following:** Division of Mental Health, Developmental Disabilities & Addictive Diseases (DMHDDAD) – currently known as the Department of Behavioral Health and Developmental Disabilities (DBHDD) Division of Aging – currently known as the Department of Human Services (DHS), Division of Aging Department of Community Health (DCH)

| **List Agency Name Used On Contract or LOA** | **List all Key Personnel Names** **Such as** CEO/President Key Management Staff, Relative or Board of Directors | **Contact Phone Number And E-Mail Address of each Key Personnel Name Listed** | **Department Issuing Contract** | **Service Provided Such as Aging, ICWP, Source etc.** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

With this *Letter of Intent to Provide Services Form,* your organization must also submit all pre-qualifiers listed within the **Recruitment and Application to Become a Provider of Developmental Disabilities Services Policy**. Any incomplete *Letter of Intent to Provide Services Form*, and/or incomplete or deficient pre-qualifier will result in no invitation to move forward to the application process.

**Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this document and that the information contained herein this document is complete, true, and correct.**

Name of Organization (please print)

Owner / Title (please print)

Signature of Owner/ Title

Date

# APPENDIX Q
# IDD NEW SITE INSPECTION CHECKLIST

D·B·H·D·D

## SITE INSPECTION REQUEST FORM

| | | | |
|---|---|---|---|
| **Person Making Request** | | **Date Emailed to Region** | |
| **Provider Agency** | | | |
| **Site-Specific CRA Number or Application Tracking Number** | | **Region of Responsibility** | |
| **Phone/Ext** | **Email** | **Targeted Move Date** | |

**Reason for Inspection:** *(mark only one category)*
- ☐ New Site
- ☐ Individual Move Within Agency (PPSV)
  - ↳ ☐ Temporary *or* ☐ Permanent
- ☐ New Admission to Agency (PPSV)
- ☐ Change of Address (COA)
- ☐ Site Conversion
- ☐ Emergency Respite ☐ Scheduled Respite
  - ↳ ☐ Within Region *or* ☐ Out of Region

| | | | |
|---|---|---|---|
| **SC Agency/PLA** | ☐ Columbus ☐ Creative ☐ GA Supports ☐ Professional ☐ PLA ☐ Compass ☐ Carestar ☐ Benchmark | | |
| **SC or PLA Name** | | **SC/PLA Phone** | |
| **SC or PLA Supervisor Name** | | **Region to Region Transfer? List regions:** | YES ☐ NO ☐ |

| **Potential New Individual for Placement** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name** | | | | **Age** | | | |
| **Axis I** | | **Axis II** | | **Axis III** | | ☐ Male ☐ Female | |
| **Assistance with Ambulation** | YES ☐ NO ☐ | **Assistance with Transfer** | YES ☐ NO ☐ | | | | |
| **Medical Needs and/or Equipment** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **Behavioral Challenges** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **ER for Behavioral or Medical Needs in Place** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **Likes/Dislikes/Hobbies** | | | | | | | |

| **Current Individual Residing in Home (if applicable)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name** | | | | **Age** | | **Date Placed** | |
| **Axis I** | | **Axis II** | | **Axis III** | | ☐ Male ☐ Female | |
| **Assistance with Ambulation** | YES ☐ NO x | **Assistance with Transfer** | YES ☐ NO x | | | | |
| **Medical Needs and/or Equipment** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **Behavioral Challenges** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **ER for Behavioral or Medical Needs in Place** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **Likes/Dislikes/Hobbies** | | | | | | | |

| **Current Individual Residing in Home (if applicable)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name** | | | | **Age** | | **Date Placed** | |
| **Axis I** | | **Axis II** | | **Axis III** | | ☐ Male ☐ Female | |
| **Assistance with Ambulation** | YES ☐ NO x | **Assistance with Transfer** | YES ☐ NO x | | | | |
| **Medical Needs and/or Equipment** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **Behavioral Challenges** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **ER for Behavioral or Medical Needs in Place** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **Likes/Dislikes/Hobbies** | | | | | | | |

| **Current Individual Residing in Home (if applicable)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name** | | | | **Age** | | **Date Placed** | |
| **Axis I** | | **Axis II** | | **Axis III** | | ☐ Male ☐ Female | |
| **Assistance with Ambulation** | YES ☐ NO ☐ | **Assistance with Transfer** | YES ☐ NO ☐ | | | | |
| **Medical Needs and/or Equipment** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **Behavioral Challenges** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **ER for Behavioral or Medical Needs in Place** | Yes ☐ No ☐ *Specify:* | | | | | | |
| **Likes/Dislikes/Hobbies** | | | | | | | |

| | | | |
|---|---|---|---|
| **Street** | | **Instructions Regarding Home Location/Entry** | |
| **City** | **Zip** | | |
| **County** | **Phone** | | |
| **Licensed PCH** YES ☐ NO ☐ | **Licensed CLA** YES ☐ NO ☐ | **Home near community resources?** | YES ☐ NO ☐ |
| *CLA/PCH will not be processed without a copy of current license/permit. | | **Host Home (Life-Sharing)**** | YES ☐ NO ☐ |
| **License Date** | (From) (To) present | ****If YES, is *Home Study* attached?** | YES ☐ NO ☐ |
| **Has this license been verified at www.dch.georgia.gov?** YES ☐ NO ☐ | | **Date License Verified** | **Verified By** |

