PART II
CHAPTERS 600 - 1200
POLICIES
AND
PROCEDURES
FOR
COMPREHENSIVE SUPPORTS WAIVER PROGRAM (COMP)
FORMERLY COMMUNITY HABILITATION SUPPORTS SERVICES (CHSS)
GENERAL MANUAL

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAID

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PART II, POLICIES AND PROCEDURES  
FOR  
COMPREHENSIVE SUPPORTS WAIVER PROGRAM  
(COMP)  
GENERAL MANUAL  

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PART II - CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

1. General

The State of Georgia believes it is critical that services and supports respect the vision of the individual. Each agency or organization must incorporate this belief into their service delivery to support individuals with mental retardation and developmental disabilities 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. Participant safeguards
4. Satisfactory participant outcomes
5. Participants rights and responsibilities
6. Participant access

601.1 OUTCOMES FOR PERSONS SERVED

The Standards that follow are applicable to the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) or organizations that provide services to individuals that are financially supported in whole or in part by funds authorized through DBHDD, regardless of the age or disability of the individual served. Participant 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.

Participant self-determination includes freedom, authority and responsibility and is considered key to achieving the vision of a meaningful life in the community for everyone.

Individuals receive Services and Supports that result in a Meaningful Life in the Community. Services and supports approaches assist the individual in:

a. Living in the most integrated community setting appropriate to their individual requirements and preferences
b. Exercising meaningful choices about their living environment, the providers of services they receive, the types of supports they use, and the manner by which services are provided; and

c. Obtaining quality services in a manner as consistent as possible with their community living preferences and priorities

This is accomplished through a holistic approach to Services and Supports to the
Individual by ensuring individualized services and supports determinations are made on the basis of an assessment of need with the individual. The purpose of the assessment is to determine the individual’s hopes, dreams or vision for their life and to determine how best to assist the individual in reaching those hopes, dreams or vision.

1. Assessments should include but are not limited to the following:
   a. The individual’s:
      i. Hopes and dreams or personal life goals;
      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 or adaptive behavior testing;
   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.
      i. NOTE that 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.

2. Additional assessments should be performed or obtained by the provider if required to fully inform the services and supports provider.

The policies, procedures and the conditions related to participation in Georgia’s Comprehensive Supports Waiver Program (COMP) to provide home and community-based waiver services for persons with mental retardation/developmental disabilities (MR/DD) are authorized by an approved waiver from the Centers for Medicare and Medicaid Services (CMS) pursuant to Section 2176 of Public Law 97-35. The waiver provides for services to eligible individuals with MR/DD who resides in or is at risk of an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) 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 services rendered by the provider in the Part III COMP Manual; and

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

The COMP Program provides the following services to participants:

(1) Adult Occupational Therapy
(2) Adult Physical Therapy
(3) Adult Speech and Language Therapy
(4) Behavioral Supports Consultation
(5) Community Access
(6) Community Guide
(7) Community Living Support
(8) Community Residential Alternative
(9) Environmental Accessibility Adaptation
(10) Financial Support Services
(11) Prevocational Services
(12) Specialized Medical Equipment
(13) Specialized Medical Supplies
(14) Support Coordination
(15) Supported Employment
(16) Transportation
(17) Vehicle Adaptation

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) 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 Monies 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 individual’s:

(3) Its religious character;
(4) The individual’s freedom not to engage in religious activities;
(5) Their right to receive services from an alternative provider;
(6) The organization shall, within a reasonable time after the date of such objection, refer the individual to an alternative provider.
(7) If the organization provides employment that is associated with religious criteria, the individual must be informed.
(8) In no case may federal or state funds be used to support any inherently religious activities, such as but not limited to:
(9) Inherently religious activities;
(10) Religious instruction; or
(11) Proselytization
(12) Organizations may use space in their facilities to provide services, supports, 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 Program participants must be in compliance with Core Requirements for All Providers and all other applicable DBHDD Standards.

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 those ‘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. DBHDD may recommend a moratorium on new admissions, a suspension or termination of the provider.

Additionally, 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.

Critical function areas include:
- Participant Rights, Responsibilities and Protections
- Non-Discrimination
- Behavior Management/Restraint and Seclusion
- Management of Participant Records
- Participant Records Documentation
- Assessment
- Individual Service Planning and Reviews
- Staff to Participant Ratios
- Orientation, Training, and Evaluation of Staff Competencies
- Routine Healthcare
- Medications and Medication Administration
- Environmental Health and Safety
- Current Level of Care (LOC) Determinations
- Current Individual Service Plans (ISPs) Based on Assessment Needs
- Oversight of Services Rendered

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 (DMA). They must be available for review at the agency or individual provider site.

A. 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.

B. 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 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.

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

D. 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 activities.

E. 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.

F. Records Management - All required records pertaining to the provision of COMP services shall be maintained in accordance with standards specified in this manual, in the Department of Behavioral Health and Developmental Disabilities Provider Manual, 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).
G. Each provider must participate in the Department of Behavioral Health and Developmental Disabilities statewide participant data reporting system.

H. 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 Certification

A. General Information:


2. There are some DD services that are not required to be accredited or to complete Standards Compliance. These include:

   a. Support Coordination
   b. Specialized Services which include Specialized Medical Equipment, Specialized Medical Supplies, Environment Accessibility Adaptation, and Vehicle Adaptation when one or more of these specialized services are the only service(s) being delivered by the organization.

B. Standards Compliance for DD providers authorized to receive less than $250,000 annually

1. Standards Compliance review conducted by DBHDD

   The Provider Compliance Unit of DBHDD conducts reviews regarding Standards Compliance. Providers receive from DBHDD a Certificate of Standards Compliance for a period not to exceed two years. DD providers must maintain a current certificate of standards to provide services.

2. Additional expectations related to demonstrating Standards Compliance:

   a. Standards Compliance must be maintained for all approved services.
   b. Providers must have maintained standards compliance for a period of six months for the services they are initially authorized to provide, and be in business a minimum of 12 months before additional services may be added.
   c. If new services are approved, they will be included in the subsequent review of Standards Compliance.
   d. Providers terminated due to failure to comply with the review
regarding Standards Compliance may not make application to become a provider for a period of one (1) year.

C. Accreditation for DD Providers with Annual Revenue Projected to be Greater 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 been authorized to receive funding in an amount more than $250,000 per year.

(b) The Provider is responsible for paying accreditation fees and providing to DBHDD Regional Coordinator 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 Coordinator results of accrediting body visit within seven (7) working days of receipt.

(e) The Provider is responsible for ensuring that all services that the organization provides are properly accredited. The organization is expected to obtain accreditation for the specific services offered by the provider.

(f) If a new service is added, the Provider must notify DBHDD and the accrediting agency and must be accredited for the new service within (12) months from the date that the new service is added.

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 DBHDD within 7 working days; this notification is done in writing via a letter sent to:

a. DBHDD Regional Office
b. DBHDD, Division of DD Provider Development Section, Suite 22-427, 2 Peachtree Street, Atlanta GA 30303
c. DBHDD Office of Provider Network Management, Suite 23-247, 2 Peachtree Street, Atlanta GA 30303 AND
d. 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 contract or letter of agreement with the provider.
b. Failure to reapply: the provider will be given sixty (60) calendar days, during which the agency must submit proof of a scheduled visit by an accreditation body. Failure to meet this time frame results in termination of the DBHDD contract or letter of agreement with the provider.

604. Provider Enrollment

604.1 To Enroll to Become a Provider

A. To enroll to become a provider agency or individual must complete DBHDD procedure on becoming a Provider of Developmental Disabilities Services. The procedure is found in Recruitment and Application to Become a Provider of Developmental Disabilities Services, located at the following website: www.dbhdd.georgia.gov.

B. The Medicaid Provider Enrollment packet is obtained from the following website: www.mmis.georgia.gov or by calling (800) 766-4456 for assistance.

Both applications are submitted to the address listed in the DBHDD provider application.

Note: 1. DBHDD recommends providers for approval or denial of enrollment to DCH. DCH requires recommendation from DBHDD in order to finalize any provider enrollment.

2. Loss of or failure to maintain Letter of Agreement with DBHDD will result in termination.

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
2. A proof of licensure is required from individual providers as defined for specific services in the Part III COMP 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 Consultation Services
- Community Living Support LPN Services
- Community Living Support RN Services
- Community Residential Alternative LPN Services
- Community Residential Alternative RN 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 participant 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 evident 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 Services (CRA) are limited to three (3) residential sites (Community Living Arrangement).

F. Providers with approval to provide Community Residential Alternative Services at the initially approved one to three site(s) can not apply to add additional sites or service, for one year and until the services/site(s) in the initial application are DBHDD standards compliant or accredited and have been DBHDD standards compliant or accredited for a minimum of 6 months.

G. Providers approved for initial services cannot add services for one year after initial approval to provide DD waiver services, and must be certified or accredited for a minimum of six months.
H. Providers who apply to provide Community Residential Alternative Services in the host home/life sharing arrangement must be a currently approved agency provider of CRA 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.

I. 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.

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

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K. The Georgia Department of Behavioral Health and Developmental Disabilities Regional 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).

   Or

   **Child Placing Agency License** (for agency providing community residential alternative services provided in host home/life sharing arrangements for participants 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).
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.

L. Current Secretary of State Registration

Rev. 04 2011 604.2 Approval of New Providers

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

2. Providers are responsible for notifying the DBHDD Regional Office that they are approved to conduct business. The DBHDD Regional Office grants approval to operate, has the provider to sign a Letter of Agreement, and notifies the applicable MRDD support coordination agency.

Rev. 04 2011 605. Changes in Enrollment Information

Enrolled providers are required to provide written notice to the DCH, DBHDD, Healthcare Facilities Regulation (as applicable), and support coordination.

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

   Provider Enrollment Unit
   Office of Provider Network Management
   Georgia Department of Behavioral Health and Developmental Disabilities
   2 Peachtree Street, Suite 23-247
   Atlanta, Georgia 30303

   AND

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

2. The Department of Community Health will verify information as needed and provide notification to HP Enterprise 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 Facilities Regulation
h. Other changes as outlined in Part I, Chapter 100, Section 105.7.

606. Staffing Requirements

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

606.1 . Agency Staffing

A. Organizational policy and practice demonstrates that appropriate professional staff conduct the following services and supports, including but not limited to:
   - Overseeing the services and supports provided to individuals;
   - Supervising the formulation of the individual service plan or individual recovery plan;
   - Conducting diagnostic and functional assessments;
   - Implementing assessment, care and treatment activities as defined in professional practice acts; and
   - Supervising high intensity services such as screening or evaluation, and assessment services.

B. The type and number of professionals staff attached to the organization are:
   1. Properly licensed or credentialed and trained in the professional field as required;
   2. Present in numbers to provide adequate supervision to staff as well as services and supports to individuals as required; and
   3. Present in numbers to provide services and supports to individuals as required;
   4. Experienced and competent in the profession they represent as well as in the services and supports they provide.
5. In 24 hour or residential care settings, at least one staff trained in CPR and first aid is present at all times.

C. The type and number of all other staff attached to the organization are:
   i. Properly trained or credentialed in the professional field as required;
   ii. Present in numbers to provide services and supports to individuals as required; and
   iii. Experienced and competent in the services and supports they provide.

D. The organization has procedures for verifying licenses, credentials, experience and competence of staff:
   iv. There is documentation of implementation of these procedures for all staff attached to the organization; and
   v. Licenses and credentials are current as required by the field.

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;
   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:
   i. Qualifications for the job;
   ii. Duties and responsibilities;
   iii. Competencies required;
   iv. Expectations regarding quality and quantity of work; and
   v. Documentation that the individual staff has reviewed understands and is working under a job description specific to the work performed within the organization.

G. There is evidence that a national criminal records check (NCIC) is completed for all employees who provide services, supports, care and treatment to persons served within the organization. See www.dbhdd.georgia.gov; Provider Information; Provider Manual; Section IV: “Criminal Records Checks and Investigations”. Fingerprints obtained by electronic fingerprint submission through Cogent Systems. See www.cogentid.com:
   i. Mandatory disqualification from employment for a minimum of five (5) years from the date of conviction, plea of no lo contendere, or release from incarceration or probation, whichever is later, is required for the following crimes:
      i. Murder or felony murder;
      ii. Attempted murder;
      iii. Kidnapping;
iv. Rape;
v. Armed robbery;
vi. Cruelty to children;
vii. Sexual offenses;
viii. Aggravated assault;
ix. Aggravated battery;
x. Arson;
xi. Theft by taking, by deception or by conversion; and
xii. Forgery in the first degree.

ii. The organization is prohibited from hiring into positions providing services and supports any persons convicted of the following:
i. Child, individual or patient abuse;
ii. Child, individual or patient neglect;
iii. Child, individual or patient mistreatment;

iii. The organization has policies and procedures detailing all human resources practices, including but not limited to:
a. Processes for determining staff qualifications including:
   1. License or certification status;
   2. Training;
   3. Experience; and

b. Processes for managing personnel information and records including but not limited to:
c. Criminal records checks; and
d. Drivers license checks.
e. Provisions for and documentation of:
   (1) Timely orientation of personnel;
   (2) Periodic assessment of training needs;
   (3) Development of activities responding to those needs; and
   (4) Annual work performance evaluations.

H. Provisions for sanctioning and removal of staff when:
1. Staff is determined to have deficits in required competencies;
2. Staff is accused of abuse, neglect or exploitation.

I. Orientation requirements are specified for all staff. Prior to direct contact with consumers, all staff and volunteer staff shall be trained and show evidence of competence in:
   C. The purpose, scope of services, supports, care and treatment offered including related policies and procedures;
   D. HIPAA and Confidentiality of individual information, both written and spoken;
   E. Rights and responsibilities of individuals;
F. Requirements for recognizing and 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; and
   d. To law enforcement agencies.

J. Within the first sixty days, all staff having direct contact with participants shall receive the following training including, but not limited to:
   1. Person centered values, principles and approaches;
   2. Holistic care of 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 and their families;
   6. The utilization of:
      a) Positive communication (*);
      b) Applied Behavior Analysis (*); and
      c) Crisis intervention techniques to de-escalate challenging and unsafe behaviors (*);
   7. Nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization);
   8. Ethics, cultural preferences and awareness;
   9. Fire safety (*);
   10. Emergency and disaster plans and procedures (*);
   11. Techniques of standard precautions, including:
      1. Preventative measures to minimize risk of HIV;
      2. Current information as published by the Centers for Disease Control (CDC); and
      3. Approaches to individual education.
   12. CPR/AED through the America Heart Association or the American Red Cross;
      i. All medical licensed staff (nurse, physicians, psychiatrist, dentists and CNAs) are required to have the Professional Rescuers level of training (Basis Life Support for Healthcare Providers and AED or CPR/AED for the Professional Rescuer);
      ii All other staff should have the lay Rescuers level of training (Heartsaver CPR and AED or CPR/AED);
   13. First aid and safety.
   14. Specific individual medications and their side effects (*);
   15. Service and support specific topics appropriate to the persons served;
   16. A minimum of 16 hours of training must be completed annually to include the trainings noted by asterisk (*) in items 4, 6, 9, 10, and 14 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 required for all other staff.
18. Regular review and evaluation of all staff is evident at least annually
   i. The evaluation should occur annually;
   ii. Managers who are clinically, administratively and experientially qualified conduct evaluations.
19. It is evident that the organization demonstrates administration of personnel policies without discrimination.

607. WAIVERS TO STANDARDS

The organization may not exempt itself from any of these standards or any portion of the provider manual. Individual standards and provider manual requirements may be requested to be waived by written request to the Regional Coordinator for the Georgia Department of Behavioral Health and Developmental Disabilities. For any request, approval must be given, in writing, by the:

1. DBHDD Regional Coordinator or designee
2. Executive Director of the Division of DD or designee

607.1 Procedures for Requests to Exceed Facility Capacity Limit

The Department of Human Behavioral Health and Developmental Disabilities (DBHDD) has a standard process for review and approval of requests for waivers of standards that are listed below.

A service provider may request that the facility capacity limit be waived when the standard creates an undue hardship or barrier for participants to access a needed service.

A service provider may not request the waiving of any standards that pertain to licensing requirements or definition of a Developmental Disability Professional (DDP). Requests to waive these standards will not be reviewed by DBHDD.

Waiver requests are sent to the DBHDD Regional Coordinator or designee, accompanied by a completed Request for Waiver of Standards Form (available online at www.dbhdd.georgia.gov, Part IV of the provider manual in the policy on requests for waiver of standards). This form includes relevant information related to the waiver of standards:
1. Justification of the reason for a waiver of standards due to an undue hardship or barrier for participants to access a needed service;
2. Plan for improvement or changes needed in order for services to be available in accordance with the standards;
3. A recommendation and affirmation of the identified need for a waiver signed by the Director of the provider organization.

607.2 Process for Review and Approval of Waivers of Standards

The DBHDD Regional Office completes an initial review to determine if the request falls within DBHDD guidelines.

1. Within five (5) days after receiving a waiver request, the DBHDD Regional Coordinator or designee submits the request, along with his/her recommendations, to the DDBHDD, Division of Developmental Disabilities.
2. The DBHDD, Division of Developmental Disabilities approves or disapprove the requested waiver within ten (10) business days of the receipt of other request.
3. All approved waivers expire at the end of the specified approved time period, not to exceed one year following approval.
4. The Division of DD is responsible to notify the provider by letter of decision that has been made. The letter outlines the decision regarding the waiver request; if the request is approved, the expectations for the provider are outlined below under provider responsibilities.
5. The DBHDD Regional Coordinator is copied on the letter.
6. For waivers of standards for services that are audited or monitored by a DBHDD External Review Organization or other contracted entity, the Division of DD copies that entity on the letter.
7. The Division of DD maintains a record of the information regarding the waiver request.

607.3 Provider Responsibilities Following Approval of a Waiver Request

1. The provider must maintain on file a copy of all approved waiver requests and have such waiver(s) available for review by the State.
2. The provider must notify the Regional Coordinator or designee when there is any change to services for which the waiver was requested.
3. For waivers of standards for services that are audited/monitored by DBHDD, copy of the waiver letter at the time of the audit is made available in order for the External Review Organization or other contracted entity to appropriately incorporate the approved waiver into the audit/monitoring activity.

Waiver Requests for More than One Year

All approved waivers expire at the end of one year following their approval. If the petitioner believes there are special circumstances justifying an extension beyond one year, they may apply again prior to the expiration date, completing another Request for Waiver of Standards Form with updated documentation.
PART II - CHAPTER 700

PARTICIPANT ELIGIBILITY CONDITIONS

701. **Eligibility Criteria**

The Department of Behavioral Health and Developmental Disabilities Intake and Evaluation Team (I&E Team) use the criteria below to determine whether a participant is appropriate for Comprehensive Supports Waiver Program (COMP) 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 Mental Retardation (ICF/MR), with the exception of the personal assistance retainer for Community Living Support Services (see COMP Part III, Policies and Procedures, Chapter 1900 for personal assistance retainer details), and who:

A. Are categorically eligible Medicaid recipients; and

B. Have a diagnosis of an intellectual disability and/or a closely developmental disability (see Section 706.2); and

C. Are currently receiving the level of care provided in an ICF/MR 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/MR 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. **Notification of Participant Approval/Disapproval**

COMP applicants are notified in writing of approval or disapproval for COMP services by the Regional DBHDD Office.

703. **Denial of Eligibility**

Eligibility for services under the waiver may be denied for the following reasons:

A. A participant fails to meet the eligibility criteria specified in this chapter.

B. The participant or his/her representative has not supplied information needed to complete the eligibility process.
C. The participant or his/her representative has not signed the Freedom of Choice form.

D. The Individual Service Plan costs are prohibitive because it increases the average cost of the COMP beyond the average ICF/MR costs.

704. **Grounds for Appeal**

A participant denied service or terminated from service because he/she does not meet the level of care requirement is informed of his/her rights to appeal or to a hearing. The DMA authorized representative sends the participant a Denial of Level of Care letter that outlines the procedure to appeal the decision and to request a hearing.

705. **Screening for Services**

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

The Intake and Evaluation (I&E) Team is responsible for the screening process. The team composition and qualifications are defined in the Official Codes of Georgia Annotated 37-4 and 37-5. An I&E Team member from the DBHDD Regional Office meets with the individual and/or his or her family member/representative to complete the Intake Screening Tool within 14 business days of the receipt of the application. Information gathered includes background information, functional abilities, developmental milestones, and behavioral and health issues.

All supporting documentation is reviewed to determine whether the individual meets the established eligibility criteria. To determine 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 I&E psychologist reviews and signs off on all determinations. Once an eligibility determination is made, a person receives services or is placed on the region’s Planning List. A Planning List Administrator will be assigned to anyone placed on the short-term planning list.

For persons recommended by the DBHDD Regional Office for enrollment in COMP funded services, a comprehensive evaluation is to be completed by the DBHDD Regional Office, including a DMA-6 or DMA-6A form (see Appendix C) signed and dated by a physician, nurse practitioner, or physician assistant and
approved by the DBHDD Regional Office. The DBHDD Regional Office determines whether the individual’s needs place him or her at risk of institutionalization in an ICF/MR. The Initial Comprehensive Evaluation, the Individual Service Plan (ISP), and a DMA-6 or DMA-6A form is used to document this determination of eligibility and is reviewed by the Regional Office for level of care determination.

Prior to the comprehensive evaluation process at enrollment in service, an individual is determined by the DBHDD Regional Office to likely require the level of care provided in an ICF/MR through the administration of functional assessment instruments, the review of presenting documentation, and application eligibility standards as defined in Section 701. The participant and his or her legal representative are: (1) provided a brief explanation of the COMP and informed of alternatives available under the waiver and (2) given the choice of either institutional or home and community-based services. The participant and/or his or her representative must sign the Freedom of Choice Form. In those cases where the beneficiary is unable to comprehend fully the options or consequences of his or her choice, a duly authorized representative of the beneficiary may act on his or her behalf. See Appendix E for Freedom of Choice Form.

706. Initial Level of Care Determination

The DBHDD Regional Office reviews copies of the following documents for the initial level of care determination:

706.1. The Initial Individual Service Plan (ISP)

Information is gathered from a variety of assessment tools to include the Health Risk Screening Tool, Supports Intensity Scale, and any assessments completed by the Intake and Evaluation Team. The Planning List Administrator or an Intake and Evaluation Team member completes the initial Supports Intensity Scale (SIS) for individuals who are 16 years or older.

The I&E nurse completes the initial Health Risk Screening Tool (HRST). The HRST assesses where the individual is likely to be most vulnerable in terms of potential health risks. If the Health Care Level is a 3 or greater on the HRST or an individual scores a “2” or two “1’s” on the SIS Exceptional Medical Needs Section, a nursing assessment is completed as part of the initial level of care determination.

DBHDD Regional Office staff, comprised of the Intake and Evaluation Team participants and the Planning List Administration staff, review all documents prior to facilitating the initial ISP meeting. 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 (for individual 16 years or
older), or HRST. The Planning List Administrator, 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. The physician’s signature is required on the ISP when the individual has a chronic medical condition defined as a Level 2 and above on the Intake and Evaluation Screening tool.

No service will be reimbursed which is not listed on the approved Individual Service Plan. The cost of service for some individual participants may exceed the average ICF/MR or SNF costs. However, the average cost for all COMP participants cannot exceed the average cost of services in an ICF/MR or SNF. Please see protocol for physician’s signature in Appendix C.

Please see Appendix C, page C-12 (Protocol for Physician Signature and Appendix D, (I & E Screening Tool for Chronic Medical Condition).

706.2 Comprehensive Evaluation

The comprehensive evaluation for initial level of care determination includes:

A. A completed DMA-6/ DMA-6A form signed by a licensed physician, nurse practitioner, or physician assistant and the participant.

- A social work assessment that must be current within ninety (90) days when submitted to the DBHDD Regional Office for the initial level of care determination.

- A psychological assessment for intellectual functioning and adaptive behavior based on a standardized instrument(s) recognized by professional organizations (American Psychological Association, American Association on Intellectual and Developmental Disabilities). The psychological assessment must document:
  - Diagnosis of an intellectual disability (see note below) defined by the following three criteria:

1. **Age of Onset**: Onset before the age of 18 years;

2. **Significantly Impaired Adaptive Functioning**: Significant limitations in adaptive functioning (two or more standard deviations below the mean) in at least two of the following skill areas: self-care, communication, home living, self-direction, functional academic skills, social/interpersonal skills, use of community resources, work, leisure, health, and safety; 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 mental retardation may be considered as having mental retardation; or

Note: A diagnosis of mental retardation 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).

- Diagnosis of a closely related developmental disability, such as cerebral palsy, epilepsy, autism, or neurological impairments, which results in impairments requiring treatment and services similar to those needed by person with a diagnosis of an intellectual disability, and that meets the following criteria (Georgia Code 37-1-1 (8):

  1. **Age of Onset:** Onset before the age of 22 years;

  2. **Support Needs:** The support needs of the individual must be the same as those required by individuals with a diagnosis of an intellectual disability as evidenced by assessment findings of:

     (a) A significant disability in intellectual functioning defined as borderline intellectual functioning or below; OR

     (b) A combination of a physical impairment and a significant disability in intellectual functioning defined as borderline intellectual functioning or below, or by assessment findings supporting that the physical impairment, such as severe cerebral palsy or epilepsy, significantly limits the individual’s daily intellectual functioning.

  3. **Substantially Impaired Adaptive Functioning:** Substantial limitations in adaptive functioning (two or more 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 developmental disability and cannot be primarily attributed to mental/emotional disorders, sensory impairments, substance abuse, personality disorder, specific learning disability, or attention-deficit/hyperactivity disorder; and
4. **Continued Disability:** The disability is likely to continue indefinitely.

5. **Participants 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 **must be current within one (1) year**. An update documenting that previous testing scores are considered currently valid is acceptable when submitted with a copy of the referenced evaluation. **Updates must include a summary of the previous testing scores in the referenced evaluation.**

### 706.3 Additional Assessment and Planning Requirements

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

B. Individuals direct decisions that impact their life.

C. Others assisting in the development of the individualized plan are persons who are significant in the life of the individual;
   i. Have a historical perspective of the wishes and preferences of the individual;
   ii. The individual gives consent to have present (if family or friends); and
   iii. Will deliver the specific services and supports identified in the plan.

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

E. Each individualized plan should be:
   1. Driven by the individual;
   2. Focused on outcomes the individual wishes to achieve;
   3. Fully explained to the individual or his or her representative using language he or she can understand;
   4. Associated risks and benefits are explained; and
   5. Individual’s involvement and acceptance, if applicable, in developing the individualized plan.

F. Components of the plan are:
   i. Statement(s) of goals or desired outcomes;
   ii. Documented objectives that are:
      a. Specific
      b. Measurable
      c. Achievable
d. Realistic

e. Time-limited with specified target dates

G. Specific services and supports to be provided related to each goal or outcome

1. The frequency or intensity that the specific service and support will be given or provided;
2. Identification of agency staff position or individual provider responsible to deliver or provide the specific service and support;
3. A page for signature, title and date by individuals participating in plan development (including the individual waiver participant) that is attached to the plan, indicating participant presence;
4. There is evidence of involvement in the formal individualized plan of all traditional service delivery providers of services and supports to the individual and specification of any participant-directed service delivery for the individual, as applicable;
5. Clear authorization of the plan.

Note: A physician, nurse practitioner, or physician assistant must authorize the level of care of a participant as required by Georgia Department of Community Health Division of Medicaid, Part II Policies and Procedures for the NOW & COMP Waiver Program. No Medicaid reimbursement will be made for any service period of an individualized plan for which there is no level of care (DMA-6/DMA-6A) in effect.

H. Behavior Support Plans

All organizations must have the capacity to address individual’s behavioral concerns. If the cause of all challenging behavior cannot be determined or satisfactorily addressed, there should be evidence of consultation with a professional who is licensed or qualified through education, supervised training and experience. A behavior support plan must be developed for participants who receive psychotropic medication for symptoms other than a mental illness or epilepsy. When a positive behavior support plan is used to reduce challenging behaviors, there must be evidence that the following issues have been addressed. The plan is:

1. Individualized;
2. Based on a functional assessment;
3. One that has ruled out medical causes;
4. Developed and overseen by a qualified professional;
5. Inclusive of rationale for the following:
i. Use of identified approaches;
ii. The timing of their use;
iii. An assessment of the impact on personal choice of the individual;
iv. The targeted behavior; and
   How the targeted behavior will be recognized for success
(1) Implemented by trained and competent staff;
   I.
   as monitoring plans and termination criteria;
   II.
   discussed with the individual and family (as permitted by the individual);
9. Developed in accordance with Best Practice standards for Behavioral Supports Services for providers of developmental Disabilities services (found at www.dbhdd.georgia.gov; Services; Developmental Disabilities; Other Information;; DD Providers)
10. Intensive, restrictive or special treatment procedures must be clearly justified, authorized and supervised by an in-field professional and may not be in conflict with federal or state laws, rules, regulations or standards;
11. Refer to the document Guidelines for Supporting Adults with Challenging Behaviors in Community Setting for additional detail, found at www.dbhdd.georgia.gov; Provider Information; Provider Tool Kit.

**Note:** Refer to the document Guidelines for Supporting Adults with Challenging Behaviors in Community Settings for additional detail, found at www.dbhdd.georgia.gov; Provider Information; Provider Tool Kit.

I. Documents Referenced in Individual Service Plan

Documents to be incorporated by reference into an individualized plan include but are not be limited to:

1. Medical updates as indicated by physician orders or notes;
2. Addenda as required when a portion of the plan requires reassessment;
3. A personal crisis plan which directs in advance the individual's desires/wishes/plans/objectives in the event of a crisis;
4. A behavior support plan for individuals demonstrating:
   i. challenging behaviors and /or
   ii. with a Developmental Disability who receive psychotropic medications for symptom management of other than a mental illness or epilepsy.
5. Safety Plan.

a. Individual Referrals Based on Assessment of Individual Need

**Agency organization** policies and procedures describe processes for referral of the individual based on ongoing assessment of individual need:

a. Internally to different programs or staff; or
b. Externally to services and supports not available within the organization including, but not limited to:
   i. Health care for
      1. Routine assessment such as annual physical examinations;
      2. Chronic medical issues;
      3. Acute and emergent needs;
   ii. Diagnostic testing such as psychological testing; and
   iii. Dental services, as available through the Medicaid State Plan.

707. Level of Care Reevaluation

A. The level of care re-assessments are completed at a minimum of every 12 months. LOC service approval may not exceed 365 days.

B. Psychological Assessment Updates: The interdisciplinary team determines if there has been a change in the participant’s condition and recommends a psychological assessment as follows:

   For participants below 18 years of age, a psychological assessment (or update 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 mental retardation or severe autism.

   For participants over 18 years of age, a psychological assessment (or update as indicated in Section 706) will be conducted when the participant scores a “2” and a total greater than 5 on the SIS Exceptional Behavioral Support Needs Section.

   Social Work Assessment Updates: The interdisciplinary team determines if there have been major changes in a participant’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 due to fire or natural disaster. Social work assessments are updated when the interdisciplinary team determines these changes have occurred.

   Nursing Assessment Updates: If the Health Care Level of the participant is a 3 or greater on the HRST or the participant scores a “2” or a total greater than 5 on the SIS Exceptional Medical Needs Section, the nursing assessment is updated.

   The participant’s support coordinator or service provider may request at any time technical assistance from the DBHDD Regional Office due to changing needs of a participant, 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.
The Support Coordinator submits to the DBHDD Regional Office the participant’s DMA-6/DMA-6A form and Individual Service Plan, along with any required copies of updated psychological, social work, and/or nursing assessment(s) as indicated above.

The DMA-6/ DMA-6A form must be signed by a licensed physician, nurse practitioner, or physician’s assistant and the participant or participant representative.

The I&E nurse reviews the DMA-6/DMA-6A form, the ISP, and any accompanying assessment updates to determine whether the person continues to meet the level of care requirement.

708. **Level of Care Approval Requirements (DMA-6/DMA-6A)**

- Each participant approved for COMP services must have a level of care determination authorized by the DBHDD Regional Office (see Appendix A).
- The DBHDD Regional 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 DMA-6/DMA-6A form is received by the DBHDD Regional Office with all additional required documentation for recertification will be the date that is entered into DBHDD Regional Office system and will constitute the earliest re-certification date once approved. The annual date of the participant’s current level of care is the date that the level of care is made effective by DBHDD Regional Office.

- The signatures of the physician, nurse practitioner, or physician assistant on the DMA-6/DMA-6A form must be no more than 30 days prior to the LOC approval date. 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/MR or SNF, unless otherwise indicated in the most recent utilization review of the participant.

- The approved level of care (DMA-6/DMA-6A) is uploaded to a web based system so that all providers have access. Services must begin within 60 days of DBHDD Regional Office approval. In the event services do 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.

- Each participant must have a current level of care (DMA-6/DMA-6A) signed by a physician, nurse practitioner, or physician assistant, and approved by the Regional DBHDD office. **No Medicaid reimbursement will be made for any service period for which there is no level of care (DMA-6/DMA-6A) in effect.**
• Each enrolled provider service type must maintain a copy of the current and approved DMA-6 forms covering all periods of services rendered, in the participant’s record. Noncompliance to this program requirement will result in a request for refund from the Department.

709. Reevaluation of Participants

The participant, his or her support network, and support coordinator as often as necessary, but no less frequently than annually will review each participant’s ISP. ISP reviews will also occur anytime there is a major life change for the individual. These reviews will explain in detail the reason for failure to achieve any anticipated outcomes. The ISP will be revised as needed to assure appropriate provision of services to each participant. All team members in attendance will sign the new ISP or addendum. I & E Team members’ signatures, for those not in attendance but who contributed to this annual ISP, can be found on the annual assessments or reviews included with the ISP. The revised start date listed on the ISP addendum is the approval date for any ISP addendum, but is no instance can the revised start date be prior to the date of the ISP addendum meeting.

710. Participant Assurances

710.1 Respect for the Dignity of the Individual

1. Access to appropriate services, supports, care and treatment is available regardless of:

   a. Age;
   b. Ethnicity;
   c. Gender;
   d. Religion;
   e. Social status;
   f. Physical disability;
   g. Intellectual disability; or
   h. Payer source.

2. There are no barriers in accessing the services, supports, care and treatment offered by the agency 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.
4. Sensitivity to individual differences and preferences is evident.
5. Practices and activities that reduce stigma are implemented.
6. Interactions with individuals demonstrate:
   a. Respect;
   b. Careful listening; and
   c. Are positive and supportive.
7. When individuals demonstrate challenging behaviors, Guidelines for Supporting Adults with Challenging Behaviors in Community Settings are implemented. (The Guidelines are found at www.dbhdd.georgia.gov; Provider Information; Provider Tool Kit.) When a behavior support plan is necessary, providers of developmental disabilities services develop these plans in accordance with the Best Practice Standards for Behavioral Support Services (found at www.dbhdd.georgia.gov; Services; Developmental Disabilities; Other Information; DD Providers). Care is taken to determine, from the perspective of the individual, what the function of that behavior may be while also considering:
   a. Physiological issues such as possible medical and psychiatric issues; including physical disabilities such as difficulty seeing, hearing, or ambulating;
   b. Social issues such as lack of available, inclusive social networks;
   c. Psychological issues;
   d. Environmental issues such as staffing concerns;
8. All organizations must have the capacity to address individuals' behavioral concerns. If the cause of the challenging behavior cannot be determined or satisfactorily addressed, there should be evidence of consultation with a professional who is licensed or qualified through education, supervised training and experience.

710.2 Human and Civil Rights

ii. The organization has policies and promotes practices that:
   a. Do not discriminate;
   b. Promote receiving equitable supports from the organization;
   c. Provide services and supports in the least restrictive environment;
   d. Emphasize the use of positive communication and less restrictive interventions; and
   e. Incorporate DBHDD Clients Rights or Patients Rights Rules, as applicable to the organization.
   f. Delineates the rights and responsibilities of persons served.

iii. In policy and practice the organization makes it clear that under no circumstances will the following occur:
   a. Threats (overt or implied);
   b. Corporal punishment;
c. Fear-eliciting procedures;

d. Abuse of any kind;

e. Withholding nutrition or nutritional care; or

f. Withholding of any basic necessity such as clothing, shelter, rest or sleep.

3. Grievance, complaint and appeals policies and processes are clearly written in language accessible to individuals served and are promulgated and consistent with all applicable DBHDD policies regarding Complaints and Grievances regarding community services. Notice of procedures is provided to individuals, staff and other interested parties, and providers maintain records of all complaints and grievances and the resolutions of same.

4. 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.

5. All individuals are informed about their rights and responsibilities:

   g. At the onset of services and supports;

   h. At least annually during service provision;

   i. Through information that is readily available, prepared and written using language accessible and understandable to the individual.

6. 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 and supports.

7. In policy and practice, the organization makes it clear whether and under what circumstances the following restrictive interventions occur. In all cases, federal and state laws and rules are followed and include but are not limited to the following.
a. Physical restraints (also known as mechanical restraint) involve the use of a device attached or adjacent to the individual’s body that one cannot easily remove. And that restricts freedom of movement of normal access to one’s body or body parts. Physical restraints are not used as punishment, for staff convenience, or through a behavioral support plan behavior management intervention for purposes of restricting a participant’s movement. Those devices which restrain movements, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or to other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints. The following requirements only apply to such devices:

Use of devices for protection of accidental injury, for medical treatment of a physical condition, or supportive or corrective needs:
   i. May be used in any service and support;
   ii. Has its use defined by a physician’s order
   iii. Has its use specified in the participant’s ISP

b. Time out
   1. Under no circumstance is egress restricted;
   2. Time out periods must be brief, not to exceed 15 minutes
   3. Procedure for time-out utilization
   4. Reason and justification for time out utilization

c. Personal restraint (also known as manual hold or manual restraint);
   • May be used in all community settings except residential settings licensed as Personal Care Homes;
   • Circumstances of use must represent an emergency safety intervention of last resort affecting the safety of the individual or of others.
   • Brief handholding or support for the purpose of providing safe crossing, safety or stabilization does not constitute a personal hold.
   • May be utilized for a period of 10 seconds or more, not to exceed 5 minutes.

d. Chemical restraint may never be used under any circumstance. Chemical examples of chemical restraint are the following:
   1. The use of over the counter medications such as Benadryl for the purpose of decreasing an individual’s activity level during regular waking hours
   2. The use of an antipsychotic medication for a person who is not psychotic but simply ‘pacing’ or mildly agitated.
f. PRN antipsychotic and mood stabilizer medications for behavioral control are not permitted (See Appendix R).

710.3 Integration into the Larger Natural Community

G. Inclusion and community integration is supported and evident.
H. Individuals have responsibilities in the community such as employment, volunteer activities, church and civic membership and participation.
I. The organization has community partnerships that demonstrate input and involvement by:
   a. Advocates; and
   b. The person served;
   c. Families;
   d. Business and community representatives.
      i. The organization makes known its role, functions and capacities to the community including other organizations as appropriate to its array of services and supports a basis for:
         1. Joint planning efforts;
         2. Continuity in cooperative service delivery;
         3. Provider networking;
         4. Referrals; and
         5. Sub-contracts.

710.4 Participant Rights and Responsibilities

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

Participant rights recognized by the provider include:

3. The right of access to accurate and easy-to-understand information
4. The right to be treated with respect and to maintain one’s dignity and individuality
5. 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
6. The right to a choice of approved service provider(s)
7. The right to accept or refuse services

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

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

10. The right to confidential treatment of all information, including information in the participant’s record

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

12. 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

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

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

15. The right to review participant’s records on request

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

17. 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

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

NOTE:
Providers must be aware of additional participant rights and responsibilities required under specific program licensure and must include signed copies of these rights and responsibilities in the participant’s record.

711. Eligibility Determination for Medical Assistance Only (MAO)

Participants who receive SSI are eligible for Medicaid. Participants 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 calculated from the participant’s income as the participant’s cost share or participant 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 by completion of the initial MAO Communicator and the responsible provider will assist the participants in setting an appointment at the local DFCS office subsequent to DBHDD Regional Director/Designee authorization to serve the participant. The Support Coordinator is responsible for assisting providers in the timely completion of subsequent MAO renewals annually.

A. Persons currently residing in ICF/MRs or SNFs and receiving Medicaid reimbursed services but not receiving SSI, and who have been approved by the DBHDD Regional Director/Designee and the DBHDD designated agency (through a DMA-6/DMA-6A) as meeting the service need criteria for the COMP are to comply with the following procedures.

1. The MAO Determination Form (see Appendix F), the application for Medical Assistance and the approved DMA-6/DMA-6A should be submitted by the responsible provider to the local DFCS office in the county where the participant resides.

2. The responsible provider must contact the DFCS office by telephone to schedule an appointment with the eligibility worker and to obtain additional information regarding the MAO determination process.

3. Participants that are currently community residents must be receiving a service that is a defined COMP service but is not reimbursed under the COMP.

B. Persons who live in the community, but who do not receive Medicaid services or SSI payments, but have been identified by the DBHDD Regional Director/Designee and DBHDD designated agency as meeting the service need criteria for the COMP waiver, must comply with the procedures outlined in Section 708.

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

D. MAO status must be reviewed annually according to DFCS guidelines. The Support Coordinator is responsible for this process.
712. **Katie Beckett**

A. **Eligibility Determination for Katie Beckett**

States are allowed, at their option, to make Medicaid benefits available to children (age 18 or under) at home who qualify as individuals with disabilities under the Social Security Act provided when certain conditions are met. TEFRA/Katie Beckett 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.

In order for a child to establish Medicaid eligibility under this program, it must be determined that:

If the child was in a medical institution, he/she would be eligible for medical assistance under the State plan for Title XIX;

The child requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded);

- It is appropriate to provide the care to the child at home; and
- The estimated cost of caring for the child outside of the institution will not exceed the estimated cost of treating the child within the institution.

The criteria used to determine a child’s eligibility in the program is found in Title 42 Code of Federal Regulations. Medical necessity is not based on specific medical diagnoses. The reviewer must review all available medical information to determine whether services are medically necessary. In addition, the reviewer must determine whether the child requires the level of care provided in a hospital, nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded).

Income qualifications for “Katie Beckett” are based solely on the child’s income, but a number of different factors are considered for approval. If approved, the same eligibility for health coverage will be available to the child as other Medicaid members. Eligibility for Medicaid under “Katie Beckett” will only be approved if ALL of the following conditions are met:

- Child is 18 years of age or younger
- Child meets the federal criteria for childhood disability
- Child meets an institutional level of care criteria
• Even though the child may qualify for institutional care, it is appropriate to care for the child at home
• The Medicaid cost of caring for the child at home does not exceed the Medicaid cost of appropriate institutional care

B. **Hearing and Appeals Process**

Due process rights associated with the denial of admission to the “Katie Beckett” program are initially commenced after the level of care assessment by Georgia Medical Care Foundation (GMCF). Participants in the “Katie Beckett” program are subject to yearly assessments by GMCF. If the level of care assessment results in the denial of admission/continuation into the “Katie Beckett” program, GMCF will send an “Initial Denial of Admission/Continued Stay” to the family (with a copy to the DFCS care worker). This notice informs the parents of the reason for the denial and the administrative review rights. To ask for a hearing, the family must make the request in writing.

The Georgia Medical Care Foundation must receive requests for administrative review within the 30-day time limit. When counting days, the family has a two (2) day period for receipt of the letter. Then, beginning on the third day after the date of the letter, regardless of whether that day is a weekend or holiday, the count of the 30 days begins. However, if the 30th day falls on the weekend or holiday, the next full business day is counted as the 30th day. The family’s request must be submitted to the following address:

Department of Community Health  
Legal Services Section  
Two Peachtree Street, NW – 40th Floor  
Atlanta, Georgia 30303-3159

713. **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. A portion of the services in the GAPP operates under a Home and Community-Based Waiver [1915(c)] approved by the Center for Medicare and Medicaid Services. 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

Skilled nursing care is provided in the home. Nurses caring for GAPP members must have a current background in pediatric critical care nursing within the past two years.

B. Medical Day Care Services

The medical day care service provides specialized pediatric services to medically fragile members, with a current Individualized Family Service Plan, (IFSP) in a licensed medical day care facility.

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

- Community Living Supports Services (CLS)
- Community Residential Alternative Services (CRA)

If the MR/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 services are approved prior to reimbursement being rendered. Prior approval does not guarantee reimbursement or participant eligibility. In order for an enrolled provider to be reimbursed for prior approved services, the participant must be Medicaid eligible at the time services are rendered and with a valid and current level of care determination.

Note: All requests to change prior authorizations for any state fiscal year must be submitted no later than the last day of the calendar year (December 31st) in which the state fiscal year ends. Changes to prior authorizations can not be made after this date.

802. Obtaining Prior Approval

The Regional DBHDD offices must complete a Prior Authorization Request as part of the enrollment process. The Prior Authorization must be submitted for approval to the Regional DBHDD Office. Once the prior authorization has been approved, it will be submitted to Medicaid electronically indicating the approved services, authorization periods in which services can be rendered, the provider of each service, and the procedure codes for the services. The Regional DBHDD Office will distribute to all providers listed on the prior authorization a copy of the approved PA. A copy of the prior authorization can be found in Appendix G. The enrolled provider’s COMP participant record must include a copy of the approved Prior Authorization forms. Noncompliance to this program requirement will result in a request for refund from the Department.
PART II - CHAPTER 900

GENERAL SERVICE REQUIREMENTS

901. Services Overview

All services provided under the Comprehensive Supports Waiver Program (COMP) are based on the assessed need of the participant 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 Part II, Appendix P for information on person-centered planning). These reimbursable services include the following and are as specified in the approved ISP:

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

b. Adult Physical Therapy – these services address the physical therapy needs of the adult participant that result from his or her developmental disabilities.

c. Adult Speech and Language Therapy – these services address the speech and language therapy needs of the adult participant that results from his or her developmental disabilities.

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

e. Community Access – these services are designed to assist the participant in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active participation and independent functioning outside the participant’s place of residence.

f. Community Guide – these services are only for participants who opt for participant direction and assist these participants with defining and directing their own services and supports and meeting the responsibilities of participant direction.

g. Community Living Support – these services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to a participant’s continued residence in his or her family home.
h. Community Residential Alternative – 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.

i. Environmental Accessibility Adaptation – these services consist of physical adaptations to the participant’s or 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.

j. 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.

k. 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 participant who opts for participant direction and his or her Support Coordinator or interdisciplinary team.