**Only completed requests will be processed for approval. Once approved, the Regional Case Expeditor will forward correspondence to appropriate parties.**

| MET | SITE INSPECTION CHECKLIST |
|---|---|
| | **OVERALL CONDITION OF THE HOME** |
| ☐ | Home is free of clutter, odor, mold, trash and dust. |
| ☐ | Heating and air conditioning systems are operational and provide adequate heat and air. |
| ☐ | No needed repair work around the home, yard, deck. |
| ☐ | The yard area is free from hazards, trash,etc. |
| ☐ | All areas are lighted sufficiently and fixtures are secured. |
| ☐ | Provides an area for use by residents and visitors that affords privacy. |
| ☐ | Furnishings are in good condition. |
| ☐ | Provides common space, such as living room and kitchen, for use by the residents without restriction. |
| ☐ | Garbage is stored/disposed of properly. |
| | **OVERALL SAFETY OF THE HOME** |
| ☐ | Residents dependent upon a wheelchair have at least 2 accessible exits. |
| ☐ | One fully wheelchair accessible bathroom (if applicable). |
| ☐ | Space heaters are not present in home. |
| ☐ | Stairways/ramps have handrails; exterior stairways/decks/porches w/handrails on open sides unless low to ground. |
| ☐ | Sufficient AC powered smoke and CO detectors with battery back-up (should keep record of when changed). |
| ☐ | Charged, 5 lb. multipurpose ABC fire extinguisher on each floor and basement, tagged by a fire extinguisher company. Staff should check the extinguisher monthly to verify it has a full charge; tag should be initialed/dated by staff after each check. |
| ☐ | Exterior doors are equipped with locks that do not require keys to open from the inside. |
| ☐ | The storage/disposal of biomedical and hazardous waste complies with applicable rules and standards (if applicable). |
| ☐ | Wall-mounted electric outlets and lamps or light fixtures are safe and operational. |
| ☐ | Poisons, caustics, and dangerous materials are stored in labeled, appropriate containers away from medication & food. |
| ☐ | Hot water temp 110 to 120 degrees Fahrenheit. |
| ☐ | An evacuation plan with clear instructions is provided, and a diagram is posted in CLA/PCH (posted diagram not required in HH). |
| ☐ | Monthly Fire Drill Report forms are present in the home, noting that individuals evacuate in under 3 minutes; 13 minutes if sprinkler system is present. |
| ☐ | Fireplace is securely screened and/or equipped with protective guards while in use. |
| ☐ | Fireplace has been cleaned and verification from professional cleaning company is available for review (if used). |
| ☐ | All stairways, halls, doorways and exits are unobstructed (including a clear exit from garages). |
| ☐ | Flammable and combustible supplies/equipment are stored away from heat sources. |
| ☐ | Firearms owned and in the home are unloaded and secured in locked cabinet (for HH ONLY). |
| ☐ | Sufficient safety precautions are taken to prevent unauthorized access to swimming pools, or any body of water. |
| ☐ | All pets are current on vaccinations (if applicable). |
| | **KITCHEN/LAUNDRY** |
| ☐ | All appliances are in good working order. |
| ☐ | Provides laundering facilities, at minimum one washer and one dryer. |
| ☐ | Food is stored properly. |
| ☐ | Maintains a 3-day supply of non-perishable foods for emergency needs. All food should have expiration dates. |
| | **RESIDENT BEDROOMS** |
| ☐ | All bedrooms provide a minimum of 80 square feet for each resident in CLA/PCH or sufficient space in a HH. |
| ☐ | All bedrooms have at least one window. |
| ☐ | All bedrooms have standard non-portable bed with springs or a specialized bed. Mattress and bedding must be clean. |
| ☐ | Sufficient bed linens for all residents including spare linens for use when soiled linens are being laundered |
| ☐ | No bedroom is a pass-through to reach another room or bathroom. |
| ☐ | All bedrooms have an adequate closet or wardrobe for each resident. |
| ☐ | All Bedrooms have lighting fixtures sufficient for reading and other activities. |
| ☐ | All bedrooms have doors that can be closed; no double-cylinder locks. |
| | **BATHROOMS** |
| ☐ | Provides at least one full functional bathroom. |
| ☐ | Grab bars and non-skid surfacing are in all showers/bath areas. |
| ☐ | Bath linens are present and sufficient . |

Grab bars and non-skid surfacing are in all showers/bath areas.