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

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

n. Respite – 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 participant requiring a short period of structured support (typically due to behavioral support needs) or due to a family emergency.

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

p. Specialized Medical Supplies – 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.
q. Support Coordination – 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 participants while ensuring access to needed waiver and other services.

r. Supported Employment – these services are supports that enable participants, 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.

s. Transportation – these services enable participants 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

t. Vehicle Adaptation – these services include adaptations to the participant’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 provides the service requirements specific to the individual COMP Services. Description of each service is discussed more fully in Part III Policies and Procedures for COMP, Chapters 1300-2900. The general service requirements for the COMP Program are specified in the section to follow.

Participants have the option to self-direct COMP services, with the exception of Community Residential Alternative Services, Financial Support Services, Prevocational Services, and Support Coordination. The Co-Employer Participant-Direction Option is available for Community Access, Community Guide, Community Living Support, Supported Employment, and Transportation Services. For details on participant-direction, refer to Part II Policies and Procedures for COMP, Chapter 1200.

902. Exclusions and Special Conditions

A. Payment directly or indirectly for any waiver services provided to participants 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 participants’ 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 or by marriage, such as spouse, stepparents, or stepsiblings. Third degree of consanguinity means mother, father, grandmother, grandfather, sister, brother, daughter, son, granddaughter, grandson, aunt, uncle, great aunt, great uncle, niece, nephew, grand niece, grand nephew, 1st cousins, once removed, and 2nd cousins). Extenuating circumstances include the following:

- lack of qualified providers in remote areas,
- lack of a qualified provider who can furnish services at necessary times and places,
- presence of extraordinary and specialized skills or knowledge by approvable relatives in the provision of services and supports in the approved ISP, and/or
- clear demonstration of being the most cost effective and efficient means to provide the services.

NOTE: Approvable relatives meeting the extenuating circumstances criteria may provide Community Access, Community Living Support, Supported Employment, and/or Transportation Services in the COMP Program.

In the case of a parent of an adult requesting to provide waiver services, there must be a clear demonstration that the provision of the waiver services by the parent is in the best interest of the participant and that the above-required extenuating circumstances are met. In addition, whenever the parent of an adult is approved to provide waiver services under extenuating circumstances, the support coordinator for the participant assures at least an annual review of whether the continued provision of the waivered service is in the best interest of the participant.

The Division of Medicaid considers on a case-by-case basis if extenuating circumstances justify approval of family members (other than spouses, parents of minor children, or legal guardians) as paid caregivers of traditional provider services. See Chapter 1200 for the policies on extenuating circumstances review for provision of participant-directed services by relatives.

Requests for consideration of extenuating circumstances are to be made in writing and submitted to the appropriate DBHDD Regional Office (see Appendix A). The responsible party will receive written notification of the Department of Community Health’s final decision for traditional provider services furnished by relatives.

B. Medical, home health, dental, and pharmacy services that are provided under the Medicaid State Plan are not included as COMP 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)
   - Waivered Home Care Services (Model Waiver)
   - Shepherd Care Project 66

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

   - Service Options Using Resources in Community Environments (SOURCE)
   - GAPP (except skilled nursing)

B. COMP and other Waiver clients are not eligible to enroll in Medicaid HMOs.

904. **Hospice Services**

If an individual enrolled in the Comprehensive Supports 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

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

When a COMP participant 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 elects hospice, the hospice agency and the waiver participant 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.
A. When a COMP participant 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 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 participant who has elected the hospice benefit as it furnishes to its participants who have not elected the hospice benefit. The participant receiving hospice services should not experience any lack of these services because of his or her status as a hospice program member.

a. Transportation Requirements

Rev 04 2009 Individual and agency providers that provide transportation as a part of a waiver service specified in the COMP Part III manual 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 participants 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 three classes:

      1. If the vehicle has a gross vehicle weight rating of 26,001 or more pounds or such lesser rating as determined by federal regulation; or
      2. If the vehicle is designated to transport 16 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 participants.

**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

### 906 Day Services Requirements

**Rev 07 2009**

The delivery of day services to include Community Access, Prevocational, and Supported Employment services must be based on the participant’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 Requirements

**Rev 10 2011**

DDP services rendered by a provider agency must be provided by a qualified individual
DDP employed by, or under professional contract with, the provider agency.

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

- Be a Developmental Disability Professional (DDP)
- Have responsibility for overseeing the delivery of waiver services to
  participants.

The same individual may serve as the agency director, nurse and/or DDP, provided the
employee meets the qualifications and/or designation of each position. However, the
duties of shared roles for each position must be separately delivered and documented.
Reporting of change in approved and designated DDP (addition or termination) is as
indicated in the current state fiscal year DBHDD Provider Manual, Part II Community

Each Development Disability Professional (DDP) has a specified schedule or contract
with sufficient hours per week to meet the duties of the DDP and level of need for
individual receiving services, which includes but are not limited to:

1. Overseeing the services and supports provided to participants that include:
   a. The agency DDP monitors and/or participates in the implementation
      and delivery of the Individual Service Plan (ISP).
b. The agency DDP supervises the delivery of service and ensures the strategies reflect the goals and objectives of the ISP.
c. The agency DDP monitors the progress toward achievement of goals in the ISP, and makes recommendations

2. Supervising the formulation of the participant’s plan for delivery of all waiver services provided to the participant by the provider, on an annual basis subsequent to ISP development and after any ISP addendum that includes, but is not limited to:
   a. Ensuring the implementation strategies reflect the ISP and the needs of the participant
   b. The agency DDP participates in the development of the ISP as indicated by signature of the ISP

3. Conducting or overseeing functional assessments to support formulation of the participant’s plan for delivery of all waiver services as indicated by the DDP signature:
   a. The Health Risk Screening Tool
   b. The Supports Intensity Scale
   c. Functional Behavioral Analysis
   d. And others as needed or required

4. Supervising high intensity services that address health and safety risks for the participants as indicated by the DDP signature:
   a. The agency DDP is involved in reviewing and/or writing, and the implementation and effectiveness of the Behavior Support Plan
   b. The agency DDP is involved in reviewing and/or writing, and the implementation and effectiveness of the Crisis Plan
   c. The agency DDP is involved in identifying ongoing supports as needed (medical and/or behavioral) in collaboration with appropriate personnel

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 above (1-4) are as follows:**
   a. Active participation in the planning meeting documented in either the meeting minutes/notes and/or progress notes prior to ISP meeting.
   b. Documented contact with the SC prior to the ISP date.
   c. Consulted with, supervised, and provided guidance to direct support staff regarding implementation of the services.
   d. The DDP will complete documentation in any individual’s record for any of the above responsibilities. This documentation shall include the signature, title/credentials, timed (start and end time of delivery of service) and date.
For additional details regarding documentation requirements, refer to Chapter 1100 of this manual.

Hours scheduled and worked must be sufficient to meet the individual needs of each participant served by the provider. The provision of DDP oversight and service provision must be documented in the participant’s record. A DDP is not scheduled to work only on a PRN (pro re nata) basis.

**NOTE:** DDP direct service provision and oversight for a participant with an approved exceptional rate is in addition to the above requirements and as specified in the letter of approval for the exceptional rate.

**Required Training for Developmental Disabilities Professionals**

The provider agency must also show participation and document the participation of each DDP in a minimum of eight (8) hours per year of additional DBHDD sponsored or other training in the area of developmental disabilities, not listed above or included in the Community Standards for all Providers.

### 908. Termination of Participant Services Requirements

Rev. 04 2011

The provider must provide a minimum of a 30 days notice when terminating COMP services to a participant. The provider must agree to be a part of the transition process with the support coordinator and DBHDD Regional Office and continue to provide COMP 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 participant.

### 909. Proxy Caregivers and Health Maintenance Activities

Rev 10 2011

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
PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. General

Reimbursement for COMP services is made by the Division of Medicaid to providers who have completed the enrollment process and rendered services to eligible participants 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 Regional DBHDD Office (See Appendix A). Failure to adhere to any provision of the COMP 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

The rates for COMP 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.

In extraordinary circumstances related to transition of an individual from an institution or imminent risk of institutionalization of an individual, providers may request:

(1) the payment of a rate that exceeds the established maximum rate for the following COMP services:

- Community Residential Alternative Services
- Community Living Support Services
- Community Access Group Services
- Respite Overnight Services

(2) the approval of units that exceed the maximum allowable units for the following COMP services:

- Specialized Medical Supplies
- Specialized Medical Equipment

Exceptional rate approval or approval to exceed the maximum allowable units is tied to the assessment of individual needs of the participant as documented in the Intake and Evaluation approved Individual Service Plan (ISP). The Interdisciplinary Team must approve the need for an exceptional rate or exceeding the maximum allowable units, as documented in the ISP (see Appendix H for required documentation for consideration of
an exceptional rate and the protocol for review of exceptional rate requests). Exceptional rate requests and requests to exceed the maximum allowable units are subject to the DBHDD approval with notification of approval to the Department. Exceptional rates are approved according to established tier rates, but in no instance, will an exceptional rate be approved that exceeds the actual provider costs to provide services. The DBHDD review of exceptional rate requests include consideration of the configuration of residential setting that is most cost effective for the State.

Providers must be authorized by the DBHDD Regional Office and the Division of Developmental Disabilities to receive exceptional rates beyond the Medicaid maximum rates for waiver services or for additional units beyond the Medicaid allowable maximum units. Any approval of an exceptional rate or additional units beyond the maximum allowable units is time limited to a maximum of one year. The provider must maintain a copy of the exceptional rate or additional units beyond the maximum approval letter in the participant’s record.

1003. **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 goals 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) and
   COS 767 - (Disease Management Organization - DMO)
2) COS 851 - (SOURCE Case Management)
3) ASO – (Administrative Services Organization)
4) COS 100 - (Case Management Support) Only participants enrolled in COS 680 or 681
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 760 - (Children At Risk Targeted Case Management)
9) COS 762 - (Adults with AIDS Targeted Case Management)
10) COS 763 - (At Risk of Incarceration Targeted Case Management)
11) COS 100 - (Case Management Support) Only MRDD participants on the Short-term planning list.
12) COS 960 - (Children Intervention School Service)
13) COS 790 - (Rehab Services/DSPS)

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.

Members cannot opt out, or terminate themselves, from a CMO or ASO.

Members enrolled in the DMO can opt out to enroll in another case management program. However, the member (not the case management agency) must contact the DMO to initiate the opt out process.
PART II - CHAPTER 1100  

DOCUMENTATION AND RECORDS  

1101. General  

This chapter specifies the general requirements for documentation and records for COMP providers. The Part III Services Manual for the Comprehensive Supports Waiver 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 hopes, dreams and vision 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 plan meeting is organized to develop a proposed services guide to the provider(s) and participant 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.  

- **Annual Individual Service Plan Document:** After the initial Individual Service Plan (ISP), the participant’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 participant, his/her family and others as appropriate annually.  

- **Choice of Service Options and Providers:** The ongoing discussion on the range of service options is repeated at the annual review. At this time, the support coordinator discusses with the participant, his/her family and others as appropriate the available service options based on the participant’s assessed support needs. The support coordinator works with the participant and/or family/representative to determine their choices among the service options for the participant and available providers prior to the formal Individual Service Plan meeting with the chosen provider(s).
• **ISP Meeting Participants and Documentation:** The participant’s support coordinator facilitates the ISP development. The support coordinator works with the participant (and his/her representative) to determine whom he or she wants to include in the ISP development meetings and the formal ISP meeting and invites those identified to these meetings. Individuals participating in these meetings should include people who best know the participant outside the service system and from other agencies and resources as deemed appropriate, with the participant or legal representative’s consent. The support coordinator informs the participant 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 participant, his/her family and others as appropriate.

• **ISP Document:** The planning process produces an organized statement of proposed services to guide the service provider(s) and the participant throughout the year. The organized statement, or Individual Service Plan (ISP), is based on what is important to/for the participant and includes the following:

  a. Desired outcomes of services (goals);

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

  c. 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);

  d. Consideration of the following:

     i. The participant’s support systems; and

     ii. The community resources available to be used

1. **ISP Listing of Services:** The ISP must list the services to be provided, the frequency of the services, and the name of provider to deliver the services. No service will be reimbursed which is not listed on the Individual Service Plan approved annually by the Regional DBHDD Intake and Evaluation Team.

2. **Participant’s Involvement and Acceptance in Developing ISP Document:** The participant’s involvement and acceptance, if applicable, in developing the ISP must be documented.

   a. The participant’s signature on the ISP signifies this acceptance.

   b. If a participant declines or is unable to sign the ISP, it is documented in the participant’s record.
3 **Family Involvement:** Unless clinically or programmatically contraindicated, participants are asked to consent to the family’s involvement in the service planning and service delivery processes. Contraindications, if present, and the participant’s refusal, if permission is not given, are documented in the record.

4. **ISP Annual Review and Amendments:** Each ISP must be reviewed and modified annually, or more often as needed to reflect all life changes. Amendments are to document progress or lack of progress, to identify changes in outcome review changes in medical, psychological or social services, or to identify new problems or goals. Circumstances warranting more frequent reviews would include, but are not limited to, significant changes in participant functioning, increases or decreases in services, change of provider(s), changes in medical, social or behavioral statuses, family crisis, and reduction in funding.

Individualized plans or portions of the plan must be reassessed as indicated by the following:
I. Changing needs, circumstances and responses of the individual, including but not limited to:
   iv. Any life change;
   v. Change in provider;
   vi. Change of address;
   vii. Change in frequency of service.
   b. As requested by the individual;
   c. As required for re-authorization;
   d. At least annually;
   e. When goals are not being met.

1. **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.

      a. Maintenance and transfer of both written and spoken information is addressed:
      b. Personal individual information;
      c. Billing information; and
      d. All service related information.
      f. HIPAA Privacy Rules, as outlined at 45 CFR Parts 160 and 164 are reviewed with staff and individuals and practiced.

      2. Authorization for release of information is obtained when individual information 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 in advance of the exchange of information;

3. Exceptions to use of a release of information are clear in policy:

a. Release if required or permitted by law;
b. Release is authorized by law as a valid exception;
c. A valid court order or subpoena is served;
d. When required to share individual information with the DBHDD or any provider under contract or LOA with the DBHDD for the purpose of meeting your own obligations to the department; or
f. In the case of an emergency treatment situation, Protected Health Information (PHI) can be released to a health care provider.

j. HIPAA Privacy Rules, as outlined at 45 CFR Parts 160 and 164 are observed.

k. Authorization for release of information is obtained when individual information is to be released or shared between organizations or with others outside the organization. The Georgia Department of Behavioral Health and Developmental Disabilities protocol No. 3.200-10 Disclosure and Authorization for Disclosure of Protected Health Information is followed. Information contained in each release of information must include:

ii. Specific information to be released or obtained;
iii. The purpose for the authorization for release of information;
iv. To whom the information may be released or given;
v. The time period that the release authorization remains in effect (reasonable based on the topic of information, generally not to exceed a year); and
vi. A statement that authorization may be revoked at any time by the individual in advance of the exchange of information;
NOTE: Exceptions to use of a release of information are clear in policy:
1. The release if required or permitted by law;
2. Release is authorized by law as a valid exception;
3. A valid court order or subpoena is served; or
4. When required to share individual information with the Georgia Department of Behavioral Health and Developmental Disabilities or any provider under contract or LOA with the Georgia Department of Behavioral Health and Developmental Disabilities for the purpose of meeting your own obligations to DBHDD.

L. Medication Oversight and Monitoring
1. Organizations having Oversight for Medication or that Administer Medication Follow Federal and State Laws, Rules, Regulations and Best Practice Guidelines
2. A copy of the physician’s order or current prescription is placed in the participant’s record for every medication administered or self-administered with supervision.
   a. These include:
      (a) Regular, on-going medications;
      (b) Controlled substances;
      (c) Over-the-counter medications;
      (d) PRN (when needed) medications, which can not include PRN antipsychotic and mood stabilizer medications for behavior control (see Appendix R); or
      (e) Discontinuance order.
   b. A valid physician's order must contain:
      B. The individual's name;
      C. The name of the medication;
      D. The dose;
      E. The route;
      F. The frequency;
      G. Special instructions, if needed; and
      H. The physician's signature.
   viii. A copy of the Medical Office Visit Record with the highlighted physician's medication order may also be kept as documentation.
   c. Anti-psychotic medications must be prescribed by a psychiatrist or psychiatric nurse practitioner.
      (a) The organization has written policies, procedures, and practices for all aspects of medication management including, but not limited to:
         o Prescribing: requires the comparison of the physician’s medication prescription to the label on the prescription drug container and to the entry on the Medication Administration Record (MAR) to ensure they are all the same before each medication is administered or supervised self-administration is done.

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- Ordering: describes the process by which medication orders are filled by a pharmacy.
- Authenticating orders: describes the required time frame for actual physician’s signature on telephone or verbal orders.
- 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.
- Labeling: includes the Rights of Medication Administration.
- Storing: includes prescribed medications, floor stock drugs, refrigerated drugs, and controlled substances.
- Security: signing out a dose for an individual, and at a minimum, a daily inventory for controlled medications and floor stock medications; and daily temperature logs for locked, refrigerated medications are required.
- Storage, inventory, dispensing and labeling of sample medications: requires documented accountability of these substances at all stages of possession.
- 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 pharmacists or physician’s signature and date when the drug was verified.
- Supervision of individual self-administration: includes all steps in the process from verifying the physician’s medication order to document and observe the individual for the medication’s effects. 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.
- Administration of medications includes all aspects of the process to be done from verifying the physician’s medication order to documentation and observation of the individual for the medication's effects. Administration of medications may be done only by those who are licensed in this state to do so.
- 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.
- Disposal of discontinued or out-of-date medication: via an environmentally friendly method such as mixing with used coffee grounds or unused cat litter; and
Education to the individual and family (as desired by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record.

Organizational policy stipulates that (and practice is consistent with policy):

3. Only licensed nurses can directly administer medication;

4. In homes licensed as Community Living Arrangements, staff may directly administer medications if:
   i. The staff member has completed a course in a Department of Technical Adult Education (DTAE) school and is certified as a Certified Nursing Assistant (CNA) and Qualified Medication Aide (QMA);
   ii. The staff member has satisfactorily passed the NCLEX-style exam for QMA’s;
   iii. An RN supervises the staff member.
   iv. Obtaining and maintaining copies of appropriate lab testing and assessment tools, if applicable, that accompany the use of the medications prescribed from the individual’s physician for the individual’s clinical record, or a minimum, documenting in the clinical record the request for the copies of these test and assessments.

5. Only physicians or pharmacists may re-package or dispense medications;
   v. This includes the re-packaging of medications into containers such as “day minders”;

   Note: An individual capable if independent self-administration of medication may be coached in setting up their personal “day minder”.

4. There are safeguards utilized for medications known to have substantial risk or undesirable effects, including but not limited to:
   i. Storage;
   ii. Handling;
   iii. Insuring appropriate follow-up, including nursing follow-up if applicable, accompany the use of the medication.

5. Education regarding the risks and benefits of the medication is documented and explained in language the individual or representative, if applicable, can understand; Medication education provided by the organization’s staff should be documented in the clinical record. Informed consent for the medication is the responsibility of the physician; however, the organization obtains and maintains copies of these, or at a minimum, documents its request for copies of these in the clinical record.

6. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication;
7. Staff are educated regarding:
   i. Medications taken by individuals, including the benefits and risks;
   ii. Monitoring and supervision of individual self-administration of medications;
   iii. The individual’s right to refuse medication;
   iv. Documentation of medication requirements.
8. 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.
9. Requirements for safe storage of medication are as required by law includes single and double locks, shift counting of the medications, individual dose sign-out recording, documented planned destruction, and refrigeration and daily temperature logs.
10. The organization defines requirements for timely notification of the prescribing professional regarding:
    i. Drug reactions;
    ii. Medication problems;
    iii. Medication errors; and
    iv. Refusal of medication by the individual.
11. When the organization allows verbal orders from physicians, those orders will be authenticated:
   1. Immediately by a fax of the order with the physician signature on the page;
   2. The fax must be included in the individual’s record; and By original physician signature within a policy-designated time frame, but not more than 72 hours.
   l. 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 of the presence of side effects;

2. Monitoring of Individuals on Medications as required include but are not limited to:
   i. Individual on medications likely to cause Tardive dyskinesia is monitored at prescribed intervals using an Abnormal Involuntary Movement Scale.
C. Monitoring of therapeutic blood levels if required by the medication such as Blood Glucose testing, Dilantin blood levels and Depakote blood levels; such as kidney or liver function tests;
D. 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.

n. There are policies and procedures governing documentation of self-administration or administration of medication.
o. Medication must be recorded each day and each time that it is given.
Missed, refused, or other reasons a medication is not given shall be recorded, including adverse reactions or implications.

A Medication Administration Record (MAR) is in place for each calendar month that an individual takes or receives medication.

Documentation of routine, ongoing medications occur in one discreet portion of the Medication Administration Record (MAR) and include but may not be limited to:

- Documentation by calendar month that is sequential according to the days of the month;
- 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:
  1. Name of the medication;
  2. Dose as ordered;
  3. Route as ordered;
  4. Time of day as ordered; and
  5. Special instruction accompanying the order, if any, such as but not limited to:
     a. Must be taken with meals;
     b. Must be taken with fruit juice;
     c. May not be taken with milk or milk products.

If the individual is to take or receive the medication more than one time during one calendar day:

- Each time of day must have a corresponding line that permits as many entries as there are days in the month;
- All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;
- When a physician discontinues a medication order, that discontinuation is reflected by:
  - The entry of “D/C” at the date and time representing the discontinuation; followed by
  - A mark through of all lines representing days and times that were discontinued.

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 Medication Administration Record (MAR) and include but may not be limited to:

- 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:
  1. Name of the medication;
  2. Dose as ordered;
  3. Route as ordered;
  4. Purpose of the medication such as but not limited to:
  5. For upset stomach;
6. For fever over 100°F;
7. For itching, etc

ii. Frequency that the medication may be taken:
8. Every four hours not to exceed five doses in 24 hours;
9. Not to exceed two doses in 24 hours;
10. Every four hours until fever drops below 100°F.

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 effectiveness is documented.

u. The “Eight Rights” for medication administration are defined and practiced within the organization and each right is expanded to describe guidelines for staff(s) use to verify that right:
   • Right person: includes the use of at least two identifiers and verification of the physician’s medication order with the label on the prescription drug container and the MAR entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
   • Right medication: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin should be verified with another person prior to administering.
   • Right time: includes the times the agency schedules medications, or the specific physician’s instructions related to the drug.
   • Right dose: includes verification of the physician’s medication order with the label on the prescription drug container and the Medication Administration Record entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
   • Right route: includes the method of administration.
   • Right position: individual should be assisted to assume the correct position for the medication method or route to ensure its proper effect, instillation, and retention.
   • Right documentation; and
   • Right to refuse medications: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
v. Each Medication Administration Record (MAR) has a legend that clarifies:
   i. Identity of authorized staff initials using full signature and title;
   ii. Reasons that a medication may be not given, is held or otherwise not received by the individual, such as but not limited to:
      1. “P” = Pass
      2. “R” = Refused
      3. “NPO” = Nothing by mouth
      4. “H” = Hospital

NOTE: For a review of medication management information in power point form, see www.dbhdd.georgia.gov; Provider Information; Provider Toolkit

M. Service Environment

The Service Environment Demonstrates Respect for the Persons Served and is Appropriate to the Services Provided

2) Services are provided in an appropriate environment that is respectful of persons supported or served. 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 room’s personalized; and
   e) Adequately lighted, ventilated, and temperature controlled.

3) There is sufficient space, equipment and privacy to accommodate:
   a) Accessibility;
   b) Safety of persons served and their families or others;
   c) Waiting;
   d) Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported; and
   e) To provide identified services and supports.

4) 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.
   b) There is evidence of compliance with fire safety codes, including but not limited to:
      i) Inspection of equipment;
      ii) Fire drills are conducted for individuals and staff;
         (1) Once a month at alternating times; including
(2) Twice a year during sleeping hours if residential services.

(3) All fire drills shall be documented with staffing involved.

(4) DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit.

c) When food service is available, required certifications related to health, safety and sanitation are available.

d) A three day supply of non-perishable emergency food and water is available for all individuals supported in residences.

e) A residence shall arrange for and serve special diets as prescribed.

5) There are policies, written procedures and evidence of practice such as but not limited to:

a) Preventative maintenance;

b) Environmental safety and hazards;

c) Equipment use; and

d) Cleanliness.

e) Policies, plans and procedures are in place that addresses emergency notification and preparedness. 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 consumer medications.

   o Plans include detailed information regarding evacuating, transporting, and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:

   ▪ Medical emergencies;

   ▪ Missing persons;

1. 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.

   ▪ Natural disasters known to occur, such as tornadoes, snow storms or floods;

   ▪ Power failures;

   ▪ Continuity of medical care as required; and

   ▪ Notifications to families or designees.

   o On a regular basis, emergency preparedness notice and plans are:

   ▪ Reviewed;

   ▪ Tested at least quarterly for emergencies that occur locally on a less frequent basis such as but not limited to flood, tornado or hurricane;

   ▪ Drilled with more frequency if there is a greater potential for the emergency.
6. Residential living support service options;
   e) Are integrated and inclusive environments within established residential neighborhoods;
   f) Are of a type ordinarily considered to be single family units;
   g) Have space for informal gatherings;
   h) Have personal space and privacy for persons supported; and
   i) Are understood to be the “home” of the person supported or served.

7. Cameras may be used in common areas of programs that are not personal residences such as Crisis Stabilization Programs where visualization of blind areas is necessary for an individual’s safety. Cameras may not be used in the following instances:
   (a) In an individual’s personal residence;
   (b) In lieu of staff presence; or
   (c) In the bedroom of individuals as it is an invasion of privacy and is strictly prohibited.

8. Children seventeen and younger may not be served with adults.
   j) Emancipated minors and juveniles who are age 17 years may be served with adults when their life circumstances demonstrate they are more appropriately served in an adult environment.
   k) Situations representing exceptions to this standard must have written documentation from the Regional DBHDD office.
      i) Exceptions must demonstrate that it would be disruptive to the living configuration and relationships to disturb the ‘family’ make-up of those living together.

9. 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.
   l) Policies and procedure apply to all vehicles used, including:
      i) Those owned or leased by the organization;
      ii) Those owned or leased by subcontractors; and
      iii) Use of personal vehicles of staff
   m) 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 attendance of person served while in vehicles;
      vii) Safe use of lift;
      viii) Availability of first aid kits;
      ix) Fire suppression equipment;
   x) Emergency preparedness;

10. Access is promoted at service sites deemed as intake and evaluation through:
   n) Clearly labeled exterior signs; and
o) Other means of direction to service and support locations as appropriate.

- The Organization that Contracts with Other Organizations Ensures the Affiliate’s Compliance and Capacity to Provide Care (Including Host Homes)

6. The organization remains responsible for the affiliate’s compliance with:
   a. Contract requirements;
   b. Standards of practice and specified requirements in the Provider Manual for the Department of BHDD, including Standards for All Providers, and all applicable DCH policies and procedures manuals;
   c. Licensure requirements;
   d. Accreditation or certification requirements; and
   e. Quality improvement and risk reduction activities.

7. The affiliate’s capacity to provide quality care is monitored, including:
   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.

8. There is evidence of active oversight of the affiliate’s capacity and compliance.

9. A report shall be made quarterly to the agency’s Board of Directors regarding:
   a. Services provided by affiliate;
   b. Quality of performance of the affiliate.

10. A report shall be made to the DBHDD Regional Office prior to the end of the first quarter and third quarter of the fiscal year that includes:
    a. Name of the affiliate or contractor;
    b. Contact name for affiliate or contractor;
    c. Contact information for affiliate or contractor;
    d. Disability group(s) served;
    e. Specific service(s) provided;
    f. Number of persons in service; and
    g. Annualized amount paid to affiliate.

1103. Provider Intake

Service providers, except for providers of participant-directed services, conduct an intake for participants 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 participant 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 participant is to be informed of projected duration of service, hours of service, rules of conduct, involvement of family members and participant rights and responsibilities.

1104. \textbf{Individual Service Plan (ISP) Goal Progress Documentation}

Providers are required to document progress towards moving the participant towards independence by meeting the participant’s ISP, which includes person-centered goals, desired outcomes in the participant’s action plan, and the amount/type of assistance/support in the Current Service Summary and the Health and Safety sections of 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 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 progress or lack of progress towards moving the participant towards independence by meeting the participant’s ISP, which includes person-centered goals, desired outcomes in the participant’s action plan, and the amount/type of assistance/support in the Current Service Summary and the Health and Safety sections of the ISP.

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 participant and participant’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 participant 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. Activity Notes must document provision of services, as indicated on the current ISP and correspond to progress towards moving the participant towards independence by meeting the participant’s ISP, which includes person-centered goals, desired outcomes in the participant’s action plan, and the amount/type of assistance/support in the Current Service Summary and the Health and Safety sections of the ISP.

c. Notation of communications from family, significant others and other community agencies that address the condition or needs of participants must be entered in the record.

d. Appointments missed or canceled by the participant or staff is to be documented along with appropriate follow-up attempts to reschedule.

e. Services for which Medicaid is billed must be accurately reflected in the services documented in the participant’s record.

f. 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 participant. 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.

Provider staff must document the service provided to a participant each time service is delivered (See Appendix S of this manual for examples of documentation). Except for providers of participant-directed services, all providers must document the following in the record of each participant 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 participant in the direction of independence by completing the participant’s ISP, which includes person-centered goals, desired outcomes in the participant’s action plan, and the amount/type of assistance/support in the Current Service Summary and the Health and Safety sections of 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 five (5) 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 Person-Centered Focus of Documentation

Person-centered focus is evident in documentation.

12. The individual’s record is a legal document that is current, comprehensive and includes those persons who are:
   a. Assessed;
   b. Served; or
   c. Supported.

13. Information in the record is:
   a. Organized;
   b. Complete;
   c. Current;
   d. Meaningful;
   e. Succinct; and
   f. Essential to:
      i. Provide adequate and accurate services, supports, care and treatment;
      ii. Tell an accurate story of services, supports, care and treatment rendered and the individual’s response;
      iii. Protect the individual; and
      iv. 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 services;
   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;
   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.

14. At a minimum, the individual 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 name, allergies and precautions must also be flagged on the medication administration record;
   b. Individual identification and emergency contact 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. Legal documentation establishing guardianship;
      iv. Evidence that individual rights are reviewed at least one time a year;
      v. Evidence that individual responsibilities are reviewed at least one time a year; and
      vi. Legal status as it relates to Title 37.
   e. Pertinent medical information;
   f. Screening information and assessments, including but not limited to:
      i. Functional assessments;
   g. Individual service plan, including:
      i. Identified outcomes or goals (in measurable terms);
      ii. Interventions or activities occurring to achieve the goals;
iii. The individual’s response to the interventions or activities (progress notes, tracking sheets, learning logs or data).

iv. A projected plan to modify or decrease the intensity of services and supports as goals are achieved; and

h. Discharge summary information provided to the individual at the time of discharge that includes:
   i. Strengths, needs, preferences and abilities of the individual;
   ii. Services and supports provided;
   iii. Achievements;
   iv. Necessary plans for referral; and, ..
   v. Service or organization to which the individual was discharged, if applicable.
      1. A dictated or hand-written summary of the course of services and supports incorporating the discharge summary information must be placed in the record within 30 days of discharge.

i. Progress notes or Learning Logs describing progress toward goals, including:
   i. Implementation of interventions specified in the plan;
   ii. The individual’s response to the intervention or activity based on data;

j. Event notes documenting:
   Issues, situations or events occurring in the life of the individual;
   The individual’s response to the issues, situations or events;
   Relationships and interactions with family and friends, if applicable;
   Missed appointments, if applicable, including:
      1. Findings of follow-up; and,
      2. Strategies to avoid future missed appointments.

k. Records or reports from previous or other current providers:

l. Correspondence

15. Documentation in the record reflects intensity of the services, supports, care and treatment.
   a. Frequency and style of documentation is appropriate to the frequency and intensity of services and supports;
   b. Documentation includes record of contacts with persons involved in other aspects of the individual’s services and supports, including but not limited to internal or external referrals.

16. The individual’s response to the services and supports is a consistent theme in documentation.

17. There is a process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts.
18. For a review of documentation requirements in power point form, see www.dbhdd.georgia.gov; Provider Information; Provider Toolkit.

19. Assessments, ISPs, and documentation required by Medicaid are to be retained in the individual records for three years.

1106. Management and Protection of Participant 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 and Social Security Guide 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 Waiver will be reviewed and monitored by the State through the Regional DBHDD 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 must provide a current Private Home Care Provider License from the Department of Community Health, Healthcare Facility Regulation Division (HFR), to the Regional DBHDD Office if providing covered PHC services as defined by HFR.
It will be the responsibility of the Regional DBHDD 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 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 consumers 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 consumer 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 consumers 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 developmental disability 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.
PART II - CHAPTER 1200

PARTICIPANT-DIRECTION

1201. General

The Comprehensive Supports Waiver (COMP) Program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant-direction that are available to participants who live in their own private residence or the home of a family member.

The participant or his or her representative, assisted by the Support Coordinator, decides which services are to be participant-directed, and may elect to exercise the Employer Authority and have decision-making authority over the support workers who provide waiver services. The participant or his or her 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 or his or her representative may also elect to exercise the Budget Authority and have decision-making authority over a budget for participant-directed waiver services. The amount of the participant-directed budget is the waiver allocation remaining after any costs for provider-managed services.

The policies, procedures and the conditions related to participation in Georgia’s Comprehensive Supports Waiver (COMP) Program, Participant-Direction Option, to provide home and community based waiver services for persons with mental retardation/developmental disabilities (MR/DD) are authorized by a waiver renewal from the Centers for Medicare and Medicaid Services (CMS) pursuant to Section 2176 of Public Law 97-35. The COMP provides for services to eligible individuals with MR/DD who resides in or is at risk of an institutional placement, and opts to self-direct their COMP Services.

1202. Participant Eligibility

The COMP provides every participant, or the participant’s representative, the opportunity to elect to direct thirteen up to (13) waiver services. Should the participant, or the participant’s representative, choose to direct allowable waiver services, the election to direct (self-direct) allowable waiver services must be specified in the Individual Service Plan (ISP).

The participant enrolled in Participant-Directed COMP Services may receive other COMP waiver services in addition to the participant-directed services except for the exclusions specified in the Part III, Policies and Procedures Manual for the COMP Program. Other waiver services are provided using enrolled Medicaid Providers as identified in the participant’s ISP, and in accordance with provider
requirements and qualifications specified for each respective service in the Part III, Policies and Procedures for the COMP Program.

Traditional service delivery methods are available for participants who decide not to self direct their services.

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 assists with participant-direction responsibilities on behalf of the participant. Representatives must follow all requirements related to the direction of waiver services, including signed documentation of their understanding of their role and responsibilities as a representative. Support coordinators assist the representative in the development of the Individual Service Plan and the Individual Budget for participant direction.

An adult waiver participant’s support coordinator may assist him or her in choosing an appropriate, qualified representative who will serve in his or her best interests. Whenever an adult waiver participant chooses a non-legal representative, his or her support coordinator assures at least an annual review of whether the continued direction of waiver services by the non-legal representative is in the best interests of the adult waiver participant.

Community Guides provide, if needed, direct assistance to the representative on ISP and Individual Budget development that support community connections. Support coordinators assure that representatives direct the inclusion of items in the Individual Budget that tie to specific ISP goals, which are based on the individual needs of the waiver participant. Under no circumstances may a representative for an individual in participant direction be approved to be the provider of service. The Financial Support Service only pays for services specified in the Individual Service Plan, and support coordinators additionally monitor the provision of these services in relation to ISP goals, the health and safety of the waiver participant, and the meeting of all participant-direction responsibilities.

1204. **Eligibility Criteria**

The Department of Behavioral Health and Developmental Disabilities (DBHDD) uses the criteria below to determine whether a participant is appropriate for COMP Participant-Directed 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), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), with the
exception of the personal assistance retainer for Community Living Support Services (see COMP Part III, Policies and Procedures, Chapter 1900 for personal assistance retainer details), and who:

I. Are categorically eligible Medicaid recipients; and

B. Are mentally retarded and/or developmentally disabled (a diagnosis of developmental disability includes mental retardation or other closely related conditions such as cerebral palsy, epilepsy, autism, or neurological impairments which result in impairments of general intellectual functioning or adaptive behavior requiring treatment and services similar to those needed by persons with mental retardation, with eligibility determined as specified in Chapter 700 of this manual); and,

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

E. Are enrolled in or eligible for COMP Services and are capable of demonstrating that he/she is able to direct his or her COMP services and follow all policies and procedures for the participant-direction option applicable to the Participant, or has a designated Representative with the demonstrated ability to assist with this responsibility; and,

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

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

H. Are able to complete and submit all required timesheets/invoices and manage the individual budget for COMP Participant-Directed services or has a designated representative with the demonstrated ability to assist with this responsibility.
Prior to enrollment in participant-directed services, the ability of the participant/representative to participant-direct COMP services shall be confirmed. An individual participant’s/representative’s ability to participant-direct COMP services may be reassessed at any time, as determined by the support coordinator, in response to objective evidence indicating changes in capacity or supports.

1205. Special Consideration for Eligibility for Participant-Direction

Participants, who do not receive the COMP Participant-Directed services but express a desire to self-direct eligible waiver services, will have their request reviewed. The Interdisciplinary Team, including the Intake and Evaluation Team, the support coordinator, provider(s), and the participant and their support network, will review the individual’s current services to determine if Participant-Direction is appropriate for the participant. If these services are determined to meet the participant’s needs and all other eligibility requirements for the participant-direction are met, the participant will be allowed to enroll in Participant-Directed COMP Services.

1206. Notification of Participant Approval/Disapproval

COMP applicants will be notified in writing of approval or disapproval for COMP services by the Regional DBHDD Office.

1207. Denial of Eligibility

Reasons for denial of eligibility for services under the Comprehensive Supports Waiver include those specified in Chapter 700. In addition, participants/representatives may be deemed ineligible to self-direct COMP Services because of insufficient demonstration of the ability of the participant or adequate supports by a designated representative to perform the responsibilities of the participant-direction.

1208. Grounds for Appeal

The right to appeal of denial of COMP funded services is specified in Chapter 700. A participant denied eligibility for Participant-Directed COMP services shall be informed of his/her rights to appeal by the support coordinator. The denial of eligibility for participant-direction of services due to a participant’s or family’s/representative’s inability to direct the COMP Services may be reassessed at any time, as determined by the support coordinator, in response to objective evidence indicating changes in capacity or supports.

Specific requirements, conditions and procedures for screening COMP applicants for services, Level of Care determinations and denials are detailed in Chapter 700 of this manual.
1209. **Requirements for Enrollment in Participant-Direction**

Once a participant or representative meets the eligibility for the Participant-Direction of COMP services, and voluntarily chooses to self-direct eligible COMP Services, the support coordinator must provide the following to initiate enrollment of the participant:

I. Documentation of willingness and ability of participant or representative to direct COMP services;

II. Documentation of training (must include training on being an employer if COMP services include employee services);

III. Documentation of a viable individual emergency back-up plan;

IV. Completed Participant-Direction Memorandum of Understanding, with signatures of participant or representative and support coordinator;

V. Provision of a minimum of thirty (30) days written notice by the support coordinator to the COMP (traditional) provider;

VI. Documentation of choice, where available, of Financial Support Services (FSS) Provider by the Participant or Representative and agreement by the Participant or Representative to remain with the chosen FSS provider for one year. In addition, after that year, to provide a minimum thirty (30) days written notice to the FSS provider prior to a change request.

**Participant-Directed COMP Services may only initiate on the first (1st) of the month.**

1210. **Eligible Waiver Services**

COMP Services eligible for Participant-Direction are as follows:

1. **Adult Occupational Therapy Services**

   Adult Occupational Therapy Services address the occupational therapy needs of the adult participant that result from his or her developmental disabilities (Chapter 1300)

   Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 1300 – 2900.
2. **Adult Physical Therapy Services**
   Adult Physical Therapy Services address the physical therapy needs of the adult participant that result from his or her developmental disabilities. Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 1400.

3. **Adult Speech and Language Therapy Services**
   Adult Speech and Language Therapy Services address the speech and language therapy needs of the adult participant that result from his or her developmental disabilities. Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 1500.

4. **Behavioral Supports Consultation Services**
   Behavioral Supports Consultation Services are the professional level services that assist the participant with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations. Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 1600.

5. **Community Access Services**
   Community Access Services are designed to assist the participant in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active participation and independent functioning outside the participant’s home or family home.

   Note: With the exception of Co-Employer Services, participant-directed Community Access Group Service provided by an individual employee for one or more participants can not exceed a ratio of one (1) employee to three (3) participants. Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 1700.

6. **Community Guide Services**
   Community Guide Services are only for participants who opt for participant direction and assist these participants with defining and directing their own services.
and supports and meeting the responsibilities of participant direction.

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 1800.

7. Community Living Support Services
Community Living Support Services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to a participant’s continued residence in his or her family home.

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 1900.

8. Environmental Accessibility Adaptation Services
Environmental Accessibility Adaptation Services consist of physical adaptations to the participant’s or 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.

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 2100.

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

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 2300.

10. Natural Support Training Services
Natural Support Training Services provide training and education to individuals who provide unpaid support, training, companionship or supervision to participant.

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 2400.
11. **Respite Services**

Respite 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 participant requiring a short period of structured support (typically due to behavioral support needs) or due to a family emergency.

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 2600.

12. **Specialized Medical Equipment**

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

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 2700.

13. **Specialized Medical Supplies**

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

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 2800.

14. **Supported Employment Services**

Supported Employment Services are only supports that enable participants, for who 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.

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 3000.

15. **Transportation Services**

Transportation Services enable participants 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.
Note: Participant Directed Transportation Services are billed as employee and vendor payments as follows: (1) Commercial Carrier Transportation Services are billed as vendor payments; (2) regularly scheduled One Way and Round Trip Transportation Services provided by individual Georgia licensed drivers are billed as employee payments; and (3) one time and short-term, intermittent One Way and Round Trip Transportation Services are billed as vendor payments.

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Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 3100.

16. Vehicle Adaptation Services
Vehicle Adaptation Services include adaptations to the participant’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.

Details on service specifications, provider requirements and licensure, covered and non-covered services, and reimbursement units and rates, can be found in Part III, COMP Policies and Procedures, Chapter 3200.

1211. Participant-Direction Opportunities

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

a. Participant – Employer Authority
The participant, or the participant’s representative, has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers.

i. Participant/Common Law Employer Model
The participant (or the participant’s 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 for Participant-Direction.

The Participant-Employer Authority Responsibilities for this model are:
a. Recruit staff in accordance with specific service requirements as specified in the Part III, Policies and Procedures Manual for the COMP Program.
b. Hire staff (common law employer).
c. Verify staff qualifications.
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.
g. Determine staff wages and benefits subject to applicable State limits.
h. Determine staff duties consistent with service specifications in the ISP.
i. Determine staff wages and benefits subject to applicable State limits.
j. Schedule staff.
k. Orient and instruct staff in duties.
l. Supervise staff.
m. Evaluate staff performance.
n. Verify time worked by staff and approve time sheets.
o. Discharge staff (common law employer).
p. Select vendors in accordance with specific service requirements as specified in the Part III, Policies and Procedures Manual for the COMP Program.

2. **Participant/Co-Employer Model**

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:

1. Community Access
2. Community Guide
3. Community Living Support
4. Supported Employment

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5. Transportation

The Participant/Representative and the Agency share these 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.

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

1) Refer staff to agency for hiring
2) Verify time worked by staff and approve time sheets.
3) Recommend discharging staff from providing services.

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

a. Verify staff qualifications
b. Obtain criminal history and/or background investigation of co-employees.
c. Conducts criminal records checks of 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.

b. Participant – Budget Authority

The participant or the participant’s representative has decision-making authority over a budget for waiver services.

The Participant-Budget Authority Responsibilities are:

a. Reallocate funds among services included in the budget.
b. Determine the amount paid for services within the State’s established limits.
c. Substitute service providers.
d. Schedule the provision of services.
e. Identify service providers and refer for provider enrollment.
f. Authorize payment for waiver goods and services.
g. Review and approve provider invoices for services rendered.

1212. **Supports for Participant-Direction**

The COMP provides for three (3) 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 Management Services  
B. Support Coordination (Case Management) Services, and  
C. Community Guide Services

**1212.1 Financial Management Services**

- **Services Overview:**

  Financial Management Services are mandatory and integral to Participant-Direction designed to perform fiscal and related finance functions for the participant or representative who elects the participant-direction option for service delivery and supports. Financial Management 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 Management Services are covered as a distinct waiver service entitled Financial Support Services (FSS) as specified in the COMP Part III, Policies and Procedures Manual, Chapter 2200. 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 participant-directed services 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 services 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. Conduct skills training and 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.

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

5. Provide the participant or representative with twice a month reports of expenditures and the status of the participant-directed budget for participants and representatives who elect to exercise the Budget Authority.

6. Conduct skills training and provide technical assistance to participants and/or their representatives on budget management, including the process of reviewing the reports of expenditures and budget status.
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 employee timesheets must be completed correctly and timely;

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

5) All invoices for vendor payments must be completed correctly and timely;

6) All timesheets and invoices must be in accordance with the approved Individual Service Plan;

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

8) 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;

9) Other reasons an employee may not get paid include: late timesheets, lack of, or incomplete, employer enrollment forms, lack of, or incomplete, employer enrollment forms, and lack of authorized Individual Service Plan;

10) The FSS provider will generate paychecks and invoices every two (2) weeks, according to the established payment schedule;

11) The pay rate for employees is established during the development of the Individual Service Plan;
12) Information on unemployment benefits, workers’ compensation coverage, and tax withholding is available from the FSS provider.

13) Participants and representatives 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;

14) Participants, representatives and their employees should be knowledgeable about Medicaid fraud. Medicaid fraud is committed when an employer or employee is not untruthful regarding services provided to Medicaid Waiver participants in order to obtain improper payment. The Medicaid Fraud and Abuse Unit of Georgia investigates and prosecutes people who commit fraud against the Medicaid Program.

1212.2 Support Coordination (Case Management) Services

Support Coordination (Case Management) Services consist of information and assistance in support of participant direction. These services are performed primarily by Support Coordinators, in addition to Planning List Administrators and Intake and Evaluation staff. Case Management Services are covered as a distinct waiver service entitled Support Coordination Services as specified in the COMP Part III, Policies and Procedures Manual, Chapter 2600.