*Last Revision 1/23/2020*

| | |
|---|---|
| ☐ | Bathrooms have a window that can be opened or forced ventilation fan. |
| ☐ | Tub/shower has a shower curtain or door. |
| ☐ | Plumbing/bathroom fixtures are clean and in good working order. |
| ☐ | Toilet tissue is available for use at each commode. |
| ☐ | Hand-washing facilities have hot and cold running water, liquid soap, and towels. |
| | **HEALTH and SAFETY** |
| ☐ | Medications are stored appropriately and under lock/key; controlled substances are double locked. |
| ☐ | Medical supplies are stored appropriately. |
| ☐ | Supply of first-aid materials available w/band aids, antiseptic, gauze, tape, probe covers, and a thermometer in home. |
| ☐ | First aid kit and fire extinguisher in vehicle. |
| ☐ | Functioning seatbelts in all vehicles used to transport individuals |
| *Notes and additional information (please explain in detail any boxes left blank above):* | |

| | | | |
|---|---|---|---|
| **Date of Provider Site Inspection (prior to request to DBHDD) :** | | **Site Inspection Completed By:** | |
| **Request Completed By/Title:** | | **Date Submitted:** | |
| **Agency Contact and Telephone Number:** | | | |
| **Approved By and Date: (DBHDD Staff)** | | | |

⚠ **Provider must <u>complete</u> the initial inspection before the site visit request is sent to the Region** ⚠

| Supplemental Information – TRANSFERS ONLY | | | |
|---|---|---|---|
| *Request for Transfer:* | ☐ Individual | ☐ Family | ☐ Provider |
| *Reason(s) for Transfer:* | ☐ Closer to family<br>☐ Conflict with staff<br>☐ Conflict with housemates<br>☐ Conflict with neighbors<br>☐ Issue with Law Enforcement | ☐ Issue with services/care<br>☐ Dissatisfied with location<br>☐ Environmental Issues<br>☐ Investigation<br>☐ Other _____ | |
| *Where is the individual moving from? (List Provider Name & Home Address)* | **Provider Name** | | |
| | **Home Address** | | |
| *What are the current support needs of the individual?* | **Medical** | | |
| | **Behavior** | | |
| | **Staffing Ratio** | | |
| | **Environmental** | | |
| | **Equipment** | | |
| | **Other** | | |
| *Critical Clinical Needs (if applicable)* | | | |
| *Choice* | **Individual was presented with several choices:**<br>With Current Provider? ☐Yes ☐No<br>With Another Provider? ☐Yes ☐No | | |
| | **Individual and/or family was able to visit/see the home:**<br>☐Yes, date: ☐No If no, explain: | | |
| | **Are there other individuals in the home?** ☐Yes ☐No<br>→ If yes, is this a good match based on age, gender, likes/dislikes, hobbies, abilities, etc.? ☐Yes ☐No | | |
| *New Provider Preparation* | **ISP Version Changes?** ☐Yes ☐No | | |
| | **Revised HRST/SIS if needed?** ☐Yes ☐No | | |
| | **New provider requested/received current list of prescribed medication(s) from pharmacy?** ☐Yes ☐No | | |
| | **Documents received from Clinical Record List?** ☐Yes ☐No | | |
| | **Does the individual have a:**<br>→ Behavior Support Plan ☐Yes ☐No Date of Plan:<br>→ Safety Plan ☐Yes ☐No Date of Plan:<br>→ Health Care Plan ☐Yes ☐No Date of Plan: | | |
| *Training of New Provider or New Home Staff* | **List all training completed by new provider and dates based on ISP, HRST, and current service needs:** | | |
| *Information reviewed with Support Coordinator/Planning List Administrator* | **Date:** ☐Yes ☐No Comments: | | |

Rev. 01 2011

# Appendix R

**Antipsychotic Medications**

| Generic | Trade |
|---|---|
| Aripiprazole | Abilify |
| Chlorpromazine | Thorazine |
| Chlorprothixene | Taractan |
| Clozapine | Clozaril |
| Fluphenazine | Permitil, Prolixin* |
| Haloperidol | Haldol* |
| Loxapine | Loxitane |
| Mesoridazine | Serentil |
| Molindone | Lidone, Moban |
| Olanzapine | Zyprexa |
| Palinperidone | Invega* |
| Perphenazine | Trilafon |
| Pimozide (for Tourette's) | Orap |
| Quetiapine | Seroquel |
| Risperidone | Risperdal* |
| Thioridazine | Mellaril |
| Thiothixene | Navane |
| Trifluoperazine | Stelazine |
| Trifluopromazine | Vesprin |
| Ziprasidone | Geodon |