Responsibilities of Support Coordinators

1. Informing the participant or representative of the benefits, risks and responsibilities of participant direction.

2. Assessing the participant or representative who request participant direction to determine the ability to assume the responsibilities of participant direction, consisting of, where applicable, being the employer of support workers.

3. Informing the participant that a representative may assist him or her with participant direction.

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

5. Assisting the participant or representative with the development of the individual emergency back-up plan.
6. Assisting the participant or representative with the development of risk management agreements.

7. Arranging Community Guide services to provide direct assistance with participant direction responsibilities, including participant-directed budget development, training to be effective employers of support workers (if applicable), and brokering of available community resources.

8. Providing the participant or representative with the process for changing the Individual Service Plan and the individual budget, as well as and the reassessment and review schedules.

9. Informing the participant or representative of state policies and procedures for participant direction.

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

11. Linking the participant or representative to the training and technical assistance provided by the Financial Support Services provider.

12. Monitoring participant-directed services, in conjunction with the employer supervision provided by the participant or representative (if applicable), in order to ensure quality of care and to protect the health and safety of the participant.

12.3 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, Chapter 1800.

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.

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.

2. Provide information, direct assistance, and training to participants in support of participant direction.

3. Assist and train participants to build the skills required for participant direction, to include, but not limited to:
   
   1. Direct assistance to participants in exploring and brokering available community resources.
   
   2. Direct assistance to participants in meeting their participant-direction responsibilities.
   
   3. Information and assistance that helps the participant in problem solving and decision-making.
   
   4. Information and assistance that helps the participant in developing supportive community relationships and other resources that promotes implementation of the Individual Service Plan.
   
   5. Assistance with developing and managing the individual budget.
   
   6. Assistance with recruiting, hiring, training, managing, evaluating, and changing employees.
   
   7. Assistance with scheduling and outlining the duties of employees.
   
   8. Training the participant to be an effective employer of support workers.
   
   9. Information and assistance in understanding provider qualifications, record keeping and other participant-direction requirements.

1212.4 Health Maintenance Activities

Under certain conditions as specified below, a proxy caregiver, without the requirement for licensure as a registered professional nurse, can perform health maintenance activities for a participant who is self-directing waiver services. Health maintenance activities are those activities that allow a participant to function and maintain his or her health status and are activities or skills that can be taught to a proxy caregiver to maintain the individual in a community setting. Participants who are self-directing their services may hire individuals to perform health maintenance activities under the conditions specified below.
**Health Maintenance Activities Definition:** Health maintenance activities, which 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 person 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 (i.e., daily management of a central line, which is intravenous tubing inserted for continuous access to a central vein for administering fluids and medicine and for obtaining diagnostic information), 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. Any activity that requires nursing judgment is not a health maintenance activity. Health maintenance activities are specified for an individual participant in written orders of the attending physician, advanced practice registered nurse, or physician assistant.

a. **Written Plan of Care Requirements:** Health maintenance activities are as defined in the written plan of care that implements the written orders of the attending physician, advanced practice registered nurse, or physician assistant and specifies the frequency of training and evaluation requirements for the individual employee, including additional training when changes in the written plan of care necessitate added duties for which such proxy caregiver had not previously been trained. The written plan of care is established by a registered professional nurse, or by an attending physician, advanced practice registered nurse, or physician assistant. This written plan of care for health maintenance activities must be maintained by the participant or representative and available for the proxy caregiver.

b. **Written Informed Consent:** A participant or individual legally authorized to act on behalf of the participant must complete a written informed consent designating a proxy caregiver and delegating responsibility to such proxy caregiver to receive training and to provide health maintenance activities to the participant pursuant to the written orders of an attending physician, or an advanced practice registered nurse or physician assistant working under a nurse protocol agreement or job description.

c. **Individual Employee Requirements:** Individuals hired by a participant or representative self-directing waiver services to provide health maintenance activities in accordance with the above conditions must meet the following:

   a. Be selected by the participant or a person legally authorized to act on behalf of the participant to serve as the participant’s proxy caregiver.
b. Receive training by a registered nurse, attending physician, advanced practice registered nurse, or physician assistant that teaches the individual provider the necessary knowledge and skills to perform the health maintenance activities documented in the participant’s written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the participant.

c. Demonstrate to the trainer (i.e., registered nurse, attending physician, advanced practice registered nurse, or physician assistant) the necessary knowledge and skills to perform the health maintenance activities documented in the participant’s written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the participant.

d. Meet employee eligibility requirements specified in Section 1213.

E. Non-Covered Health Maintenance Activities: Health maintenance activities that meet any of the following are non-covered:

a. Complex care such as administration of intravenous medications, central line maintenance, and complex wound care.

b. Provided by an individual employee without written informed consent designating that individual as a proxy caregiver and delegating responsibility to such proxy caregiver to receive training.

c. Provided without the written orders of an attending physician, or an advanced practice registered nurse or physician assistant working under a nurse protocol agreement of job description, respectively, pursuant to Georgia Code Section 43-34-25 or 43-34-23.

d. Provided without a written plan of care as defined above.

e. Provided by individual employees who do not meet the requirements specified above.

1213. Employee Eligibility

Participants/Representatives who opt to participant-direct Community Access, Community Guide, Community Living Support, Supported Employment, or Transportation Services are the common law employer or co-employer of employees who provide these services. These employees must meet the following, in addition to the specific provider requirements, specified for these services in the Part III, Policies and Procedures Manual for the 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; and must have demonstrated the experience, training, education or skills necessary to meet the participant’s needs, consistent with the requirements for the specific services.

E.  Are prohibited from working overtime and shall not work in excess of 40 hours per week.

F.  Agree to a criminal records check, prior to employment, to ensure that the employee has no history of a felony conviction.

G.  Are willing to attend training (e.g., safety training) at the participant’s or representative’s request.

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

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

1214. **Hiring Family/Relatives to Provide Participant-Directed Waiver Services**

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

Other family members or relatives of the participant may be compensated for providing participant-directed COMP services if there are documented extenuating circumstances. Under these circumstances, family members may be considered to provide the following participant-directed 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 may not be approved to provide COMP services for the participant.

In situations with extenuating circumstances, prior approval is obtained through the Department of Behavioral Health and Developmental Disabilities, according to the protocol outlined below. Extenuating circumstances include:
A. A lack of qualified providers in remote areas;

B. The presence of extraordinary and specialized skills or knowledge by approvable family/relatives in the provision of services and supports in the approved Individual Service Plan (ISP); 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.

1214.1 **Steps for Approval of Extenuating Circumstances**

A. The individual or representative must work with the Support Coordinator on any letter requesting extenuating circumstances.

B. Requests for consideration of extenuating circumstances are to be made in writing and submitted to the designated regional Intake and Evaluation Team member.

C. The designated regional Intake and Evaluation Team member reviews the request and notifies in writing the individual or representative of the decision. The Support Coordinator is copied on this decision.

1214.2 **Appeals of Denials of Requests**

The individual or representative must work with the support coordinator on any letter requesting an appeal for denial of a request to hire family/relative. The written request for an appeal is sent to the regional Intake and Evaluation Manager. If the request is denied by the Intake and Evaluation Manager, a written appeal of this denial may be sent to the Regional Coordinator. If the Regional Coordinator denies the request, the final level of appeal may be made in writing to the Division of Developmental Disabilities in the Georgia Department of Behavioral Health and Developmental Disabilities. The responsible party will receive written notification of the Division of DD final decision.

1215. **Special Requirements and Conditions of Participation of Employees**

A. A participant’s spouse or parent, if the participant is a minor, may **not** be paid for COMP Participant-Directed services.

B. The utilization of other family members/relatives of the Participant as providers of COMP Participant-Directed services must be approved by the Department of Behavioral Health and Developmental Disabilities and documented in the ISP.
C. A participant’s legal guardian (appointed by a probate court) may not be paid to provide services under the Participant-Directed Option.

D. An individual who is employed to provide COMP Participant-Directed services for the participant and paid by the FSS provider may not also serve as the participant’s representative.

E. Individuals employed by the participant/representative to provide COMP Participant-Directed services are prohibited from working overtime and shall not work in excess of 40 hours per week.

F. Employees are not paid to provide services while the individual is admitted to a hospital or nursing facility, except where approved with the provision of a personal assistance retainer for Community Living Services (see COMP Part III, Policies and Procedures, Chapter 1900 for personal assistance retainer details).

G. Persons with a history of abuse, neglect, or exploitation may not be paid to provide any services under the Participant-Direction Option.

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

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

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

1216. Participant-Directed Services Documentation and other Requirements

Key documentation required for Participant-Directed Services consist of:

1) Employee timesheets.

2) Vendor payments.

3) Written summaries of the participant’s progress on ISP goals.

1216.1 Participant-Direction through a FSS Provider

The participant/representative who opts for participant-direction through
a FSS Provider must:

1. Maintain copies of timesheets and vendor payments for documentation of date and time of service delivery.

2. Maintain copies of CLS Personal Assistance Retainer Timesheet for any claims of this retainer for Community Living Support Services.

Note: see Part III, COMP Policies and Procedures, Chapter 1900 and Appendix C for additional information on the personal assistance retainer.

3. Require employees and professional vendors to provide a written summary of the participant’s progress on the ISP goals for the applicable service ninety (90) days prior to the formal ISP meeting.

1216.2 Participant-Direction through a Co-Employer Agency

The Co-Employer agency of any participant/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.

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.
   3. Scheduled days and units per day for Community Living Support Services as specified in the ISP.

Note: see Part III, COMP Policies and Procedures, Chapter 1900 and Appendix C for additional information on the personal assistance retainer.

3) Require employees and professional vendors to provide a written summary of the participant’s progress on the ISP goals for the applicable service ninety (90) days prior to the formal ISP meeting.

4) Meet all documentation requirements for any co-employer service that requires a license in accordance with the specified documentation requirements of the license.
1217. **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 five (5) years. Copies of these evaluations must be made available to the State 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 Case Management Information System (CIS) for a period of five (5) years. Copies of these evaluations must be made available to the Department upon request.

1218. **Exclusions and Special Conditions**

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

B. Payment directly or indirectly for COMP services provided to recipients in the Participant-direction Option 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 COMP services as indicated in Section 1214 of this manual.

C. Services provided by relatives or friends, except as noted above, may be covered only if:

- The family member or friend must meet 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 must meet the training qualifications prior to rendering services to a COMP participant;
- An agreement must be in place between the participant and employee before services are rendered;
- The participant must pay the employee at a rate that does not exceed that which would otherwise be paid to a provider of a similar service;
The service must not be an activity that the family would ordinarily perform or is responsible to perform;

An individual caregiver may not provide more than 40 hours of paid COMP services in a seven-day period. For participants that have hired a family member as a caregiver, 40 hours is the total amount that can be paid to the caregiver;

The caregiver must maintain and submit timesheets and other required documentation for hours paid.

1219. **Termination of Participant-Direction**

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

B. Involuntary termination of participant direction occurs due to the failure of the participant or representative to meet the responsibilities of participant direction or because of identified health and safety issues for the participant.

C. The support coordinator is responsible for a timely revision of the ISP, ensuring continuity in services by linking the participant to alternate waiver providers, and assuring the participant’s health and welfare during the transition period.

D. A period of twelve (12) months must elapse prior to consideration for re-enrollment in the participant-directed option.
## Appendix A

### REGIONAL OFFICE OF DBHDD CONTACT LIST

<table>
<thead>
<tr>
<th>DBHDD Region 1</th>
<th>DBHDD Region 2</th>
<th>DBHDD Region 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paula McHenry</strong></td>
<td><strong>Karla Brown</strong></td>
<td><strong>Lorraine Brooks</strong></td>
</tr>
<tr>
<td>Regional Services Administrator - DD</td>
<td>Regional Services Administrator - DD</td>
<td>Regional Services Administrator - DD</td>
</tr>
<tr>
<td><a href="mailto:pnmchenry@dhr.state.ga.us">pnmchenry@dhr.state.ga.us</a></td>
<td><a href="mailto:kbrown@dhr.state.ga.us">kbrown@dhr.state.ga.us</a></td>
<td><a href="mailto:lbrooks@dhr.state.ga.us">lbrooks@dhr.state.ga.us</a></td>
</tr>
<tr>
<td>705 North Division Street</td>
<td>3405 Mike Padgett Highway</td>
<td>100 Crescent Centre Parkway</td>
</tr>
<tr>
<td>Rome, Georgia 30165</td>
<td>Augusta, Georgia 30906</td>
<td>Tucker, Georgia 30084</td>
</tr>
<tr>
<td>Phone 706-802-5272</td>
<td>Phone 706-792-7733</td>
<td>Phone 770-414-3052</td>
</tr>
<tr>
<td>Fax 706-802-5280</td>
<td>Fax 706-792-7740</td>
<td>Fax 770-414-3048</td>
</tr>
<tr>
<td>1-800-646-7721</td>
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<tr>
<th>DBHDD Region 4</th>
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<tr>
<td><strong>Robin Vanwy</strong></td>
<td><strong>Lorr Elias (Acting)</strong></td>
<td><strong>Joseph Coleman</strong></td>
</tr>
<tr>
<td>Regional Services Administrator - DD</td>
<td>Regional Services Administrator - DD</td>
<td>Regional Services Administrator - DD</td>
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<tr>
<td><a href="mailto:rwvanwy@dhr.state.ga.us">rwvanwy@dhr.state.ga.us</a></td>
<td><a href="mailto:lbelias@dhr.state.ga.us">lbelias@dhr.state.ga.us</a></td>
<td><a href="mailto:jcoleman@dhr.state.ga.us">jcoleman@dhr.state.ga.us</a></td>
</tr>
<tr>
<td>P.O. Box 1378</td>
<td>1915 Eisenhower Dr., Building 2</td>
<td>3000 Shatulga Rd., Bldg. 4</td>
</tr>
<tr>
<td>Thomasville, Georgia 31799</td>
<td>Savannah, GA 31406</td>
<td>Columbus, Georgia 31907-2435</td>
</tr>
<tr>
<td>Phone 229-225-5099</td>
<td>Phone: 912-303-1670</td>
<td>Phone (706)565-7835</td>
</tr>
<tr>
<td>FAX 229-227-2918</td>
<td>FAX: 912 303-1681</td>
<td>FAX (706)565-3565</td>
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<tr>
<td>1-877-683-8557</td>
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APPENDIX B

Developmental Disabilities Services
Georgia Department of Human Resources
OFFICE OF DEVELOPMENTAL DISABILITIES
APPLICATION FOR DEVELOPMENTAL DISABILITIES/MENTAL RETARDATION SERVICES

IF YOU NEED ASSISTANCE COMPLETING THIS APPLICATION, PLEASE CONTACT THE LOCAL INTAKE AND EVALUATION OFFICE BY CONTACTING:

I. GENERAL INFORMATION (APPLICANT)

Name: ___________________________ ___________________________ ___________________________
First Middle Last

Address:__________________________________________________________
Street Address (Apartment Number if Applicable)
City: ___________________________ County: ___________________________ State: ___________________________ Zip Code: ___________________________

Mailing Address (if different): ____________________________________________________________

Telephone Number: ___________________________ Area Code:__________________________
Marital Status: S M D W Sex: ___________________________
Birthdate: ___________________________ Medicare #: ___________________________
Social Security #: ___________________________ Medicaid #: ___________________________

PRIMARY CONTACT: _________________________________________________________________

Address:__________________________________________________________
City: ___________________________ County: ___________________________ State: ___________________________ Zip Code: ___________________________

Relationship to Applicant: ___________________________ Telephone Number: ___________________________ Area Code: ___________________________

LEGAL STATUS OF APPLICANT: __Minor __Competent __Legally Incompetent (Documentation Required)

Name of Legal guardian, if applicable: ___________________________________________________

Address:__________________________________________________________
Street Address (Apartment Number if Applicable)
City: ___________________________ County: ___________________________ State: ___________________________ Zip Code: ___________________________

Relationship to Applicant: ___________________________ Telephone Number: ___________________________ Area Code: ___________________________

II. ASSESSMENT OF DEVELOPMENTAL DISABILITY AND ELIGIBILITY

Application for DD Waiver Services
Division of MIDDAD 1 of 2 AUGUST 2006
To be eligible for Georgia’s Developmental Disabilities Waiver services, you must be:
   a. Medicaid eligible
   b. Have mental retardation since birth or before age 18, or another developmental disability since birth or before age 22, which requires similar services to those needed by people with mental retardation
   c. Be at risk for going into an institution for people with mental retardation if you do not get the services you need in your community.

During your initial screening appointment, specific medical information will be collected to confirm the disability. Please read the Information for Applicant checklist at the front of this application, and have items or copies available.

III. SERVICE NEEDS

Describe the type of services you believe you need. For example do you need help with getting a job, do you need assistance to get dressed, do you need family support or do you need some place to live.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

IV. COMPLETED BY:

Signature: ______________________ Date: ______________________

Check one:  __ Applicant  __ Guardian  __ Other: ______________________

Printed Name: ______________________

What is the best way to contact you?

__________________________________________________________________________

When this application is received, it will be stamped with a date. Within fourteen working days of that date, you will be notified that your application has been received and you will be offered a screening appointment. If this does not occur, please call the Intake and Evaluation listed above.

Return this application in the envelope provided.
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**

**PHYSICIAN'S RECOMMENDATION CONCERNING NURSING FACILITY CARE OR INTERMEDIATE CARE FOR THE MENTALLY RETARDED**

**Section A — Identifying Information**

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<thead>
<tr>
<th>7. Medicaid Case Number</th>
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**Section B — Physician's Examination Report and Recommendation**

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**Hospital Diagnosis**

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**Medications**

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**Diagnostic and Treatment Procedures**

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<tr>
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| 30. Indicate Frequency Per Week |

| 31. Record Appropriate Legend |

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| 33. Pre-Admission Certification Number |
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| 38. Attachments to GMHCF: 1. Yes 2. No |
|----------------------------------------|----------|
|                                        |          |
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., 11222333444;

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 parent or legal representative think the applicant should be institutionalized?
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 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, 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.

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.

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.

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.

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.

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 are completed by Contractor staff only.
Summary:

**INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE**

1. ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.

2. An ICF/MR level of care is generally indicated if one condition of Column A is satisfied in addition to the conditions Column B and Column C being satisfied. Conditions derived from 42 C.F.R. 440.150, 435.1009, and 483.440(a).

3. Column B refers to "an aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services." These active treatment services, as defined in 42 C.F.R. 483.460, provide aggressive, consistent monitoring, supervision and/or assistance as defined in the plan of care to address the specific medical conditions, developmental and behavioral needs, and/or functional limitations identified in the comprehensive functional assessment. This comprehensive functional assessment must be age appropriate.

4. The following conditions meet ICF/MR institutional level of care criteria, as these individuals would be institutionalized regardless of ability to participate in an aggressive program of specialized and generic training, treatment, health services, and related services as outlined in Column B:
   - Those children with an IQ of 50 or below (moderate to profound mental retardation) or
   - Those children who meet the criteria for Autism, Autism-Spectrum, Asperger's, Pervasive Developmental Disorder, Developmental Delay, Mental Retardation, Down's Syndrome, and any other Developmental Disability as evidenced by:
     - a score on a standardized adaptive functioning tool of 2 standard deviations below the norm in three or more of any of the following behavior domains: self-care skills, understanding and use of verbal and nonverbal language learning in communication with others, mobility, self-direction, and age-appropriate ability to live without extraordinary assistance or an overall standard score < 70, or
     - If their age equivalency composite score is less than 50% of their chronological age, and/or
   - The child has a Childhood Autism Rating Scale (CARS) score of above 37, a Gillam Autism Rating Scale (GARS) of 121 or greater, or any other equivalent standardized assessment tool which indicate severe autism.

<table>
<thead>
<tr>
<th>COLUMN A (Diagnosis)</th>
<th>COLUMN B (Plan of Care)</th>
<th>COLUMN C (Functional Need)</th>
</tr>
</thead>
</table>
| 1. The individual has mental retardation. OR 2. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy. OR 3. The individual has a condition, other than mental illness, (i.e., Autism, Autism-spectrum, Asperger's, Pervasive Developmental Disorder, Down's Syndrome or Developmental Delay) which is found to be closely related to useful retardation because it is likely to last indefinitely, and requires similar treatment and services. AND 4. The impairment for these conditions outlined above constitutes an impairment of general intellectual functioning, and results in substantial limitations in one or more of the following functional limitations: Self-care skills such as feeding, toileting, dressing, and bathing; Understanding and use of verbal and nonverbal language learning in communication with others; Mobility; Self-direction in managing one's social and personal life and the ability to make decisions necessary to protect one's self as per age-appropriate ability; and Age-appropriate ability to live without extraordinary assistance. | On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards:
   a. The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and
   b. The prevention of further decline of the current functional status or loss of current optimal functional status. This is evidenced in the Plan of Care by the individual's participation (at least five (5) days a week) in interventions which are required to correct/ameliorate the condition/diagnosis, and are compatible with acceptable professional practice in light of the condition(s) at the time of treatment. Active treatment does not include:
   - Interventions that address age-appropriate limitations; or
   - General supervision of children whose age is such that supervision is required by all children of the same age or
   - Physical assistance for persons who are unable to physically perform tasks but who understand the process needed to do them | 1. The services have been ordered by a licensed physician. AND 2. The services will be furnished either directly by, or under the supervision of, appropriately qualified providers (see definition): AND 3. The services, as a practical matter, would have ordinarily been provided in an ICF/MR, in the absence of community services. |

Revised 3/3/06
INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE

INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE — COLUMN A

I. The individual has mental retardation.

2. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy.

3. The individual has a condition, other than mental illness, which is found to be closely related to mental retardation because it is likely to last indefinitely, requires similar treatment and services, constitutes an impairment of general intellectual functioning, and results in substantial limitations in three or more of the following: self-care, understanding and use of language learning, mobility, self-direction, and capacity for independent living.

EXPLANATIONS

42 CFR 435.1009

I. Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that:
(a) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions.

2. Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: It is attributable to cerebral palsy or epilepsy.
   • It is manifested before the person reaches age 22.
   • It is likely to continue indefinitely.
   • It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

3. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
   • It is manifested before the person reaches age 22.
   • It is likely to continue indefinitely.
   • It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction.
1. On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards—

- The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and
- The prevention of further decline of the current functional status or loss of current optimal functional status.

### EXPLANATIONS

**42 CFR 483.440**

1. Standard: Active treatment. (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:
   - The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and
   - The prevention or deceleration of regression or loss of current optimal functional status.

### INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE — COLUMN C

1. The service needed has been ordered by a physician.

2. The service will be furnished either directly by, or under the supervision of, appropriately licensed personnel.

   1. The facility must ensure the availability of physician services 24 hours a day.
   2. The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires care ordinarily given on an inpatient basis. This plan must be integrated in the individual program plan.

2. Standard: Qualified mental retardation professional. Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional who
   1. Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and
   2. Is one of the following:
      - A doctor of medicine or osteopathy.
      - A registered nurse.
### 3. The service required is ordinarily furnished, as a practical matter, on an inpatient basis.

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<table>
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<tbody>
<tr>
<td></td>
<td>An individual who holds at least a bachelor’s degree in a professional category specified in paragraph (b) (3) of this section.</td>
</tr>
<tr>
<td>42 CFR 483.460(a)(1-2)</td>
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</tr>
<tr>
<td></td>
<td>(1) The facility must ensure the availability of physician services 24 hours a day.</td>
</tr>
<tr>
<td></td>
<td>(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires care ordinarily given on an inpatient basis. This plan must be integrated in the individual program plan.</td>
</tr>
</tbody>
</table>
Protocol for Physicians Signature

A physician’s signature is required on the ISP if-

- When the completed HRST indicates a level 3 or above, a physician review is required. When the CMC screening tool indicates a level 3 or above, a physician review is required. 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. *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

<table>
<thead>
<tr>
<th>Consumer Name:</th>
<th>Allergies:</th>
<th>Physician's Review Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>NKA</td>
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<tr>
<td>MI:</td>
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<tr>
<td>Last Name:</td>
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<tr>
<td>Preferred Name:</td>
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</table>

Physician will –

- Complete and sign the Physician Review form 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 goals/ action plan and or risk protection page will be recommended accordingly
- OA's will approve the ISP
**Section A – Identifying Information**

<table>
<thead>
<tr>
<th>1. Applicant's Name/Address</th>
<th>2. Medicare Number</th>
<th>3. Social Security Number</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>DFD's County</td>
<td></td>
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<tr>
<td>Mailing Address</td>
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</table>

1. In the caregiver's opinion, would the child have received the same level of care at home? **Yes**
2. (continued) **No**

6. Applicant's Telephone #

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

13. Diagnosis:

<table>
<thead>
<tr>
<th>1. ICD-10</th>
<th>2. ICD-10</th>
<th>3. ICD-10</th>
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16. Treatment Plan:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Route</th>
<th>Frequency</th>
<th>Type</th>
<th>Frequency</th>
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</table>

20. Patient Traveled from: **HOSPITAL**

21. Length of Time on Plan: **0** months

22. Is patient free of communicable disease? **Yes**

27. Physician's License No.:

28. Physician's Telephone #:

**Section C – Evaluation of Nursing Care Needs (Check appropriate box only)**

29. Nutrition:

<table>
<thead>
<tr>
<th>1. Low Calorie</th>
<th>2. Low Sodium</th>
<th>3. High Protein</th>
<th>4. Low Fat/Restrict Fat</th>
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30. Bowel:

<table>
<thead>
<tr>
<th>1. Constipation</th>
<th>2. Diarrhea</th>
<th>3. Incontinence</th>
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31. Cardiopulmonary Status:

<table>
<thead>
<tr>
<th>1. Hypertension</th>
<th>2. Heart Failure</th>
<th>3. Congestive Heart Failure</th>
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32. Mobility:

<table>
<thead>
<tr>
<th>1. Wheelchair</th>
<th>2. Crutches</th>
<th>3. Assistive Device</th>
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33. Behavioral Status:

<table>
<thead>
<tr>
<th>1. Agitation</th>
<th>2. Depression</th>
<th>3. Anxiety</th>
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34. Integument System:

<table>
<thead>
<tr>
<th>1. Diarrhea</th>
<th>2. Incontinence</th>
<th>3. Ulcers</th>
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35. Dermatological:

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36. Surgery:

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37. Therapy Visits:

<table>
<thead>
<tr>
<th>1. Physical Therapy</th>
<th>2. Occupational Therapy</th>
<th>3. Speech Therapy</th>
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38. Pharmacological Status:

<table>
<thead>
<tr>
<th>1. Medication</th>
<th>2. Allergies</th>
<th>3. Alcohol Use</th>
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39. Other Therapies:

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40. Remarks:

<table>
<thead>
<tr>
<th>1. Medication</th>
<th>2. Allergies</th>
<th>3. Alcohol Use</th>
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42. Date Signed:

<table>
<thead>
<tr>
<th>1. Signature of MD or RN</th>
<th>2. Signature of RD or RN</th>
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**PEDIATRIC DNA (A)**

**PHYSICIAN’S RECOMMENDATION FOR PEDIATRIC CARE**

**Type of Program:**

- Nursing Facility
- GASP
- TFRR/Katell Beckett
- MRRD

**Comprehensive Supports Waiver Program**

**C-13**
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 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.

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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.

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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

<table>
<thead>
<tr>
<th>Consumer Name:</th>
<th>Allergies:</th>
<th>Physician's Review Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>MI:</td>
<td></td>
</tr>
<tr>
<td>Last Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Name:</td>
<td></td>
<td>NKA</td>
</tr>
</tbody>
</table>

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 goals/action plan and or risk protection page will be recommended accordingly
• OA's will approve the ISP
## Appendix D
### I&E Screening Tool for Chronic Medical Conditions

*NOTE: All conditions Level 3 and above require forwarding ISP to I&E Physician for Review; Conditions at Level 2 require nurse judgment for forwarding for I & E Physician Review

<table>
<thead>
<tr>
<th>Individual:</th>
<th>Birthdate:</th>
<th>Completed by:</th>
<th>Date Completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Diabetes**  
*If end stage organ damage present increase to next level (Ex: Kidney Disease, Heart Disease, Eye Involvement)* | L-1 | L-2 * | L-3 * |
| Diabetes Diagnosis; no medications | Fasting Blood sugar 100-120 | 1-2 oral meds | 2 or more oral meds |
| A1C (If available) – Under 6% | Fasting Blood Sugar 120-140 | Fasting Blood Sugar 140-180 | Fasting Blood Sugar 180+ |
| | A1C Over 6% | A1C Over 7% | A1C Over 7% |
| **Hypertension**  
*If end stage organ damage present increase to next level (Ex: Kidney Disease, Heart Disease, Eye Involvement)* | L-1 | L-2 * | L-3 * |
| Hypertension BP 120/80 – 139/89 | No prescribed medications | BP 140/90-159/99 | BP 160/100 or higher |
| No prescribed medications | Less than 2 meds | 2 or more meds and/or Organ damage | |
| **Hyperlipidemia** | L-1 | L-2 * | L-3 * |
| Hyperlipidemia Total Cholesterol – over 200 | Cholesterol Triglycerides, HDL, LDL, same as *Level 1* Plus | Level 2 with a history of CAD,CVD, or PAD | |
| Triglycerides – over 200 | Takes prescribed medications | | |
| HDL under 50 LDL over 130 | No history of CAD | | |
| Diet only – No prescribed medications and history of Coronary Artery Disease | | | |
| **Respiratory Conditions**  
*Symptoms may include wheeze, chest tightness, shortness of breath, and/or cough* | L-1 | L-2 * | L-3 * |
<p>| Respiratory Conditions Symptoms less than 2 x month | Symptoms more than 2 x week; Night-time-symptoms more than 2 x month Daily use of albuterol or other bronchodilator (rescue inhaler) | Continuous symptoms with severe exacerbations Frequent night time symptoms History or current (inhaled or oral) corticosteroids | |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Diagnosis of COPD (Emphysema, Chronic Bronchitis)</th>
<th>Same as level 1 Plus Dyspnea on exertion Mild-Moderate airflow obstruction per spirometry May use PRN Oxygen Therapy</th>
<th>Continuous Oxygen Therapy Dyspnea with little exertion Severe airflow obstruction per Spirometry With or without history of Respiratory Failure/Right Heart Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>Chronic cough with presence of sputum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Conditions</td>
<td>Asymptomatic, but has a history of MI, Angina, Valvular Heart Disease, Heart Failure No activity limitations</td>
<td>Symptomatic (Ex: Angina, Dyspnea, Edema, etc) Heart Failure Limited functional status</td>
<td></td>
</tr>
<tr>
<td>ESRD End Stage Renal Disease or Chronic Kidney Disease</td>
<td>Stable with prescribed medications</td>
<td>Undergoing Dialysis on routine basis and/or awaiting kidney transplant</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>BMI 25-30lbs (Overweight)</td>
<td>BMI over 30 (Obese)</td>
<td>BMI Over 40 (Morbid or Severe Obesity)</td>
</tr>
<tr>
<td></td>
<td>If unable to obtain weight, note reason. Mention any reported weight changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>History of cancer in remission and no treatment</td>
<td>Current diagnosis malignancy. Current or recent history of Immune-Suppressive therapy.</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Under 65 years of age with no history of fractures. And Any known risk factors:</td>
<td>Any age with a history of fracture and/or the following: Any known risk factors: May or may not have proven Osteopenia or Osteoporosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk Factors: Non-ambulatory, Anticonvulsant., Small frame, Caucasian, Natural or artificial menopause, Smoking, Family History</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

April 1, 2012 Comprehensive Supports Waiver Program D-2
<table>
<thead>
<tr>
<th></th>
<th>History of alcohol, drugs, or nicotine abuse.</th>
<th>Current abuse of alcohol, drugs or nicotine.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chronic Pain</strong></td>
<td></td>
<td>As determined by levels L2 on the “smiley face” scoring sheet</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td></td>
<td>Dementia of any etiology and a Developmental Disability</td>
</tr>
<tr>
<td><strong>Electrolyte Imbalance</strong></td>
<td>Any risk factor that could cause an imbalance</td>
<td>Treatment requiring interventions in the past or current treatment.</td>
</tr>
<tr>
<td><strong>Risk Factors:</strong></td>
<td>Medication, Kidney disease, History Diabetes Insipidus, Psychogenicpolydypsia</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>No medication History of mental illness</td>
<td>Current Diagnosis with medications</td>
</tr>
<tr>
<td>Medical Condition</td>
<td>Description</td>
<td>Detailed on “Risks” sheet? yes/no</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Diabetes, Type 2 aka adult-onset diabetes (Takes two oral meds)</td>
<td>Carbohydrate metabolism disturbance that results in inadequate secretion or utilization of the hormone insulin; symptoms include polyuria (excessive urination), polydipsia (excessive thirst), polyphagia (excessive hunger), weight loss and high sugar levels in the blood and urine. Type 2: develops most often in adults and persons who are overweight; characterized by high blood sugar that results from the body’s impaired ability to use and secrete insulin.</td>
<td></td>
</tr>
<tr>
<td>Hyperlipidemia (takes no prescribed meds)</td>
<td>Increased triglycerides/cholesterol (excess fat or lipids) in blood stream: Triglycerides &gt; 200; HDL &lt; 50; LDL &gt; 130; Total Cholesterol &gt; 200</td>
<td></td>
</tr>
</tbody>
</table>
**I&E Screening Tool for Chronic Medical Conditions**

*NOTE: All conditions Level 3 and above require ISP signature by I&E Physician Review; Conditions at Level 2 require nurse judgment for forwarding for I & E Physician Review*

<table>
<thead>
<tr>
<th>Individual:</th>
<th>Birthdate:</th>
<th>Completed by:</th>
<th>Date Completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Medical Condition</td>
<td>L-1</td>
<td>L-2</td>
<td>L-3</td>
</tr>
<tr>
<td>Diabetes</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperlipidemia</td>
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<td></td>
<td></td>
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<tr>
<td>Respiratory Conditions</td>
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<tr>
<td>COPD</td>
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<td></td>
<td></td>
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<tr>
<td>Cardiac Conditions</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ESRD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
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<td></td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Osteoporosis</td>
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<tr>
<td>Substance Abuse</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Pain</td>
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<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrolyte Imbalance</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

RN Signature: _________________________________  Date: __________________________
APPENDIX E
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

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.

________________________________________ Date
Recipient

________________________________________ Date
Authorized Representative

Witness Date

Refusal

I and/or my authorized representative have been informed of my choices and have chosen to refuse waiver services.

________________________________________ Date
Recipient

________________________________________ Date
Authorized Representative

Witness Date
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.
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

<table>
<thead>
<tr>
<th>Last Name, First Name</th>
<th>Prior Auth. Number:</th>
<th>Fiscal Year:</th>
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<tbody>
<tr>
<td></td>
<td>1111111111111</td>
<td>2005</td>
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<tr>
<td>MHN Number:</td>
<td></td>
<td></td>
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<tr>
<td>Medicaid Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth: 12/02/1945</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Intake Provider**

Columbus Community Services - Atlanta
2300 Henderson Mill Road
Suite 100
Atlanta, GA 30345
Office: 770-938-5310 (24 hrs.)
Toll Free: 800-579-7669

**Diagnosis**

*A minimum of one ICD-9 Code is required.*

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Date of Diagnosis</th>
<th>Primary</th>
<th>Date of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>317</td>
<td>06/01/1954</td>
<td>yes</td>
<td>05/24/2004</td>
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</table>

**Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Start Date</th>
<th>End Date</th>
<th>Number of Units</th>
<th>Rate Per Unit</th>
<th>Max Units Per Day</th>
<th>Max Units Per Month</th>
<th>Max Units Per Year</th>
<th>Annualized Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2021</td>
<td>GWNENET CO ARC, INC. - 0000000000B</td>
<td>07/01/2004</td>
<td>06/30/2005</td>
<td>5760</td>
<td>$3.04</td>
<td>24</td>
<td>0</td>
<td>5760</td>
<td></td>
</tr>
<tr>
<td>T2055- US</td>
<td>GWNENET CO ARC, INC. - 0000000000A</td>
<td>07/01/2004</td>
<td>06/30/2005</td>
<td>365</td>
<td>$122.99</td>
<td>1</td>
<td>0</td>
<td>365</td>
<td></td>
</tr>
</tbody>
</table>

**Program Information**

Check if this is Retroactive Request due to MAO Eligibility: ☐

<table>
<thead>
<tr>
<th>Status</th>
<th>Effective Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saved</td>
<td>5/24/2004 7:23:35 AM</td>
<td>Saved</td>
</tr>
<tr>
<td>Approved</td>
<td>5/27/2004 8:30:21 AM</td>
<td>Approved</td>
</tr>
<tr>
<td>Accepted</td>
<td>5/28/2004 5:10:24 AM</td>
<td>Accepted</td>
</tr>
</tbody>
</table>
APPENDIX H

Documentation for Exceptional Rate Request or Request to Exceed Maximum Allowable Units

Consideration of an exceptional rate requires submission of the following documentation to the applicable DBHDD Regional Office:

- Cover letter stating the individual is currently in an institution awaiting movement to the community or the individual is in the community but currently at imminent risk of institutionalization;

- The most current Health Risk Screening Tool (HRST) and Supports Intensity Scale (SIS) full assessment findings.

- Any enhanced staffing requirements, including as applicable, the following: (a) specification of additional paraprofessional, direct care staffing requirements in amount and time of day; (b) for any Community Access Group requests, specification of enhanced paraprofessional, direct care staff supervision of participants in the group setting; (c) specification of number of hours of specialized, direct care skills, which include, but are not limited to, delegated medically related tasks and/or implementation of behavioral support plans; (d) specification of hours of direct service provision by nursing and behavior specialist staff; (e) specification of hours needed of nursing or behavior specialist oversight of the service provision required.

Note: For consideration of an exceptional rate request only, a licensed practical nurse (LPN) meets the definition of a Developmental Disability Professional.

- For Specialized Medical Supplies requests, 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.

- Individual Service Plan (ISP) documentation of the enhanced service delivery required, including specification of staffing requirements as above.

- Interdisciplinary Team approval of the need for an exceptional rate, as documented in the ISP.

- Budget for the participant, which includes the host home provider payment if services are provided in a host home/life sharing arrangement, and for any congregated residential site, the budgets for all participants served at that site.

- Documentation of the education, training, and experience of any Developmental Disability Profession (DDP) that supports the qualifications of that DDP to provide direct service or oversight for the exceptional medical or behavioral support needs of the participant.
9. Crisis Plan for any crisis defined as an occurrence that poses a health and safety risk to the participant and/or others as a result of the exceptional behavioral or medical support needs of the participant; the Crisis Plan includes, but is not limited to, the following:

- Back up plans when critical staff are absent;
- Crisis 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
- Action plan for any participant at risk of elopement in the event of an elopement.

10. Requests for exceptional rates based on the exceptional behavioral support needs of the participant must include the following:

- An agency developed and approved behavioral support plan applicable to service provision by the provider agency requesting the exceptional rate.
- Documentation that provider agency employees, or individuals under contract, supporting the participant with exceptional behavioral support needs are trained in the use of emergency safety interventions. These employees or individuals must maintain certification in a DBHDD approved emergency safety intervention curriculum. The circumstances under which the emergency intervention shall be implemented should be detailed in the participant’s behavior support plan and crisis plan.
- Quantitative data in the form of frequency, rate, or duration should be provided for each target behavior identified in the behavior support plan. This data must include the most recent three (3) month period of continuous data collection for each behavior targeted by the behavior support plan. Data should be in an objective, numerical, and graphical form. If available, a graph, or graphs, of the behavioral data are preferred submissions.

The DBHDD Division of Developmental Disabilities does not approve any exceptional rate requests with inadequate documentation.

Comprehensive Supports Waiver (COMP) Exceptional Rate or Exceeding Maximum Allowable Units Request Procedures

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 of a rate that exceeds the established maximum rate for a Comprehensive Supports Waiver (COMP) service. Exceptional rate 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 exceptional rates beyond the Medicaid maximum rates for waiver services. Any approval of an exceptional rate is time limited up to a
maximum of one year.

**Exceptional Rate Requests and COMP Waiver Services:** Exceptional rate requests may be submitted for the following COMP waiver services:

a. Community Residential Alternative Services  
b. Community Living Support Services  
c. Community Access Group Services  
d. Respite Overnight Services  

**Requests to Exceed Maximum Allowable Units:** Requests to exceed the maximum allowable units may be submitted for the following COMP services:

a. Specialized Medical Supplies  
b. Specialized Medical Equipment  

**Extraordinary Circumstances Requirements for Exceptional Rate Consideration or Exceeding Maximum Allowable Units:** To be considered for an exceptional rate 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 due to needed services requiring rate(s) above the established maximum rate(s), OR

   The extent of an individual participant’s needs presents imminent risk of institutionalization (i.e., the only options are institutionalization or enhanced waiver service delivery beyond that provided by the established Medicaid maximum rate);  

   **AND**

2. **Assessed Exceptional Needs of the Participant:** Exceptional needs of the participant must be documented by at least one of the following assessment findings from the Health Risk Screening Tool or the Supports Intensity Scale:

   a. **Health Risk Screening Tool (HRST)**

      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
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 Mental Retardation Professional (QMRP) level psychology professional, OR

c. Any rating of 4 on Treatments in the HRST Category III – Physiological, with Georgia licensed Registered Nurse review and signature, OR

d. Four or more ratings of 4 overall on the HSRT, with Georgia licensed Registered Nurse review and signature,

OR

b. **Supports Intensity Scale (SIS)**

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

b. A rating of 2 (Extensive Support Needed) on Prevention of Assaults/Injuries to Others, Prevention of Property Destruction, or Prevention of Tantrums/Outbursts in the SIS Section 3B: Exceptional Behavioral Supports Needed with Georgia licensed Registered Nurse review, signature, and documented consultation of RN with Qualified Mental Retardation Professional (QMRP) level psychology professional, OR

b. A Total Rating of at least 6 that includes a minimum of one rating of 2 in the SIS Section 3A: Exceptional Medical Supports Needed or the SIS Section 3B: Exceptional Behavioral Supports Needed, with Georgia licensed Registered Nurse review and signature, and documented consultation of RN with Qualified Mental Retardation Professional (QMRP) level psychology professional if exceptional rate request relates to exceptional behavior support needs;

**AND**

3. **Enhanced Service Delivery Requirements:** Service delivery requirements for the participant must be demonstrated to:

   Exceed that provided by the established Medicaid maximum rate for the service for which the exceptional rate is being requested; AND

   Link to the assessed exceptional needs of the participant;

   **AND**
4. **Individual Service Plan:** The assessed exceptional needs of the participant that support the exceptional rate request, including specification of the enhanced service delivery required (e.g., specific staff to participant ratio required; time of day enhanced staffing ratio required; number of hours of professional staffing or oversight required), must be documented in the Intake and Evaluation Team approved Individual Service Plan (ISP);

**AND**

5. **Interdisciplinary Team Approval:** The Interdisciplinary Team must approve the need for an exceptional rate, as documented in the ISP.

**Exceptional Rate Determination:** An exceptional rate for a waiver service is based on assessed exceptional needs of the participant that require enhanced waiver service delivery beyond that provided by the established Medicaid maximum rate for that service. Any exceptional rate cannot provide for room and board and related items. The exceptional rate must derive from the enhanced service delivery specific to the exceptional needs of the participant, which include one or more of the following:

- **Extraordinary Staffing Requirements:** Additional paraprofessional, direct care or Developmental Disability Professional staffing requirements, which include enhanced paraprofessional, direct care staffing ratios, enhanced paraprofessional, direct care staff supervision of participants in a group setting, and/or required hours of DD Professional direct service provision.

- **Specialized Paraprofessional, Direct Care Staff Skills:** Specialized paraprofessional, direct care staff skills, which include, but are not limited to, 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.

- **Enhanced Professional Oversight:** Added DD Professional oversight of the service provision, which includes specified hours needed of DD Professional(s) overseeing service delivery.

**Determination of Exceeding Maximum Allowable Units**

- **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.

**Exceptional Rate or Exceeding Maximum Allowable Units Request Review:** DBHDD, Division of Developmental Disabilities conducts a clinical/programmatic review of the basis for the exceptional rate or exceeding maximum allowable units request and a review of the enhanced
service delivery requirements associated with the requested exceptional rate as follows:

- **Clinical/Programmatic Review:** The Division of DD will deny any exceptional rate or exceeding maximum allowable units request that:
  
  a. Does not meet or adequately document the meeting of Extraordinary Circumstances Requirements for an Exceptional Rate; OR
  
  b. Does not adequately link the Enhanced Service Delivery Requirements to the exceptional needs of the individual participant.

- **Enhanced Service Delivery Requirements Review:** The Division of DD does not approve any exceptional rate request that has inadequate documentation of the Enhanced Service Delivery Requirements for the participant.

**Exceptional Rate Tiers:** Exceptional rates are approved according to tier levels, which are based on documented enhanced service delivery requirements for the participant due to his or her exceptional needs. Administrative costs are based on 15 percent of the standard maximum rate for the service. Failure by the provider to deliver services as approved will result in recoupment. The following tables provide the Exceptional Rate Tiers and their Enhanced Service Delivery Requirements as indicated for specific waiver services:

**Table 1: Community Residential Alternative and Community Living Support Services**

<table>
<thead>
<tr>
<th>Exceptional Rate Tier</th>
<th>Exceptional Rate Amount</th>
<th>Enhanced Service Delivery Requirements</th>
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<tbody>
<tr>
<td>Tier 1</td>
<td>1.0 to 1.5 times the established standard rate</td>
<td>a. <strong>Extraordinary Staffing Requirements:</strong> Enhanced paraprofessional, direct care staffing ratios, or a minimal to moderate amount of Developmental Disability Professional direct service provision (up to 25 hours per week) in place of paraprofessional, direct care staffing and no enhanced paraprofessional, direct care staffing ratio requirements; AND</td>
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<td></td>
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<td>b. <strong>Specialized Paraprofessional, Direct Care Staff Skills:</strong> none to minimal (up to 1 hour per day) specialized paraprofessional, direct care staff skills required; AND</td>
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<td></td>
<td>c. <strong>Enhanced Professional Oversight:</strong> no additional Developmental Disability Professional oversight required.</td>
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<tr>
<td>Tier 2</td>
<td>1.5 to 1.8 times the established standard rate</td>
<td>1. <strong>Extraordinary Staffing Requirements:</strong> Enhanced paraprofessional, direct care staffing ratios and a minimal amount of Developmental Disability Professional direct service provision (up to 4 hours per month), or a moderate to substantial amount of</td>
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Developmental Disability Professional direct service provision (more than 25 hours and up to 50 hours per week) in place of paraprofessional, direct care staffing and no enhanced paraprofessional, direct care staffing ratio requirements; AND

2. **Specialized Paraprofessional, Direct Care Staff Skills:** Specialized paraprofessional, direct care staff skills that include a minimal to moderate amount (more than one and up to 4 hours per day) of specialized, paraprofessional direct care staff skills required, or none to minimal (up to 1 hour per day) specialized paraprofessional, direct care staff skills required but a moderate to substantial amount of Developmental Disability Professional direct service provision requirements as indicated above; AND

**Enhanced Professional Oversight:** a minimal amount of additional Developmental Disability Professional oversight (up to 2 hours per month) required.

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<th>Exceptional Rate Tier</th>
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</table>
| Tier 3                | 1.8 to 2.2 times the established standard rate | **Extraordinary Staffing Requirements:** Enhanced paraprofessional, direct care staffing ratios and a moderate amount of Developmental Disability Professional direct service provision (more than 4 hours per month and up to 24 hours per month), or an intensive amount of Developmental Disability Professional direct service provision (more than 50 hours and up to 75 hours per week) in place of paraprofessional, direct care staffing and no enhanced paraprofessional, direct care staffing ratio requirements; AND

**Specialized Paraprofessional, Direct Care Staff Skills:** A moderate to substantial amount (more than 4 hours per day and up to 8 hours per day) of specialized paraprofessional, direct care staff skills required, or none to moderate (up to 4 hours per day) specialized paraprofessional, direct care staff skills required but an intensive amount of Developmental Disability Professional direct service provision requirements as indicated above; AND

**Enhanced Professional Oversight:** a moderate amount of additional Developmental Disability Professional oversight (more than 2 hours and up to 4 hours per month) required.
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<th>Exceptional Rate Tier</th>
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<th>Enhanced Service Delivery Requirements</th>
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</table>
| Tier 4                | 2.2 to 2.9 times the established standard rate | **Extraordinary Staffing Requirements:** Extraordinary levels of additional staffing, which includes enhanced paraprofessional direct care staffing ratios (continuous 1:1 or 2:1 staff to participant ratios throughout the day) and extensive Developmental Disability Professional level staffing (more than 24 hours per month), or an extraordinary amount of Developmental Disability Professional direct service provision (more than 75 hours per week) in place of paraprofessional, direct care staffing and; AND  
**Specialized Paraprofessional, Direct Care Staff Skills:** Extraordinary amounts (more than 8 hours per day) of specialized paraprofessional, direct care staff skills required, or none to extraordinary (zero to more than 8 hours per day) specialized paraprofessional, direct care staff skills required but an extraordinary amount of Developmental Disability Professional direct service provision requirements as indicated above; AND  
**Enhanced Professional Oversight:** extraordinary levels of professional oversight (more than 4 hours per month) required. |
| Tier 5                | COMP Individualized Budget Limit | **Extraordinary Staffing Requirements:** Exceedingly extensive levels of additional staffing, which includes highly enhanced paraprofessional direct care staffing ratios (24-hour 1:1 or 2:1 staff to participant ratios) and highly extensive Developmental Disability Professional level staffing (more than 30 hours per month), or an exceedingly extensive amount of Developmental Disability Professional direct service provision (more than 84 hours per week) in place of paraprofessional, direct care staffing and; AND  
**Specialized Paraprofessional, Direct Care Staff Skills:** Exceedingly extensive amounts (more than 12 hours per day) of specialized paraprofessional, direct care staff skills required, or none to exceedingly extensive (zero to more than 12 hours per day) specialized paraprofessional, direct care staff skills |
required but an exceedingly extensive amount of Developmental Disability Professional direct service provision requirements as indicated above; AND

**Enhanced Professional Oversight:** Exceedingly extensive levels of professional oversight (more than 12 hours per month) required.

**Note:** Exceptional Rate Tier 5 is only approved in highly unusual circumstances.

### Table 2: Respite Overnight Services

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<thead>
<tr>
<th>Exceptional Rate Tier</th>
<th>Exceptional Rate Amount</th>
<th>Enhanced Service Delivery Requirements</th>
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</table>
| **Tier 1**            | 1.0 to 1.5 times the established standard rate | • **Extraordinary Staffing Requirements:** Enhanced paraprofessional, direct care staffing ratios, or a minimal to moderate amount of Developmental Disability Professional direct service provision (up to 25 hours per week) in place of paraprofessional, direct care staffing and no enhanced paraprofessional, direct care staffing ratio requirements; AND  
• **Specialized Paraprofessional, Direct Care Staff Skills:** none to minimal (up to 1 hour per day) specialized paraprofessional, direct care staff skills required; AND  
• **Enhanced Professional Oversight:** no additional Developmental Disability Professional oversight required. |
| **Tier 2**            | 1.5 to 2.0 times the established standard rate | • **Extraordinary Staffing Requirements:** Enhanced paraprofessional, direct care staffing ratios and a minimal amount of Developmental Disability Professional direct service provision (up to 4 hours per month), or a moderate to substantial amount of Developmental Disability Professional direct service provision (more than 25 hours and up to 50 hours per week) in place of paraprofessional, direct care staffing and no enhanced paraprofessional, direct care staffing ratio requirements; AND  
• **Specialized Paraprofessional, Direct Care Staff Skills:** Specialized paraprofessional, direct care staff skills that include a minimal to moderate amount (more than one and up to 4 hours per day) of specialized, paraprofessional direct care staff skills required, or
none to minimal (up to 1 hour per day) specialized paraprofessional, direct care staff skills required but a moderate to substantial amount of Developmental Disability Professional direct service provision requirements as indicated above; AND

- **Enhanced Professional Oversight:** a minimal amount of additional Developmental Disability Professional oversight (up to 1 hour per week) required.

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<th>Enhanced Service Delivery Requirements</th>
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</table>
| Tier 3                | 2.0 to 2.5              | - **Extraordinary Staffing Requirements:** Enhanced paraprofessional, direct care staffing ratios and a moderate amount of Developmental Disability Professional direct service provision (more than 4 hours per month and up to 24 hours per month), or an intensive amount of Developmental Disability Professional direct service provision (more than 50 hours and up to 75 hours per week) in place of paraprofessional, direct care staffing and no enhanced paraprofessional, direct care staffing ratio requirements; AND  
- **Specialized Paraprofessional, Direct Care Staff Skills:** A moderate to substantial amount (more than 4 hours per day and up to 8 hours per day) of specialized paraprofessional, direct care staff skills required, or none to moderate (up to 4 hours per day) specialized paraprofessional, direct care staff skills required but an intensive amount of Developmental Disability Professional direct service provision requirements as indicated above; AND  
- **Enhanced Professional Oversight:** a moderate amount of additional Developmental Disability Professional oversight (more than 1 hour and up to 2 hours per week) required. |

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<tbody>
<tr>
<td>Tier 4</td>
<td>2.5 to 3.0</td>
<td>- <strong>Extraordinary Staffing Requirements:</strong> Extraordinary levels of additional staffing, which includes enhanced paraprofessional direct care staffing ratios (continuous 1:1 or 2:1 staff to participant ratios throughout the day) and extensive Developmental Disability Professional level staffing (more than 24 hours per month), or an</td>
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extraordinary amount of Developmental Disability Professional direct service provision (more than 75 hours per week) in place of paraprofessional, direct care staffing and; AND

- **Specialized Paraprofessional, Direct Care Staff Skills:** Extraordinary amounts (more than 8 hours per day) of specialized paraprofessional, direct care staff skills required, or none to extraordinary (zero to more than 8 hours per day) specialized paraprofessional, direct care staff skills required but an extraordinary amount of Developmental Disability Professional direct service provision requirements as indicated above; AND

- **Enhanced Professional Oversight:** extraordinary levels of professional oversight (more than 2 hours and up to 3 hours per week) required.

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<th>Enhanced Service Delivery Requirements</th>
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</table>
| Tier 5 | 3.0 to 4.0 | - **Extraordinary Staffing Requirements:** Exceedingly extensive levels of additional staffing, which includes highly enhanced paraprofessional direct care staffing ratios (24-hour 1:1 or 2:1 staff to participant ratios) and highly extensive Developmental Disability Professional level staffing (more than 30 hours per month), or an exceedingly extensive amount of Developmental Disability Professional direct service provision (more than 84 hours per week) in place of paraprofessional, direct care staffing and; AND

- **Specialized Paraprofessional, Direct Care Staff Skills:** Exceedingly extensive amounts (more than 12 hours per day) of specialized paraprofessional, direct care staff skills required, or none to exceedingly extensive (zero to more than 12 hours per day) specialized paraprofessional, direct care staff skills required but an exceedingly extensive amount of Developmental Disability Professional direct service provision requirements as indicated above; AND

- **Enhanced Professional Oversight:** Exceedingly extensive levels of professional oversight (more than 3 hours per week) required.
Table 3: Community Access Group Services

<table>
<thead>
<tr>
<th>Exceptional Rate Tier</th>
<th>Exceptional Rate Amount</th>
<th>Enhanced Service Delivery Requirements</th>
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</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>1.0 to 1.3 times the established standard rate</td>
<td><strong>Extraordinary Staffing Requirements:</strong> Enhanced paraprofessional, direct care staff supervision that modifies the staff to participant ratio requirement for the group by a factor of 1.00 to 1.30.</td>
</tr>
<tr>
<td>Tier 2</td>
<td>1.3 to 1.5 times the established standard rate</td>
<td><strong>Extraordinary Staffing Requirements:</strong> Enhanced paraprofessional, direct care staff supervision that modifies the staff to participant ratio requirement for the group by a factor of 1.30 to 1.50.</td>
</tr>
<tr>
<td>Tier 3</td>
<td>1.5 to 1.7 times the established standard rate</td>
<td><strong>Extraordinary Staffing Requirements:</strong> Enhanced paraprofessional, direct care staff supervision that modifies the staff to participant ratio requirement for the group by a factor of 1.50 to 1.70.</td>
</tr>
<tr>
<td>Tier 4</td>
<td>1.7 to 2.0 times the established standard rate</td>
<td><strong>Extraordinary Staffing Requirements:</strong> Enhanced paraprofessional, direct care staff supervision that modifies the staff to participant ratio requirement for the group by a factor of 1.70 to 2.00.</td>
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**Specialized Medical Supplies**

The approval of the amount to exceed the maximum allowable units of Specialized Medical Supplies is based on the determined list of supplies allowed by the COMP waiver and not available through the Durable Medical Equipment (DME) program. Administrative costs are based on 8 to 10 percent of the standard maximum units for the service. Failure by the provider to deliver services as approved will result in recoupment.

**Specialized Medical Equipment**

The approval of the amount to exceed the maximum allowable units of Specialized Medical Equipment (SME) is based on the equipment allowed by the COMP waiver and not available through the Durable Medical Equipment (DME) program up to the lifetime maximum amount for SME. This amount is decreased by any prior Specialized Medical Equipment expenditures. Administrative costs are based on 8 to 10 percent of the standard maximum units for the service. Failure by the provider to deliver services as approved will result in recoupment.

**Procedures for Exceptional Rates Requests:** Requests for exceptional rates must include documentation supporting Extraordinary Circumstances Requirements and Enhanced Service Delivery Requirements as documented in the Intake and Evaluation Team approved Individual Service Plan (ISP). Enhanced Service Delivery Requirements included in these requests must be direct service delivery related to the care of the participant and cannot include room and board or

Note: Exceptional Rate Tier 5 is only approved in highly unusual circumstances.
related items established in policy. Requests to exceed the maximum allowable units must include documentation supporting Extraordinary Circumstances Requirements and the need to exceed the maximum allowable units in the Intake and Evaluation Team approved ISP. Requests for exceptional rates or to exceed the maximum allowable units must be in accordance with the following procedures.

1. The Provider is responsible for submitting a written request for an exceptional rate or to exceed the maximum allowable units for a participant with exceptional needs, along with required supporting documentation, to the DBHDD Regional Office. Requests must be received by the Regional Office at least 90 days prior to the expiration.

2. If requests are not received in a timely manner or are incomplete/incorrect, a delay in approval will occur.

3. The Enhanced Service Delivery Requirements include only direct service delivery related to the direct care of the participant. Room and board costs and all items related to room and board are excluded. The following items should not be included in the Enhanced Service Delivery Requirements:

   Room and Board and Related Items:
   - Rent
   - Utilities
   - Household supplies
   - Paper products
   - Personal spending
   - Food
   - Lawn care
   - Vehicles
   - Personal Products

4. The enhanced service delivery requirements must be specified in measurable terms in supporting documentation for the exceptional rate request. The documentation, including the Intake and Evaluation Team approved ISP, provides specification of the enhanced service delivery requirements, such as increased paraprofessional, direct care staffing ratios, times of day increased paraprofessional, direct care staffing needed, type and amount (i.e., hours) of Developmental Disability Professional direct service provision required, type and amount of extra, specialized paraprofessional, direct care staff required, type and amount of additional Developmental Disability Professional oversight.

5. For Specialized Medical Supplies and Specialized Medical Equipment, there must be itemization of required supplies or equipment and frequency of use.

6. The specified enhanced service delivery requirements for a participant with exceptional needs become part of support coordinator monitoring of service delivery for any participant with an approved exceptional rate.

**Regional Office Review of Exceptional Rates Requests:** DBHDD Regional Offices review each exceptional rate request or request to exceed the maximum allowable units for the inclusion of required supporting documentation related to Extraordinary Circumstances Requirements and
Enhanced Service Delivery Requirements or the need to exceed maximum allowable units. The Regional Office may request additional information from the provider if all required supporting documentation is not included in the exceptional rate request or request to exceed maximum allowable units. After review of all information presented by the provider, the Regional Office recommends approval of or denies the request as follows:

1. **Regional Office Denial of Request:** If the Regional Office determines there is not sufficient evidence to support the exceptional rate request or request to exceed maximum allowable units, then:

   - A written denial letter with specific reasons for the denial is sent to the provider within five (5) business days.

   - The provider can request a face-to-face meeting with Regional Office staff, including the Regional Coordinator, to discuss the denial.

2. **Regional Office Recommended Approval of Request:** If the Regional Office recommends approval of the request for an exceptional rate or request to exceed the maximum allowable units, then:

   The Regional Coordinator or his or her designee notifies the Division of Developmental Disabilities in writing that the Regional Office has recommended approval of the exceptional rate request within five (5) business days.

   At a minimum, the Regional Office notification of recommended approval includes the person’s name, Medicaid #, service(s) (only include service(s) for which an exceptional rate is requested), Provider #(s) for exceptional rate service(s), effective date (start date) and review date (expiration date, normally date of next ISP), and Extraordinary Circumstances and Enhanced Service Delivery bases for the exceptional rate request or request to exceed the maximum allowable units. It is important that the justification is specific to the participant’s assessed exceptional needs and his or her enhanced service delivery requirements or need to exceed the maximum allowable units. *After reading this letter, the reader should be able to answer the question: “What are the participant’s exceptional needs and what enhanced service delivery would occur with the payment of an exceptional rate or need to exceed maximum allowable units?”*

   The region letter of recommended approval is sent to the Executive Director of the Division of DD and copied to the Waiver Coordinator.

**Division of DD Review of Exceptional Rate Requests or Requests to Exceed the Maximum Allowable Units:** The Division of DD notifies the Regional Office if additional information is needed for the review of the exceptional rate request or request to exceed the maximum allowable units. Once any additional information is obtained, the Division of DD conducts a clinical/programmatic review and an enhanced service delivery requirements review of the exceptional rate request. After the reviews are completed, the Division of DD approves or denies the request as follows:
1. **Division of DD Denial of Request:** If the Division of DD determines that the clinical/programmatic review and/or the enhanced service delivery requirements review do not support the exceptional rate request or request to exceed the maximum allowable units, then:

   - A written notification with specific reasons for the denial is sent to the Regional Office.
   - Regional Office follows-up with written notification to the provider of the denial and specific reasons for the denial within five (5) business days.

2. **Division of DD Approval of Request:** If the Division of DD determines that both the clinical/programmatic review and the enhanced service delivery requirements review support the exceptional rate request or request to exceed the maximum allowable units, then:

   A written notification of the approval from the Executive Director of the Division of DD is sent to the Regional Office.

   All approved exceptional rate requests or requests to exceed the maximum allowable units are copied to the Department of Community Health.

   Each approval of an exceptional rate or exceeding the maximum allowable units is time limited up to a maximum of one year.

   The Regional Office, Operation Analyst enters the exceptional rate or additional approved units in WIS *only after receiving written approval from the Division of DD*. The Operation Analyst checks WIS monthly for exceptional rates or additional approved units above the annual maximum that are ready to expire.

**Review of Exceptional Rate or Additional Approved Units Above the Annual Maximum Prior to Expiration:** Exceptional rates must be reviewed prior to expiration as follows:

- The review date for any exceptional rate or additional approved units above the annual maximum is the date of the person’s next ISP, unless specified otherwise in the approval request letter from the Regional Office.

- The provider *must* request a continuation of the exceptional rate or additional units above the annual maximum at least 90 days prior to the expiration of the exceptional rate or additional units above the annual maximum approval.

- The Intake and Evaluation Team/Support Coordinator reviews the need for an exceptional rate or additional approved units prior to the ISP meeting to determine if an exceptional rate or additional units above the allowable maximum is still needed.

- If the interdisciplinary team approves the need for continuation of the exceptional rate or additional approved units, the provider must send a new written exceptional rate request or request to exceed the maximum allowable units, meeting all the above stated requirements to the Regional Office.
• The Regional Office (I & E Manager) and Division of DD review and notification of decisions are as stated above for original exceptional rate requests or requests to exceed the annual allowable maximum units.

• **ANY EXCEPTIONAL RATE OR ADDITIONAL UNITS ABOVE THE ANNUAL MAXIMUM 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.**

**Changes in Individual Participant Needs:** If the needs of the individual participant change prior to the review date (change in needs such that the person needs more/less services), the Regional Office must be notified and a new exceptional request or request for additional units above the maximum submitted (if service delivery requirements go up or down).

**Changes in Provider:** If the provider changes for an individual participant who had an exceptional rate request or request for additional units above the maximum approved for a different provider, the new provider must send a new written exceptional rate request or request to exceed the maximum allowable units, meeting all the above stated requirements to the Regional Office. Approval of this new exceptional request rate or request to exceed the annual allowable units by the Division of DD is required prior to any reimbursement above the Medicaid maximum rate or maximum allowable units for the waiver service.
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.

Certification
A review process conducted by the Certification 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 “Core Requirements for All Providers.”

COMP – Comprehensive Supports Waiver Program
A home and community based services waiver developed to serve individuals with mental retardation/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.

Developmental Disability Professional (DDP)
All intellectual/developmental disabilities services are provided by or under the direct supervision of a Developmental Disability Professional. The following are considered to be Developmental Disability Professionals:

a. Advanced Practice Nurse - A registered professional nurse who meets those educational, practice, certification requirements, OR any combination of such requirements, as specified by the Georgia Board of Nursing AND includes certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists in psychiatric/mental health, AND others recognized by the board AND who have one year experience in treating
individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.

b. **Behavior Specialist** – A behavior specialist who has completed a Master’s degree in psychology, school psychology, counseling, vocational rehabilitation or a related field which included one course in psychometric testing and two courses in any combination of the following: behavior analysis or modification, therapeutic intervention, counseling, or psychosocial assessment, AND one year of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual disabilities OR developmental disabilities OR completion of a Bachelor’s degree in psychology, counseling, OR a related field which included one course in psychometric testing and two courses in any combination of the following: behavior analysis or modification, counseling, learning theory or psychology of adjustment AND two years of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual/developmental disabilities.

c. **Board Certified Behavior Analyst (BCBA)** – A BCBA who has completed a Master’s degree, with 225 hours of approved graduate coursework, AND 1500 hours of experience in the field with 5% of those hours being supervised by a BCBA, AND has received a passing score on the Behavior Analyst Certification Board Exam, AND maintains a prescribed number of continuing education units annually, AND has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.

d. **Educator** - An educator with a degree in education from an accredited program that includes a concentration in Special Education in college coursework OR teaching certificate in Special Education, AND one year of classroom experience in teaching individuals with intellectual/developmental disabilities.

e. **Human Service Professional** - A human services professional with a bachelor’s degree in social work OR a bachelor’s degree in human services field other than social work (including the study of human behavior, human development or basic human care needs) AND with specialized training OR one year of experience in providing human services to individuals with intellectual/developmental disabilities.

f. **Master’s or Doctoral Degree Holders** - A person with a Masters or Doctoral degree in one of the behavioral OR social sciences AND with specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.

g. **Physical or Occupational Therapist** - A licensed physical or occupational therapist who has specialized training in developmental disabilities as evidenced by college coursework OR
practicum/internship experience OR one year of experience in treating individuals with intellectual/developmental disabilities.

h. **Physician** - A physician licensed under State law to practice medicine or osteopathy AND with specialized training in developmental disabilities OR one year of experience in treating individuals with intellectual/developmental disabilities in a medical setting.

i. **Physician’s Assistant** - A skilled person qualified by academic and practical training to provide patients’ services not necessarily within the physical presence but under the personal direction or supervision of a physician, AND who has one year experience in treating individuals with intellectual/developmental disabilities in a medical setting.

j. **Psychologist** - A holder of a doctoral degree from an accredited university or college, AND who is licensed in the State of Georgia AND who has specialized training in developmental disabilities OR one year of experience in evaluating or providing psychological services to individuals with intellectual/developmental disabilities.

k. **Registered Nurse (Associate Degree or Diploma)** - A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing AND who has three years of experience, two of which are in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.

l. **Registered Nurse (Bachelor Degree)** - A registered nurse who is authorized by a license to practice nursing as a registered professional nurse AND who holds a bachelor’s degree in nursing with one year experience in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.

m. **Speech Pathologist or Audiologist** - A licensed speech pathologist or audiologist who has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship experience OR one year of experience in treating individuals with intellectual/developmental disabilities.

n. **Therapeutic Recreation Specialist** - A therapeutic recreation specialist who graduated from an accredited program AND who had specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year experience in providing therapeutic recreational services to individuals with intellectual/developmental disabilities.

**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
Family is defined as a person who is related by blood within the third degree of consanguinity or by marriage. Third degree of consanguinity means mother, father, grandmother, grandfather, sister, brother, daughter, son, granddaughter, grandson, aunt, uncle, great aunt, great uncle, niece, nephew, grand niece, grand nephew, 1st cousins, 1st cousins once removed and 2nd cousins.

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.

GHP - Georgia Health Partnership
DMA contracts with GHP to process all Provider Enrollment Applications, assign provider enrollment numbers, and process provider claims.

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
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).

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
2. Crisis Stabilization Programs
3. Community Living Arrangements

**NOW – New Options Waiver Program**
A home and community based services waiver developed to serve individuals with mental retardation/developmental disabilities who live in their own or family home.

**Regional DBHDD Offices**
The Regional DBHDD Office coordinates and monitors the waiver as well as funding for other services and resources for Georgia’s MR/DD population. The state is currently divided into 5 regions. Individuals seeking MR/DD services should apply through the Regional Office that serves their county.

**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.
APPENDIX J
Georgia Health Partnership (GHP)

**Provider Correspondence**
(Including claims submission)
HPES
P.O. Box 105200
Tucker, GA 30085-5200

**Provider Enrollment**
HPES
P.O. Box 105201
Tucker, GA 30085-5201

**Prior Authorization &**
**Electronic Data Interchange**
**(EDI)**
**Pre-Certification**
GMCF
P.O. Box 105329
Atlanta, GA 30348
1-877-261-8785

5. Asynchronous
6. Web portal
7. Physical media
8. Network Data Mover (NDM)
9. Systems Network Architecture (SNA)
10. Transmission Control Protocol/
    Internet Protocol (TCP/IP)

**Provider Inquiry Numbers:**

~ 800-766-4456 (Toll free)

The web contact address is [www.mmis.georgia.gov](http://www.mmis.georgia.gov)
APPENDIX L
Medicaid Provider Application Process for DBHDD Services
APPENDIX M
Georgia Families

Georgia Families (GF) is a statewide program designed to deliver health care services to members of Medicaid and PeachCare for Kids. The program is a partnership between the Department of Community Health 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 Medicaid 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:

<table>
<thead>
<tr>
<th>Amerigroup Community Care</th>
<th>Peach State Health Plan</th>
<th>WellCare of Georgia</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-600-4441</td>
<td>800-704-1484</td>
<td>866-231-1821</td>
</tr>
</tbody>
</table>

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. Children in foster care will not be enrolled in Georgia Families.

Specific eligibility information:

<table>
<thead>
<tr>
<th>Included Populations</th>
<th>Excluded Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>PeachCare for Kids</td>
<td>Foster Care</td>
</tr>
<tr>
<td>LIM</td>
<td>Aged, Blind and Disabled</td>
</tr>
<tr>
<td>RSM</td>
<td>Nursing home</td>
</tr>
<tr>
<td>Breast and Cervical Cancer</td>
<td>Long-term care</td>
</tr>
</tbody>
</table>

Medicaid and PeachCare members will continue to be eligible for the same services they receive through traditional Medicaid as well as some new services which are unique to each plan. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs as well as expanded access to plans and providers, 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.

By offering at least two health care plans in each service region, Georgia Families gives members choices in making important decisions about health care services for themselves. The Department of Community Health has contracted with three CMOs to provide these services: Amerigroup Community Care, Peach State Health Plan and WellCare. Members can contact Georgia Families for assistance in determining which CMOs are offered in their area and 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](http://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.
Health Care Providers

Who to call to find out more about the participating health plans (enrollment, rates, and procedures). How to enroll with a Georgia Families health plan.

The Department of Community Health has partnered with three health plans to provide care to Medicaid and PeachCare for Kids members enrolled in a Georgia Families. To request information about contracting with the health plans, a provider can call the CMO’s provider enrollment services.

Prior to providing services, a provider should contact the member’s health plan to verify eligibility, PCP assignment and covered benefits. A provider should also contact the health plan to check prior authorizations and submit claims.

<table>
<thead>
<tr>
<th>Amerigroup Community Care</th>
<th>Peach State Health Plan</th>
<th>WellCare of Georgia</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-454-3730 (general information)</td>
<td>866-874-0633 (general information)</td>
<td>866-231-1821</td>
</tr>
<tr>
<td>888-821-1108 (eligibility)</td>
<td>866-874-0633 (claims)</td>
<td><a href="http://www.wellcare.com">www.wellcare.com</a></td>
</tr>
</tbody>
</table>

What is important for the provider to know/do when the member comes in:

Understanding the process for verifying eligibility is now more important than ever. The provider will need to determine if the patient is eligible for Medicaid/PeachCare for Kids benefits, 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 from their health plan, which will include the plan’s contact information for verifying enrollment and PCP assignment.

The provider may also contact the Georgia Health Partnership at 1-800-766-4456 (statewide) or www.ghp.georgia.gov for information on a member’s health plan.

Use of the GHP web portal:

The Georgia Health Partnership call center and web portal will be able to provide a provider with information about a member’s Medicaid eligibility and health plan enrollment. GHP will not be able to assist with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. A provider will need to contact the member’s plan directly for this information.

Participating in a Georgia Families’ health plan:

A Medicaid provider makes a business decision whether to participate in one, two or all three health plans. To participate in a health plan, the provider must sign a contract and be credentialed by the health plan. Each health plan has its own contracting procedures and credentialing requirements. If a provider is interested in participating with a health plan, he/she should contact the plan’s provider enrollment department.
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, file claims with the member’s health plan.

If a claim is submitted to HPES in error:

HPES will deny the claim with a specific denial code. Prior to receiving this denial, a provider 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 a provider should consult the health plan about their payment procedures.
APPENDIX N
Non-Emergency Transportation Broker System

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?
If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, you must contact the NET Broker serving the county you live in to ask for non-emergency transportation. 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 NET 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. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, call the Member CIC at 866-211-0950.

<table>
<thead>
<tr>
<th>Region</th>
<th>Broker / Phone number</th>
<th>Counties served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Toll free</td>
<td>1-866-388-9844</td>
</tr>
<tr>
<td></td>
<td>Local</td>
<td>678-510-4555</td>
</tr>
<tr>
<td>Atlanta</td>
<td>Southeastrans</td>
<td>Fulton, DeKalb</td>
</tr>
<tr>
<td></td>
<td>404-209-4000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Toll free</td>
<td>1-866-991-6701</td>
</tr>
<tr>
<td></td>
<td>Local</td>
<td>404-305-3535</td>
</tr>
<tr>
<td>East</td>
<td>LogistiCare</td>
<td>Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tatnall, Toombs, Ware, Warren, Wayne, Wilkes</td>
</tr>
<tr>
<td></td>
<td>Toll free</td>
<td>1-888-224-7988</td>
</tr>
<tr>
<td>Southwest</td>
<td>LogistiCare</td>
<td>Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster, Worth</td>
</tr>
<tr>
<td></td>
<td>1-888-224-7985</td>
<td></td>
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</table>
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)

<table>
<thead>
<tr>
<th>Legal Name:</th>
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<tbody>
<tr>
<td>Tax ID #:</td>
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<tr>
<td>Corporate Street Address:</td>
</tr>
<tr>
<td>City:</td>
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<td>County:</td>
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<td>State:</td>
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<td>Zip Code:</td>
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<tr>
<th>Service Site Name:</th>
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<td>Service Site Address:</td>
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<td>City:</td>
</tr>
<tr>
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<tr>
<td>State:</td>
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<td>Zip Code:</td>
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<tr>
<th>Mailing Address (if different):</th>
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<tr>
<td>City:</td>
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<tr>
<td>County:</td>
</tr>
<tr>
<td>State:</td>
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<table>
<thead>
<tr>
<th>Owner:</th>
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<tbody>
<tr>
<td>Telephone:</td>
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<tr>
<td>Fax:</td>
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<tr>
<td>Email Address:</td>
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<table>
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<tr>
<th>Director:</th>
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<td>Telephone:</td>
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<td>Telephone:</td>
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<td>Email Address:</td>
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<td>Website:</td>
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<tr>
<th>Developmental Disabilities Professional:</th>
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<tr>
<td>Telephone:</td>
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<td>Fax:</td>
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<td>Email Address:</td>
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<td>Website:</td>
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*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.

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Number of Individuals to be Served In Each Service</th>
<th>County of Service Provision</th>
<th>Region of Service Provision</th>
<th>Licensed Service Y/N?</th>
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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.

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Location of Service</th>
<th>Length Of Service</th>
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<tbody>
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</tbody>
</table>
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:
the Department of Human Resources (DHR), Division of Mental Health, Developmental Disabilities & Addictive Diseases (DMHDDAD) – currently known as the Department of Behavioral Health and Developmental Disabilities (DBHDD)
the Department of Human Resources (DHR), Division of Aging – currently known as the Department of Human Services (DHS), Division of Aging
Department of Community Health (DCH)

<table>
<thead>
<tr>
<th>List Agency Name Used On Contract or LOA</th>
<th>List all Key Personnel Names Such as CEO/President, Key Management Staff, Relative or Board of Directors</th>
<th>Contact Phone Number And E-Mail Address of each Key Personnel Name Listed</th>
<th>Department Issuing Contract</th>
<th>Service Provided Such as Aging, ICWP, Source etc.</th>
</tr>
</thead>
<tbody>
<tr>
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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

April 1, 2012

Comprehensive Supports Waiver Program`
APPENDIX Q
MR/DD NEW SITE INSPECTION CHECKLIST

<table>
<thead>
<tr>
<th>Met Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL CONDITION OF THE HOME</strong></td>
</tr>
<tr>
<td>Home is clean, no odors</td>
</tr>
<tr>
<td>Heating and air conditioning systems operational and provides adequate heat and air</td>
</tr>
<tr>
<td>No needed repair work around the home, yard, deck</td>
</tr>
<tr>
<td>All areas are lighted sufficiently</td>
</tr>
<tr>
<td>Provides an area for use by residents and visitors that affords privacy</td>
</tr>
<tr>
<td>Furnishings and housekeeping present a clean and orderly appearance</td>
</tr>
<tr>
<td>No visible evidence of infestation</td>
</tr>
<tr>
<td><strong>KITCHEN/LAUNDRY</strong></td>
</tr>
<tr>
<td>Provides laundering facilities, at minimum 1 washer and 1 dryer</td>
</tr>
<tr>
<td>Provides common space, such as living room, and kitchen, for use by the residents without restriction</td>
</tr>
<tr>
<td>Food is stored properly</td>
</tr>
<tr>
<td>Maintains a 3-day supply of non-perishable foods for emergency needs. Check expiration dates on food</td>
</tr>
<tr>
<td><strong>RESIDENT BEDROOMS</strong></td>
</tr>
<tr>
<td>All bedrooms provide at a minimum 80 square feet for each resident</td>
</tr>
<tr>
<td>Bedrooms have at least one window</td>
</tr>
<tr>
<td>All bedrooms have standard non portable bed with springs and clean mattress</td>
</tr>
<tr>
<td>No Bedroom is a pass-through to reach another room or bathroom</td>
</tr>
<tr>
<td>All bedrooms have an adequate closet or wardrobe for each resident</td>
</tr>
<tr>
<td>All Bedrooms have lighting fixtures sufficient for reading and other activities</td>
</tr>
<tr>
<td>Sufficient bedding for all residents: Two sheets/pillow/pillowcase/blanket/bedspread for</td>
</tr>
<tr>
<td>Met</td>
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<tr>
<td>-----</td>
</tr>
<tr>
<td><strong>BATHROOMS</strong></td>
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<tr>
<td><strong>EXTERIOR/YARD</strong></td>
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<tr>
<td><strong>SAFETY</strong></td>
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</tbody>
</table>
(Host Homes) Fire arms stored in locked cabinet and ammunition store separately
Fireplace securely screened and/or equipped with protective guards while in use.
Stairways, halls, doorways and exits from the rooms and from the house are unobstructed.
Flammable and combustible supplies/equipment stored away from the heat sources.
First Aid Kit in vehicle and Fire extinguisher in vehicle

Notes and Information:

<table>
<thead>
<tr>
<th>SITE MEETS ALL CRITERIA:</th>
<th>LICENSE ATTACHED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ______  NO ________</td>
<td>YES ______  NO ________</td>
</tr>
</tbody>
</table>

Inspector Signature:  
Date:  
Printed Name:  
Title:  
RC or Support Coord. Signature:  
Date Reviewed:  
Printed Name:  
Title:  
Regional Coordinator or Designee Signature:  
Date Approved:  

April 1, 2012  
Comprehensive Supports Waiver Program  
Q-3
## Appendices R

### Antipsychotic Medications

<table>
<thead>
<tr>
<th>Generic</th>
<th>Trade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole</td>
<td>Abilify</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
</tr>
<tr>
<td>Chlorprothixene</td>
<td>Taractan</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Clozaril</td>
</tr>
<tr>
<td>Fluphenazine</td>
<td>Permitil, Prolixin*</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Haldol*</td>
</tr>
<tr>
<td>Loxapine</td>
<td>Loxitane</td>
</tr>
<tr>
<td>Mesoridazine</td>
<td>Serentil</td>
</tr>
<tr>
<td>Molindone</td>
<td>Lidone, Moban</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Zyprexa</td>
</tr>
<tr>
<td>Palinperidone</td>
<td>Invega*</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>Trilafon</td>
</tr>
<tr>
<td>Pimozide (for Tourette’s)</td>
<td>Orap</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Seroquel</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Risperdal*</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>Mellaril</td>
</tr>
<tr>
<td>Thiothixene</td>
<td>Navane</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>Stelazine</td>
</tr>
<tr>
<td>Trifluopromazine</td>
<td>Vesprin</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>Geodon</td>
</tr>
</tbody>
</table>

*Also has a sustained release injectable form*
## Mood Stabilizer Medications

<table>
<thead>
<tr>
<th>Generic</th>
<th>Trade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium Carbonate</td>
<td>Eskalith</td>
</tr>
<tr>
<td>Lithium Carbonate</td>
<td>Lithonate</td>
</tr>
<tr>
<td>Divalproex Sodium</td>
<td>Depakote</td>
</tr>
<tr>
<td>Tiagabine</td>
<td>Gabatril</td>
</tr>
<tr>
<td>Levetiracetam</td>
<td>Keppra</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>Lamitcal</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Neurontin</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Tegretol</td>
</tr>
<tr>
<td>Oxcarbazepine</td>
<td>Trileptal</td>
</tr>
<tr>
<td>Topiramate</td>
<td>Topamax</td>
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<tr>
<td>Zonisamide</td>
<td>Zonegran</td>
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<tr>
<td>Verapamil</td>
<td>Calan</td>
</tr>
<tr>
<td>Clonidine</td>
<td>Catapres</td>
</tr>
<tr>
<td>Propranolol</td>
<td>Inderal</td>
</tr>
<tr>
<td>Mexiletine</td>
<td>Mexitil</td>
</tr>
<tr>
<td>Guanfacine</td>
<td>Tenex</td>
</tr>
</tbody>
</table>
Appendix S
Documentation Progress Note and Summary Examples
(For all services except CRA, CLS and Respite)
Individual Progress Note Log

<table>
<thead>
<tr>
<th>Person’s Name:</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHN ID Number:</td>
<td>Service:</td>
</tr>
<tr>
<td>Support Plan Date:</td>
<td>Addendum date:</td>
</tr>
<tr>
<td>Addendum date:</td>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Month/Year:</td>
<td></td>
</tr>
<tr>
<td>Peer Quality Assurance Review:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Codes:  
Disclaimer: The use of this form does not guarantee compliance with all policies/standards for documentation.

**ISP Goal A:**

<table>
<thead>
<tr>
<th>Service:</th>
<th>Date:</th>
<th>Time: In</th>
<th>Time: Out</th>
<th>Total hours/Units:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Objectives listed on ISP Action Plan

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

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Identified Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did he/she enjoy?</td>
<td>What did he/she not enjoy?</td>
</tr>
<tr>
<td>What worked and needs to be continued?</td>
<td>What did not work and needs to be changed?</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>a. Person’s Name:</th>
<th>g. Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. MHN ID Number:</td>
<td>h. Service:</td>
</tr>
<tr>
<td>c. Support Plan Date:</td>
<td>i. Procedure Code:</td>
</tr>
<tr>
<td>d. Month/Year:</td>
<td>j. Date:</td>
</tr>
<tr>
<td>e. Peer Quality Assurance Review:</td>
<td></td>
</tr>
</tbody>
</table>

- **Person’s Name**: Name of the individual served
- **MHN ID Number**: Individual’s MHN ID number
- **Support Plan Date**: Identify the ISP timeframe
- **Month/Year**: Identify month and year of when services are being documented
- **Peer Quality Assurance Review**: Professional reviewer’s name and signature
- **Addendum date**: Identify any addendum date if applicable
- **Provider Name**: This is where you place your provider name
- **Service**: Specific service documenting
- **Procedure Code**: Code for the service providing.
- **Date**: Date reviewed by the Peer Quality Assurance reviewer (not pre-filled by the provider agency)

Section II  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=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:

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</tbody>
</table>

**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. **Objectives:** List objectives 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/objectives. 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**

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Identified Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. What did he/she enjoy?</td>
<td>b. What did he/she not enjoy?</td>
</tr>
<tr>
<td>c. What worked and needs to be continued?</td>
<td>d. What did not work and needs to be changed?</td>
</tr>
<tr>
<td>e. <strong>You can place any other information about the goal into this section. OPTIONAL</strong></td>
<td></td>
</tr>
<tr>
<td>f. Direct Support Staff printed name/title:</td>
<td>g. Signature of Direct Support Staff:</td>
</tr>
<tr>
<td>h. Date:</td>
<td></td>
</tr>
</tbody>
</table>

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 goals/objectives 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):

b. Additional Comments/Significant Events(s) (If no comments/significant events, indicate N/A):

c. **Additional Comments/Significant Events(s)** (If no comments/significant events, indicate N/A):

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.)

<table>
<thead>
<tr>
<th>Person’s Name:</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Plan/ Addendum Date:</td>
<td>Procedure Code:</td>
</tr>
<tr>
<td>MHN ID Number:</td>
<td>Month/ Year:</td>
</tr>
</tbody>
</table>

Disclaimer: The use of this form does not guarantee compliance with all policies/standards for documentation.

Support Plan Goals and Objectives by Service

Goal from ISP:

Objectives:

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)

<table>
<thead>
<tr>
<th>a. Person’s Name:</th>
<th>b. Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Support Plan/Addendum Date:</td>
<td>d. Procedure Code:</td>
</tr>
<tr>
<td>e. MHN ID Number:</td>
<td>f. Month/Year:</td>
</tr>
</tbody>
</table>

- **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 Goals and Objectives by Service

<table>
<thead>
<tr>
<th>a. Goal from ISP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Objectives:</td>
</tr>
</tbody>
</table>

- **a. Goal from ISP:** List the goals directly from the ISP
- **b. Objectives:** List objectives identified on the person’s ISP

Section III Contact with Direct Support Professional

<table>
<thead>
<tr>
<th>a. Name of Direct Support Staff:</th>
<th>b. Date of Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Monthly Summary by Service:</td>
<td>d. Follow-up from previous month:</td>
</tr>
</tbody>
</table>

- **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 goals? What changes has the person requested to make to their supports, services and goals? 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 goals/objectives? 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)

<table>
<thead>
<tr>
<th>a. Person’s Name:</th>
<th>g. Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. MHN ID Number:</td>
<td>h. Service:</td>
</tr>
<tr>
<td>c. Support Plan Date:</td>
<td>f. Addendum date:</td>
</tr>
<tr>
<td>d. Month/Year:</td>
<td>i. Procedure Code:</td>
</tr>
<tr>
<td>e. Peer Quality Assurance Review:</td>
<td>j. Date:</td>
</tr>
</tbody>
</table>

**Disclaimer:** The use of this form does not guarantee compliance with all policies/standards for documentation.

**HOME SERVICES TRAINING LOG**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Frequency/Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

**Staff Instructions**

<table>
<thead>
<tr>
<th>Date:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>...</th>
<th>25</th>
<th>26</th>
<th>27</th>
<th>28</th>
<th>29</th>
<th>30</th>
<th>31</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Objective number (1-4) – which objective worked on</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective met (+) or (-) not met</td>
<td></td>
</tr>
<tr>
<td>Prompt Code Required – from list above</td>
<td></td>
</tr>
<tr>
<td># of prompts or cues</td>
<td></td>
</tr>
<tr>
<td>Staff Initials</td>
<td></td>
</tr>
<tr>
<td>Time In</td>
<td></td>
</tr>
<tr>
<td>Time Out</td>
<td></td>
</tr>
</tbody>
</table>

**Monthly Additional Person Centered Progress**

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Identified Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>What he/she enjoyed?</td>
<td>What he/she did not enjoy?</td>
</tr>
<tr>
<td>What worked and/or needs to continue?</td>
<td>What didn’t work and/or needs to change?</td>
</tr>
</tbody>
</table>

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:  

**Monthly Additional Routine Person Centered Supports:**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**Additional Comments/Significant Event(s) (If no comments/significant events, indicate N/A):**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

Direct Support Staff printed name/title:  
Signature of Direct Support Staff:  
Date:  

April 1, 2012  
Comprehensive Supports Waiver Program  
S-9
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:                   & i. Procedure Code:                      |
| d. Month/Year:                          & j. Date:                                |
| e. Peer Quality Assurance Review:       &                                        |
| f. Addendum date:                       &                                        |

- **Person’s Name:** Name of the individual served
- **MHN ID Number:** Individual’s MHN ID number
- **Support Plan Date:** Identify the ISP timeframe
- **Month/Year:** Identify month and year of when services are being documented
- **Peer Quality Assurance Review:** Professional reviewer’s name and signature
- **Addendum date:** Identify any addendum date if applicable
- **Provider Name:** This is where you place your provider name
- **Service:** Specific service documenting
- **Procedure Code:** Code for the service providing.
- **Date:** Date reviewed by the Peer Quality Assurance reviewer (not pre-filled by the provider agency)

Section II  Codes

| 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. Objectives: |
| c. Frequency/completion date |

| 1. |
| 2. |
| 3. |
| 4. |
| d. Staff Instructions: |

- **Goal**  This is the Goal for the service listed in the individual’s ISP
- **Objectives:** List objectives identified on the person’s ISP, list each objective by number
- **Frequency/completion date**  For the objective (1) include the frequency on the ISP or if the objective was met, identify the completion date
- **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 |   |   |   |   |   |   |   |   |   |    |    |    |     |    |    |    |    |    |    |    |
| j. Time In |   |   |   |   |   |   |   |   |   |    |    |    |     |    |    |    |    |    |    |    |
| k. Time Out |   |   |   |   |   |   |   |   |   |    |    |    |     |    |    |    |    |    |    |    |
| l. Objective Number | List each objective by number that was worked on |
| m. Objective status | List if the object was met or not met by using a plus or negative symbol (+ / -) |
| n. Prompt code | The codes used to implement the objective |
| o. Number of Prompts | List how many times prompts or codes were used |
| p. Staff Initials | Initials of staff training |
| q. Time In | Start time |
| r. Time Out | End time |

**Section IV** Monthly Additional Person Centered Progress

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Identified Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. What did he/she enjoy?</td>
<td>j. What did he/she not enjoy?</td>
</tr>
<tr>
<td>k. What worked and needs to be continued?</td>
<td>l. What did not work and needs to be changed?</td>
</tr>
<tr>
<td>m. You can place any other information about the goal into this section. OPTIONAL</td>
<td></td>
</tr>
<tr>
<td>n. Direct Support Staff printed name/title:</td>
<td>o. Signature of Direct Support Staff:</td>
</tr>
<tr>
<td>p. Date:</td>
<td></td>
</tr>
</tbody>
</table>

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)* Can be a weekly summary of the person’s progress on goals/objectives 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. **Monthly 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):** |

<table>
<thead>
<tr>
<th>d. Direct Support Staff printed name/title:</th>
<th>e. Signature of Direct Support Staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td>f. Date:</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Notes

- **Monthly 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.

- **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.

- **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.).

- **Direct Support Staff printed name/title:** Name of direct support professional working with the individual.

- **Signature of Direct Support Staff:** Can be hand written or a secure electronic signature.

- **Date:** Date note written and service rendered.

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