*Also has a sustained release injectable form

**Mood Stabilizer Medications**

| Generic | Trade |
|---|---|
| Lithium Carbonate | Eskalith |
| Lithium Carbonate | Lithonate |
| Divalproex Sodium | Depakote |
| Tiagabine | Gabatril |
| Levetiracetam | Keppra |
| Lamotrigine | Lamitcal |
| Gabapentin | Neurontin |
| Carbamazepine | Tegretol |
| Oxcarbazepine | Trileptal |
| Topiramate | Topamax |
| Zonisamide | Zonegran |

| | |
|---|---|
| Verapamil | Calan |
| Clonidine | Catapres |
| Propranolol | Inderal |
| Mexiletine | Mexitil |
| Guanfacine | Tenex |

Rev. 04 2013

# Appendix S
## Documentation Progress Note and Summary Examples
(For all services except CRA, CLS and Respite)
## Individual Progress Note Log

| | | |
|---|---|---|
| **Person's Name:** | | **Provider Name:** |
| **MHN ID Number:** | | **Service:** |
| **Support Plan Date:** | **Addendum date:** | **Procedure Code:** |
| **Month/Year:** | | |
| **Peer Quality Assurance Review:** | | **Date:** |

**Codes:**

***Disclaimer: The use of this form does not guarantee compliance with all policies/standards for documentation.***

***ISP Goal A:***

| | | | | | | |
|---|---|---|---|---|---|---|
| **Service:** | **Date:** | **Time: In** | | | **Total hours/Units:** | |
| | | **Time: Out** | | | | |

| **Objective(s) listed on ISP Action Plan** | **Frequency/completion date** | **Code** |
|---|---|---|
| 1. | | |
| 2 | | |
| 3. | | |
| 4. | | |

**Progress Note (Optional – Documentation can be written here if the person is not working on a specific goal for the day):**

| | |
|---|---|
| **Direct Support Staff printed name/title:** | **Signature of Direct Support Staff:** **Date:** |

**Weekly Additional Person Centered Progress**

| **Achievements** | **Identified Barriers** |
|---|---|
| **What did he/she enjoy?** | **What did he/she not enjoy?** |
| **What worked and needs to be continued?** | **What did not work and needs to be changed?** |
| ***You can place any other information about the goal into this section. OPTIONAL*** | |
| **Direct Support Staff printed name/title:** | **Signature of Direct Support Staff:** **Date:** |

***Weekly Additional Routine Person Centered Supports (Supports are pre-filled by the provider agency and additional supports can be added if necessary):***

| | | | | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

***Additional Comments/Significant Events(s)(If no comments/significant events, indicate N/A):***

| | |
|---|---|
| **Direct Support Staff printed name/title:** | **Signature of Direct Support Staff:** **Date:** |

***Legend Individual Progress Note Log***

**Section I Individual Identifiable Information (This section is pre-filled by the provider agency)**

| | | |
|---|---|---|
| **a. Person's Name:** | | **g. Provider Name:** |
| **b. MHN ID Number:** | | **h. Service:** |
| **c. Support Plan Date:** | **f. Addendum date:** | **i. Procedure Code:** |
| **d. Month/Year:** | | |
| **e. Peer Quality Assurance Review:** | | **j. Date:** |

a. **Person's Name:** Name of the individual served
b. **MHN ID Number:** Individual's MHN ID number
c. **Support Plan Date:** Identify the ISP timeframe
d. **Month/Year:** Identify month and year of when services are being documented
e. **Peer Quality Assurance Review:** Professional reviewer's name and signature
f. **Addendum date:** Identify any addendum date if applicable
g. **Provider Name:** This is where you place your provider name
h. **Service:** Specific service documenting
i. **Procedure Code:** Code for the service providing.
j. **Date:** Date reviewed by the Peer Quality Assurance reviewer (not pre-filled by the provider agency)

**Section II Codes**

| |
|---|
| **Codes:** |

**Codes:** In this section you identify the codes used to identify the level of intervention/support the person required at the time of the training. For example: I=Independent, GP=Gestural prompt, VP=Verbal prompt, H-H=Hand-over-Hand assistance, M=Modeling, PPA=Partial physical assistance, FPA=Full physical assistance, N/A=Not applicable at this stage of progress, R= Refused (**The cues should be individualized and may depend on the objective. Codes can be added in this section**)

**Section III *ISP Goal A:***

| | | | | | | |
|---|---|---|---|---|---|---|
| **a. Service:** | **b. Date:** | **c. Time: IN** | | | **e. Total hours/Units:** | |
| | | **d. Time: Out** | | | | |
| **f. Objective(s) listed on ISP Action Plan** | | | | | **g. Frequency/completion date** | **h. Codes** |
| 1. | | | | | | |
| 2 | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| **i. Progress Note (Optional – Documentation can be written here if the person is not working on a specific goal for the day):** | | | | | | |
| **J. Direct Support Staff printed name/title:** | | | | **K. Signature of Direct Support Staff:** **l. Date:** | | |

**Section III**
**ISP Goal A:** This is the Goal for the service listed in the individual's ISP.

a. **Service:** Service rendered
b. **Date:** Date service provided
c. **Time In:** Start time
d. **Time Out:** End Time
e. **Total hours/Units:** Identify the total number of hours and units to be billed for the day
f. **Objective(s):** List objective(s) identified on the person's ISP
g. **Frequency/completion date:** For the objective (1) include the frequency on the ISP or if the objective was met, identify the completion date
h. **Code:** In this section you identify the codes used to identify the level of intervention or supports the person required at the time of the training.
i. **Progress Notes:** Optional – Documentation can be written here if the person is not working on a specific goal for the day): Staff can document on what the person did related to the services provided outside the scope of the goal/objective(s). Include how the person responded, any significant event, new experiences, and/or what is next. Any requests the person makes for the service/supports provided. Elaborating on any progress needing to be documented or completion of objective/goal.
j. **Direct Support Staff printed name/title:** Name of direct support professional working with the individual on the goal
k. **Signature of Direct Support Staff:** Can be hand written or a secure electronic signature
l. **Date:** Date note written and service rendered

**Section IV Weekly Additional Person Centered Progress**

| **Achievements** | **Identified Barriers** |
|---|---|
| **a. What did he/she enjoy?** | **b. What did he/she not enjoy?** |
| **c. What worked and needs to be continued?** | **d. What did not work and needs to be changed?** |
| ***e. You can place any other information about the goal into this section. OPTIONAL*** | |
| **f. Direct Support Staff printed name/title:** | **g. Signature of Direct Support Staff:**<br>**h. Date:** |

a. **What did he/she enjoy?** For the week services were rendered identify what the person enjoyed doing, working on and/or experiencing.
b. **What did he/she not enjoy?** For the week services were rendered identify what the person did not enjoy doing, working on and/or experiencing.
c. **What worked and needs to be continued?** For the week services were rendered identify what strategies, methods, techniques and supports worked for the person and needs to become a regular part of how supports and services are provided.
d. **What did not work and needs to be changed?** For the week services were rendered identify what strategies, methods, techniques and supports did not work for the person and needs to change.

e. ***You can place any other information about the goal into this section.*** *(Example: who, what, where, why, when and what's next to progress)* Can be a weekly summary of the person's progress on goal(s)/objective(s) and/or the supports and services provided and how the person responded.

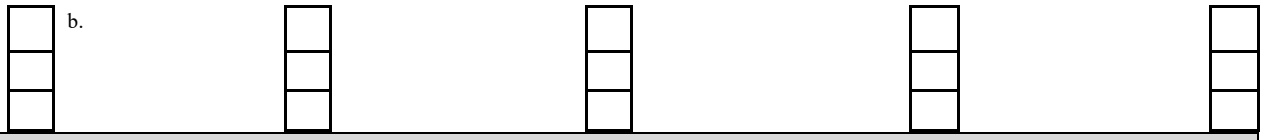
f. **Direct Support Staff printed name/title:** Name of direct support professional working with the individual

g. **Signature of Direct Support Staff:** Can be hand written or a secure electronic signature

h. **Date:** Date note written and service rendered

***Section V***

a. ***Weekly Additional Routine Person Centered Supports*** ***(Supports are pre-filled by the provider agency and additional supports can be added if necessary):***




| c. *Additional Comments/Significant Events(s) (If no comments/significant events, indicate N/A):* | |
|---|---|
| | |
| **d. Direct Support Staff printed name/title:** | **e. Signature of Direct Support Staff:**<br>**f. Date:** |

a. **Weekly Additional Routine Person Centered Supports:** This section is designed for routine supports/needs that the person may require on an on-going basis. This section should be individualized based upon the identified needs in the ISP.

b. **Identified additional support:** Identify any additional ongoing support/needs by each box. This section can be prefilled with the regular supports provided to the person and the staff will check off which specific supports occurred during the reporting period.

c. **Additional Comments/Significant Events:** The box below can be utilized to capture any significant events from the day or week that is in direct relationship to the person. The box below will expand when you write! (Examples: how the person reacted to a new experience, new faces-new places, significant event changes in the person life, choices made, and any information about rights, health, safety, community connections, etc.).

d. **Direct Support Staff printed name/title:** Name of direct support professional working with the individual.

e. **Signature of Direct Support Staff:** Can be hand written or a secure electronic signature.

f. **Date:** Date note written and service rendered.

***Disclaimer: The use of this form does not guarantee compliance with all policies/standards for documentation.***

## Monthly Quality Assurance Summary of Services

***(This summary will be done by case manager or whoever is designated by the provider to have professional clinical oversight of individual's services. When the clinical oversight staff provide direct supports and complete progress notes, the provider must assure oversight of this direct service provision.)***

| | |
|---|---|
| **Person's Name:** | **Provider Name:** |
| **Support Plan/ Addendum Date:** | **Procedure Code:** |
| **MHN ID Number:** | **Month/ Year:** |

***Disclaimer: The use of this form does not guarantee compliance with all policies/standards for documentation.***

### Support Plan Goal(s) and Objective(s) by Service

| |
|---|
| **Goal from ISP:** |
| **Objective(s):** |

### Contact with Direct Support Professional

**Name of Direct Support Staff:** **Date of Contact:**

**Monthly Summary by Service:**

**Follow-up from previous month:**

**Expectations: (Of these expectations, this summary must address B, H, I and J. Others are optional.)**

A. **Health/Medical/ Behavioral:**

B. **Person's Perspective/Person Directed Planning:**

C. **Choice:**

D. **Rights:**

E. **Community Life:**

F. **Safety:**

G. **Collaboration:**

H. **Progress (what's working/not working):**

I. **Significant Changes and Events:**

J. **Follow Up/Next Steps for future progression:**

| | |
|---|---|
| **Printed Name of Clinical Oversight Staff:** | **Credentials:** |
| **Signature of Clinical Oversight Staff:** | **Date:** |

### Legend Monthly Quality Assurance Summary of Services

***(This summary will be done by case manager or whoever is designated by the provider to have professional clinical oversight of individual's services. When the clinical oversight staff provide direct supports and complete progress notes, the provider must assure oversight of this direct service provision.)***

**Section I** Individual Identifiable Information (Prefilled by the provider agency)

| | |
|---|---|
| a. Person's Name: | b. Provider Name: |
| c. Support Plan/Addendum Date: | d. Procedure Code: |
| e. MHN ID Number: | f. Month/Year |

- **a. Person's Name:** Name of the individual served
- **b. Provider Name:** This is where you place your provider name
- **c. Support Plan/Addendum Date:** Identify the ISP timeframe or addendum date
- **d. Procedure Code:** Code for the service providing
- **e. MHN ID Number:** Individual's MHN ID number
- **f. Month/Year:** Identify month and year of when services are being documented

**Section II Support Plan Goal(s) and Objective(s) by Service**

| |
|---|
| **a. Goal from ISP:** |
| **b. Objective(s):** |

a. **Goal from ISP:** List the goal(s) directly from the ISP
b. **Objective(s):** List objective(s) identified on the person's ISP

**Section III Contact with Direct Support Professional**

a. **Name of Direct Support Staff:** Name of DSP contacted for this report

b. **Date of Contact:** Day met with DSP
c. **Monthly Summary by Service:** Identify the service the monthly summary reflects
d. **Follow-up from previous month:** Identify what activities or actions completed to follow-up from the previous month's summary

**Section IV Expectations (Of these expectations, this summary must address B, H, I and J. Others are optional)**

**A. Health/Medical/ Behavioral:**
What education/ training took place on health related topics to support the individual to manage their own healthcare? Identify any health/medical/behavioral issues (picture a holistic approach) addressed or identified? Identify changes in health, medical and behavioral matters such as: doctor appointments, medications, critical incidents, behavioral incidents and tracking. Identify any follow-up done or needed, including but not limited to referrals for treatment (Physical Therapy, Occupational Therapy, Speech & Language Pathologist, Registered Nurse, Physician, Registered Dietitian, and Mental Health Practitioner). Identify any adaptive equipment needs/repairs/modifications.

**B. Person's Perspective/Person Directed Planning:**

How does the person feel he/she has progressed on his/her goal(s)? What changes has the person requested to make to their supports, services and goal(s)? Have they used their circle of supports to assist them in directing their goal this month? Reflect here what matters most to the person and any new preferences.

**C. Choice:**

What choice/ options have been explored by the person? What Education, Exposure and Experiences have been presented to the person in all areas of life? Identify any informed choices the person has made. Identify all options presented and/or rejected by the person.

**D. Rights:**

What training based upon the person's learning style has the person received and/or learned concerning rights? Have they expresses what right matters most to them? Have they self-advocated for one of their rights to be upheld? Has any unresolved issue concerning rights been resolved this month? Has training taken place for the person's legal representative concerning rights restrictions this month? Identify any complaints or grievances the person has expressed and the results/resolution. Identify any preferences related to exercising rights expressed by the person. What education, exposure and experiences were provided to the person to expand their knowledge of rights?

**E. Community Life:**

Has the person made any new acquaintances (other than paid staff/teachers/providers) or developed a social role within his/her community? What social and community inclusion (new places) have been explored to promote community integration this month based on the person's preferences? How have already established social roles been supported?

**F. Safety:**

Identify any critical incidents filed on behalf of the individual and if necessary any interventions put into place to prevent further incidents. What education has taken place concerning abuse, neglect and exploitation? How has the person responded to training concerning prevention of abuse, neglect and exploitation and/or understanding for each of these? If the person has had a previous event from their past that needs to be addressed, what was done? Describe safety training in all areas of the person's life, i.e. mobility, travel, community, home and personal safety. Document any skills the person has gained in self preservation. List any referrals for environmental safety modifications and results.

**G. Collaboration:**

Has any communication taken place with the person's circle of support/team? What were the results of any brainstorming on behalf of the person? What self-advocacy has taken place by the person concerning his/her referrals or follow-ups? Has the process worked to the satisfaction of the person? Does further action need to be taken and who will take the lead?

**H. Progress (what's working/not working):**

What has the person achieved on their Support plan/targeted goal(s)/objective(s)? What are the results of the monthly tracking? What are the necessary steps left to take to assist the person to accomplish his/her targeted goal(s)? If the targeted goal is accomplished how did the person choose to celebrate? What mattered most to the person concerning his/her goal progress, and what would the person change or need to change to accomplish his/her goal? Have there been any changes developed based upon the lack of progress made to the person's action plan? Has the supports and services been altered based upon the person's learning style, communication style or other impact?

I. **Significant Changes and Events:**
Describe any additional changes or events not captured above and the person's response.

J. **Follow Up/Next Steps for future progression:**
List the next steps and follow up needed based upon the summaries above and which will be worked on for the following month.

**Section IV Printed Name of Person who has Clinical oversight and credentials**

a. **Printed Name of Clinical Oversight Staff**: Name of the clinical oversight staff
b. **Credentials**: Credentials or job title
c. **Signature of Clinical Oversight Staff**: Can be hand written or a secure electronic signature
d. **Date**: Date report written

***Disclaimer: The use of this form does not guarantee compliance with all policies/standards for documentation.***

Home Services Individual Training Log
(CRA, CLS & Respite services Only)

| | | |
|---|---|---|
| **a. Person's Name:** | | **g. Provider Name:** |
| **b. MHN ID Number:** | | **h. Service:** |
| **c. Support Plan Date:** | **f. Addendum date:** | **i. Procedure Code:** |
| **d. Month/Year:** | | |
| **e. Peer Quality Assurance Review:** | | **j. Date:** |

***Disclaimer: The use of this form does not guarantee compliance with all policies/standards for documentation.***

| |
|---|
| **Code:** |

***HOME SERVICES TRAINING LOG***

| Goal: | |
|---|---|
| Objective | Frequency/Completion Date |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| Staff Instructions | |

| Date: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | … | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Objective number (1-4) – which objective worked on | | | | | | | | | | | | | | | | | | | | |
| Objective met (+) or (-) not met | | | | | | | | | | | | | | | | | | | | |
| Prompt Code Required – from list above | | | | | | | | | | | | | | | | | | | | |
| # of prompts or cues | | | | | | | | | | | | | | | | | | | | |
| Staff Initials | | | | | | | | | | | | | | | | | | | | |

**Direct Support Staff printed name/title:**
**Signature of Direct Support Staff:** (can be hand written or a secure electronic signature)

***Weekly Additional Person Centered Progress***

| **Achievements** | **Identified Barriers** |
|---|---|
| **What he/she enjoyed?** | **What he/she did not enjoy?** |
| **What worked and/or needs to continue?** | **What didn't work and/or needs to change?** |
| ***You can place any other information about the goal into this section. OPTIONAL*** | |
| **Direct Support Staff printed name/title:** | **Signature of Direct Support Staff:**<br>**Date:** |

***Weekly Additional Routine Person Centered Supports:***

| | | | | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| **Additional Comments/Significant Event(s)** ***(If no comments/significant events, indicate N/A)*****:** | |
|---|---|
| | |
| **Direct Support Staff printed name/title:** | **Signature of Direct Support Staff:**<br>**Date:** |

## Legend for Home Services Training Log

**Section I** Individual Identifiable Information (**This section is pre-filled by the provider agency**)

| | | |
|---|---|---|
| **a. Person's Name:** | | **g. Provider Name:** |
| **b. MHN ID Number:** | | **h. Service:** |
| **c. Support Plan Date:** | **f. Addendum date:** | **i. Procedure Code:** |
| **d. Month/Year:** | | |
| **e. Peer Quality Assurance Review:** | | **j. Date:** |

a. **Person's Name:** Name of the individual served
b. **MHN ID Number:** Individual's MHN ID number
c. **Support Plan Date:** Identify the ISP timeframe
d. **Month/Year:** Identify month and year of when services are being documented
e. **Peer Quality Assurance Review:** Professional reviewer's name and signature
f. **Addendum date:** Identify any addendum date if applicable
g. **Provider Name:** This is where you place your provider name
h. **Service:** Specific service documenting
i. **Procedure Code:** Code for the service providing.
j. **Date:** Date reviewed by the Peer Quality Assurance reviewer (not pre-filled by the provider agency)

**Section II** Codes

| **Codes:** |
|---|

**Codes:** In this section you identify the codes used to identify the level of intervention/support the person required at the time of the training. For example: I=Independent, GP=Gestural prompt, VP=Verbal prompt, H-H=Hand-over-Hand assistance, M=Modeling, PPA=Partial physical assistance, FPA=Full physical assistance, N/A=Not applicable at this stage of progress, R= Refused (**The cues should be individualized and may depend on the objective. Codes can be added in this section**)

**Section III** Home Services Residential Training Log

| **a. Goal** | |
|---|---|
| **b. Objective(s):** | **c. Frequency/completion date** |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| **d. Staff Instructions:** | |

a. **Goal** This is the Goal for the service listed in the individual's ISP
b. **Objective(s):** List objective(s) identified on the person's ISP , list each objective by number
c. **Frequency/completion date** For the objective (1) include the frequency on the ISP or if the objective was met, identify the completion date

d. **Staff Instructions:** Identify what strategies, methods, techniques and supports needed for the person to meet their goal/objectives

| Date: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | … | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| e. Objective number (1-4) – which objective worked on | | | | | | | | | | | | | | | | | | | | |
| f.Objective met (+) or (-) not met | | | | | | | | | | | | | | | | | | | | |
| g.Prompt Code Required – from list above | | | | | | | | | | | | | | | | | | | | |
| h.# of prompts or cues | | | | | | | | | | | | | | | | | | | | |
| i. Staff Initials | | | | | | | | | | | | | | | | | | | | |
| **Direct Support Staff printed name/title:**<br>**Signature of Direct Support Staff:** (can be hand written or a secure electronic signature) | | | | | | | | | | | | | | | | | | | | |

e. **Objective Number** List each objective by number that was worked on

f. **Objective status** List if the object was met or not met by using a plus or negative symbol (+ / -)

g. **Prompt code** The codes used to implement the objective

h. **Number of Prompts** List how many times prompts or codes were used

i. **Staff Initials** Initials of staff training

**Section IV Weekly Additional Person Centered Progress**

| **Achievements** | **Identified Barriers** |
|---|---|
| **i. What did he/she enjoy?** | **j. What did he/she not enjoy?** |
| **k. What worked and needs to be continued?** | **l. What did not work and needs to be changed?** |
| **m. You can place any other information about the goal into this section. OPTIONAL** | |
| **n. Direct Support Staff printed name/title:** | **o. Signature of Direct Support Staff:**<br>**p. Date:** |

i. **What did he/she enjoy?** For the week services were rendered identify what the person enjoyed doing, working on and/or experiencing.

j. **What did he/she not enjoy?** For the week services were rendered identify what the person did not enjoy doing, working on and/or experiencing

k. **What worked and needs to be continued?** For the week services were rendered identify what strategies, methods, techniques and supports worked for the person and needs to become a regular part of how supports and services are provided.

l. **What did not work and needs to be changed?** For the week services were rendered identify what strategies, methods, techniques and supports did not work for the person and needs to change. *(Example: who, what, where, why, when and what's next to*

*progress)* A weekly summary of the person's progress on goal(s)/objective(s) and/or the supports and services provided and how the person responded.

m. **Direct Support Staff printed name/title:** Name of direct support professional working with the individual
n. **Signature of Direct Support Staff:** Can be hand written or a secure electronic signature
o. **Date:** Date note written and service rendered

**Section V** ***a. Weekly Additional Routine Person Centered Support s*** ***(Supports are pre-filled by the provider agency and additional supports can be added if necessary):***

| | | | | |
|---|---|---|---|---|
| b. | | | | |
| | | | | |
| | | | | |

| ***c. Additional Comments/Significant Event(s) (If no comments/significant events, indicate N/A):*** | |
|---|---|
| | |
| ***d. Direct Support Staff printed name/title:*** | ***e. Signature of Direct Support Staff:***<br>***f. Date:*** |

**a. Weekly Additional Routine Person Centered Intervention:** This section is designed for routine supports/needs that the person may require on an on-going basis. This section should be individualized based upon the identified needs in the ISP.

**b. Identified additional support:** Identify any additional ongoing support/needs by each box. This section can be prefilled with the regular supports provided to the person and the staff will check off which specific supports occurred during the reporting period.

**c. Additional Comments/Significant Events:** The box below can be utilized to capture any significant events from the day or week that is in direct relationship to the person. The box below will expand when you write! (Examples: how the person reacted to a new experience, new faces-new places, significant event changes in the person life, choices made, and any information about rights, health, safety, community connections, etc.).

**d. Direct Support Staff printed name/title:** Name of direct support professional working with the individual.

**e. Signature of Direct Support Staff:** Can be hand written or a secure electronic signature.

**f. Date:** Date note written and service rendered.

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**APPENDIX T**

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**APPENDIX U**
**Georgia Families 360$^{0}$ SM,**




***Information for Providers Serving Medicaid Members***
**in the Georgia Families 360$^{0}$ SM Program**

**Georgia Families 360$^{0}$ SM**, the state's (took out "new") managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system. launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360$^{0}$SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

**Georgia Families 360$^{0}$ SM** Every member in Georgia Families 360$^{0}$ is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

**Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.**

**To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov**