

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF SECOND PUBLIC HEARING

November 24, 2020
1:00 p.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 888-820-1398; Participant code: 3213662#

The purpose of this hearing is to receive additional comments on proposed changes to Title 480 of the Nebraska Administrative Code (NAC) – *Home and Community-Based Waiver Services and Optional Targeted Case Management Services*. Title 480 regulates providers and recipients of early intervention services as well as home and community-based services. The proposed changes update and clarify the early intervention services program; state the administrative, participant, and provider requirements for home and community-based services; update definitions; adopt the traumatic brain injury waiver program; remove internal processes and direction to staff from the regulations; restructure the title; and update formatting. Additional proposed changes include: adding new federal guidance; updating definitions and references to align with other chapters; revising the provider requirements; and updating service descriptions.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Due to the current public health crisis, the agency will enforce any Directed Health Measure Order on the size of gatherings that is in effect at the time of the hearing. In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments.

Interested persons may provide verbal comments by participating via phone conference line by calling 888-820-1398; Participant code: 3213662#.

Interested persons may provide written comments by mail, fax, or email, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at <http://www.sos.ne.gov>, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8223. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 480	Prepared by: Jason Davis
Chapter: 1 to 6	Date prepared: June 4, 2019
Subject: Home and Community-Based Waiver Services	Telephone: (402) 471-6059

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(<input checked="" type="checkbox"/>)	(<input checked="" type="checkbox"/>)	(<input checked="" type="checkbox"/>)
Increased Costs	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Decreased Costs	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Increased Revenue	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Decreased Revenue	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Indeterminable	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

TITLE 480 HOME AND COMMUNITY-BASED SERVICES

CHAPTER 1 EARLY INTERVENTION SERVICES COORDINATION

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Early Intervention Program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 43-2501 to 43-2516.

002. RELATIONSHIP TO NEBRASKA ADMINISTRATIVE CODE (NAC) TITLE 480 WAIVER REGULATIONS. The provisions outlined in this 480 Nebraska Administrative Code (NAC) Chapter 1 apply solely to this chapter. The provisions of this chapter apply to the Early Intervention Program and do not apply to Home and Community-Based Services unless otherwise specifically stated.

003. DEFINITIONS. The following definitions apply:

003.01 APPROVED COOPERATIVE. An approved cooperative is an agreement between two or more school districts for an Educational Service Unit (ESU) approved by the Nebraska Department of Education pursuant to 92 NAC 51 to jointly perform special education functions, including receipt of special education payments.

003.02 CHILD ASSESSMENT. The ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs. Child assessment procedures are identified in Nebraska Department of Education regulations at 92 NAC 52.

003.03 CO-LEAD AGENCIES. The Nebraska Department of Health and Human Services and the Nebraska Department of Education and any other agencies appointed by the Governor responsible for planning, implementation, and administration of the federal early intervention service program and the Nebraska Early Intervention Act.

003.04 CONSENT. Consent means that the parent has been informed, in the parent's native language, of all information relevant to the activity for which consent was requested. The consent form describes the activity and lists the early intervention records that will be released and to whom they will be released. The parent understands that the granting of consent is voluntary and may be revoked at any time. Consent cannot be revoked retroactively.

003.05 EARLY INTERVENTION SERVICES. Early intervention services are defined in 92 NAC 52. Early intervention services are provided under public supervision, are selected in collaboration with the parent, and are provided at no cost. These services are designed to

meet the developmental needs of each eligible infant or toddler with disabilities and the needs of the family to assist appropriately in the infant's or toddler's development as identified by the Individualized Family Service Plan (IFSP) team.

003.06 ELIGIBLE INFANTS AND TODDLERS WITH DISABILITIES. Children two years of age or younger who are verified for early intervention services. Toddlers who reach age three during the school year remain eligible through the end of the school's fiscal year.

003.07 ENTITLEMENT. Benefit(s) of a program granted by law to persons who fit within defined eligibility criteria. Entitlement through the Nebraska Early Intervention Act includes services coordination and development of the Individualized Family Service Plan (IFSP).

003.08 FAMILY ASSESSMENT. A voluntary interview with family members through the use of an assessment tool by qualified personnel to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability.

003.09 INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP). A written plan for providing early intervention services for an eligible infant or toddler and the infant's or toddler's family. The plan is developed and implemented in accordance with regulations in this chapter and with the Nebraska Department of Education regulations at 92 NAC 52.

003.10 INFANT OR TODDLER WITH A DISABILITY. An individual under three years of age who needs early intervention services because the individual is experiencing a significant developmental delay in one or more areas as defined in Nebraska Department of Education regulations at 92 NAC 52.

003.11 NATIVE LANGUAGE. When used with respect to an individual who has limited English proficiency, native language means the language normally used by that individual. For evaluations and assessments for a child, native language is the language normally used by the child if determined developmentally appropriate for the child by qualified personnel conducting the assessment. When used with respect to an individual who is hearing impaired, visually impaired, or for an individual with no written language, native language means the mode of communication that is normally used by the individual.

003.12 NATURAL ENVIRONMENTS. Settings that are natural or typical for a child of the same age who have no disabilities.

003.13 NOTICE. A written statement provided to the parents of an eligible child a reasonable time before a public agency or service provider proposes or refuses to initiate or change services. This includes identification, evaluation, or placement of the child or the provision of appropriate early intervention services to the child and the child's family. The statement must contain a description of the action, reasons, and an explanation of procedural safeguards. The notice must be provided in the native language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so.

003.14 PARENT. A biological or adoptive parent, **an individual acting in the place of a biological or adoptive parent**, or legal guardian of a child, but does not include the state if the

child is a ward of the State. [A parent includes a surrogate parent appointed as provided in 92 NAC 52.](#)

003.15 PERIODIC REVIEW. A review of the Individualized Family Service Plan (IFSP) which must be conducted every six months, or more frequently if conditions warrant, or the family requests such a review.

003.16 PLANNING REGION TEAM. An organized group of parents, advocates and representatives from school districts, agencies, educational service units, Head Start, and other relevant agencies or persons responsible for assisting in the planning and implementation of the Nebraska Early Intervention Act in each local community or region.

003.17 SCREENING. Optional procedures and activities adopted by the school district or approved cooperative under Nebraska Department of Education regulations at 92 NAC 52 to identify, at the earliest possible age, infants and toddlers suspected of having a disability and in need of early intervention services; and includes the administration of appropriate instruments by trained personnel.

003.18 SERVICES COORDINATION. An ongoing flexible, individualized process of interaction facilitated by a services coordinator to assist the family of an eligible infant or toddler with disabilities within a community to gain access to, and coordinate the provision of, early intervention services and coordinate the other services identified in the Individualized Family Service Plan (IFSP) that are needed by, or are being provided to, an eligible infant or toddler and their family. The services coordinator assists the family to identify and meet the family and child's needs through coordination of informal and formal supports. This includes activities carried out by a services coordinator to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the Early Intervention Program.

003.19 SERVICES COORDINATION AGENCY. An agency identified in each planning region which assumes the responsibility to deliver the entitlement of services coordination in the region through an agreement or contract with the Department.

003.20 TRANSITION PLAN. Documentation in the Individualized Family Service Plan (IFSP) which includes steps for the toddler with a disability and the toddler's family to exit from the program; and any transition services that the Individualized Family Service Plan (IFSP) team identifies as needed by that toddler and the toddler's family.

004. PLANNING REGION TEAM. Each planning region, as required in Nebraska Department of Education regulations at 92 NAC 52, must establish an interagency planning region team and is required by state statute to assist in the planning functions related to the implementation and maintaining of the Nebraska Early Intervention Act in the region.

004.01 TEAM ROLE AND RESPONSIBILITIES. The planning region team is responsible for establishing a services coordination system in the region.

004.01(A) SERVICES COORDINATION AGREEMENT OR CONTRACT AWARD ACTIVITIES. The planning region team must:

- (i) Complete an assessment to identify the needs of eligible children and families in the region, and the capacity of the region to meet the assessed needs. This process is to be completed before entering into the agreement or contract to ensure the recruitment, selection, and hiring of services coordinator(s) meets the region's identified needs; and
- (ii) Be responsible for identifying potential provider(s) to ensure a community-based decision. The planning region team does not have legal authority to enter into a contract for services coordination. The planning region team must:
 - (1) Provide general information to the community about services coordination contracting; and
 - (2) Distribute the State's proposal guidelines to agencies in the region and submit proposals that meet the proposal requirements for review.

004.02 NEGOTIATIONS. Negotiations for the provision of services coordination and systems support for the region will be conducted by the co-lead agencies.

004.03 ONE AGREEMENT PER REGION. One agreement or contract for services coordination will be awarded per planning region; however, the services coordination agency may serve multiple planning regions or may sub-contract with other providers in the region to provide services coordination, supervision or administrative support.

004.04 PROVIDER LOCATION ASSISTANCE. If the planning region team is unable to identify a potential agency or agencies to enter into an agreement or contract for the provision of services coordination, the co-leads will assist the region to identify an agency to provide services coordination for the region.

004.05 EFFECTIVE DATE. Services coordination will be effective upon the completion of the agreement or contract and upon adherence to all applicable rules and regulations as set forth in NAC Titles 465, 471, and 480, and 92 NAC 52. An agreement or contract must be in effect before services coordination is billable for reimbursement.

005. SERVICES COORDINATION ENTITLEMENT. Services coordination is an entitlement for early intervention families. Eligible children and their family must be assigned a services coordinator who is responsible for:

- (A) Coordinating all services across agency lines; and
- (B) Serving as the single point of contact for carrying out the activities specified below.

005.01 SPECIFIC SERVICES COORDINATOR ACTIVITIES INCLUDE:

- (A) Assisting parents of eligible children in obtaining access to needed early intervention services and other services identified in the Individualized Family Service Plan (IFSP), including making referrals to providers for needed services and scheduling appointments for eligible children and their families;
- (B) Coordinating the provision of early intervention services and other educational, social, or medical services that the eligible child needs or is being provided;
- (C) Coordinating screenings, evaluations, and assessments;
- (D) Facilitating and participating in the development, review, and evaluation of Individualized Family Service Plans (IFSPs);

- (E) Conducting referral and other activities to assist families in identifying available service providers;
- (F) Coordinating, facilitating, and monitoring the delivery of services to ensure that the services are provided in a timely manner;
- (G) Conducting follow-up activities to determine that appropriate early intervention services are being provided;
- (H) Informing families of their rights and procedural safeguards and ensuring that the family rights are safeguarded;
- (I) Coordinating the funding sources for early intervention services; and
- (J) Facilitating the development of a transition plan to preschool or other services, if appropriate.

005.02 POLICY CONFORMITY. All policies and procedures in the Early Intervention Program must conform to the definition of case management in the Medicaid Program, 471 NAC 40-000.

005.03 PROVISION OF MEDICAID HOME AND COMMUNITY-BASED SERVICES. The services coordinator will ensure that all eligible infants and toddlers requiring nursing facility level of care services will be offered Aged and Disabled Medicaid Home and Community-Based Waiver services as an option for services coordination. The waiver services provided to eligible children are governed by 480 NAC Chapter 2-6.

006. REFERRAL. Referrals may be made by anyone who suspects a developmental delay in an infant or toddler no more than seven days after a child has been identified by a primary referral source. This includes referrals on behalf of children who have medically complex needs that have impact on their development; Indian infants and toddlers with disabilities residing on a reservation geographically located in the state; infants and toddlers with disabilities who are homeless, in foster care, and wards of the State; and infants and toddlers with disabilities who are the subjects of substantiated cases of child abuse or neglect, or are identified as directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

006.01 PRIMARY REFERRAL SOURCES. Primary referral sources include, but are not limited to, hospitals, physicians, parents, child care programs and early learning programs; public health facilities; other social service agencies; public agencies and staff in the child welfare system, including child protective services and foster care; homeless family shelters; domestic violence shelters and agencies; and other health care providers.

006.02 REFERRAL TRANSFER. Upon receipt of a referral, the school district or approved cooperative must immediately transfer the referral information to the agency responsible for providing services coordination in the planning region.

006.03 SERVICE COORDINATION BEGIN DATE. A child age birth to three and the child's family referred to the Early Intervention Program may immediately begin receiving services coordination, regardless of whether the child has been verified as eligible for early intervention services. This initial eligibility remains in effect until the family is informed of the results of the multidisciplinary evaluation team (MDT) evaluation. The initial need for services coordination is jointly determined and documented by the family and the services coordinator.

006.04 SERVICE COORDINATION AGENCY REQUIREMENTS. The services coordination agency must:

- (A) Accept referrals from any source;
- (B) Document the date of referral and gather general demographic information about the child and family; and
- (C) Assign a services coordinator who will be responsible for:
 - (i) Contacting the family within seven calendar days of the receipt of the referral to set up a face-to-face meeting at a time and place mutually agreed upon; and
 - (ii) Completing the face-to-face meeting within seven calendar days of the initial contact, unless the family requests a delay. The face-to-face meeting must include:
 - (1) Providing written notice and obtaining written consent for the child's initial screening and evaluation;
 - (2) Continuing to work with the family, according to the family's needs and wishes until a decision is made as to the eligibility of the child; and
 - (3) Notifying the referral source of the referral outcome, with the permission of the family.

007. CHILD SCREENING PROCEDURES AND MULTIDISCIPLINARY EVALUATION TEAM (MDT) ELIGIBILITY DETERMINATION. School district or approved cooperative staff must determine eligibility for early intervention services and must explain rights to families, as described in Nebraska Department of Education regulations at 92 NAC 52.

007.01 SERVICES COORDINATOR RESPONSIBILITY. The services coordinator must:

- (A) Provide written notice and obtain consent for screening, multidisciplinary evaluation, and child assessment. If screening procedures are utilized to identify whether the child is suspected of having a disability, and the screening indicates the child is suspected of having a disability, written notice for evaluation and child assessment must be provided and written consent must be obtained by the services coordinator prior to the evaluation and child assessment being conducted;
- (B) Coordinate screenings, evaluations, and assessments, and assist families to understand the screening and multidisciplinary evaluation team (MDT) process and how it relates to the Early Intervention Program; and
- (C) Maintain contact with the family during the screening and evaluation period and assist the multidisciplinary evaluation team (MDT) as appropriate. If, at any time during the screening process, the parent requests and consents to an evaluation, the service coordinator must immediately provide written notice and obtain consent for the evaluation and child assessment from the parent and inform the district or approved cooperative accordingly.

007.02 ELIGIBILITY FOR SERVICES COORDINATION. The family is eligible for ongoing services coordination when the multidisciplinary evaluation team (MDT) evaluation supports the child's eligibility for early intervention services. A child is eligible and may be referred for services coordination through the end of the school's fiscal year, August 31, in which the child reaches age three.

007.02(A) INELIGIBILITY. When the screening or multidisciplinary evaluation team (MDT) evaluation does not support eligibility for early intervention services, the child and the

child's family is not eligible to receive services coordination through the Early Intervention Program.

007.02(B) SERVICES PROVIDED. The family's need and priority for services coordination is jointly determined and documented by the Individualized Family Service Plan (IFSP) team, including the family and the services coordinator. The amount and duration of services coordination is based on the documented need, is provided in accordance with Department policy and standards, and is identified in the Individualized Family Service Plan (IFSP).

007.03 POST-REFERRAL TIMELINES. The screening, evaluation, and assessment of the child, family assessment, and the Individualized Family Service Plan (IFSP) meeting must take place within 45 calendar days of the referral.

007.03(A) EXTENDED TIMELINE. The family may extend the 45-day process at any time. In this circumstance, the Early Intervention Program must document that the family does not want to complete the Individualized Family Service Plan (IFSP) within the required timeline. The 45-day process timeline also does not apply when the child or parent is unavailable to complete the screening, the initial evaluation, the initial assessments of the child and family, or the initial Individualized Family Service Plan (IFSP) meeting due to exceptional family circumstances that are documented in the child's record; or the parent has not provided consent for the screening, the initial evaluation, or the initial assessment of the child, despite documented, repeated attempts by the services coordinator to contact the family or obtain parental consent. When the family wants to resume the process, the screening, initial evaluation, initial assessments, and the initial Individualized Family Service Plan (IFSP) meeting must be completed as soon as possible after the documented exceptional family circumstances no longer exist or parental consent is obtained.

007.04 DENIAL NOTICE. For children who do not qualify for early intervention services, the services coordinator must:

- (A) Send the family written notice of denial or termination on the required Department form. This notice must contain:
 - (i) A clear statement of the action to be taken;
 - (ii) A clear statement of the reason for the action;
 - (iii) A specific policy reference which supports such action; and
 - (iv) A complete statement of the family's right to appeal.
- (B) Service delivery ends and the case is closed.

008. CHILD AND FAMILY ASSESSMENT. Child and family assessment assists the family to identify concerns and desired priorities and understand the scope of services that will be available to their child and family including the provision of these services in home and community settings. School districts and approved cooperatives are responsible for conducting the child assessment and related procedural safeguards as described in Nebraska Department of Education regulations at 92 NAC 52.

008.01 SERVICE COORDINATOR RESPONSIBILITIES. The services coordinator must:

- (A) Assist the family in becoming fully informed of the results of the multidisciplinary evaluation team (MDT) evaluation;

- (B) Provide the family with referrals to other agencies and supports according to the family's and child's needs;
- (C) Facilitate coordinated intake as the family accesses services in the community; and
- (D) Meet with the family to:
 - (i) Conduct a family assessment to identify the family's daily routines, activities, and options for supporting the family in identifying their resources, priorities, and concerns. The family-directed assessment must be voluntary on the part of each family member participating and include the family's description of its resources, priorities, and concerns and the supports and services necessary related to enhancing the child's development. The family is assisted in identifying the supports and resources present in the child's environment and activities in the child's daily routine that offer opportunities for the child to learn the new skills; and
 - (ii) Prepare for the Individualized Family Service Plan (IFSP) meeting by:
 - (1) Determining the goals, desired results, and outcomes for the child and family as identified through the family assessment. Based on the results of the multidisciplinary evaluation team (MDT) evaluation, other assessments, and the wishes of the family, Individualized Family Service Plan (IFSP) team membership is established per federal and state regulatory requirements;
 - (2) Scheduling the Individualized Family Service Plan (IFSP) meeting at a location and time convenient to the family and providing written notice to all team members in sufficient time to allow them to attend; and
 - (3) Ensuring team members who will not be attending the Individualized Family Service Plan (IFSP) meeting have the opportunity to provide input in an alternative way.

009. INTERIM INDIVIDUALIZED FAMILY SERVICE PLAN. An interim Individualized Family Service Plan (IFSP) must be developed using the Individualized Family Service Plan (IFSP) process to document and initiate early intervention services for an eligible child and the child's family before the completion of the evaluation and assessment if the following conditions are met:

- (A) School district personnel notify the services coordinator that, based on professional judgment and available information, the child may be eligible;
- (B) Parental consent is obtained;
- (C) An interim Individualized Family Service Plan (IFSP) is developed that includes:
 - (i) The name of the services coordinator who will be responsible for the interim Individualized Family Service Plan (IFSP) and coordination with other agencies and persons; and
 - (ii) The early intervention services that have been determined to be needed immediately by the child and the child's family; and
- (D) The evaluation and assessment are completed within the 45 calendar day timeline.

009.01 INTERIM MEETING TEAM MEMBERS. Team members must include:

- (A) Family and family members, as requested by parent(s);
- (B) Advocate or person outside of family, as requested by parent;
- (C) Services coordinator; and
- (D) A representative of the school district or approved cooperative who has the authority to commit resources.

009.02 EXIT PROCEDURES. If the child is not then verified as eligible for early intervention services through the multidisciplinary evaluation team (MDT) process, the services coordinator must implement formal exit procedures as stated in this chapter.

010. PROCEDURES FOR INDIVIDUALIZED FAMILY SERVICE PLAN DEVELOPMENT, REVIEW, AND EVALUATION.

010.01 INITIAL INDIVIDUALIZED FAMILY SERVICE PLAN MEETING. For each infant or toddler with a disability, a meeting must be held to develop the initial Individualized Family Service Plan (IFSP) by a multidisciplinary team, which includes the parent and services coordinator, within the regulatory required timelines.

010.02 PERIODIC REVIEW. A review of the Individualized Family Service Plan (IFSP) must be conducted every six months or more frequently if warranted or requested by the family to determine the degree to which results or outcomes are being achieved, and whether modification or revision of services, results, or outcomes are necessary.

010.02(A) MEETING. This review may be carried out by a meeting or by another means acceptable to the family and other participants.

010.02(B) INITIATION. All reviews are initiated by the services coordinator, but can be requested by any team member.

010.03 ANNUAL INDIVIDUALIZED FAMILY SERVICE PLAN MEETING. A meeting chaired by the services coordinator or the family must be conducted on at least an annual basis to evaluate and revise, as appropriate, the Individualized Family Service Plan (IFSP). The results of any current evaluations and other information available from the assessments of the child and family must be used in determining the early intervention services that are needed and will be provided.

010.04 ANNUAL MEETING TEAM MEMBERS. Initial and annual Individualized Family Service Plan (IFSP) meeting team members must include:

- (A) Family and family members, as requested by parent(s);
- (B) Advocate or person outside of family, as requested by parent;
- (C) Services coordinator;
- (D) As appropriate, person(s) who will be providing early intervention services to the child or family;
- (E) Person(s) directly involved in conducting evaluations and assessments: If this person(s) is unable to attend a meeting, arrangements must be made for the person's involvement through other means, including one of the following:
 - (i) Participating in a telephone conference call;
 - (ii) Having a knowledgeable authorized representative attend the meeting; or
 - (iii) Making pertinent records available at the meeting; and
- (F) A representative of the school district or approved cooperative who has the authority to commit resources.

010.05 PERIODIC REVIEW TEAM MEMBERS. Periodic review team members must include:

- (A) Family and family members, as requested by parent(s);

- (B) Advocate or person outside of family, as requested by parent;
- (C) Services coordinator;
- (D) As appropriate, persons directly involved in conducting any additional evaluations or assessments, and service provision for the child; and
- (E) If changes in special education or related services are proposed, a school district representative who has the authority to commit district resources.

010.06 INDIVIDUALIZED FAMILY SERVICE PLAN TEAM MEETING AND PERIODIC REVIEW. For each initial and annual Individualized Family Service Plan (IFSP) team meeting and periodic review, the services coordinator must:

- (A) Arrange, conduct, and chair the Individualized Family Service Plan (IFSP) meeting with the family in a setting and at a time convenient for the family;
- (B) Provide written notice to all team members a reasonable time before the meeting. Written notice must be provided in the native language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so;
- (C) Ensure the meeting is conducted in the native language, or primary mode of communication, of the family;
- (D) Draft the Individualized Family Service Plan (IFSP) document, which must contain the following elements:
 - (i) Information about the child's present levels of physical development; cognitive development; communication development; social and emotional development; and adaptive development based upon the information from the child's evaluation and assessments;
 - (ii) With the family's agreement, the Individualized Family Service Plan (IFSP) must include a statement of the family's priorities, concerns, and resources related to enhancing the development of the child as identified through the voluntary assessment of the family;
 - (iii) The measurable results or outcomes expected to be achieved for the child and family, including the criteria, procedures and timelines used to determine progress toward achieving the results or outcomes;
 - (iv) Specific early intervention services to achieve the desired results or outcomes of the child and family including:
 - (1) Frequency;
 - (2) Length of time the service is provided during each session of that service;
 - (3) Intensity or the number of days or sessions the service is provided, and whether the service is provided on an individual or group basis;
 - (4) Method of delivery;
 - (5) The natural environments in which early intervention services will be provided;
 - (6) Justification of the extent, if any, to which the services will not be provided in a natural environment. The justification must be made by the Individualized Family Service Plan (IFSP) team and only when early intervention services cannot be achieved satisfactorily in a natural environment, and is based on the child's outcomes that are identified by the Individualized Family Service Plan (IFSP) team;
 - (7) Location where a service will be provided;
 - (8) Payment arrangements, if any;
 - (9) Projected dates for beginning of services; and

- (10) Anticipated duration of those services (projecting when a given service will no longer be provided, such as when the child is expected to achieve the results or outcomes of his or her Individualized Family Service Plan (IFSP));
- (v) For children who are three years of age, the Individualized Family Service Plan (IFSP) must include an educational component that promotes school readiness and incorporates pre-literacy, language, and numeracy skills;
- (vi) To the extent appropriate, the Individualized Family Service Plan (IFSP) must include medical and other services that the child and the child's family may need or is receiving through other sources, but that are not required to be provided nor funded through early intervention. If those services are not currently being provided, include a description of the steps the services coordinator or family may take to assist the child and family in securing those other services. Identifying these services in the Individualized Family Service Plan (IFSP) does not impose an obligation to any specific agency to provide the services free of charge;
- (vii) The name of the services coordinator who will be responsible for implementing the Individualized Family Service Plan (IFSP), including transition services, and coordinating with other agencies and persons; and
- (viii) The Individualized Family Service Plan (IFSP) must include the steps and services to be taken to support the transition of the child to preschool or other services as required in this chapter;
- (E) Fully explain the contents of the Individualized Family Service Plan (IFSP) to the parent(s). The Individualized Family Service Plan (IFSP) provides for the written consent of the parent to provide services to the child and family. If the parent(s) does not provide consent with respect to a particular early intervention service or withdraws consent after first providing it, that service may not be provided. Although the parent may accept or reject any part of the early intervention services offered, the child will not receive services until the parent(s) have signed the Individualized Family Service Plan (IFSP). The early intervention services to which parental consent is obtained must be provided as soon as possible, but no later than 30 days from date of parental consent; and
- (F) Distribute a written copy of the Individualized Family Service Plan (IFSP) to each person attending within seven calendar days of the meeting. Parent(s) must give specific consent for distribution of the Individualized Family Service Plan (IFSP) document to any individuals or agencies not on the Individualized Family Service Plan (IFSP) team. A written copy of the family assessment must also be distributed to the parent within seven calendar days of the Individualized Family Service Plan (IFSP) meeting.

010.07 IMPLEMENTATION PROCEDURES. Individualized Family Service Plan (IFSP) Implementation procedures conducted by the services coordinator must include:

- (A) Assisting the child and family to gain access to, and coordinate the provision of, the early intervention services and other services identified in the Individualized Family Service Plan (IFSP) in settings most natural and within daily routines;
- (B) Coordinating the funding sources for services required under this part;
- (C) Monitoring implementation of the plan as written by the team members designated on the Individualized Family Service Plan (IFSP);
- (D) Advocating for the family;

- (E) Coordinating, facilitating, and monitoring the delivery of services required under this part to ensure the services are provided within 30 days of parental consent; and
- (F) Contacting the family at least monthly to review the progress of the Individualized Family Service Plan (IFSP) and to conduct follow-up activities to determine that appropriate early intervention services are being provided. This contact must be face-to-face contact with the family and child at least every other month.

010.08 PROVIDER RESPONSIBILITIES. Each agency or person who has a direct role in the provision of early intervention services is responsible for making a good faith effort to assist each eligible child in achieving the outcomes in the child's Individualized Family Service Plan (IFSP); however, this does not require that any agency or person be held accountable if an eligible child or the child's family does not achieve the outcomes projected in the child's Individualized Family Service Plan (IFSP).

011. TRANSITION PROCESS. If a toddler with a disability may be eligible for preschool services, with the approval of the family of the toddler, the services coordinator must convene a conference among the family, team members, and school district or approved cooperative, not fewer than 90 days, and at the discretion of all parties, not more than nine months, before the toddler's third birthday to discuss any services the toddler may receive under Nebraska Department of Education regulations at 92 NAC 51.

011.01 ANNUAL TRANSITION NOTICE. The Annual Transition Notice must be provided to the family at the transition conference which must contain:

- (A) A description of the rights of the parents to elect to receive early intervention services or preschool services pursuant to Nebraska Department of Education regulations at 92 NAC 51;
- (B) An explanation of the differences between early intervention services pursuant to Nebraska Department of Education regulations at 92 NAC 52 and services provided under Nebraska Department of Education regulations at 92 NAC 51;
- (C) The types of services and the locations at which the services are provided;
- (D) The procedural safeguards that apply; and
- (E) A description that the Individualized Family Service Plan (IFSP) services provided will include an educational component that promotes school readiness and incorporates pre-literacy, language, and numeracy skills for children who are at least three years of age.

011.02 ELIGIBILITY FOR OTHER SERVICES. If a toddler is not potentially eligible for preschool services under Nebraska Department of Education regulations at 92 NAC 51, the services coordinator, with the approval of the child's family, must make reasonable efforts to convene a conference among the family, the school district or approved cooperative and providers of other appropriate services for the toddler to discuss services the toddler may receive.

011.03 CONFERENCE REQUIREMENTS. Any transition conference or meeting to develop the transition plan must meet the Individualized Family Service Plan (IFSP) meeting requirements in this chapter.

011.04 TRANSITION PLAN. The services coordinator, along with the family and Individualized Family Service Plan (IFSP) team, must ensure for each toddler with a disability, the transition plan is contained in the Individualized Family Service Plan (IFSP) not fewer than 90 days, and at the discretion of all parties, not more than nine months, before the toddler's third birthday, and includes, as appropriate:

- (A) A review of the program options for the toddler with a disability for the period from the toddler's third birthday through the remainder of the school year;
- (B) The family in the development of the transition plan for the child;
- (C) Steps for the toddler with a disability and the toddler's family to exit from the Early Intervention Program to support the smooth transition of the toddler, to include discussions with, and training of, parents, as appropriate, regarding future placements and other matters related to the child's transition; and procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in a new setting;
- (D) Any transition services or other activities that the Individualized Family Service Plan (IFSP) team identifies as needed by the child and family;
- (E) Confirmation that information about the child has been transmitted to the designated program if parental consent was obtained; and
- (F) Transmission of additional information needed, with parental consent, to ensure continuity of services to the receiving program, including a copy of the most recent evaluation and assessments of the child and family and the most recent Individualized Family Service Plan (IFSP).

012. FAMILY RIGHTS. The rights in this section are based on federal **and state** special education law and Medicaid law and regulations in addition to the Nebraska Early Intervention Act. To assure fair treatment of families within the Early Intervention Program statewide, it is important that families know their rights and that their rights are protected. See 34 CFR Part 303 and Nebraska Department of Education regulations at 92 NAC 51 and 52.

012.01 NOTIFICATION OF RIGHTS. Families must receive their rights for participation in the Early Intervention Program which include Medicaid provisions for the right to apply, the right to receive a timely response, and the right to appeal for Home and Community-Based Services (HCBS). The rights that govern the Early Intervention Program are defined in federal and state regulations (See 34 CFR 303, 465 NAC, 471 NAC, and 480 NAC).

012.02 LEGAL ASSISTANCE IN HEARING. In the case of a parent initiating hearing procedures as outlined in Nebraska Department of Education regulations at 92 NAC 52, the services coordination agency must inform the parent of any free or low-cost legal and other relevant services available in the area if the parent requests the information or if the parent initiates a hearing under Nebraska Department of Education regulations at 92 NAC 55.

012.03 NOTIFICATION OF ADVERSE DECISIONS. Persons who request, apply for, or receive Home and Community-Based Services (HCBS) may appeal any adverse action or inaction. The services coordinator must send written notice of denial, reduction, or termination of services to the child's guardian as outlined in 480 NAC 2. Notice to the child's guardian must contain:

- (A) A clear statement of the action to be taken;
- (B) A clear statement of the reason for the action;

- (C) Specific policy reference which supports such action; and
- (D) A complete statement of the guardian's right to appeal.

012.04 ELIGIBILITY HEARING. Matters regarding the eligibility for Home and Community-Based Services (HCBS) will be processed through the Department's Medicaid eligibility hearing procedures.

013. SERVICES COORDINATION RECORDS. Service coordination contracting agencies are responsible for maintaining early intervention records as described in this section.

013.01 CONFIDENTIALITY. Confidentiality must be maintained consistent with the following requirements:

- (A) Written parent or guardian consent must be obtained before personally identifiable information is disclosed, verbally or in writing, to anyone other than service coordination staff;
- (B) Each services coordination agency must protect the confidentiality of personally identifiable information at all stages including content of meetings, staff discussions, information collection, record storage, disclosure, and destruction. All information contained in the files or available to staff members is considered confidential;
- (C) In order to protect information about persons requesting or receiving services, the services coordination agency must store and process information in secured areas so that such information can be accessed only by authorized personnel. Adequate supervision of the secured areas must be provided to prevent unauthorized removal or loss of information;
- (D) One official at each services coordination agency must assume responsibility for insuring the confidentiality of any personally identifiable information. This official must maintain, for public inspection, a current listing of the names and positions of those employees within the agency who may have access to personally identifiable information;
- (E) Each services coordination agency must keep a record of persons obtaining access to the early intervention records collected, maintained, or used, including the name of the person, the date access was given, and the purpose for which the person is authorized to use the records. This record keeping requirement does not apply to access by parents or authorized staff members of the agency;
- (F) When a release is signed so that confidential records can be disclosed, the release must, in the parent's native language or other mode of communication:
 - (i) Fully inform parents of their rights to refuse to sign and the consequences of failure to sign;
 - (ii) List agencies and individuals who may receive information and specify the type of information for each and for what purpose;
 - (iii) Allow parents to limit both the information released and to whom it may be released;
 - (iv) Inform parents that they may revoke consent at any time; and
 - (v) Provide a time limit on consent;
- (G) Parents must be given the opportunity to inspect and review records relating to screening, evaluations and assessments, eligibility determinations, development and implementation of Individualized Family Services Plans (IFSPs), provision of early intervention services, individual complaints dealing with the child, and any other

- aspect of the Early Intervention Program involving records about the child and the child's family with the exception of child protective services and foster care records. Parents have the right to have the information in records explained and interpreted by a professional staff person and in their primary mode of communication. Agencies must comply with a parent's request to inspect and review records without unnecessary delay and before any Individualized Family Service Plan (IFSP) meeting or hearing and in no case more than 10 days after the request has been made;
- (H) Parents must be provided a list of the types and locations of early intervention services coordination records collected, maintained, or used by the services coordination agency, upon parental request;
 - (I) As a child transitions out of the Early Intervention Program, records having to do with family goals and not pertinent to the child's education and related services do not follow the child and do not become part of the educational record of the child. Rather, they are kept in confidential storage in the Early Intervention Program and destroyed after six years with other records or destroyed at the request of the parents;
 - (J) Parents have the right to copies of their child's records but there may be a reasonable copying charge for this;
 - (K) Parents have the right to have someone they choose inspect and review the records;
 - (L) Parents have the right to ask that early intervention records be changed if they believe that information in the records is inaccurate or misleading or violates the privacy or other rights of their child or family. The right to request a change in the records includes:
 - (i) The right to be informed if the agency refuses to change the information as requested;
 - (ii) The right to a hearing on the refusal to change the record; and
 - (iii) The right to include an explanation of the family's statement of disagreement if the agency refuses to change the record. This statement must be kept with the portion of the record the family disagrees with and included with any request to see the record; and
 - (M) Parents have the right to be informed when personally identifiable information is no longer needed to provide early intervention services to their child or family. They then have the right to ask that information in the early intervention record be destroyed; however, a permanent record of a child's name, date of birth, parent contact information (including address and phone number), names of services coordinator(s) and early intervention service provider(s), and exit data, including year and age upon exit and any programs entered into upon exiting, may be maintained without time limitation.

013.02 RETENTION AND DESTRUCTION. The services coordination agency must:

- (A) Retain the early intervention records for six years after the completion of the activities for which early intervention funds were used. If an audit or appeal is in progress, the Department of Health and Human Services or the Nebraska Department of Education may direct that records be retained beyond six years;
- (B) Make reasonable effort to locate and notify parents before records are destroyed; and
- (C) Destroy records using a method that ensures that no personally identifiable information remains accessible.

014. NOTIFICATION IN NATIVE LANGUAGE. All notices must be written in language understandable to the general public and in the family's native language, including the following considerations, unless clearly not feasible to do so.

014.01 EXPLANATION OF SERVICES. The services coordinator explains to the family, in a way that they can understand, what the Early Intervention Program has to offer and the process for determining eligibility under early intervention. If the native language or other mode of communication of the parent is not a written language, the services coordinator must take steps to ensure that

- (A) The notice is translated orally or by other means to the parent in the parent's native language or other mode of communication;
- (B) The parent understands the notice; and
- (C) There is written evidence that these requirements have been met.

014.02 FAMILY RIGHTS. Families must be provided written notice of their right to a timely, comprehensive, multidisciplinary evaluation for the child, including assessment activities related to the child, and, if eligible, the provision of appropriate early intervention services.

014.03 SERVICE PLAN MEETING NOTICE. Families must be provided written notice of Individualized Family Service Plan (IFSP) meetings with adequate time for them to make arrangements to attend. These meetings should be arranged around the family's ability to attend.

015. CONSENT. Families have the right to informed consent in the Early Intervention Program which includes:

- (A) Families have the right to be fully informed of all information about the activity for which consent is sought in their native language or other means of communication;
- (B) Families have the right to know that consent is voluntary and may be withdrawn at any time;
- (C) Families have the right to accept or refuse any or all early intervention services without losing the remaining early intervention services. The Individualized Family Service Plan (IFSP) provides written notice of the appropriate services which will be provided to the child and family;
- (D) Families must give written consent before:
 - (i) The first screening, evaluation and assessment of the child and any later evaluation; and
 - (ii) Implementation of early intervention services as part of the Individualized Family Service Plan (IFSP). The Individualized Family Service Plan (IFSP) provides for the written consent of the family to provide services to the child and family. Although the family may accept or reject any part of the early intervention services offered, the child will not receive services until the parents have provided written consent for the service(s) on the Individualized Family Service Plan (IFSP).

016. SURROGATE PARENTS. A surrogate parent has the same rights as a parent for all purposes under this regulation. No state employee, or anyone providing services to the child or the child's family member, nor any person who has a personal or professional interest that conflicts with the interest of the child he or she represents may act as a surrogate. Appointment of a surrogate is outlined in Nebraska Department of Education regulations at 92 NAC 52.

017. FORMS. All forms utilized in the Early Intervention Program are state-mandated to ensure consistency and adherence to family rights and all laws and regulations that govern the Program.

018. COMPLAINT PROCEDURES. An individual or organization may file a written signed complaint regarding the violation of the provision of services coordination and the Individualized Family Service Plan (IFSP) entitled under the Nebraska Early Intervention Act.

018.01 SUBMISSION. Complaints must be submitted to the Nebraska Department of Education, Special Education Office, in writing. The written, signed complaint must contain an explanation of specific information relating to the possible violation. Special accommodation will be made, if writing is a barrier. Contact the Special Education Office in person or by telephone to make arrangements.

018.02 SERVICE COORDINATION VIOLATION. If the complaint can be determined to be related to a violation of the provision of services coordination and the Individualized Family Service Plan (IFSP), the following procedures will be carried out. The Nebraska Department of Education and the Department of Health and Human Services will notify in writing the individual or organization filing the complaint and the applicable services coordination agency the complaint has been received. This written notification to the services coordination agency will include a copy of the complaint, substance of the alleged violation, and timelines for response. The services coordination agency has 14 calendar days to submit a written response.

018.03 INVESTIGATION. The Nebraska Department of Education and Department of Health and Human Services will investigate each complaint received from an individual or organization to determine whether there has been a failure to comply with these regulations and may require further written or oral submission of information by all parties and may conduct an independent on-site investigation, if necessary.

018.04 REVIEW. Within 60 calendar days of receipt of a signed written complaint, the Nebraska Department of Education and Department of Health and Human Services will review all relevant information and provide written notification of findings of facts and conclusions and the basis for such findings to all parties involved.

018.05 EXTENUATING CIRCUMSTANCES. If, as a result of extenuating circumstances the Nebraska Department of Education and Department of Health and Human Services are not able to complete the investigation within the 60 calendar days, an extension will be implemented. The Nebraska Department of Education and Department of Health and Human Services will notify the person or organization filing the complaint and the service coordination agency of the extension.

018.06 FAILURE TO COMPLY. If it is determined there has been a failure to comply, there will be included in the notification of findings the specific steps which must be taken by the services coordination agency to bring the agency into compliance including technical assistance, negotiations and corrective actions. The notification must also set forth a reasonable period of time to voluntarily comply.

019. SERVICES COORDINATION PROVIDERS. All services coordination agencies must complete all required steps to become an enrolled Medicaid provider. The services coordination agency must follow all requirements, provisions and scope of services as set forth in NAC Titles 465, 471, and 480.

019.01 SUBCONTRACT AUTHORIZATION. Written authorization is required for subcontracting for services coordination services with another agency. The services coordination agency must assure that all subcontractors meet the requirements set forth in the services coordination agreement or contract.

019.02 MONITORING. The co-lead agencies are responsible for monitoring the Early Intervention Program which will occur on a cyclical basis to ensure adherence to all rules and regulations governing the Program.

019.03 NO ADVOCACY. The family has the right to appeal, however the services coordinator must not provide assistance nor serve as advocate or representative in any adverse issue related to Medicaid or these regulations.

TITLE 480 HOME AND COMMUNITY-BASED SERVICES

CHAPTER 2 PROGRAM REVIEW AND ADMINISTRATION

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statutes (Neb. Rev. Stat.) § 68-901 Et seq. (the Medical Assistance Act).

002. DEFINITIONS.

002.01 ACTIVITIES OF DAILY LIVING (ADL). Refer to [Title 471 Nebraska Administrative Code \(NAC\) 42-000.](#)

002.02 ADULT. For the purposes of Medicaid and Home and Community-Based Services, an adult is an individual age 18 or older.

002.03 AGED. For the purposes of Medicaid and Home and Community-Based Services, an aged individual is age 65 or older.

002.04 AGENCY PROVIDER. Providers who have one or more employees or will be subcontracting any one or part of the service for which they are requesting approval.

002.05 ASSESSMENT. A process which includes receiving referrals, gathering information, interviewing, and jointly determining participant strengths, needs and desired outcomes.

002.06 AUTHORIZED REPRESENTATIVE. A person appointed by the participant to sign documentation or apply for benefits on their behalf.

002.07 CAREGIVER. A provider, either formal or informal who assists, and assumes responsibility for the care of the participant.

002.08 CHILD. For the purposes of Medicaid and Home and Community-Based Services, a child is an individual age 17 or younger.

002.09 COMMON CARRIER. Any person who or which undertakes to transport passengers or household goods for the general public in intrastate commerce by motor vehicle for hire, whether over regular or irregular routes, upon the highways of this state.

002.10 DEPARTMENT. The Department of Health and Human Services as established by the Health and Human Services Act. For the purposes of these regulations, a reference to the Department also includes a reference to the designee of the Department.

002.11 DEPARTMENT STAFF. Employees of the Department or its designees.

002.12 ESCORT. A person who accompanies or personally assists a participant who is unable to travel or wait alone. This may include assistance to and from a vehicle or place of destination, supervision, or support.

002.13 EXEMPT TRANSPORTATION PROVIDER. Transportation carriers exempted from Nebraska Public Service Commission certification as defined in Neb. Rev. Stat. §§ 75-303 to 75-303.03.

002.14 HEALTH MAINTENANCE ACTIVITIES. Noncomplex interventions which can be safely performed according to exact direction, which do not require alteration of the standard procedure, and for which the results and participant responses are predictable.

002.15 HOME AND COMMUNITY-BASED SERVICES. Services not otherwise furnished under the State's Medicaid plan which are furnished under a waiver granted under the provisions of 42 CFR Subpart G.

002.16 INDIVIDUAL PROVIDER. Providers who have no employees. Individual providers are independent contractors and not employees of the Department or the State of Nebraska. For the purpose of Federal Insurance Contribution Act (FICA) withholding, the provider is considered an employee of the participant.

002.17 INDIVIDUAL TRANSPORTATION PROVIDER. An individual carrier who meets the requirements of Neb. Rev. Stat. § 75-303 (11), (12), or (13), has an approved service provider agreement with the Department and is chosen by the participant.

002.18 INFORMAL SUPPORTS. Unpaid supports that are provided voluntarily to the individual in lieu of Waiver services and supports. Informal supports are typically provided by friends, family members, or other persons in the community and can include services such as cleaning or transportation. Informal supports may include support provided by or to another person which results in a benefit that is shared by the participant.

002.19 INSTITUTIONAL SETTING. An institutional setting is a medical facility where a person may reside on a short- or long-term basis, including a hospital, nursing facility, institution for developmental disabilities, or an institution for mental diseases. For the purposes of Home and Community-Based Services, any institution will be presumed to be an institutional setting if it has the following attributes: located in a publicly or privately operated facility that provides inpatient institutional treatment; located in a building on the grounds of, or adjacent to, a public institution; or the location has the effect of isolating individuals receiving Home and Community-Based Services from the broader community of individuals not receiving Home and Community-Based Services.

002.20 INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL). Tasks that are performed in the regular course of independent living. The tasks include the following but are not limited to:

- (A) Performing essential household chores;
- (B) Traveling around and participating in the community;

- (C) Shopping for food, clothing and other essential items;
- (D) Meal planning and preparation;
- (E) Managing finances; and
- (F) Communicating by phone or other media.

002.21 NOTICE OF ACTION. Written notice to the participant, legal representative, or provider, which includes a statement of what action will be taken, the reason for the intended action, and the specific policy manual reference that supports the action or the change in federal or state law that requires the action.

002.22 NURSING FACILITY. A facility licensed by the Department's Regulation and Licensure Unit as a nursing facility.

002.23 PARTICIPANT. An individual either applying for or receiving Waiver services. For the purposes of these regulations, a reference to a participant may include the participant's guardian, legal representative, or any person authorized to act on the participant's behalf.

002.24 PERSON-CENTERED PLAN (PCP). An individualized, written plan for each participant documenting the provision of services and supports that takes into consideration each participant's strengths, needs, priorities, and resources. This plan describes the full range of services to be furnished (regardless of funding source), their frequency, and the type of provider – formal or informal - who will furnish each.

002.25 PRIOR AUTHORIZATION. A process that is employed to control the use of covered services. When services are subject to prior authorization, payment is not made unless approval for the service is obtained in advance by Department staff.

002.26 PROVIDER IDENTIFICATION NUMBER. A nine digit federal identification (FID) number or a nine digit Social Security number (SSN).

002.27 RESIDENT SERVICE AGREEMENT (RSA). An assisted living provider must evaluate each resident and have a written service agreement negotiated with the resident and authorized representative, if applicable, to delineate the services to be provided to meet the needs identified in the evaluation, in accordance with 175 Nebraska Administrative Code (NAC) 4-006.06.

002.28 SERVICE PROVIDER AGREEMENT. A legally binding document which may include service specific agreements, description of service to be provided, and the maximum rate(s) allowed for each service. The responsibilities of the provider and of the Department are stated in the agreement. Refer to 471 NAC 2-000.

002.29 SHARE OF COST (SOC). A participant's monthly financial out-of-pocket obligation for medical services when the participant's income exceeds the program limits. When a participant has excess income resulting in a share of cost, the amount of the share of cost is deducted from the Medicaid payment to the provider. The participant is obligated to pay the share of cost amount to the provider in order to receive services.

002.30 SPECIALIZED ASSISTED LIVING (SAL). A licensed assisted living facility which delivers specialized services to residents. In order to provide Waiver services to otherwise qualified residents, the following criteria must be met:

- (A) The person has completed the acute phase of rehabilitation;
- (B) The person has conditions that are severe, chronic, and disabling, requiring in excess of four hours of care per day, but who do not require complex medical interventions;
- (C) The person has the capacity to direct their own care as well as communicate those needs in a traditional or non-traditional manner;
- (D) The person's projected costs reflect savings to the state over institutional care or services provided in the home; and
- (E) The person's ultimate long-term goal is to transition to safe, independent living elsewhere in the community, when appropriate.

~~002.31 SUBCONTRACTING. Occurs when a service provider pays someone other than an employee to provide the contracted service.~~

002.312 TARGETED CASE MANAGEMENT. An individualized, goal-oriented process, based on participant choices, which makes the best use of resources to maximize independence and attain the level of care that is consistent with the participant's level of need.

002.323 TRAUMATIC BRAIN INJURY (TBI). A non-degenerative, non-congenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness. This term does not apply to brain injuries induced or caused by birth trauma.

002.334 WAIVER. Medicaid Home and Community-Based services are commonly referred to as Waiver services. The reference comes from Section 1915(c) of the Social Security Act which allows normal Medicaid rules to be waived in order to provide additional services in the participant's residence.

002.345 WAIVER CAPACITY. A term used to describe the maximum unduplicated number of individuals who may participate in a Waiver during the year.

003. ADMINISTRATION.

003.01 APPLICABILITY. The provisions outlined in 480 NAC 2-000 apply to all services in Title 480 Chapters 2-000 to 6-000.

003.02 COST EFFECTIVENESS. The average cost of Waiver services funded by Medicaid must not exceed the average cost to Medicaid for nursing facility services. Medicaid Waiver services must be cost effective in two distinct ways:

- (A) In any year that the Waiver is in effect, the average per capita expenditures under the Waiver cannot exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the specified level of care had the Waiver not been granted; and

- (B) In any year that the Waiver is in effect, the actual total expenditures for Home and Community-Based Waiver and other Medicaid services, including the corresponding claim for Federal Financial Participation (FFP) in expenditures for the services provided to individuals under the Waiver, cannot exceed 100 percent of the amount that would be incurred in the absence of the Waiver by the State's Medicaid program for these individuals in the specified institutional setting.

003.03 STATEWIDE PROVISION OF SERVICES. Waiver services are provided statewide to eligible participants depending on Waiver capacity availability.

003.04 AVAILABLE WAIVER CAPACITY. If a statewide waiting list is required due to limited Waiver capacity, the Department may determine that an individual qualifies for a priority placement into an available Waiver opening. The Department retains sole discretion to determine the applicability of criteria and the need for prioritization. The next available opening is assigned based upon the following priority criteria:

- (A) Needs in domains which define nursing facility level of care are so severe that the health and welfare of the participant are jeopardized, but the needs could safely be met with immediate Waiver services;
(B) Family or caregivers are in a crisis or high stress situation;
(C) No informal support network is available to meet identified needs;
(D) Inappropriate out-of-home placement is being planned;
(E) No other program is available to meet the needs identified in the referral;
(F) Support services are required to allow the participant to return home; or
(G) A participant with an identified Waiver service need of Assistive Technology Supports or Home and Vehicle Modifications lacks access to resources to meet these specific needs and Waiver eligibility is the only method of addressing the identified needs.

003.05 WAIVER PARTICIPATION. A participant may receive services from only one Nebraska Home and Community Based Services (HCBS) Medicaid Waiver at a time.

003.06 FUNCTIONAL STABILITY. When a participant's functioning has stabilized due to the provision of Waiver services, the participant's history of risk and initial assessment will be considered and documented in determining whether level of care eligibility continues to apply.

003.07 SERVICE NEEDS FOR CHILD PARTICIPANTS. Participants who are children will always have a legally responsible caregiver; and therefore, will have differences in service needs when compared to adult participants. Service needs such as (but not limited to) meal preparation, food, shelter, access to education, and transportation should be met by the legally responsible caregiver.

003.08 PARTICIPANT SAFETY, HEALTH, AND WELFARE. Medicaid Home and Community-Based Waiver services must ensure the participant's health and welfare, including the consideration of acceptable risk with respect to participant choice, and must prevent the provision of unnecessary or inappropriate services and supports. If, despite consideration of the full range and scope of services, the participant's safety, health or welfare is in jeopardy, Waiver services may not be provided. The participant will be presented with alternate service delivery options, which are available to maintain a safe plan. The participant will be afforded notice and hearing rights in accordance with this chapter.

004. REQUIREMENTS APPLICABLE TO ALL MEDICAID HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER SETTINGS. In addition to the participant rights outlined in 480 NAC 3-000, and requirements outlined in each service specific section each provider must ensure that their setting affords each participant, specific person-centered opportunities.

004.01 INTEGRATION AND ACCESS. The setting must be integrated in and support full access of individuals receiving Medicaid Home and Community-Based Services (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings based on services offered or available under each Waiver, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid Home and Community-Based Services (HCBS).

004.02 PARTICIPANT CHOICE. The setting must be selected by the participant from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The settings options must be identified and documented in the person-centered service plan and be based on the individual's needs, preferences and, for residential settings, resources available for room and board.

004.03 PARTICIPANT RIGHT TO PRIVACY. The setting must ensure a participant's rights of privacy, dignity, respect, and freedom from coercion and restraint.

004.04 PARTICIPANT INDEPENDENCE. Each participant must have the opportunity to optimize individual initiative, autonomy, and independence. The setting must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and interactions with individuals of the participant's choice.

004.05 FACILITATION OF CHOICE. The setting must facilitate individual choice regarding services and supports, and who provides them.

005. NOTIFICATION OF ADVERSE DECISIONS. Refer to 465 NAC 2-000 and 6-000, and title 477 NAC 3-000, 9-000, and 10-000. Persons who request, apply for, or receive services may appeal any adverse action or inaction. These may include, but are not limited to, a potential Waiver participant being denied services, a Waiver participant's services being reduced, or a Waiver participant determined ineligible for Waiver services.

005.01 MEDICAID ELIGIBILITY. If the termination of Waiver services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility.

005.02 DENIAL OR TERMINATION OF ELIGIBILITY. Eligibility for Medicaid Waiver services may be denied or terminated for any of the following reasons:

- (A) The unavailability of Waiver capacity;
- (B) The participant has no Waiver service need;
- (C) The participant has not used Waiver services in the most recent 60 calendar days;
- (D) The participant's needs are being met by another source;

- (E) The participant does not meet priority assessment criteria;
- (F) The participant or their guardian has not supplied needed information to complete the eligibility or person-centered plan (PCP) review process;
- (G) The participant fails to meet the specified eligibility criteria at the initial determination or a later re-determination;
- (H) A person-centered plan (PCP) cannot be developed and maintained which protects the participant's health and welfare;
- (I) The participant or their guardian has not signed necessary forms consenting to Waiver services;
- (J) The participant or their guardian voluntarily withdraws;
- (K) The participant moves out of Nebraska;
- (L) The death of the participant;
- (M) The agency loses contact with the participant and the participant's whereabouts are unknown;
- (N) The need for Assistive Technology Supports (ATS), Home and Vehicle Modifications (H/VM) has been addressed and no other Waiver services are needed;
- (O) The participant or their guardian is not able to meet in-person with their Services Coordinator at least every three months; or
- (P) The participant has become a resident of a nursing facility, intermediate care facility for the developmentally disabled (ICF/DD), or an institute for mental disease and is expected to remain there for more than 60 days.

005.03 PROVIDER NOTICE. Refer to 471 NAC 2-000 for specific information regarding notice of action information sent to providers. When a Waiver participant's services are being changed or terminated, the services coordinator will provide written notice to the provider of the change in service provision or termination of payment for Waiver services.

006. APPEALING DECISIONS OR ACTIONS. The Department provides opportunities for fair hearings as defined in 42 Code of Federal Regulations (CFR) 431, Subpart E, to participants or their legal representatives who are not given the choice of Medicaid Home and Community-Based Services (HCBS) as an alternative to nursing facility services or who are denied the services of their choice. Refer to 465 NAC 2-000 and 6-000, and title 477 NAC 3-000, 9-000, and 10-000.

006.01. RIGHT TO APPEAL. Medicaid Waiver participants or their guardians have the right to appeal the following decisions or actions:

- (A) Refusal to accept a request for Waiver assessment;
- (B) Failure to act upon a request within the mandated time period;
- (C) Failure to offer the choice between Medicaid Aged and Disabled Waiver services and nursing facility services;
- (D) Denial, termination, or reduction of services; and
- (E) Termination of the Medicaid Waiver case.

TITLE 480 HOME AND COMMUNITY-BASED SERVICES

CHAPTER 3 PARTICIPANT ACCESS AND REQUIREMENTS

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statutes (Neb. Rev. Stat.) § 68-901 Et seq. (the Medical Assistance Act).

002. PARTICIPANT RIGHTS AND RESPONSIBILITIES.

002.01 PARTICIPANT RIGHTS. In addition to the rights afforded to all persons, a participant enrolled in the Department's Division of Medicaid and Long-Term Care (MLTC) program has the right to:

- (A) Be treated with dignity and respect;
- (B) Be protected from abuse, neglect, exploitation and other threats to personal health, safety and well-being;
- (C) Appoint an authorized representative to act on their behalf as a paid provider cannot sign their own claim on behalf of the participant; the signature of another competent representative of the participant, with the knowledge of the service delivery is required;
- (D) Participate with the services coordinator in the service plan development process, and receive services in a person-centered manner that is in accordance with the approved service plan. Lead the process of service plan development when possible; and, include a representative that the individual has freely chosen, as well as other individuals chosen by the participant to contribute to the process. Person-centered services are delivered in a manner that is attentive to the participant's needs and maximizes personal independence;
- (E) Have the services coordinator explain what services are available, how those services will assist the participant and what the participant's rights and responsibilities are;
- (F) Request assistance with finding appropriate providers;
- (G) Confirm that services were received in the manner authorized in the person-centered plan (PCP) according to Department procedures.
- (H) Openly communicate with the services coordinator and receive information in a manner that is easy to understand;
- (I) Meet privately with the services coordinator;
- (J) Receive ongoing assistance from the services coordinator;
- (K) Choose the participant's services coordinator among approved and willing services coordination options. Request changes of services coordination in accordance with availability in the service area;

- (L) Make informed choices regarding the services and supports outlined in the person-centered plan (PCP), and the provider from which the participant will receive the services and supports. Access files, records or other information related to enrollment in and delivery of services under the Medicaid Home and Community-Based Services (HCBS) Waiver Program;
- (M) Be assured of confidentiality of personal and sensitive health care information pursuant to relevant confidentiality and information disclosure laws;
- (N) Request assistance with problems, concerns and issues, and suggest changes without fear of repercussion;
- (O) Be fully informed about how to contact the services coordinator with problems, concerns, issues or inquiries;
- (P) Be informed of the right to appeal decisions made by the Department about Waiver eligibility or services pursuant; and
- (Q) Be informed of the right to file a formal complaint with the Department.

002.02 PARTICIPANT RESPONSIBILITIES. Participants of Waiver services have the following responsibilities:

- (A) Upon enrollment, the participant must sign a Waiver consent form;
- (B) Participate in determinations of eligibility and enrollment in the Waiver and development and implementation of the person-centered plan (PCP), and any back-up service plans. Cooperation includes providing accurate and complete information and medical history. The participant must continue to cooperate with any re-determination of eligibility or services. Lack of cooperation during the determination process may lead to denial of eligibility and enrollment;
- (C) Decide who, besides the services coordinator, will participate in the service planning process;
- (D) Participate in the recruitment, selection, and dismissal of providers;
- (E) It is the participant's responsibility to ensure that the provider is properly trained. The participant will work with the services coordinator and their physician to ensure that the provider is properly trained to deliver Waiver services that meet the participant's specific needs. When appropriate, the participant will personally train the provider;
- (F) Not direct the service provider to provide a service, perform a function, or take any action that is not permitted under Medicaid rules and regulations and all other applicable laws, rules, regulations, or that has not been authorized by the Department or the contracted agency;
- (G) Notify the services coordinator within 10 calendar days when a change in provider or services is desired. Notification must include the proposed end date of the former provider or service, and the proposed start date of the new provider or service;
- (H) Authorize the exchange of information for development of the service plan with all of the participant's service providers, and in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations set forth in 45 Code of Federal Regulations (CFR) parts 160 and 164 and the Medicaid safeguarding information requirements set forth in 42 CFR 431.000 to 431.306 along with Neb. Rev. Stat. § 68-312 to 68-314;
- (I) Communicate to the provider personal preferences about the duties, tasks and procedures to be performed, and when appropriate, about provider performance concerns;

- (J) Report to, and work with, the services coordinator to resolve problems and concerns with any service delivery issues including, but not limited to, service disruption, complaints and concerns about the provider, or health and safety issues;
- (K) Keep scheduled appointments and notify the provider and Services Coordinator if a scheduled visit or service is going to be missed;
- (L) Treat the services coordinator and providers with respect;
- (M) Provide a safe environment in which services can be delivered;
- (N) Report to the services coordinator within 10 calendar days, any significant changes in the participant's condition, living arrangements, or circumstances; ~~and~~
- (O) Refuse to participate in dishonest or illegal activities involving providers. Report dishonest or illegal activities to the services coordinator; ~~and~~
- (P) Validate service delivery in accordance with Department procedures, including but not limited to, the date and location of service delivery, arrival and departure times of the provider, and verification of service delivery by both the provider and the participant, or their authorized representative.

003. PARTICIPANT ELIGIBILITY.

003.01 ELIGIBILITY CRITERIA. Participants eligible for Waiver services must:

- (A) Be eligible for Nebraska Medicaid in a category authorized to receive services from the Waiver under which services are being requested;
- (B) Have conditions which place the individual in the target populations identified in the Waiver under which services are being requested;
- (C) Have participated in an assessment, including any reassessments, with a services coordinator in accordance with this chapter;
- (D) Meet the nursing facility level of care criteria outlined in ~~Title~~ 471 Nebraska Administrative Code (NAC) ~~42-000~~;
- (E) Be determined that meeting the care needs of the participant would not result in Nebraska violating the cost effectiveness requirements outlined in this chapter;
- (F) Receive an explanation of nursing facility services and Waiver services and choose to receive Waiver services; and
- (G) Use Waiver services at least every 60 days. Exceptions apply for cases that are Assistive Technology Supports (ATS) or Home and Vehicle Modification (H/VM) requests only, or in the event there is a delay in enrollment of the preferred provider.

003.02 ELIGIBILITY DETERMINATION. All participants must have an eligibility determination in order to be able to access Waiver services. Eligibility determinations include:

003.02(A) ASSESSMENT. An in-person assessment will be completed by the services coordinator, participant, and legal guardian when applicable. A child must be reassessed as an adult when they reach age 18. The following steps are included within the intake process:

- (i) A referral for services will be accepted from any source;
- (ii) Each participant must be determined Medicaid eligible, or under consideration for Medicaid eligibility; and
- (iii) The services coordinator will contact the participant and schedule an in-person meeting to evaluate nursing facility level of care, within 14 calendar days of the referral date. Assessments are scheduled at a time and date convenient to the

participant and their guardian, when applicable this may result in scheduling outside the 14 calendar day window.

003.02(B) PRIORITY CRITERIA FOR ASSESSMENT. If a statewide waiting list is required due to limited Waiver capacity, the Department may determine that an individual qualifies for a priority placement into an available Waiver opening. The Department retains sole discretion to determine the applicability of criteria and the need for prioritization of an assessment. Criteria to be considered to expedite the assessment include, but are not limited to:

- (i) Needs that are so severe the health and welfare of the participant are jeopardized, but the needs could safely be met with immediate Waiver services;
- (ii) Family or caregivers are in a crisis situation;
- (iii) No informal support network is available to meet identified needs;
- (iv) Inappropriate out-of-home placement is being planned;
- (v) No other program is available to meet the needs identified in the referral;
- (vi) Support services are required to allow the participant to return home such as, a Medicaid-eligible recipient is ready to be discharged from a hospital or nursing facility; and
- (vii) A participant with an identified Waiver service need of Assistive Technology Supports or Home and Vehicle Modifications (ATS, H/VM) lacks access to resources to meet these specific needs AND Waiver eligibility is the only method of addressing the identified needs.

003.02(C) ONGOING ASSESSMENTS. An in-person re-evaluation of nursing facility level of care and needs assessment are required at least annually or any time that there is a change in a participant's condition in order to ensure the participant continues to meet criteria identified in 471 NAC 12-000 to be eligible for Waiver services.

003.02(D) DETERMINATION OF NURSING FACILITY LEVEL OF CARE. The Department will determine nursing facility level of care in accordance with [Title 471 NAC 12-000](#).

003.02(E) PERSON-CENTERED PLAN (PCP). A Person-Centered Plan (PCP) must be developed for each participant. For children aged 0-3 years old that are also utilizing early intervention services, the Individual Family Service Plan (IFSP) is the person-centered plan (PCP). The service planning process should be directed by the participant and any applicable representative. Steps included in the person-centered planning process are:

- (i) PLAN DEVELOPMENT. The participant, together with the services coordinator, develops a person-centered plan (PCP) based upon assessment results of the potential participant's strengths, needs, priorities, preferences and resources.
- (ii) PLAN REQUIREMENTS. The person-centered plan (PCP) must meet the following requirements:
 - (1) Reflect that the setting in which the participant resides is chosen by the individual;
 - (2) Reflect the participant's strengths and preferences;
 - (3) Reflect clinical and support needs;
 - (4) Include individually identified goals and desired outcomes;

- (5) Reflect the services and supports (paid and unpaid) that will assist the client to achieve identified goals, and the providers of services and supports, including informal supports;
 - (6) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies;
 - (7) Identify the individual and entity responsible for monitoring the plan;
 - (8) Document that any modification ~~of the additional conditions, under 480 NAC 2-000, 3-000 and 4-000,~~ is supported by a specific assessed need and justified. The following requirements must be documented in the person-centered plan (PCP):
 - (a) Identify a specific and individualized assessed need;
 - (b) Document the positive interventions and supports used prior to any modifications to the person-centered plan (PCP);
 - (c) Document less intrusive methods of meeting the need that have been tried but did not work;
 - (d) Include a clear description of the condition that is directly proportionate to the specific assessed need;
 - (e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
 - (f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
 - (g) Include informed consent of the participant; ~~and,~~
 - (h) ~~Include an assurance that interventions and supports will cause no harm to the individual.~~
- (iii) PLAN IMPLEMENTATION. The person-centered plan (PCP) must be finalized and agreed to, with the informed consent of the participant, and the participant's legal representative when applicable.

004. TARGETED CASE MANAGEMENT. Targeted case management will be provided by Department staff or a designee. Regulatory references addressing participation by the services coordinator are also intended to allow participation by the services coordinator's supervisor, if necessary.

004.01 WAIVER CONSENT. If the participant accepts Waiver services, the participant or legal guardian must sign the Waiver consent form. The Waiver consent form must be updated any time there is a change in the legal ability of the participant or legal guardian to consent to Waiver services. The Waiver consent form is not valid until the date the participant's eligibility for Medicaid has been determined. The participant's Waiver ~~services may not be authorized until eligibility period may begin no earlier than the first day of the month in which~~ the participant ~~signed~~ the Waiver consent form and Medicaid eligibility ~~was~~ approved.

004.02 MONITORING. Monitoring of Waiver services includes:

- (A) Monthly contact between the participant and the services coordinator. Contact may be more frequent based on participant need. In-person visits must occur at least quarterly, and may occur more often if determined to be necessary by the services coordinator. All in-person contacts will be at a time, date, and location convenient to the participant. Each participant contact includes the following:

- (i) Confirmation services being provided by both formal and informal supports and services continue to meet the participant's needs based on participant interview and observation;
- (ii) Review of service usage and cost;
- (iii) Review of the participant's desired outcomes;
- (iv) Review the participant's satisfaction with the services provided;
- (v) Review of the participant's overall health status;
- (vi) Review of medical information; and
- (vii) Verification that providers comply with the requirements of service provision.
- (B) Revisions to the person-centered plan (PCP) as necessary to account for changes identified in (A)(i)-(vii) after each monthly contact; and
- (C) Notice to the Department within two working days that the participant has had a significant change in health or needs, the services coordinator will determine whether a reassessment of the participant's level of care, strengths, needs, and resources is necessary. A reassessment may be initiated based upon the services coordinator's observation of any improvement or decline in functioning during the participant contact.

004.03 COST EFFECTIVENESS DETERMINATION. To ensure ongoing cost effectiveness of the Waiver Program in accordance with 480 NAC 2-000, the Department will determine the estimated cost effectiveness for each participant.

3-000 EARLY INTERVENTION SERVICES COORDINATION

3-001 GLOSSARY OF TERMS

Aged and Disabled Medicaid Waiver: A Medicaid-funded program which pays for services coordination and supportive services for eligible infants and toddlers in the Early Intervention Program who have needs which qualify them for Nursing Facility level of care.

Annual Individual Family Services Plan Meeting: IFSP team meeting held each year to evaluate and, as appropriate, revise the child's IFSP.

Child Assessment: The ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs. Child Assessment procedures are identified in Nebraska Department of Education regulations at 92 NAC 52.

Co-lead Agencies: The Nebraska Department of Health and Human Services and the Department of Education and any other agencies appointed by the Governor responsible for planning, implementation, and administration of the federal early intervention program and the Nebraska Early Intervention Act.

Consent: The parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language; the parent understands and agrees in writing to the carrying out of the activity and the consent form describes that activity and lists the early intervention records (if any) that will be released and to whom they will be released; and the parent understands that the granting of consent is voluntary and may be revoked at any time.

Developmental Delay: The disability classifications or conditions which qualify a child for early intervention services as described in NDE regulations at 92 NAC 52.

Early Intervention Service Program: The single point of entry to services coordination for eligible infants and toddlers as identified by each planning region team via the systems contract.

Early Intervention Services: The early intervention system contains entitled services and access to other available services that are provided under public supervision; are selected in collaboration with the parents; are provided at no cost, except, where Federal or State law provides for a system of payments by families; and are designed to meet the developmental needs of each eligible infant or toddler with disabilities and the needs of the family to assist appropriately in the infant's or toddler's development, as identified by the IFSP team.

~~Eligible Infants and Toddlers with Disabilities: Children two years of age or younger who are verified for early intervention services. Toddlers who reach age three during the school year remain eligible through the end of the school's fiscal year.~~

~~Entitlement: Benefit(s) of a program granted by law to persons who fit within defined eligibility criteria. Entitlement through the Early Intervention Act includes services coordination and development of the individualized family service plan.~~

~~Family: Parent(s), guardian(s), and/or other persons identified by the family.~~

~~Family Assessment: A voluntary interview with family members through the use of an assessment tool by qualified personnel to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability.~~

~~Individualized Family Service Plan (IFSP): A written plan for providing early intervention services for an eligible infant or toddler and the infant's or toddler's family. The plan is developed and implemented in accordance with 480 NAC 3-008 and NDE regulations at 92 NAC 52.~~

~~Individuals with Disabilities Education Act, Part C: Federal law establishing the Early Intervention Program for Infants and Toddlers with Disabilities.~~

~~Infant or Toddler with a Disability: An individual under three years of age who needs early intervention services because the individual is experiencing a significant developmental delay in one or more areas as defined in NDE regulations at 92 NAC 52-006.~~

~~Local Educational Agencies: School districts, approved cooperatives, and educational service units.~~

~~Multidisciplinary: The involvement of two or more separate disciplines or professions and, with respect to the IFSP Team, one of these individuals must be the services coordinator; and the IFSP team must include the involvement of the parent.~~

~~Multidisciplinary Evaluation Team (MDT): A group of persons responsible for evaluating the abilities and needs of an infant or toddler to determine whether or not the infant or toddler is eligible to receive early intervention services.~~

~~Native Language: Mode of communication normally used by a child's family; except for evaluations and assessments of the child, the native language of a child with limited English proficiency is the language normally used by the child if qualified personnel conducting the evaluation or assessment determine that this language is developmentally appropriate for the child given the child's age and communication skills.~~

~~Natural Environments: Settings that are natural or typical for the child's age peers who have no disabilities.~~

~~NDE regulations at 92 NAC 51: Nebraska Department of Education regulations for special education programs serving children from age 3 to 21, found in Title 92, Chapter 51 of the Nebraska Administrative Code.~~

~~NDE regulations at 92 NAC 52: Nebraska Department of Education regulations for early intervention programs serving children from Birth to age 3, found in Title 92, Chapter 52 of the Nebraska Administrative Code.~~

~~Need: Shall mean the extent of services coordination necessary as based on the circumstances in each family but shall include the activities that are required to be provided in 34 CFR 303.34.~~

~~Notice: A written statement provided to the parents of an eligible child a reasonable time before a public agency or service provider proposes or refuses to initiate or change services. This includes identification, evaluation, or placement of the child or the provision of appropriate early intervention services to the child and the child's family. The statement must contain a description of the action, reasons, and an explanation of procedural safeguards. The notice must be provided in the native language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so.~~

~~Parent: A biological or adoptive parent, or legal guardian of a child (but not the State if the child is a ward of the State); and as defined in 34 CFR 303.27~~

~~Periodic Review: A review of the IFSP which must be conducted every six months, or more frequently if conditions warrant, or the family requests such a review.~~

Personally Identifiable: Information that would cause a child and his/her family to be recognized (e.g., name, address, social security number, and characteristics that would make it possible to identify the child and/or family with reasonable certainty).

Planning Region Team: An organized group of parents, advocates and representatives from school districts, agencies, educational service units, Head Start, and other relevant agencies or persons responsible for assisting in the planning and implementation of the Early Intervention Act in each local community or region.

Public Agency: Includes the lead agency and any other political subdivision of the State that is responsible for providing early intervention services to children eligible under Part C and their families.

Referral: a systematic method to link infants and toddlers, ages birth to three, who may have developmental delays, and their families, to the Early Development Network.

Screening: optional procedures and activities adopted by the school district or approved cooperative under NDE regulations at 92 NAC 52-006.03 to identify, at the earliest possible age, infants and toddlers suspected of having a disability and in need of early intervention services; and includes the administration of appropriate instruments by trained personnel.

Services Coordination: An active, ongoing flexible, individualized process of interaction facilitated by a services coordinator to assist a family of an eligible infant or toddler with disabilities within a community to gain access to, and coordinate the provision of, early intervention services and coordinate the other services identified in the IFSP that are needed by, or are being provided to, an eligible infant or toddler and their family. The services coordinator assists the family to identify and meet the family and child's needs through coordination of informal and formal supports. This includes activities carried out by a services coordinator to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the early intervention program.

Services Coordination Agency: An agency identified in each planning region which assumes the responsibility to deliver the entitlement of services coordination in the region through a provider agreement with the Department of Health and Human Services.

Transition Plan: Documentation in the IFSP which includes steps for the toddler with a disability and his or her family to exit from the Part C program; and any transition services that the IFSP team identifies as needed by that toddler and his/her family.

TITLE 480 HOME AND COMMUNITY-BASED SERVICES

CHAPTER 4 PROVIDER REQUIREMENTS

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 68-901 Et seq. (the Medical Assistance Act).

002. GENERAL PROVIDER REQUIREMENTS.

002.01 COMPLIANCE WITH MEDICAID PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, providers of Home and Community-Based Waiver services must comply with all applicable provider participation requirements identified in 471 Nebraska Administrative Code (NAC) Chapters 1-000, 2-000 and 3-000. In the event that provider participation requirements in 471 NAC Chapters 1-000, 2-000 or 3-000 conflict with requirements outlined in this Chapter, the individual provider participation requirements in this chapter will govern.

002.02 SERVICE AUTHORIZATION. Waiver services will be authorized for each participant up to a 12 month period. All authorized services are based on needs identified in the person-centered plan (PCP) and the results of ongoing monitoring activities. A copy of the authorization is supplied to both the participant and the provider identifying which tasks the provider is authorized to perform. Providers are responsible for knowing and understanding the tasks they are authorized to perform for each participant they serve. The service authorization must be complete before services are performed.

002.03 PROVIDER CAPABILITIES. Providers must have the knowledge and skills to respond to emergency situations. Additionally, providers must have the physical and mental abilities to safely perform all requirements of the service that has been authorized. Failure to meet these standards will be grounds for termination or denial.

002.04 REASONABLE CAUTION. Providers must exercise reasonable caution and care in the use and storage of participants' property, resources, equipment, appliances, tools, and supplies.

002.05 PROVIDER OWNED AND OPERATED SETTINGS. If services are provided in a provider owned and operated setting, the provider must comply with the following requirements. Failure to meet these standards will be grounds for termination or denial of a Medicaid provider agreement.

- (A) Ensure that the facility or home is architecturally designed to accommodate the needs of the participants being served;
- (B) Have available an operable telephone;
- (C) Post emergency phone numbers by the telephone;
- (D) Ensure that the home or facility is accessible to the participant, clean, in good repair, free from hazards, and free of rodents and insects;
- (E) Ensure that the facility or home is equipped to provide comfortable temperature and ventilation conditions;
- (F) Ensure that toilet facilities are clean and in working order;
- (G) Ensure that the eating areas and equipment are clean and in good repair;
- (H) Ensure that the home or facility is free from fire hazards;
- (I) Ensure that the furnace, water heater, any firearms, medications, and poisons are inaccessible to the participant; and
- (J) Ensure that any household pets have all necessary vaccinations;:-
- (K) The unit or dwelling in which the participant resides must be a specific place owned, rented, or occupied under a legally enforceable residency agreement; and
- (L) The provider must cooperate with the Department in completing any assessments regarding the community-based nature of the property.

002.06 PARTICIPATION STANDARDS. All Home and Community-Based Services (HCBS) Waiver providers must meet the standards outlined in 471 NAC 2-000. Additional standards including but not limited to the following apply for providers of Home and Community-Based Waiver services:

- (A) Follow all applicable Department policies and procedures found in NAC Titles 465, 471, 473, 474, and 480;
 - (i) Bill only for services which are authorized and actually provided;
- (B) Accept payment as payment in full for the agreed upon service(s) unless the participant has been assigned a portion of the cost by the Department. Provider will not charge participants any difference between the agreed upon rate and private pay rate;
- (C) No one may provide services for a spouse, minor child, or any participant that the provider has an obligation to support;
- (D) Not engage in any activity that influences service approval or utilization if they are an employee of the Department, the relative of a Department staff person;
- (E) Retain all records related to provider enrollment and service provision, including financial records. Records must be maintained for retention periods in compliance with federal and state law, but no record may be destroyed prior to expiration of a six year retention period;
- (F) Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site;
- (G) Provide services as an independent contractor, if the provider is an individual, recognizing that they are not an employee of the Department or of the State;
- (H) Understand that any false claims, including claims submitted electronically, statements, documents, or concealment of material fact may be prosecuted under applicable state or federal laws per 42 CFR 455.18;
- (I) Respect every participant's right to confidentiality and safeguard confidential information;

- (J) Understand and accept responsibility for the participant's safety and property;
- (K) Not transfer this agreement to any other entity or person;
- (L) Not use any federal funds received to influence agency or congressional staff;
- (M) Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom they provide services. This may include a listing on the child or adult central registries of abuse and neglect, ~~a listing on sex offender registries, or a history of criminal convictions;~~
- (N) Agency providers agree to allow Department staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place. The agency provider must allow the Department access to records in order to establish compliance with this requirement;
- (O) Have the knowledge, experience, and skills necessary to perform the tasks;
- (P) Be capable of recognizing signs of distress in a participant and know how to access available emergency resources if a crisis situation occurs;
- (Q) Report changes to appropriate Department staff including but not limited to no longer being able or willing to provide the service, or changes in participant function;
- (R) Report all incidents in which there is reasonable cause to believe the participant has been subjected to abuse, neglect, or exploitation. All such incidents will be reported to law enforcement and to the Department;
- (S) Be age 19 or older if an individual provider; or assure that agency staff who assume the following roles are age 19 or older: director, administrator, agency representative for signing legal documents, or provider of in-home participant services;
- (T) Persons may not be eligible to provide services if they are also a recipient of Chore, Personal Assistance Services (PAS), or similar assistance services; and
- (U) Providers entering the participant's home to provide services may not be accompanied in the participant's home by any individuals, including the provider's minor children, whose presence is unnecessary to the provision of services to the participant, or who are not authorized to provide services to the participant.

002.07 DENIAL, TERMINATION AND SANCTION OF HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER PROVIDERS. In addition to the reasons for denial, termination, and sanction listed in 471 NAC Chapter 2-000, Waiver Providers are subject to sanction, termination or denial of service approvals and service provider agreements when charges are pending, or a conviction has occurred. No service provider agreement will be issued or remain in effect if there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, or crimes involving the illegal use of a controlled substance on the part of the provider or any other household members when services are provided in the same location the provider lists as their home address. The provider and household members must not engage in or have a history of behavior injurious to, or which may endanger the health or safety of the participant. Agency providers are responsible for screening their employees for the listed provider standards. Agency providers approved to provide Home and Community-Based Waiver services may not employ persons that have such charges in their history if that person will be providing direct care services. ~~Offenses include, but are not limited to, the following:~~

- ~~(A) Child pornography;~~
- ~~(B) Child sexual abuse;~~
- ~~(C) Driving Under the Influence;~~

- ~~(i) For providers of transportation services, a driving under the influence (DUI) charge is pending or a conviction has occurred within the past five years; or~~
- ~~(ii) For providers of non-transportation services, two or more driving under the influence (DUI) charges are pending, or convictions have occurred within the last five years, or two of any combination of driving under the influence (DUI) charges pending or convictions occurred within the last five years.~~
- ~~(D) Domestic violence;~~
- ~~(E) Theft within the last three years;~~
- ~~(F) Felony or misdemeanor fraud within the last 10 years;~~
- ~~(G) Termination of provider status for cause from any Department program within the last 10 years;~~
- ~~(H) Possession of, or possession with intent to deliver any controlled substance within the last five years;~~
- ~~(I) Felony or misdemeanor assault with or without a weapon in the last 15 years;~~
- ~~(J) Prostitution or solicitation of prostitution within the last five years;~~
- ~~(K) Felony or misdemeanor robbery or burglary within the last 10 years;~~
- ~~(L) Rape or sexual assault;~~
- ~~(M) Homicide; or~~
- ~~(N) Any other offense that resulted in prison confinement for 10 years or more.~~

002.08 REPORTS OF ABUSE OR NEGLECT. Agency providers must ensure they have policies that strictly comply with this chapter to ensure that appropriate procedures regarding abuse or neglect are in place.

002.08(A) REGISTRY CHECKS. Medicaid providers ~~must be cross-referenced with the are subject to~~ Adult Protective Services and Child Protective Services Central Registries ~~checks to determine if any reports of abuse or neglect by the provider exist.~~ For services being provided in the same location the provider lists as their home, members of the household must also be checked in the Central Registries ~~to determine if any reports of abuse or neglect exist.~~

002.08(B) REPORTED ABUSE OR NEGLECT. If a report of abuse or neglect concerning a provider, or a household member when service is provided in the same location the provider lists as their home address Department staff will immediately terminate the service provider agreement. If a report of abuse or neglect is indicated, the Department will not enroll the provider.

002.09 ONGOING PARTICIPATION REQUIREMENTS. Annually, the Department will conduct an in-person review with each provider to ensure the provider continues to meet general and service specific provider standards. ~~This review will also include a screening of the sex offender, Adult Protective Services, and Child Protective Services Central Registries, and may include an additional criminal background check.~~

002.10 CLAIMS SUBMISSION. Refer to 471 NAC 3-000. Services must be delivered before they can be billed. Providers are responsible for verifying that the information is accurate and complete prior to submission.

002.11 SOCIAL SECURITY TAX WITHHOLDING. When required by law, the Department withholds Social Security taxes, also known as Federal Insurance Contribution Act, (FICA) from provider payments. The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not affiliated with an agency. The Department, upon receiving a signed "Employer Appointment of Agent," acts on behalf of participants who receive in-home services to withhold mandatory Federal Insurance Contribution Act (FICA) taxes from individual providers and pays the participant's matching tax share to the Internal Revenue Service (IRS).

002.11(A) EARNINGS TAXED FOR SOCIAL SECURITY. Affected providers are subject to Social Security tax payment for each calendar year in which they are paid a federally determined amount or more for services provided to one participant. The Department will withhold this tax from all payments to affected providers. If a provider's earnings do not reach this annual amount for Federal Insurance Contribution Act (FICA) services per participant, the amount withheld for that year is refunded.

002.11(B) SOCIAL SECURITY TAX RATES. The Department remits to the IRS an amount equal to the current Social Security tax rate for specified "in-home" services. Half of this amount is withheld from the provider as the employee's share; the other half is provided by the Department on behalf of the participant employer.

002.12 RECORD REQUIREMENTS. Providers of Waiver services must retain for six years the following material:

- (A) Documentation which supports provision of services to each participant served under the Waiver;
- (B) Any other documentation determined necessary by the Department to support selection and provision of services under a person-centered plan (PCP);
- (C) Financial information necessary to allow for an independent audit under the Waiver;
- (D) Documentation which supports requests for payment under the Waiver; and
- (E) Provider agreements with the Department.

003. SERVICE SPECIFIC PROVIDER REQUIREMENTS.

003.01 ADULT DAY HEALTH SERVICES (ADHS). The Department enrolls providers of Adult Day Health Services (ADHS) ensuring all applicable federal, state, and local laws and regulations are met. These standards include but are not limited to, regulations located in Title 175 NAC 5-000. Providers are subject to the additional standards that follow.

003.01(A) PROVIDER STANDARDS. Providers of Adult Day Health Services (ADHS) must obtain adequate information on the medical and personal needs of each participant, if applicable; and observe and report all changes to the services coordinator.

003.01(B) FACILITY STANDARDS. Each Adult Day Health Service (ADHS) facility must meet all applicable federal, state, and local fire, health, and other standards prescribed in law or regulation. The provider is responsible for ensuring that services are provided in an integrated, community-based setting. This includes the following standards:

- (i) ATMOSPHERE AND DESIGN.

- (1) The facility must be architecturally designed to accommodate the needs of the participants being served;
- (2) Furniture and equipment used by participants must be adequate;
- (3) Toilets must be in working order and easily accessible from all program areas;
and
- (4) A telephone must be available for participant use.
- (ii) LOCATION AND SPACE. The provider must ensure that the facility has sufficient space to accommodate the full range of program activities and services including:
 - (1) Flexibility for large and small group and individual activities and services;
 - (2) Storage space for program and operating supplies;
 - (3) A rest area, adequate space for special therapies, and designated areas to permit privacy and isolate participants who become ill;
 - (4) Adequate table and seating space for dining;
 - (5) Outside space available for outdoor activities and accessible to participants;
and
 - (6) Adequate space for outer garments and private possessions of the participants.
- (iii) SAFETY AND SANITATION. The facility must ensure that:
 - (1) The facility is maintained in compliance with all applicable local, state, and federal health and safety regulations. See 175 NAC 5-000, Nebraska Revised Statute § 81-2,257.01 and 81-2,244.01, and the Nebraska Food Code as published by the Nebraska Department of Agriculture;
 - (2) If food is prepared at the center, the food preparation area must comply with all applicable federal, state, and local laws. See 175 NAC 5-000, Nebraska Revised Statute § 81-2,257.01 and 81-2,244.01, and the Nebraska Food Code as published by the Nebraska Department of Agriculture;
 - (3) At least two well-identified exits are available;
 - (4) Stairs, ramps, and interior floor have non-slip surfaces or carpet;
 - (5) The facility is free of hazards including but not limited to, exposed electrical cords, improper storage of combustible material;
 - (6) All stairs, ramps, and barrier-free bathrooms are equipped with usable handrails; and
 - (7) A written plan for emergency care and transportation is documented in the participant's file.

003.01(C) STAFFING. Each center must be staffed at all times by at least one full-time trained staff person during operating hours. The center must maintain an appropriate ratio of direct care staff to participants sufficient to ensure that participant needs are met. The center must develop written job descriptions and qualifications for each professional, direct care, and non-direct care position.

- 003.01(D) PROVIDER SKILLS AND KNOWLEDGE. Direct care staff members must:
- (i) Have training or, one or more years of experience in working with adults in a health care or social service setting;
 - (ii) Have training or knowledge of cardiopulmonary resuscitation (CPR) and first aid;
 - (iii) Be able to recognize distress or signs of illness in participants;
 - (iv) Have knowledge of available medical resources, including emergency resources;

- (v) Have access to information on each participant's address, telephone number, and means of transportation; and
- (vi) Know reasonable safety precautions to exercise when dealing with participants and their property.

003.01(E) LICENSED NURSE. The provider must have a licensed nurse on staff, or contract with a licensed nurse, who will provide the health assessment and nursing service component of Adult Day Health Service (ADHS) and supervise activities of daily living (ADLs) as well as activities of daily living (ADL) training components.

003.01(F) ADULT DAY HEALTH SERVICE (ADHS) RATES AND FREQUENCY. The frequency of service is a calendar day of at least four hours. In the event that a Waiver participant must leave the Adult Day Health Services (ADHS) facility due to an unplanned need and has been there less than four hours, this is considered a full day for reimbursement purposes. The Department establishes a statewide rate for Adult Day Health Services (ADHS).

003.02 ASSISTED LIVING STANDARDS. The Department enrolls providers of assisted living services ensuring all applicable federal, state, and local laws and regulations are met. Each year the Department will perform an in-person site visit with enrolled Waiver providers of assisted living services to ensure that all applicable federal, state, and local laws and regulations are met.

003.02(A) PROVIDER OWNED AND OPERATED SETTING STANDARDS. The following minimum standards apply to assisted living providers that serve Waiver individuals. These standards are in addition to standards required by the Department's licensure unit:

- (i) Each assisted living (AL) provider must be licensed as an assisted living facility and certified as an assisted living (AL) provider of Waiver services;
- (ii) The assisted living (AL) providers must provide a private room with bathroom consisting of a toilet and sink for each participant receiving Waiver assisted living service. Semi-private rooms will be considered on a case-by-case basis, and require prior approval of the Department;
- (iii) An assisted living facility that is adjacent to a mutually-owned nursing facility must be separately licensed and be in accordance with the requirements in 175 NAC 4-000. The assisted living (AL) provider must have policies, procedures, activities, dining and common areas that are specifically for individuals residing the in the assisted living facility. Direct care staff do not include administrative, laundry, housekeeping, dietary, or maintenance staff.
- (iv) The assisted living (AL) provider must provide essential furniture, at a minimum, a bed, dresser, nightstand or table, and chair, if a participant does not have those items;
- (v) The assisted living (AL) provider must provide normal, daily personal hygiene items including, at a minimum, soap, shampoo, toilet paper, facial tissue, laundry soap, and dental hygiene products. Other personal products or brand choices are the responsibility of the participant;

- (vi) The assisted living (AL) provider must provide privacy in the unit including lockable doors, and access by the participant to the facility and to the individual apartment; and
- (vii) The assisted living (AL) provider must provide a grievance process for review of denials of individualized participant requests. Denials of individualized participant requests must be documented in the person-centered plan (PCP) including the outcome of any grievances filed.

003.02(B) ASSISTED LIVING RATES. Medicaid provides payment for assisted living services in monthly increments through rates established by the Department. Variable rates may be utilized and may change annually. Assisted living (AL) provider rates have the following characteristics:

- (i) OCCUPANCY. Rates differentiate between the single occupancy of an assisted living unit and the multiple occupancy of one unit;
- (ii) RATE ELEMENTS. Each rate consists of three parts:
 - (1) The amount the facility must collect for room and board from the participant;
 - (2) The participant's share of cost (SOC) that must be obligated before the Department will assume financial responsibility; and
 - (3) The Medicaid responsibility for services provided.

003.02(C) ASSISTED LIVING RECORD KEEPING. The provider must maintain at least the following in each participant's file:

- (i) The current Resident Service Agreement (RSA); and
- (ii) Phone numbers of persons to contact in case of an emergency and the participant's physician's name and phone number.

003.02(D) DEPOSIT. Assisted living (AL) providers and specialized assisted living providers (SALP) cannot charge a deposit to Waiver participants, with the exception of a pet deposit. Assisted living (AL) providers and specialized assisted living (SAL) providers must refund any deposit previously paid by a participant when in private pay status, if the amount is considered a resource for Medicaid eligibility. The provider is allowed to evaluate the living unit at the time the participant's payment status changes from private pay to Medicaid Waiver. If there are repairs to be made, the facility may make the necessary repairs, deduct the amount from the deposit and refund the balance, if any, to the participant.

003.02(E) ASSISTED LIVING FREQUENCY. Units of service for assisted living are daily or monthly. A monthly rate is used for ongoing months. A daily rate is used for the months of admission and discharge if the participant resides in the assisted living for less than the full month.

003.02(F) ABSENCE NOTIFICATION. Assisted living (AL) provider and specialized assisted living (SAL) provider staff must notify the Services Coordinator within five calendar days when the resident is out of the facility more than 24 hours for a medical absence. The Department has the authority to impose a fiscal sanction if an absence is not reported.

003.03 ASSISTIVE TECHNOLOGY SUPPORTS, HOME AND VEHICLE MODIFICATIONS (ATS, H/VM).

003.03(A) ASSISTIVE TECHNOLOGY SUPPORTS, HOME AND VEHICLE MODIFICATIONS (ATS, H/VM) RATES. The Department does not have an annual maximum for each of the two components. This allows flexibility for the participant's needs to be met if a modification is necessary to remain or return home.

003.04 CHORE. The Department enrolls providers of Chore ensuring all applicable federal, state, and local laws and regulations are met.

003.04(A) CHORE RATES. Chore rates are established by the Department. **Negotiated and These** established rates may change annually. Services may be authorized in frequencies of hourly, daily, or occurrence. Providers must bill for the quarter of the hour if the participant is not in attendance for a full hour.

003.04(B) OVERNIGHT CARE. In order for a Chore provider to be eligible to bill for care during overnight sleeping hours, the participant's person-centered plan (PCP) must outline care needs that require a caregiver's attention and the care tasks from the plan will be outlined in the service authorization. These tasks can include, but are not limited to: re-positioning and turning, attending to participant's incontinence issues, or tracheostomy suctioning.

003.05 EXTRA CHILD CARE FOR CHILDREN WITH DISABILITIES. Waiver providers of Extra Child Care for Children with Disabilities must be approved or licensed through the Department. Waiver providers of Extra Child Care for Children with Disabilities must obtain adequate information on the medical and personal needs of each child and observe and report all changes to the services coordinator.

003.05(A) EXTRA CHILD CARE FOR CHILDREN WITH DISABILITIES. Rates for Extra Child Care for Children with Disabilities are set by the Department. The parent or primary caregiver of the child is responsible for the cost of routine child care. That amount is determined by the provider rates published by the Child Care Subsidy Program in Title 392 for care provided in the provider's home or a center. For care provided in the child's home, the license-exempt family child care home rate chart applies to individual providers and the child care center chart applies to agency providers. The Department is responsible for payment of the approved cost of the service above the basic cost of routine child care.

003.05(B) FREQUENCY. Frequency of service is hourly or daily rate dependent upon the setting in which the services are provided. Participants may have authorization for both hours and days if services are provided outside the participant's home. For hourly billing, providers must bill for the quarter of the hour if the participant is not in attendance for a full hour. Six or more hours of care provided outside the child's home must be paid at a day rate, if that option is offered by the provider to private pay families.

003.06 HOME AGAIN SERVICES.

003.06(A) HOME AGAIN RATES. The Home Again rate consists of payment for the actual cost of items and services necessary for the participant's move and any payment to the sponsor. The maximum amount allowed for the Home Again service is determined annually by the Department. Payment for the Home Again service is not counted in the participant's monthly cost for Waiver services.

003.06(B) HOME AGAIN PROVIDER BILLING. Home Again Sponsors must bill for services by:

- (i) Totaling and submitting dated receipts for purchases made on behalf of the participant;
- (ii) Totaling and submitting receipts or other written documentation of the financial obligation incurred by the sponsor on behalf of the participant for security deposits, utility installation, and fees;
- (iii) Providing a detailed listing of the dates and activities performed if payment for the sponsor's time is authorized; and
- (iv) Submitting a billing request for the total amount of expenses incurred.

003.07 HOME-DELIVERED MEALS.

003.07(A) PROVISION OF SERVICES. ~~Providers of Home-Delivered Meals must obtain adequate information on the medical and personal needs of each participant. The need for home-delivered meals is jointly determined by the services coordinator and the participant.~~ Any changes should be reported to the services coordinator.

003.07(B) HOME-DELIVERED MEAL STANDARDS. The Department enrolls providers of Home-Delivered Meals ensuring all applicable federal, state, and local laws and regulations are met. See Neb. Rev. Stat. §§ 81-2,257.01 and 81-2,244.01, and the Nebraska Food Code as published by the Nebraska Department of Agriculture.

- (i) Providers must ensure that food preparation facilities and areas must conform to all established local, state, or federal fire prevention, sanitation, zoning, and facility maintenance standards.
- (ii) Food preparation personnel must be in good health and free from contagious disease and skilled and instructed in sanitary food handling, preparation, and serving practices.

003.07(C) HOME-DELIVERED MEALS RATES. Home-Delivered Meals rates are established by the Department. This established rate may change annually. A frequency is one meal.

003.08 INDEPENDENCE SKILLS BUILDING. The Department enrolls providers of Independence Skills Building ensuring that all applicable federal, state, and local laws and regulations are met. Each provider must have experience in the components of Independence Skills Building or be directly supervised by a person with experience. In addition, experience with formalized teaching methods is preferred.

003.08(A) FACILITY STANDARDS. Any facility used in connection with the provision of Independence Skills Building must meet at least the following environmental and fire and safety standards:

- (i) Be architecturally designed to accommodate the needs of the clients being served;
- (ii) Have adequate equipment and furniture for use by the participant;
- (iii) Have toilets in working order;
- (iv) Have a telephone available for participants to use;
- (v) Have at least two well-identified exits;
- (vi) Have non-slip surfaces or carpets on stairs, ramps, and interior floors;
- (vii) Be free of hazards, including but not limited to: exposed electrical cords, or improper storage of combustible materials; and
- (viii) Have usable handrails for all stairs, ramps, and barrier-free bathrooms.

003.08(B) INDEPENDENCE SKILLS BUILDING (ISB) RATES. Independence Skills Building (ISB) rates are set by the Department. Frequency of service may be hourly or occurrence.

003.08(C) INDEPENDENCE SKILLS BUILDING (ISB) RECORD KEEPING. The provider must maintain at least the following in each participant's file:

- (i) The Independence Skills Building (ISB) plan and any recommended changes;
- (ii) The monthly progress reports;
- (iii) The name of the participant's physician; and
- (iv) Pertinent medical information such as, activity restrictions, medications and administration schedule, or special diets.

003.09 NON-MEDICAL TRANSPORTATION.

003.09(A) NON-MEDICAL TRANSPORTATION RATES. Transportation rates are set by the Department according to statutory limits in Neb. Rev. Stat. § 75-304.01. Frequency of service is by mileage or trip or hourly for escort service.

003.10 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS).

003.10(A) PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) PROVIDER SPECIFIC STANDARDS. Providers of Personal Emergency Response Systems (PERS) must:

- (i) Instruct the participant about how to use the Personal Emergency Response System (PERS) device;
- (ii) Obtain a participant signature verifying receipt of the Personal Emergency Response Systems (PERS) unit;
- (iii) Ensure that response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days a week;
- (iv) Furnish a replacement Personal Emergency Response Systems (PERS) unit to the participant within 24 hours of notification of malfunction of the original unit while it is being repaired;
- (v) Update list of responder and contact names at a minimum of semi-annually to ensure accurate and current information;
- (vi) Ensure monthly testing of the Personal Emergency Response Systems (PERS) unit; and

- (vii) Furnish ongoing assistance when needed to evaluate and adjust the Personal Emergency Response Systems (PERS) device or to instruct participants in the use of Personal Emergency Response Systems (PERS) devices, as well as to provide for system performance checks.

003.10(B) PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) RATES. Frequency of service is a monthly rental fee. Installation and removal fees will be authorized separately.

003.10(C) PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) RECORD KEEPING. Providers of Personal Emergency Response Systems (PERS) must maintain at least the following in each participant's file:

- (i) Documentation of service delivery including client orientation to the system and installation of Personal Emergency Response Systems (PERS) device;
- (ii) List of responder and contact names;
- (iii) Case log documenting participant and responder contacts; and
- (iv) Record of monthly testing of the Personal Emergency Response Systems (PERS) unit.

003.11 RESPITE CARE. A provider may be an individual or agency. The Department enrolls providers of respite care ensuring that all applicable federal, state, and local laws and regulations are met. Respite providers must obtain adequate information on the medical and personal needs of each participant. The provider must observe and report all changes to the services coordinator.

003.11(A) AGENCY PROVIDER STANDARDS. Each agency provider must:

- (i) Employ respite care staff based upon their qualifications, experience, and demonstrated abilities;
- (ii) Provide training to ensure that respite staff are qualified to provide the necessary level of care. Agree to make training plans available to the Department; and
- (iii) Ensure adequate availability and quality of service.

003.11(B) RESPITE CARE RATES. Respite care rates are established by the Department. This established rate may change annually. Frequency of service is hourly or daily rate dependent upon the setting in which the services are provided. Participants may have authorization for both hours and days if services are provided outside the participant's home. For hourly billing, providers must bill for the quarter of the hour if the participant is not in attendance for a full hour. The rate for respite care may include the cost of three full meals per day only when respite care is provided on a 24 hour basis in a facility that is not a private residence.

004. PROVIDER ENROLLMENT. Refer to 471 NAC 2-000 for guidance regarding provider enrollment. Additional standards applicable to providers of Medicaid Home and Community-Based Waiver services follow.

004.01 PROVIDER SCREENING. In addition to requirements for provider screening found in 471 NAC 2-000, Department staff, or a designee of the Department, must conduct an in-person interview with each potential provider upon initial application and annually to review

compliance with current service specific program standards. Monitoring visits will occur if a potential provider is approved. If the provider does not meet service specific standards at the time of the interview, but is willing to correct the deficiency within 30 days, staff will continue the interview when proof of compliance is received. If the provider is not willing to correct deficiencies within 30 days the provider will be denied or terminated.

004.02(A) DEPARTMENT STAFF RELATIVES AS PROVIDERS. In situations where a Department staff person's relative is the only resource, staff will obtain administrative approval. Department staff cannot approve, reapprove, evaluate, or negotiate provider agreements with, or authorize service provision from, providers to whom they are related.

004.02(B) PARTICIPANT RELATIVES AS PROVIDERS. A provider may not provide services for a relative participant that the provider has a legal responsibility to support.

~~004.02(C) AGENCY USE OF SUBCONTRACTORS. If an agency provider plans to use a subcontractor, the provider must obtain approval prior to subcontracting with another organization or individual to provide a portion of service delivery. The agency provider must first provide the following information:~~

~~(i) Name of subcontractor; and~~

~~(ii) Federal Tax Identification Number, Social Security Number, and any licensure information.~~

004.03 DENIAL OR TERMINATION OF ENROLLMENT. Refer to 471 NAC 2-000.

004.03(A) DENIAL OR TERMINATION OF ENROLLMENT. Refer to 471 NAC 2-000. The Department, in its discretion, may deny or terminate a provider's enrollment for good cause.

004.03(B) VOLUNTARY WITHDRAWAL. Written notice to the potential provider is not required if the potential provider voluntarily withdraws from the evaluation process.

004.04 SERVICE PROVIDER AGREEMENT. Refer to 471 NAC 2-000.

004.04(A) AGREEMENT POLICIES. The following ~~additional~~ standard applies ~~in addition to requirements as~~ found in 471 NAC 2-000:

(i) Service provider agreements are effective up to five years. Service provider agreements ~~may be back-dated at the discretion of the Department, and~~ must be agreed upon and signed by all parties on or before the effective date.

004.05 APPEAL RIGHTS. Refer to 471 NAC 2-000. A provider of Waiver services has the right to appeal decisions or actions related to their enrollment as a Medicaid provider, including but not limited to:

(A) Reductions in rates;

(B) Sanctions; and

(C) Termination or denial of enrollment as a provider of Medicaid services.

TITLE 480 HOME AND COMMUNITY-BASED SERVICES

CHAPTER 5 AGED AND DISABLED WAIVER SERVICE REQUIREMENTS

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statutes §§ 68-901 et seq. (the Medical Assistance Act).

002. GENERAL SERVICE REQUIREMENTS.

002.01 PARTICIPANT ELIGIBILITY. Prior to initiation of services, all requirements outlined in 480 NAC 3-000 must be finalized.

002.02 SERVICE NEEDS. The need for each of the covered Waiver Services outlined in 480 Nebraska Administrative Code (NAC) 5-000 must be reflected in one or more assessment areas of the participant's person-centered plan (PCP).

002.03 SERVICE DUPLICATION. Medicaid does not cover Waiver services simultaneously provided by two or more paid caregivers for the same service. Services that are available under the State Plan cannot be duplicated by this Waiver.

003. COVERED WAIVER SERVICES. Medicaid services available to persons eligible for this Home and Community-Based Waiver program are:

- (A) Adult Day Health Services (ADHS);
- (B) Assisted Living Service (AL);
- (C) Assistive Technology and Supports, and Home and Vehicle Modifications (ATS, H/VM);
- (D) Chore;
- (E) Extra Care for Children with Disabilities;
- (F) Home Again;
- (G) Home-Delivered Meals;
- (H) Independence Skills Building;
- (I) Non-Medical Transportation;
- (J) Personal Emergency Response System (PERS); and
- (K) Respite Care

003.01 ADULT DAY HEALTH SERVICES (ADHS).

003.01(A) SERVICE DESCRIPTION. Adult Day Health Services (ADHS) is a service which allows for structured social, and health activities. It may:

- (i) Offer socialization;
- (ii) Aid in transition from one living arrangement to another;
- (iii) Provide a supervised environment while the regular caregiver is working or otherwise unavailable; or
- (iv) Provide a setting for receipt of multiple health services in a coordinated setting.

003.01(B) LOCATION AND TIME. Adult Day Health Service (ADHS) is provided outside of the participant's place of residence for a period of four or more hours daily, but less than 24 hours. Adult Day Health Service (ADHS) may be occasionally provided to a participant for less than four hours in a day when the participant must leave the adult day program due to an emergency or illness.

003.01(C) CONDITIONS OF PROVISION.

003.01(C)(i) SERVICE COMPONENTS. Providers must offer, or make available through arrangements with community agencies or individuals, each of the services listed below, which are required to meet the needs identified in the person-centered plan (PCP). Depending on the participant's assessed needs, and participant preferences, these services include:

- (1) PERSONAL CARE SERVICES. Services to address limitations in activities of daily living (ADL). Assistance with activities of daily living (ADL) will be provided by staff and supervised by a licensed nurse. Personal care services must be provided to each participant regardless of whether it is specifically identified in the person-centered plan (PCP);
- (2) HEALTH ASSESSMENT AND NURSING SERVICE. Service includes observation of changes in participant health and notification of family and doctors, health education and counseling, skilled nursing care, and administration of medications, whether done by staff or by the participant. Health assessment and nursing services must be provided to each participant regardless of whether it is specifically identified in the person-centered plan (PCP);
- (3) MEAL SERVICES. Meal services include preparation and serving of at least one daily meal. Menus must be planned by staff or a contracted individual who has knowledge of dietetic requirements and nutrition. If a dietitian is not on staff, one staff person must be designated as responsible for food service. Each participant must be provided with a noon meal if the participant attends at mealtime. This meal must include at least one-third of the daily dietary allowance required for adults. Each participant who is in attendance for a full day must also be provided with two snacks daily which are controlled for sugar, salt, and cholesterol levels, as appropriate. Special diets must be provided according to the individual participant's plan. Meal services must be provided to each participant regardless of whether it is specifically identified in the person-centered plan (PCP);
- (4) RECREATIONAL THERAPY. Recreational therapy includes social and recreational activities. Center staff must provide individual and group activity. The dignity, interests, and therapeutic needs of individual participants must be considered in the development of activity programs. Recreation therapy

must be provided to each participant when it is specifically identified in the person-centered plan (PCP);

- (5) SUPPORTIVE SERVICES. Supportive services include individual and group programs provided to participants and their families in the following areas: coping skills, and personal, social, family, and adjustment problems. Supportive Services may be provided only by a certified social worker, certified professional counselor, or a certified master social worker. Supportive services must be provided to each participant when it is specifically identified in the person-centered plan (PCP); and
- (6) OTHER ACTIVITIES. The provider must ensure that the program offers a balance of activities to meet each participant's needs and interests. Participants are encouraged to engage in activities, but are free to decline. Other activities must be provided to each participant when it is specifically identified in the person-centered plan (PCP).

003.01(C)(ii) SCHOOL SYSTEM SERVICES. No service which is the responsibility of the school system may be provided under the Waiver. Adult Day Health Services (ADHS) will not be authorized for the hours set forth in the school district's days and hours of regular attendance.

003.01(C)(iii) ADULT DAY HEALTH SERVICES (ADHS) PLAN. In addition to the person-centered plan (PCP) the provider must ensure that there is a written plan for each participant. The written plan must be jointly developed with the participant and services coordinator and must include the participant's strengths, needs, and desired outcomes as they pertain to Adult Day Health Services (ADHS), a plan to meet the needs and desired outcomes, and Adult Day Health Services (ADHS) components to be provided. The plan must also include an up-to-date listing of the participant's current medications and treatments, emergency contact information, any special dietary requirements, a description of any limitations to participate in activities, and any recommendations for special therapies. Provider staff must, together with the participant and services coordinator, review and revise the plan as appropriate, but at least semiannually. A copy must be submitted to the participant's services coordinator.

003.02 ASSISTED LIVING SERVICE.

003.02(A) SERVICE DESCRIPTION. Assisted living is an array of support services that promote participant self-direction and participation in decisions which incorporate respect, independence, individuality, privacy, and dignity in a home environment. These services include assistance with or provision of personal care activities, activities of daily living (ADL), instrumental activities of daily living (IADL), and health maintenance.

003.02(B) CONDITIONS OF PROVISION.

003.02(B)(i) SERVICE COMPONENTS. Providers must offer and make available each of the services listed below, which are required to meet the needs identified in the person-centered plan (PCP). Depending on the participant's assessed needs, and participant preferences, these services include:

- (1) SOCIALIZATION ACTIVITIES. Structured social and health activities geared for the needs of the participants identified in the person-centered plan (PCP). The assisted living (AL) provider must ~~provide ensure that~~ socialization activities ~~are provided both~~ in the assisted living setting and ~~provide information on activities available~~ in the community. Socialization activities must be offered to each participant regardless of whether it is specifically identified in the person-centered plan (PCP);
- (2) ESCORT SERVICES. Accompanying or personally assisting a participant who is unable to travel or wait alone, unless the participant has made their own arrangements for assistance. This may include assistance to and from a vehicle and place of local destination. This may also include providing, or making arrangements for supervision and support to the participant while away from the assisted living setting, as determined on an individual basis, and specified in the person-centered plan (PCP). The escort will remain with the participant until the participant is returned to the assisted living setting. Escort services must be provided to each participant when it is specifically identified in the person-centered plan (PCP);
- (3) ESSENTIAL SHOPPING. Obtaining clothing and personal care items for the participant when the client is unable to do so. This does not include financing the purchases of clothing and personal care items. Essential shopping must be provided to each participant when it is specifically identified in the person-centered plan (PCP);
- (4) HEALTH MAINTENANCE ACTIVITIES. Non-complex interventions which can safely be performed according to exact directions, which do not require alterations of standard procedure, and for which the results and participant's responses are predictable which includes but is not limited to: recording height and weight, monitoring blood pressure, monitoring blood sugar, and providing insulin injections as long as the participant is stable and predictable. Health maintenance activities must be provided to each participant when it is specifically identified in the person-centered plan (PCP);
- (5) HOUSEKEEPING ACTIVITIES. Cleaning of public areas as well as a participant's private residence, such as dusting, vacuuming, cleaning floors, cleaning of bathroom and making and changing of the bed. Bed linens must be changed when soiled, but at least weekly. Clean bath linens must be made available daily. A participant must be provided the opportunity to participate, or perform, housekeeping activities as permitted by their mental or physical ability. Housekeeping activities must be provided to each participant regardless of whether it is specifically identified in the person-centered plan (PCP);
- (6) LAUNDRY SERVICES. Washing, drying, folding and returning participant's clothing to their room. Dry cleaning is the responsibility of the participant but the facility will assist the participant in arranging for this service if needed. A participant must be provided the opportunity to participate, or perform, laundry services as permitted by their mental or physical ability. Laundry services must be provided to each client regardless of whether it is specifically identified in the person-centered plan (PCP);

- (7) MEDICATION ASSISTANCE. Assistance with the administration of prescription and nonprescription medications must be provided at the participant's requested location. If the participant cannot self-administer medication, the assisted living (AL) provider must provide written notice to the participant identifying the recommended pharmacy used by the assisted living (AL) provider. In compliance with State licensure requirements, if the provider has notified the participant ~~prior to~~ ~~upon~~ admission, or within 30 days in advance of a change, that the facility contracts with a specific pharmacy provider, the participant's choice of pharmacy requirement is considered met. If the participant is able to self-administer medication, the participant may choose their pharmacy provider. The appropriate level of medication assistance is determined on an individual basis as described in 175 NAC 4-000. The assisted living (AL) provider's level of involvement with the participant's medication must be strictly limited to those items and services identified in the person-centered plan (PCP);
- (8) PERSONAL CARE SERVICES. Personal care will be provided to the participant in a manner in which the individual maintains as much independence and privacy as possible. Personal Care services must be provided to each participant when it is specifically identified in the ~~person-centered plan (PCP)~~ resident service agreement (RSA). The assisted living (AL) provider must provide assistance with ~~all any of the following~~ activities of daily living (ADLs) ~~that are identified in the resident service agreement (RSA) or the person-centered plan (PCP).~~
- (a) EATING. The facility must ~~also~~ provide assistance with eating. Assistance with eating includes opening packages, cutting food, adding condiments, and other activities which the participant is unable to perform for their self in preparing to eat the food. If the participant is unable to eat independently, the facility will feed the participant or will assure other arrangements are made for this care; ~~and~~
- (b) BATHING. Participant preferences with respect to the bathing schedule must be taken into consideration by the assisted living (AL) provider. The assisted living (AL) provider may not charge fees for additional baths needed if they exceed the number stated in the Resident Service Agreement (RSA); ~~and~~
- (c) MOBILITY. Assistance with moving from place to place indoors or outside;
- (d) DRESSING/GROOMING. Assistance with putting on and removing clothing as needed from upper and lower body. Assistance with routine daily personal hygiene;
- (e) TOILETING. Assistance with getting to and from the toilet, including transfer to and from the toilet, management of clothing, and cleansing;
- (f) TRANSFERRING. Assistance with moving from one place to another including bed to chair and back, and into and out of a vehicle; and
- (g) CONTINENCE. Assistance with changing incontinence briefs or pads, cleansing, and disposing of soiled articles.
- (9) TRANSPORTATION SERVICES. The assisted living (AL) provider must provide transportation services based on the needs of each participant. Based on participant need, each month the assisted living (AL) provider must

directly provide a minimum of five round trips to medical appointments. Medical transportation for round trips in excess of 50 miles and round trips in excess of five per month may be approved for additional reimbursement. The assisted living (AL) provider must also ~~make reasonable accommodation for~~ ~~provide~~ round trip transportation for ~~activities and resources identified in the participant's person-centered plan (PCP) non-medical appointments.~~ The assisted living (AL) provider must ~~make a reasonable attempt to~~ assist with making arrangements for any transportation that exceeds the minimum requirements. Transportation services must be provided to each participant regardless of whether it is specifically identified in the person-centered plan (PCP).

003.02(B)(ii) RESIDENT SERVICE AGREEMENT (RSA). The assisted living (AL) provider must have a Resident Service Agreement (RSA) for each participant, which must include, at a minimum:

- (1) LEASE AGREEMENT. The assisted living (AL) provider and the participant must enter into an agreement which incorporates the following requirements:
 - (a) The lease agreement must be consented to by both the individual and the assisted living provider;
 - (b) The lease agreement must, at a minimum, comply with assisted living facility licensure requirements in 175 NAC 4-000, including eviction protections;
 - (c) Unless otherwise specified in the individual service plan, a statement that the individual:
 - (i) Has a right to select their roommate;
 - (ii) Has a right to privacy and security including a means to access to their own living unit;
 - (iii) Has a right to decorate their living unit;
 - (iv) Has a right to have visitors of their choosing at any time;
 - (v) Has the freedom and support to control their own schedule and activities; and
 - (vi) Has a right to access food at any time.
 - (d) Each provider owned and operated setting must be physically accessible to the individual.
- (2) ~~RESIDENT SERVICE AGREEMENT (RSA) PERSON-CENTERED PLAN (PCP).~~ The provider must ensure that there is a written ~~resident service agreement (RSA) plan~~ for each participant. The ~~agreement plan~~ must also include an up-to-date listing of the participant's current medications and treatments, any special dietary requirements, and a description of any limitations to participate in activities. Assisted living staff will, together with the participant and services coordinator, review and revise the ~~resident service agreement (RSA) person-centered plan (PCP)~~ as appropriate, but at least annually. If an assisted living (AL) provider or the services coordinator determines that a participant's needs are beyond the assisted living provider's capabilities or capacities to meet the participant's needs, the assisted living (AL) provider, the services coordinator and the participant will initiate alternative arrangements. Both a copy of the

original resident service agreement (RSA) person-centered plan (PCP), and any subsequent revisions to the resident service agreement (RSA) person-centered plan (PCP), must be submitted to the participant's services coordinator.

- (3) MEALS. The assisted living (AL) provider must furnish three meals per day seven days per week. The meals are furnished as part of the resident's room and board costs paid to the facility. Each meal must consist of a variety of properly prepared foods containing at least one-third of the Minimum Daily Nutritional Requirements for adults, and take into account cultural and personal preference for foods served at specific times of day.

003.02(B)(iii) MODIFICATION OF CONDITIONS. Any modification of the lease agreement conditions, as outlined in this chapter, must be supported by a specific assessed need and justified in the person-centered plan (PCP). The following requirements must be documented in the person-centered plan (PCP):

- (1) Identify a specific and individualized assessed need;
- (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan;
- (3) Document less intrusive methods of meeting the need that have been tried but did not work;
- (4) Include a clear description of the condition that is directly proportionate to the specific assessed need;
- (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification;
- (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; and
- (7) Include the informed consent of the individual.

003.03 ASSISTIVE TECHNOLOGY SUPPORTS AND HOME AND VEHICLE MODIFICATIONS (ATS, H/VM).

003.03(A) SERVICE DESCRIPTION.

003.03(A)(i) ASSISTIVE TECHNOLOGY SUPPORTS (ATS). Specialized equipment and supplies that enable a participant to increase, maintain, or improve their functional capacities. It includes the evaluation and purchasing, but not leasing, of the assistive technology. It includes selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing the assistive technology device and any training or technical assistance for the participant and family members, guardians, and other interested parties.

003.03(A)(ii) HOME AND VEHICLE MODIFICATIONS (H/VM). The physical adaptations to the primary residence, automobile, or van of the participant or participant's family to accommodate the participant or improve their function.

003.03(B) CONDITIONS OF PROVISION. Consultation and determination of the available options for Assistive Technology Supports (ATS) and Home and Vehicle

Modifications (H/VM) are provided by the Nebraska Department of Education Assistive Technology Partnership (ATP).

003.03(B)(i) ASSISTIVE TECHNOLOGY SUPPORTS (ATS), HOME AND VEHICLE MODIFICATION (H/VM) STANDARDS. All items and assistive equipment must meet applicable standards of manufacture, design, and installation. All general contractors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate licenses and certifications. Home modifications will be provided in accordance with applicable local and state building codes.

003.03(B)(ii) EXCLUDED SERVICE COMPONENTS. The following list of items are excluded from eligibility for this service:

(1) HOME MODIFICATIONS.

(a) General utility and home repairs;

(b) Standard housing obligations:

(i) Carpeting;

(ii) Roof repair;

(iii) Sidewalks;

(iv) Storage and organizers;

(v) Hot tubs;

(vi) Whirlpool tubs; and

(vii) Landscaping;

(c) General construction costs in a new home or additions to a home purchased after enrollment in the Waiver;

(d) Adaptations that add to the total square footage of the home except when necessary to complete an adaptation such as, in order to improve entrance or egress to a residence or to configure a bathroom to accommodate a wheelchair;

(e) Improvements exclusively required to meet local building codes; and

(f) Adaptations to assisted living apartments.

(2) ASSISTIVE TECHNOLOGY SUPPORTS.

(a) Supports not directly benefiting the participant medically or physically; and

(b) Durable medical equipment.

003.04 CHORE SERVICES.

003.04(A) SERVICE DESCRIPTION. Chore is a service for adults which includes general household activities necessary for maintaining and operating the participant's home when the participant is unable to perform these activities. Chore activities provided are limited to those activities that are required to maintain the participant's health and safety. Chore is comprised of the following components:

(i) Personal care service and supervision;

(ii) Bill paying, errand service, essential shopping, food preparation, laundry service, and supervision light housekeeping, and communication; and

(iii) Heavy household chores: simple home repairs and maintenance, housekeeping activities.

003.04(B) CONDITIONS OF PROVISION.

003.04(B)(i) CHORE ACTIVITIES. The following chore activities are those which could normally be performed by the participant ~~if the participant did not have a disability or chronic condition, but which the participant is presently unable to perform.~~ Each activity provides assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or supervision. The need for each activity must be identified during participant assessment.

- (1) BILL PAYING. Assisting participants to organize ~~finances~~ and pay bills if necessary;
- (2) ERRAND SERVICE. Providing service in relation to needs described for escort service when not generally accompanied by the participant. If the participant does accompany the provider, the provider cannot bill an additional amount for transportation;
- (3) ESSENTIAL SHOPPING. Obtaining food, clothing, housing, or personal care items;
- (4) FOOD PREPARATION. Preparing meals necessary to maintain independence. The participant must provide necessary meal preparation supplies;
- (5) LAUNDRY SERVICE. Washing, drying, ironing, folding, and storing laundry in the participant's home; or utilizing laundromat services on behalf of the participant. The participant must provide soap and machine-use fees;
- (6) ~~LIGHT HOUSEKEEPING. Dusting, wiping off counters, sweeping and mopping floors, take out trash, vacuuming;~~
- (7) ~~COMMUNICATION. Assist participant with using a phone, computer, or device of the participant's choice for their means of communication;~~
- (86) PERSONAL CARE SERVICE. Providing basic personal care and grooming including bathing, shaving, shampooing, assisting with dressing, ambulation, and toileting, ~~continency, transferring, eating, and mobility;~~ and
- (97) SUPERVISION. Engaging with the participant for part of a day when the participant would otherwise be alone. Tasks can include but are not limited to: ~~cues and reminders,~~ performing non-medical activities necessary to provide for the safety and comfort of the participant, accompanying the participant to appointments to assist with activities of daily living (ADL) needs, being present in the home and providing assistance to the participant due to safety concerns related to unsafe exit seeking secondary to dementia or other memory impairment, or monitoring to ensure participant does not choke while eating.

003.04(B)(ii) HEAVY HOUSEHOLD CHORES. The following heavy household chore activities are those which occur less frequently than previous activities listed but assist with ensuring the health and safety of the participant in their own home. If the participant lives in a rental property, the lease agreement will be reviewed to determine the responsibilities of the landlord to provide repairs or maintenance.

- (1) HOUSEKEEPING ACTIVITIES. In-home cleaning and care of household equipment, appliances, or furnishings. The participant must provide necessary supplies;
- (2) REPAIRS. Providing minor repair of windows, screens, steps or ramps, furnishings, and household equipment; and
- (3) LANDSCAPING. Mowing, raking, removing trash (to garbage pickup point), removing snow and ice, pest remediation, and cleaning water of drains may

also be provided. Mowing is limited to that which is necessary to meet the health and safety of the participant and to meet local codes.

003.05 EXTRA CARE FOR CHILDREN WITH DISABILITIES.

003.05(A) SERVICE DESCRIPTION. Extra Care for Children with Disabilities is that portion of child care provided to children related to their medical and disability-related needs. Extra Care for Children with Disabilities is provided to children from birth through age 17 on the average of less than 12 hours per day, but more than two hours per week on a regular basis, in lieu of caregiver supervision. Care is provided in a child's home by an approved provider or in a setting approved or licensed by the Department. The parent or primary caregiver is responsible for the basic cost of routine child care. Payment of the service above the basic cost of routine child care is covered in accordance with the person centered plan (PCP).

003.05(B) CONDITIONS OF PROVISION. Extra Care for Children with Disabilities is only available while the usual caregiver is unavailable, and in the case with multiple caregivers, all must be simultaneously unavailable. Caregiver unavailability must be related to care for the child during their working, vocational or educational attendance hours. Extra Care for Children with Disabilities only allows the usual caregiver to:

- (i) ACCEPT OR MAINTAIN EMPLOYMENT. Extra Care for Children with Disabilities expenditures must be equal to or less than employment wages and benefits received by the usual caregiver. Parents who receive Extra Care for Children with Disabilities service to maintain employment and are self-employed or employed part-time may be required to submit income documentation. The average monthly income shown must meet or exceed the projected average Extra Care for Children with Disabilities Medicaid costs. An exception may be granted when there are extenuating circumstances, which may include but are not limited to self-employment income verified by an annual tax return which also reflects business expenses or losses. Goods or services received in place of wages are not considered in comparison of costs. Verification of the hours and schedule of employment is required. Persons who are self-employed must provide a statement of hours worked;
- (ii) SEEK EMPLOYMENT. To meet this need, Extra Care for Children with Disabilities may be authorized up to 12 hours per week. Parents who receive Extra Care for Children with Disabilities service to seek employment may be required to submit documentation evidencing that they are actively engaged in a search for employment; or
- (iii) EDUCATIONAL ACTIVITIES. Enroll in and attend in-person, regularly scheduled vocational or educational training to attain a high school or equivalent diploma or an undergraduate degree or certificate. Verification of class schedule is required. This excludes students pursuing second undergraduate degrees and any graduate degree or higher. Exclusion also applies to second certificates or licenses, or classes to maintain a professional certificate or license. Extra Care for Children with Disabilities cannot be authorized to provide study time for vocational or educational training. Online classes are not considered in-person attendance.

003.05(C) SCHOOL SYSTEM SERVICES. No service which is the responsibility of the school system may be provided under the Waiver. Extra Care for Children with Disabilities services will not be authorized for the hours set forth in the school district's days and hours of regular attendance.

003.05(C)(i) EXCEPTION. A participant's school attendance schedule may be outlined in the Individual Education Plan (IEP) and vary from the school district's normal operating hours in the event the participant is homebound due to medical reasons.

003.065 HOME AGAIN SERVICE.

003.065(A) SERVICE DESCRIPTION. Home Again service is available to support and enable Medicaid-eligible nursing facility residents to move to a more independent living situation of their choice. Items and services covered include but are not limited to:

- (i) Furniture, furnishings, and household supplies;
- (ii) Security deposits, utility installation fees or deposits; and
- (iii) Moving expenses.

003.065(B) NEED FOR SERVICE. All items and services covered must be essential to:

- (i) Ensure that the person is able to transition from the current nursing facility; and
- (ii) Remove identified barriers or risks to the success of the transition to a more independent living situation.

003.065(C) PERSONS ELIGIBLE. To receive this service, a person aged 18 or older must be a current nursing facility resident whose nursing facility services have been paid by Medicaid for at least three months. Persons whose nursing facility stay is rehabilitative are not eligible for this service.

003.065(D) ITEMS AND SERVICES COVERED. All covered items become the property of the participant. Any prior-authorized transition expenses incurred in good faith will be covered by the program even if the transition does not ultimately occur due to unforeseen circumstances, including but not limited to the participant experiencing a medical emergency. The participant may be authorized for services in one or more of the following areas:

- (i) Essential furniture, appliances, furnishings, and household supplies;
- (ii) Deposits and fees such as security, utility, application, and installation;
- (iii) Moving expenses;
- (iv) Assistance from a Home Again Sponsor; and
- (v) Expenses for other services or items related to the move which are essential to remove barriers to the transition or its success. Approval of services or items are strictly at the discretion of the Department.

003.065(E) ITEMS AND SERVICES NOT COVERED.

- (i) Rent;
- (ii) Items or services that are not essential to supporting the move or ensuring its success;

- (iii) Items or services that are available through the Medicaid state plan or through another service of this Waiver program;
- (iv) Items are services that are available at no cost from relatives, friends, or any other source; or
- (v) Items or services that are the responsibility of the assisted living (AL) provider or included in the participant's public assistance budget.

003.065(F) SERVICE DURATION. Home Again services may be authorized only once during a 12 month period. The authorization period for Home Again services may begin as soon as the participant, Services Coordinator, and nursing facility staff agree that a discharge plan indicates a move to a more independent setting. Expenditures may be authorized up to 60 days in advance of the planned move date and for 30 days after the actual move date.

003.065(G) HOME AGAIN SPONSOR. Each participant eligible for Home Again service must have a designated Home Again sponsor. The role of the sponsor includes but is not limited to:

- (i) Assisting the participant as necessary to locate and procure accessible, affordable housing;
- (ii) Providing support in dealing with the changes related to the transition move; and
- (iii) Providing the up-front funding to obtain the essential items and services included in the person-centered plan (PCP).

003.065(H) HOME AGAIN SPONSOR STANDARDS. A Home Again sponsor may be an individual, a business, an organization or an agency. In addition to the general standards for all Waiver providers, a Home Again sponsor must:

- (i) Recognize and support the participant choice in selection of items and services provided through this service;
- (ii) Have experience in carrying out activities related to locating housing and setting up a household; and
- (iii) Assure that any vehicle and driver transporting a participant to look for housing or other transition need meets applicable licensing and safety laws and regulations.

003.076 HOME-DELIVERED MEALS.

003.06(A) SERVICE DESCRIPTION. Home-Delivered meals is a service for adults which provides a meal prepared outside the participant's residence and delivered to the participant's residence. Each meal must consist of a variety of properly prepared foods containing at least one-third of the Minimum Daily Nutritional Requirements for adults. Service may not include a full daily nutritional regimen.

003.076(B) CONDITIONS OF PROVISION. The need for home-delivered meals is jointly determined by the services coordinator and the participant. Home-delivered meals must:

- (i) Be delivered on an established schedule;
- (ii) Be transported and delivered using utensils and equipment which are sanitary and maintain proper food temperatures. Thermos-type containers and disposable or serving dishes which can be sterilized must be used;

- (iii) Reflect the general dietary needs of persons who are aged or have disabilities, as well as the specific dietary needs of each participant; and
- (iv) Contain one-third of the minimum daily nutrition requirement per meal for adults using a variety of foods from day-to-day; and
- (v) Not duplicate a meal also provided as a congregate meal.

003.087 INDEPENDENCE SKILLS BUILDING.

003.087(A) SERVICE DESCRIPTION. Independence Skills Building is training for aged persons and adults and children with disabilities in activities of daily living (ADLs), instrumental activities of daily living (IADLs), and home management to increase independence. It may be provided to the participant and to a primary caregiver to promote independence of the participant. Training may occur in the participant's home or in the community, and may be provided individually or in a group setting. This service differs from chore because it involves training the participant or caregiver, not the actual provision of completing the activities of daily living (ADL) or instrumental activities of daily living (IADL).

003.087(B) CONDITIONS OF PROVISION. Independence Skills Building training is provided to the participant or the participant's caregiver as indicated in the participant's person-centered plan (PCP). Independence Skills Building training will be provided in the most appropriate setting to meet the participant's needs. Participants must not reside with their Independence Skills Building providers.

003.087(B)(i) EXCLUSIONS. Independence Skills Building services cannot be authorized for the following reasons:

- (1) When the public school system or rehabilitation services are responsible for providing training for independent living; and
- (2) When the training would fall in any of the following categories:
 - (a) Basic education or academic remedial training to acquire the general educational background, knowledge and skills to prepare for vocational training;
 - (b) Work adjustment training to acquire work habits, work tolerance, or on-the-job behaviors essential to employment;
 - (c) Vocational training to acquire knowledge and skills essential to performing tasks involved in an occupation; or
 - (d) Training which can only be performed by licensed audiologists, hearing aid dealers, occupational therapists, optometrists, physical therapists, speech pathologists, and other related health care professionals.

003.087(B)(ii) TERMINATION OF INDEPENDENCE SKILLS BUILDING. Independence Skills Building services will be terminated when:

- (1) The outcomes identified in the participant's Independence Skills Building (ISB) Plan have been achieved; or
- (2) No measurable progress has been demonstrated.

003.09 NON-MEDICAL TRANSPORTATION.

003.09(A) SERVICE DESCRIPTION. Non-medical transportation service is transporting a participant age 19 or older to and from community resources identified during participant assessment as directly contributing to the ability of the individual to remain at home. This service may be provided by an individual, agency (exempt transportation provider), or by common carrier. This service includes:

- (i) Transportation to and from other Waiver services;
- (ii) Transportation to community activities where Waiver services are not provided;
- (iii) The purchase of public transit tokens or passes; or
- (iv) Escorting a participant to non-medical activities or appointments. Not eligible to bill for Chore service while providing non-medical escort.

003.09(B) ELIGIBILITY. Eligibility for non-medical transportation participant will be met by one of the following criteria:

- (i) Participant does not own or does not have access to a working licensed vehicle;
- (ii) Participant does not have a current valid driver's license;
- (iii) Participant is unable to drive due to a documented physical, cognitive, or developmental limitation;
- (iv) Participant is unable to travel or wait by alone due to a documented physical, cognitive, or developmental limitation; or
- (v) Participant is unable to secure free transportation.

003.09(C) CONDITIONS OF PROVISION. Non-medical transportation is covered by this Waiver program for the following assessed needs:

- (i) APPLY FOR BENEFITS. To allow the participant to apply or be recertified for benefits and services when an in-person interview is required for programs:
 - (1) Nebraska Department of Health and Human Services;
 - (2) Social Security Administration; or
 - (3) Veteran's Administration.
- (ii) SHOP FOR FOOD AND ESSENTIAL ITEMS. To allow a participant to shop for food and essential items a maximum of one round trip per calendar week;
- (iii) OBTAIN LEGAL SERVICES. To allow the participant to receive legal counsel from legal aid societies, private attorneys, county attorneys and other professional legal sources for non-criminal matters a maximum of one round trip per calendar month;
- (iv) OBTAIN FINANCIAL SERVICES. To allow the participant to take care of financial matters at a banking institution a maximum of one round trip per calendar month;
- (v) ACCESS WAIVER SERVICES. To allow the participant transportation to and from Adult Day Health Services (ADHS) or Independence Skills Building (ISB);
- (vi) SECURE HOUSING. To allow a participant to tour and secure adequate housing or an independent living arrangement. Authorization is allowed for a maximum of five round trips in any 12 month period. Additional trips may be authorized if the participant's health and safety is jeopardized;
- (vii) ACCESS COMMUNITY ACTIVITIES. To allow participant transportation to and from activities of their choosing to promote community integration. A maximum of one round trip per week;
- (viii) ACCESS WORK. To allow the participant transportation to and from work when public transportation is not available or accessible; and

- (ix) EDUCATIONAL ACTIVITIES. Enroll in and attend in-person, scheduled vocational or educational training to attain a general education development (GED) or an undergraduate degree or certificate. This excludes students pursuing second undergraduate degrees, second certificates or licenses, and any graduate degree or higher. Verification of class schedule is required. Online classes are not considered in-person attendance. Transportation may not be authorized to obtain educational services offered by a local school district for persons aged 20 or younger.

003.10 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS).

003.10(A) SERVICE DESCRIPTION. Personal Emergency Response Systems (PERS) provides participants 19 years or older immediate access to emergency help at any time through communication connection systems.

003.10(B) CONDITIONS OF PROVISION. The participant's cognitive and physical ability to use the Personal Emergency Response Services (PERS) devices must be jointly determined by the services coordinator and the participant.

003.11 RESPITE CARE.

003.11(A) SERVICE DESCRIPTION. Respite Care is temporary care to relieve the usual caregiver from continuous support and care responsibilities. Respite care may be provided in the participant's home or out of the home. If respite is provided by a hospital or other facility, the individual is not considered a facility resident. Components of respite care service are supervision, tasks related to the individual's physical needs, tasks related to the individual's psychological needs, and social or recreational activities.

003.11(B) CONDITIONS OF PROVISION. Medicaid Waiver coverage of respite care is limited by an annual maximum of either days or hours, as determined by the Department. Respite care may be authorized for one or more of the following situations:

- (i) An emergency or crisis arises which:
 - (1) Requires the usual caregiver's absence; or
 - (2) Places an unusual amount of stress on the usual caregiver;
- (ii) The usual caregiver requires health services including but not limited to: dental care, doctor appointments, hospitalization, or temporary incapacity of caregiver;
- (iii) The usual caregiver needs relief for regular, prescheduled, personal activities including but not limited to: time to study, religious services, grocery shopping, or club meetings;
- (iv) The usual caregiver requires irregular periods of "time out" for rest and relaxation;
or
- (v) Usual caregiver vacations.

003.11(C) EXCEPTIONS TO PROVISION. Respite care may not be used to allow the usual caregiver to accept or maintain employment or attend educational training designed to fit the participant for paid employment or professional advancement.

DRAFT
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NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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003.11(D) ANNUAL LIMITS. Authorization of respite care is subject to an annual limit in hours. The annual limit is determined by the Department.

_____ TITLE 480
_____ HOME AND COMMUNITY-BASED WAIVER SERVICES
_____ FOR AGED PERSONS OR ADULTS OR CHILDREN WITH DISABILITIES

Chapter 5 Home and Community-Based Waiver Services for Aged Persons or Adults or Children With Disabilities

5-001 INTRODUCTION

A. GENERAL INTRODUCTION

Home and community-based waiver services offer eligible persons a choice between entering a Nursing Facility (NF) or receiving supportive services in their homes. Medicaid funding through the Nebraska Medical Assistance Program (NMAP) is used to fund either service option. The average cost of waiver services funded by Medicaid must not exceed the average cost to Medicaid for NF services.

To be eligible for support through this "Aged and Disabled Waiver," a potential client must meet the following general criteria:

1. Have care needs equal to those of Medicaid-funded residents in Nursing Facilities;
2. Be eligible for Medicaid; and
3. Work with the services coordinator to develop an outcome-based, cost effective service plan.

B. PHILOSOPHICAL BASE

Waiver services build on client/family strengths and are intended to strengthen and support informal and formal services already in place to meet the needs of the client and are not intended to replace them.

Waiver services utilize a self-directed services philosophy and vision that holds that each client has the right and responsibility to participate to the greatest extent possible in the development and implementation of his/her service plan.

The services coordinator and the client together shall identify appropriate levels of services coordination by considering risk factors or capacity to direct their own services. The services coordination levels include:

- ! Self-Directed Services Coordination
- ! Supportive Services Coordination
- ! Comprehensive Services Coordination

Elements in the following areas shall be considered to determine the level of services coordination both initially and as service levels change:

1. ~~Determination of strengths, priorities, and resources.~~
2. ~~Planning for services.~~
3. ~~Connecting with needed services.~~
4. ~~Advocacy.~~
5. ~~Monitoring.~~

C. ADMINISTRATION

The Health and Human Services (HHS) System administers Nebraska's Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities. Administrative activities include—

1. ~~Obtaining waiver approval and reapproval from the Health Care Financing Administration (HCFA);~~
2. ~~Establishing policies and procedures to implement the waiver;~~
3. ~~Developing and maintaining a priority process for access to the waiver;~~
4. ~~Determining children's level of care eligibility for the waiver;~~
5. ~~Monitoring expenditures under the waiver;~~
6. ~~Developing and maintaining a quality assurance process for the waiver;~~
7. ~~Performing on-site reviews to determine compliance with waiver requirements;~~
8. ~~Performing case record reviews;~~
9. ~~Maintaining statistics;~~
10. ~~Conducting training;~~
11. ~~Providing technical assistance and consultation;~~
12. ~~Processing billings for services provided; and~~
13. ~~Reporting required data to HCFA.~~

D. IMPLEMENTATION

1. ~~Services coordination activities~~

Staff assigned services coordination assume the following responsibilities:

- a. ~~Utilizing the priority process when accepting referrals;~~
- b. ~~Assessing, together with the client, his/her strengths, needs, priorities, and resources;~~
- c. ~~Determining a potential waiver client's eligibility for waiver services;~~
- d. ~~Jointly developing a plan of services and supports with each waiver client;~~
- e. ~~Determining appropriate resources to meet the client's needs and desired outcomes;~~

- f. Determining the estimated total monthly cost of a proposed plan of services and supports and comparing the estimated cost to the Medicaid monthly payment for care in a NF. This dollar amount is referred to as "the ongoing cap";
- g. Offering the client/legal guardian the choice of nursing facility or waiver services;
- h. Arranging for support and services identified in the plan of services and supports, while maintaining the client's freedom of choice in providers;
- i. Authorizing a plan of services and supports for each waiver client;
- j. Contacting, coordinating, and confirming the client's service provision with providers of service;
- k. Coordinating services from all available sources to ensure that client needs and desired outcomes are met;
- l. Working with the client depending upon the level of services coordination needed;
- m. Jointly reviewing needs;
- n. Jointly measuring outcome achievement;
- o. Monitoring ongoing service provision;
- p. Annually reevaluating level of care;
- q. Annually reviewing plan of services and supports;
- r. Assisting the client and the client's Medicaid eligibility staff in tracking spenddown obligation/shared cost;
- s. Monitoring ongoing Medicaid eligibility; and
- t. Providing documentation to support case decisions and actions.

2. Resource development activities

Staff assigned resource development assume the following responsibilities:

- a. Recruiting or locating providers to allow each waiver client's freedom of choice;
- b. Approving and contracting with providers;
- c. Monitoring provider service provision;
- d. Providing narrative documentation; and
- e. Conducting public information activities.

E. GLOSSARY OF TERMS

Adult: For the purposes of Medicaid and this waiver, an individual age 18 or older.

Aged: For the purposes of Medicaid and this waiver, an individual age 65 or older.

Assessment: A process which includes receiving referrals, gathering information, interviewing, and jointly determining client strengths, needs and desired outcomes.

Cap: The average Medicaid monthly expenditure for care in a NF. This dollar amount is referred to as "the cap."

Caregiver: A person who resides with the client and is available on a 24-hour per day basis to assume responsibility for the care and supervision of the client. This may include a caregiver who is employed outside the home if s/he retains "on-call" responsibility while away from the client.

Child: For the purposes of Medicaid and this waiver, an individual age 17 or younger.

Cost Effective: A requirement that the expenditures reflected in the Plan of Services and Supports be within "the cap" and also reflect a service rate appropriate for the client's individualized service need.

Guardian: The biological or adoptive parent of a minor child, or an individual appointed by a court to ensure that an adult's needs are met and well-being is protected.

Institutional Setting: A hospital or a nursing facility.

Nursing Facility (NF): A facility licensed by the Department of Health and Human Services Regulation and Licensure as a nursing facility.

Plan of Services and Supports: A process for providing services and supports that takes into consideration each client's strengths, needs, priorities, and resources and results in an individualized, written plan for each client. This plan describes the full range of services to be furnished (regardless of funding source), their frequency, and the type of provider who will furnish each.

Senior Care Options: Nebraska's NF preadmission screening program for aged persons and Aged and Disabled Waiver services coordination system for eligible persons who choose to explore home care.

Services Coordination: An individualized, goal-oriented process, based on client choices, that makes the best use of resources to maximize independence and attain the level of care that is consistent with the client's level of need. Services coordination is federally referred to as case management.

Slots: Nebraska's quota of waiver clients.

Waiver: Nebraska's Home and Community-Based Waiver for Aged Persons or Adults and Children with Disabilities.

Moved to 480 NAC chapter 2, section 002

5-002 CLIENT ELIGIBILITY CRITERIA

Clients eligible for waiver services must-

1. — Be eligible for the Nebraska Medical Assistance Program (NMAP);
2. — Have participated in an assessment with a services coordinator;
3. — Meet the Nursing Facility (NF) level of care criteria (471 NAC 12-000);
4. — Have care needs which could be met through waiver services at a cost that does not exceed the cap; and
5. — Have received an explanation of NF services and waiver services and elected to receive waiver services.

Waiver services are provided statewide to eligible clients for whom a slot is available. Moved to 480 NAC chapter 3, section 003.01 as modified

5-003 SERVICES COORDINATION PROCESS

Services coordination is an individualized, goal-oriented process, based on client/family choices, that makes the best use of resources to maximize independence and attain the level of care that is consistent with the client's level of need. Waiver services coordination may be provided by HHS staff or, staff under contract with HHS.

A. AGED PERSONS AND ADULTS WITH DISABILITIES

1. ACCESS

PURPOSE: To allow easy entry into the health and human services system for persons who are in need of services.

To allow for multiple entry points into the health and human services system for persons via familiar professionals/sites.

Potential clients access long term care services through either the Department of Health and Human Services, Vocational Rehabilitation Services, Area Agencies on Aging, Independent Living Centers or other community agencies.

2. INTAKE/SCREENING

PURPOSE: To collect information to further identify the potential client's needs, evaluate waiver level of care eligibility, and prioritize the referral.

The services coordinator shall -

a. Accept referrals of potential waiver clients from any source (e.g., the potential client, the potential client's relative, HHS staff, Care Management Unit staff, hospital staff, nursing facility staff, a physician, advocacy agencies).

b. Document the date of referral and gather demographic information.

c. Gather functional information needed to determine whether the potential client meets the NF level of care required for eligibility while interviewing the referral source and/or collateral contacts. This information is gathered in the following assessment categories:

~~(1) Activities of daily living-~~

~~(a) Bathing: The ability to get to the bathing area and cleanse all parts of the body and the hair to maintain proper hygiene and prevent body odor, including tub, shower, and/or sponge bath.~~

~~(b) Continence: The control of one's body to empty the bladder and/or bowel on time; the ability to change incontinence pads/briefs, cleansing, and disposing of soiled articles; ability to manage ostomy equipment; ability to self-catheterize.~~

~~(c) Dressing/Grooming: The ability to put on and remove clothing as needed from both upper and lower body; the ability to do routine daily personal hygiene (combing hair, brushing teeth, caring for dentures, washing face and hands, and shaving).~~

~~(d) Eating: The ability to take nourishment. This may include the act of getting food from the plate to the mouth, and does not include meal preparation.~~

~~(e) Mobility: The ability to move from place to place indoors or outside.~~

~~(f) Toileting: The ability to get to and from the toilet, commode, bedpan, or urinal, including transfer to and from the toilet, management of clothing, and cleansing.~~

~~(g) Transferring: The ability to move from one place to another, including bed to chair and back, and into and out of a vehicle. (It does not include toilet transfer.)~~

~~(2) Risk Factors-~~

~~(a) Behavior: The ability to act on one's own behalf, including the interest or motivation to eat, take medications, care for one's self, safeguard personal safety, participate in social situations, and relate to others in a socially-appropriate manner.~~

~~(b) Frailty: The ability to function independently without the presence of a support person, including good judgment about abilities and combinations of health factors to safeguard well-being and avoid inappropriate safety risk.~~

~~(c) Safety: The availability of adequate housing, including the need for home modification or adaptive equipment to assure safety and accessibility; the existence of a formal and/or informal support system; and/or freedom from abuse or neglect.~~

~~(3) Medical Treatment or Observation~~

~~(a) A medical condition is present which requires observation and assessment to assure evaluation of the individual's need for treatment modification or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self-observe and/or evaluate the need to contact skilled medical professionals; or~~

~~(b) Due to the complexity created by multiple, interrelated medical conditions, the potential for the individual's medical instability is high or exists; or~~

~~(c) The individual requires at least one ongoing medical/nursing service. The following is a non-inclusive list of such services which may, but not necessarily, indicate need for medical or nursing supervision or care:~~

~~(1) Application of aseptic dressing;~~

~~(2) Routine catheter care;~~

~~(3) Respiratory therapy;~~

~~(4) Supervision for adequate nutrition and hydration due to clinical evidence of malnourishment or dehydration or due to a recent history of weight loss or inadequate hydration which, if unsupervised, would be expected to result in malnourishment or dehydration;~~

~~(5) Therapeutic exercise and positioning;~~

~~(6) Routine colostomy or ileostomy care or management of neurogenic bowel and bladder;~~

~~(7) Use of physical (side rails, poseys, locked wards) and/or chemical restraints;~~

~~(8) Routine skin care to prevent pressure ulcers for individuals who are immobile;~~

~~(9) Care of small, uncomplicated pressure ulcers and local skin rashes;~~

~~(10) Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;~~

~~(11) Chemotherapy;~~

~~(12) Radiation;~~

~~(13) Dialysis;~~

~~(14) Suctioning;~~

~~(15) Tracheostomy care;~~

~~(16) Infusion therapy;~~

~~(17) Oxygen;~~

~~(18) Open lesions other than stasis or pressure sores (e.g., cuts);~~

~~(19) Wound care or treatment (e.g., pressure ulcer care, surgical wound);~~

~~(20) Intravenous medications;~~

~~(21) Transfusions;~~

~~(22) Medication monitoring; and/or~~

~~(23) Other special treatment or procedure.~~

~~(4) Cognition~~

- ~~(a) Memory: Ability to remember past and present events; does not need cueing;~~
- ~~(b) Orientation: Fully oriented to person, place, and time.~~
- ~~(c) Communication: Ability to communicate information in an intelligible manner, and the ability to understand information conveyed.~~
- ~~(d) Judgment: Ability to solve problems well and make appropriate decisions.~~

~~The services coordinator may administer a standard mini-mental test, as appropriate, to further identify memory, orientation, and communication limitations. Additional exploration of judgment may also be necessary.~~

~~d. Determine NF level of care.~~

~~Services coordinators collect the above information on each individual seeking NF or waiver services to determine the functional abilities and care needs of that individual. Information may be gathered from a variety of sources (e.g., the individual, family, care providers, physicians, facility staff, case files, medical charts), using observation, documentation review, and/or interview until sufficient information is obtained to determine the individual's current functioning in each area.~~

~~Persons who require assistance, supervision, or care in at least one of the following four categories meet the level of care criteria for Nursing Facility or Aged and Disabled Home and Community-based Waiver services:~~

- ~~I. Limitations in three or more Activities of Daily Living (ADL) AND Medical treatment or observation.~~
- ~~II. Limitations in three or more ADLs AND one or more Risk factors.~~
- ~~III. Limitations in three or more ADLs AND one or more Cognition factors.~~
- ~~IV. Limitations in one or more ADLs AND one or more Cognition AND one or more Risk factors.~~

~~For those clients who meet NF level of care, the services coordinator shall then determine if the client meets priority criteria.~~

~~If the potential client does not meet the NF level of care criteria, the services coordinator shall inform the referral source of this decision and provide notice to the potential client/guardian, if that contact has been made. The services coordinator shall also provide appropriate information and referral. Notices to clients must contain—~~

- ~~(1) A clear statement of the action to be taken;~~
- ~~(2) A clear statement of the reason for the action;~~
- ~~(3) A specific policy reference which supports such action; and~~
- ~~(4) A complete statement of the client's right to appeal.~~ Moved to 480 NAC chapter 3, section 003.02(D) as modified

e. Determine priority.

The services coordinator shall assign priority to potential clients who have been verified as being NF level of care and who are awaiting initial assessment by obtaining sufficient information about client needs and current services using the following criteria:

- (1) Needs in domains which define NF level of care are so severe that the health and welfare of the client are jeopardized, but the needs could safely be met with immediate waiver services;
- (2) Family/caregivers are in a crisis/high stress situation;
- (3) No informal support network is available to meet identified needs;
- (4) Inappropriate out-of-home placement is being planned;
- (5) No other program is available to meet the needs identified in the referral;
- (6) Support services are required to allow the client to return home (e.g., a Medicaid-eligible recipient is ready to be discharged from a hospital);
- (7) A client with an identified waiver service need lacks access to resources to meet needs in domains which define NF level of care AND waiver eligibility is the only method of obtaining Medicaid eligibility; and/or
- (8) A client with an identified waiver service need of Assistive Technology and Supports or Home Modifications lacks access to resources to meet these specific needs AND waiver eligibility is the only method of addressing the identified needs.

Based upon this information, the services coordinator shall determine the priority ranking. Prioritization of need is a process that occurs throughout multiple elements of services coordination from access through determination of strengths, priorities, and resources. Moved to 480 chapter 3, section 003.02(B) as modified

Priority Criteria Met:

~~If the client appears to meet NF level of care criteria and is determined to be a priority referral, the services coordinator shall contact the potential client/guardian to inform him/her that the client is eligible to be assessed for waiver services and obtain an initial request. The services coordinator shall document the date of the request in the case narrative and arrange an assessment visit.~~

~~Note: If the services coordinator has not already done so, s/he shall determine whether the potential client has been determined eligible or has applied for Medicaid. If the client has not applied for Medicaid, the services coordinator shall immediately refer him/her to Medicaid intake.~~

Priority Criteria Not Met:

~~If the potential client does not meet priority criteria, the services coordinator shall inform the referral source of this decision and provide notice to the potential client/guardian, if that contact has been made. The services coordinator shall also provide appropriate information and referral.~~

3. ~~DETERMINATION OF STRENGTHS, PRIORITIES, AND RESOURCES~~

~~**PURPOSE:** To identify the potential client's individual strengths, needs, priorities, and resources so an appropriate plan of services and supports can be developed.~~

~~The services coordinator shall meet in person with the potential client and legal guardian, if any, to confirm the NF level of care determination and to complete an assessment of the potential client's strengths, needs, priorities, and resources. This meeting must be arranged and completed within 14 days of the request date and be held on a date and time convenient to the client/guardian. In emergency situations, the assessment must be completed within 24 hours.~~

~~If the potential client has been assessed using the program's assessment instrument within the past year, the services coordinator may use the previous assessment or obtain a release from the client to request a copy of the completed form to determine whether further assessment is indicated.~~

~~If at any point during the eligibility process, the client/legal guardian chooses NF services instead of waiver services, the services coordinator shall work with appropriate HHS staff to make these arrangements.~~

~~If at any point after the assessment, the client/legal guardian voluntarily withdraws from receiving waiver services, the services coordinator shall provide written notice of ineligibility and also provide appropriate referrals.~~

~~4. PLANNING FOR SERVICES~~

~~PURPOSE: To identify specific individual services to be provided in a coordinated and organized manner.~~

~~The services coordinator shall -~~

~~a. Together with the potential client, develop a plan of services and supports based upon assessment results. This is accomplished by identifying desired client outcomes. Outcomes should occur in one or more of the following NF assessment categories: activities of daily living; high risk factors, joint motion; locomotion; nursing observations; orientation; and medical and nursing needs.~~

~~The plan of services and supports must ensure the potential client's health and welfare, including the consideration of acceptable risk. If, despite consideration of the full range and scope of services, the client's health or welfare is in jeopardy, waiver services may not be provided.~~

~~The potential client has freedom of choice in selecting providers of waiver services. The client's choice of providers is documented in the client's case narrative.~~

~~Copies of the plan of services and supports are distributed to other persons and agencies at the directive, and with the consent of, the client/guardian.~~

~~b. Determine the cost of serving the potential client and determine that the estimated total monthly cost, excluding the costs of Assistive Technology and Supports (ATS) and Home Modifications, does not exceed the ongoing cap. The ongoing cap may change annually.~~

~~Services included in calculating the cost of the plan of services and supports are the Medicaid non-waiver services of home health care, personal care aide, and medical transportation and all ongoing waiver services. ATS and home modifications are one-time or annually-only waiver services and are separately capitated. This separate cap may change annually.~~

~~Ongoing caps established for persons who are partially or completely ventilator dependent may not be exceeded but may change annually.~~

~~The ongoing cap for aged persons who are not partially or completely ventilator dependent may be exceeded by no more than an established average amount per month for no more than six months in a 12-month period. If the cost of the potential client's plan of services and supports does exceed the ongoing cap and does not meet this criteria, the services coordinator shall provide written notice of ineligibility to the client/guardian. The services coordinator shall also provide appropriate information and referral.~~

~~For adults with disabilities who are not partially or completely ventilator dependent, if the estimated monthly cost of the plan of services and supports exceeds the ongoing cap, the services coordinator shall contact HHS Central Office to discuss possible approval to exceed the ongoing cap. Central Office considers the following factors in making this decision and may approve or disapprove the request based upon them:~~

- ~~(1) Client demographics (e.g., living situation, diagnosis, treatment plan, and prognosis);~~
- ~~(2) Health and welfare concerns;~~
- ~~(3) A description of the plan of services and supports;~~
- ~~(4) The costs of the ongoing waiver services (i.e., plan totals aside from home health, personal care aide, ATS, home modifications, and medical transportation);~~
- ~~(5) Available support systems; and~~
- ~~(6) Possible funding shifts to other programs (e.g., Social Services Block Grant).~~

~~If the cost of the potential client's plan of services and supports does exceed the ongoing cap and an exception is not approved, the services coordinator shall provide written notice of ineligibility to the client/guardian. The services coordinator shall also provide appropriate information and referral.~~

~~Note: The ongoing cap for aged persons applies to adults with disabilities when they reach age 65.~~

~~c. Offer the client or his/her guardian the option of accepting NF or waiver services as described in the plan of services and supports, after the client has been determined to meet the NF level of care criteria, an assessment completed, and a plan of services and supports developed. If the client or the guardian chooses to accept waiver services, the services coordinator shall obtain the proper signature on the waiver consent form. The consent form must be signed at initial determination only and remains valid as long as the waiver case is open.~~

~~Note: The waiver consent form is not valid and must not be signed until the client's eligibility for Medicaid has been determined or presumptive waiver eligibility has been established. The client's waiver eligibility period may begin no earlier than the date of the client/guardian's signature on the consent form.~~

~~Presumptive Waiver Eligibility: Waiver eligibility may be presumed for any potential waiver client for whom a signed Medicaid application has been received by Medicaid eligibility staff and when the applicant is willing to cooperate with its completion (e.g., is willing to provide all requested financial records; is willing to pay a spenddown/shared cost, if required). The services coordinator shall contact the Medicaid eligibility staff to determine if it is likely the client will become Medicaid eligible prior to obtaining the client's signature on the consent form. Notation must be made on the consent form indicating presumptive waiver eligibility until a final Medicaid eligibility decision has been made.~~

~~The services coordinator shall have ongoing contact with the Medicaid eligibility staff until a final Medicaid eligibility decision has been made. If the client is determined not to be Medicaid eligible, the services coordinator shall provide written notice, effective immediately, to the client/guardian and also provide appropriate information and referral. Ten-day notice is not allowed.~~

~~Services which may be presumptively authorized are ongoing waiver services and medical transportation. Presumptive authorization for ATS and home modifications is not allowed. Any authorized services shall result in the payment of the provider.~~

~~5. CONNECTING/LINKING NEEDED SERVICES~~

~~PURPOSE: To translate the plan of services and supports into action.~~

~~To locate or develop resources to address identified service gaps.~~

~~To identify and promote an effective/optimum use of community resources.~~

~~The services coordinator shall prior authorize waiver services for up to a 12-month period, based on the plan of services and supports and the results of ongoing monitoring activities. Waiver services may not be authorized until the client's Medicaid eligibility has been determined and the waiver consent form has been signed.~~

~~The services coordinator shall provide a written description to the provider, clearly defining the parameters of service delivery. This must include at least the amount and frequency of service provision, specific service components authorized, and any applicable time limitations. Any applicable conditions or limitations relate solely to the eligibility of the waiver client and program policies and do not constitute an effort to directly control contract performance by the provider.~~

~~6. ADVOCACY~~

~~PURPOSE: To ensure the client's interests and concerns are represented and protected.~~

~~To promote client self-sufficiency and self-advocacy as appropriate.~~

~~To promote community responsiveness to the needs and concerns of clients.~~

~~The services coordinator shall provide timely notices and fully inform the client/guardian of his/her rights and responsibilities. The services coordinator shall also provide encouragement and referral for training to promote client self-directed services, self-sufficiency, and self-advocacy.~~

~~7. MONITORING~~

~~PURPOSE: To continually evaluate the effectiveness of the jointly developed plan of services and supports.~~

~~To ensure quality service delivery.~~

~~The services coordinator shall:~~

- ~~a. Contact the client depending upon the level of services coordination needed. For clients directing their own services and for clients needing supportive services coordination, minimum contact shall be monthly, with at least quarterly in-person visits. For clients needing comprehensive services coordination, minimum contact shall be monthly with in-person visits at least every other month. All in-person contacts shall be at a time, date, and location convenient to the client.~~
- ~~b. Ensure, by both client interview and observation, that the formal and informal supports and services being provided continue to meet the client's needs, and revise the plan of services and supports accordingly.~~
- ~~c. Review the client's needs monthly, including service usage and cost, and revise the plan of services and supports to meet newly identified needs.~~
- ~~d. Review the client's desired outcomes regularly with the client and revise the plan of services and supports to refine action steps to meet previously identified outcomes and develop action steps to meet newly identified outcomes.~~
- ~~e. Maintain regular communication with Medicaid eligibility staff, especially in regard to the client's spenddown/shared cost obligation and ongoing Medicaid eligibility.~~
- ~~f. Determine whether a reassessment of the client's level of care and strengths, needs, and resources is necessary when information is received that the care needs of the client have changed. This determination shall be made within two working days of the receipt of this information. A reassessment may also be initiated based upon the services coordinator's observation of client functioning (either improvement or decline) during a routine services coordinator contact. If a reassessment is completed and the client remains NF level of care, a new plan of services and supports must be developed. The services coordinator shall document any provider change in the case narrative.~~
- ~~g. Review the client's satisfaction with the services provided, reviewing the client's overall health status, and verify that the provider(s) is complying with the requirements of perspective service provision.~~

B. CHILDREN WITH DISABILITIES

1. ACCESS

~~PURPOSE: To allow easy entry into the health and human services system for children with disabilities and their families who are in need of services.~~

~~Children with disabilities and their families access home and community-based services through the Department of Health and Human Services, community agencies, or personnel who provide services for children with disabilities and their families.~~

2. INTAKE/SCREENING

~~PURPOSE: To collect information to further identify the child/family's needs and prioritize the referral.~~

~~The services coordinator shall -~~

~~a. Accept referrals of potential waiver eligible children from any source (e.g., the child's relative, HHS staff, hospital staff, a physician, school staff, advocacy agencies).~~

~~b. Document the date of referral and gather demographic information.~~

~~c. Prioritize needs of children awaiting initial assessment by obtaining sufficient information about child and family needs and current services using the following criteria:~~

~~(1) Needs in NF domains are so severe that the health and welfare of the child are jeopardized, but the needs could safely be met with immediate waiver services;~~

~~(2) Family is in a crisis/high stress situation;~~

~~(3) No informal support network is available to meet identified needs;~~

~~(4) Inappropriate out-of-home placement is being planned;~~

~~(5) No other program is available to meet the needs identified in the referral;~~

~~(6) Support services are required to allow the child to return home (e.g., a Medicaid-eligible child is ready to be discharged from a hospital);~~

~~(7) Family of a child with an identified waiver service need lacks access to resources to meet the child's needs in NF domains AND waiver eligibility is the only method of obtaining Medicaid eligibility; and/or~~

~~(8) A client with an identified waiver service need of Assistive Technology and Supports or Home Modifications whose family lacks access to resources to meet these specific needs AND waiver eligibility is the only method of addressing the identified needs.~~

~~Based on this information, the services coordinator shall determine the priority ranking.~~

If the potential waiver eligible child does not meet priority criteria, the services coordinator shall inform the referral source of this decision and provide notice to the child's guardian, if that contact has been made. The services coordinator shall also provide appropriate information and referral.

d. Contact the child's guardian to inform him/her that the child is eligible to be assessed for waiver services, if the child is determined to be a priority referral, and obtain an initial request. The services coordinator shall document the date of the request in the case narrative and arrange an assessment visit.

Note: If the services coordinator has not already done so, s/he shall determine whether the child has been determined eligible or application has been made for Medicaid. If application has not been made for Medicaid, the services coordinator shall immediately refer the child's guardian to Medicaid intake.

3. DETERMINATION OF STRENGTHS, PRIORITIES, AND RESOURCES.

PURPOSE: To identify the potential waiver eligible child's and family's strengths, needs, priorities, and resources so an appropriate plan of services and supports can be developed.

The services coordinator shall

a. Meet in person with the child and his/her guardian to complete an assessment of the child's and family's strengths, needs, priorities, and resources. This meeting must be arranged and completed within 14 days of the request date and be held on a date and time convenient to the family. In emergency situations, the assessment must be completed within 24 hours.

During the assessment, the services coordinator, together with the child and family, shall begin to develop the plan of services and supports.

The services coordinator may conduct an initial assessment of a child with a contracted nurse as appropriate, when the child's medical condition warrants interdisciplinary assessment. Written authorization for the assessment must be provided to the nurse.

If the child has been assessed using the program's assessment instrument within the past year, the services coordinator may use the previous assessment or obtain a release from the guardian to request a copy of the completed form to determine whether further assessment is indicated.

~~Early Intervention Exception: If an infant or toddler is receiving services coordination through Early Intervention, assessment provided through the Individualized Family Service Plan (IFSP) process substitutes for this and any other subsequent face-to-face assessments. The waiver services coordinator may be involved as a member of the IFSP team or may only offer technical assistance and program-specific support to the Early Intervention services coordinator/family. The Early Intervention services coordinator provides ongoing services coordination and arranges periodic interagency, interdisciplinary review. (See 480 NAC Chapter 10.)~~

~~If, at any point during the eligibility process, the child's guardian chooses NF services instead of waiver services, the services coordinator shall work with appropriate HHS staff to make these arrangements.~~

~~If at any point after the assessment, the parent/guardian voluntarily withdraws from receiving waiver services, the services coordinator shall provide written notice of ineligibility and also provide appropriate referrals.~~

~~b. Gather functional information to determine a child's NF level of care eligibility that reflects the child's developmental level and includes information in the following NF domains:~~

~~(1) Activities of daily living—~~

~~(a) Behavior: The ability to exhibit actions that are developmentally and socially appropriate in the areas of independence, maturation, learning, and social responsibility.~~

~~(b) General hygiene, including:~~

~~(1) Bathing: The ability to get to the bathing area and cleanse all parts of the body and the hair to maintain proper hygiene and prevent body odor, including tub, shower, and/or sponge bath.~~

~~(2) Dressing: The ability to put on and remove clothing, as needed. This includes both upper and lower body.~~

~~(3) Grooming: The ability to do routine daily personal hygiene (combing hair, brushing teeth, and washing face and hands).~~

~~(c) Feeding/eating: The ability to take nourishment. This may include the act of getting food from the plate to the mouth or self-use of mechanical feeding devices.~~

~~(d) Movement, including:—~~

~~(1) Mobility: The ability to move from place to place indoors or outside.~~

~~(2) Transferring: The ability to move from one place to another, including bed to chair and back, and into and out of a vehicle. (Toilet transfer is not included.)~~

~~(e) Sight: The ability to visualize or see, especially one's environment. This may include the use of glasses, contacts, prisms, or other adaptive devices.~~

~~(f) Hearing: The ability to perceive sound, including by the use of equipment such as hearing aids, cochlear implants, etc.~~

~~(g) Communication: The ability to make oneself understood through the use of words, sounds, signs, facial expressions, communication boards, or other adaptive devices.~~

~~(h) Toileting, including bladder and bowel continence: The ability to get to and from the toilet, commode, bedpan, or urinal, including transfer to and from the toilet; management of clothing, and cleansing; and the ability to get to the toilet on time to empty the bladder and bowel, including changing incontinence pad/briefs, cleansing, and disposing of soiled articles.~~

~~(2) Cognition -~~

~~The ability to remember, reason, understand, and use judgment.~~

~~(3) Environment -~~

~~The ability to function in his/her living situation, including health, housing, and accessibility.~~

~~(4) Medical/health status -~~

~~Any medical or health condition that impacts the child's ability to function independently. The complexity of care and unstable medical conditions are also factors.~~

~~(5) Support network -~~

~~The ability and capacity of extended family, friends, and community resources to provide informal and formal supports. This may include in-home supports, school services, and therapies. In addition, this includes the family's and the support network's effectiveness in protecting the child from abuse and neglect.~~

~~(6) Transition-~~

~~The availability of a coordinated set of activities designed to promote independence and movement through services and developmental stages. This may include, but is not limited to, movement from early intervention services to preschool services, child to adult services, or from one type of living situation to another.~~

~~c. Route functional information gathered during the in-person assessment and other documentation to HHS Central Office for a NF level of care determination.~~

~~The services coordinator may require medical information and/or educational material (e.g., most recent Multi-Disciplinary Team (MDT) report, most recent psychological) as a method of gathering additional functional information upon which a NF level of care determination may be based.~~

~~If the child does not meet the NF level of care criteria, the services coordinator shall provide written notice of this decision to the child's guardian. The services coordinator shall also provide appropriate information and referral.~~

~~4. PLANNING FOR SERVICES~~

~~PURPOSE: To identify specific individual services to be provided in a coordinated and organized manner.~~

~~The services coordinator shall-~~

~~a. Together with the child and family, further develop the plan of services and supports. This is accomplished by identifying desired client outcomes. Outcomes should occur in one or more of the following NF domains: activities of daily living; cognition; environment; medical/nursing status; support network; and transition.~~

~~The plan of services and supports must ensure the child's health and welfare, including consideration of acceptable risk. If, despite consideration of the full range and scope of services, the child's health or welfare is in jeopardy, waiver services may not be provided.~~

~~The child's guardian has freedom of choice in selecting providers of waiver services. The guardian's choice of providers is documented in the child's case narrative.~~

~~Copies of the plan of services and supports are distributed to other persons and agencies at the directive, and with the consent of, the child's guardian.~~

~~Note: If a child under the age of three receives services coordination through an Early Intervention Program, the Individualized Family Service Plan (IFSP) developed for that program meets the plan of services and supports requirement for this waiver. The IFSP document must specify needed service(s) to be authorized through this waiver, with a copy maintained in the waiver case record.~~

~~b. Determine the cost of serving the child and determine that the estimated total monthly cost, excluding the costs of Assistive Technology and Supports (ATS) and Home Modification services, does not exceed the ongoing cap. The ongoing cap may change annually.~~

~~Services included in calculating the cost of the plan of services and supports are the Medicaid non-waiver services of home health care, personal care aide, and medical transportation and all ongoing waiver services. ATS and home modifications are one-time or annually-only waiver services and are separately capitated. This separate cap may change annually.~~

~~If the estimated monthly cost of the plan of services and supports exceeds the ongoing cap for children, the services coordinator shall contact Central Office to discuss possible approval to exceed the ongoing cap. Central Office considers the following factors in making this decision and may approve or disapprove the request based upon them:~~

- ~~(1) Child demographics (e.g., living situation, diagnosis, treatment plan, and prognosis);~~
- ~~(2) Health and welfare concerns;~~
- ~~(3) A description of the plan of services and supports;~~
- ~~(4) The costs of the ongoing waiver services (i.e., plan totals aside from home health, personal care aide, ATS, home modifications, and medical transportation);~~
- ~~(5) Available support systems; and~~
- ~~(6) Possible funding shifts to other programs.~~

~~If the cost of the child's plan of services and supports does exceed the ongoing cap and an exception is not approved, the services coordinator shall provide written notice of ineligibility to the child's guardian. The services coordinator shall also provide appropriate information and referral.~~

~~c. Offer the child's guardian the option of accepting NF or waiver services as described in the plan of services and supports after the child has been determined to meet the NF level of care criteria, an assessment completed, and a plan of services and supports developed. If the guardian chooses to accept waiver services, the services coordinator shall obtain his/her signature on the waiver consent form. The consent form must be signed at initial determination only, and remains valid as long as the waiver case is open.~~

~~Note: The waiver consent form is not valid and must not be signed until the child's eligibility for Medicaid has been determined or presumptive waiver eligibility has been established. The child's waiver eligibility period may begin no earlier than the date of the guardian's signature on the consent form.~~

~~Presumptive Waiver Eligibility: Waiver eligibility may be presumed for any potential waiver eligible child from whose guardian a signed Medicaid application has been received by Medicaid eligibility staff and when the guardian is willing to cooperate with its completion (e.g., is willing to provide all requested financial records; is willing to pay a spenddown/shared cost, if required). The services coordinator shall contact the Medicaid eligibility staff to determine if it is likely the child will become Medicaid eligible prior to obtaining the guardian's signature on the consent form. Notation must be made on the consent form indicating presumptive waiver eligibility until a final Medicaid eligibility decision has been made.~~

~~The services coordinator shall have ongoing contact with the Medicaid eligibility staff until a final Medicaid eligibility decision has been made. If the child is determined not to be Medicaid eligible, the services coordinator shall provide written notice, effective immediately, to the child's guardian and also provide appropriate information and referral. Ten-day notice is not allowed.~~

~~Services which may be presumptively authorized are waiver services and medical transportation. Presumptive authorization for ATS and home modifications is not allowed. Any authorized services shall result in the payment of the provider.~~

~~5. CONNECTING/LINKING NEEDED SERVICES~~

~~PURPOSE: To translate the plan of services and supports into action.~~

~~To locate or develop resources to address identified service gaps.~~

~~To promote an effective/optimum use of community resources.~~

~~The services coordinator shall prior authorize waiver services for up to a 12-month period, based on the plan of services and supports and the results of ongoing monitoring activities. Waiver services may not be authorized until the child's Medicaid eligibility has been determined and the waiver consent form has been signed.~~

~~The services coordinator shall provide a written description to the provider, clearly defining the parameters of service delivery. This must include at least the amount and frequency of service provision, specific service components authorized, and any applicable time limitations. Any applicable conditions or limitations relate solely to the eligibility of the waiver client and program policies and do not constitute an effort to directly control contract performance by the provider.~~

~~6. ADVOCACY~~

~~PURPOSE: To ensure the child/family's interests and concerns are represented and protected.~~

~~To promote child-centered, family-driven, comprehensive service delivery.~~

~~To promote community responsiveness to the needs and issues of children with disabilities and their families.~~

~~The services coordinator shall provide timely notices and fully inform the child's guardian of his/her rights and responsibilities. The services coordinator shall also provide referrals for family and community training to promote child-centered, family-driven, comprehensive service delivery.~~

~~7. MONITORING~~

~~PURPOSE: To continually evaluate the effectiveness of the jointly developed plan of services and supports.~~

~~To ensure quality service delivery.~~

~~The services coordinator shall -~~

~~a. Contact the family depending upon the level of services coordination needed. For families coordinating/directing their own services, and for families needing supportive services coordination, minimum contact shall be monthly, with at least quarterly in-person visits. For families needing comprehensive services coordination, minimum contact shall be monthly with in-person visits at least every other month. All in-person contacts shall be at a time, date, and location convenient to the client/family.~~

~~b. Ensure, by both child/family interview and observation, that the formal and informal supports and services being provided continue to meet the child's and family's needs, and revise the plan of services and supports accordingly.~~

~~c. Review the child/family's needs monthly, including service usage and cost, and revise the plan of services and supports to meet newly identified needs.~~

~~d. Review the child/family's desired outcomes regularly with the child/family and revise the plan of services and supports to refine action steps to meet previously identified outcomes and develop action steps to meet newly identified outcomes.~~

~~e. Maintain regular communication with Medicaid eligibility staff, especially in regard to the family's spenddown/shared cost obligation, if any, and ongoing Medicaid eligibility.~~

f. Determine whether a reassessment of the child's level of care and strengths, needs, and resources is necessary when the information is received that the care needs of the child have changed. This determination shall be made within two working days of the receipt of this information. A reassessment may also be initiated based upon the services coordinator's observation of the child's functioning (either improvement or decline) during a routine services coordinator contact. If a reassessment is completed and the child remains NF level of care, a new plan of services and supports must be developed. The services coordinator shall document any provider change in the case narrative.

g. Review the family's satisfaction with the services provided, review the child's overall health status, and verify that the provider(s) is complying with the requirements of perspective service provision.

Note: A child must be reassessed as an adult when s/he reaches age 18. If the child remains NF level of care, a new plan of services and supports must be completed. A new waiver consent form must be completed when the child reaches the age of majority (age 19) if the parents are not court-appointed legal guardians.

Early Intervention Exception: If the Early Intervention services coordinator receives information that the care needs of an infant or toddler have changed, indicating a change in level of care, the waiver services coordinator shall offer assistance to the Early Intervention services coordinator to obtain a new NF level of care determination by HHS Central Office.

C. NOTIFYING OF ADVERSE DECISIONS

Persons who request, apply for, or receive services may appeal any adverse action or inaction. These may include, but are not limited to a potential waiver client being denied services, a waiver client's services being reduced, or a waiver client determined ineligible for waiver services. The services coordinator shall send written notice of denial, reduction, or termination of services to the client/guardian. Notice to clients/guardians must contain—

- (1) A clear statement of the action to be taken;
- (2) A clear statement of the reason for the action;
- (3) A specific policy reference which supports such action; and
- (4) A complete statement of the guardian's right to appeal.

Notice of reduction or termination of services must be mailed at least ten calendar days before the effective date of action. Exception: If the termination of waiver services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility. **Moved to 480 NAC chapter 2, section 005 as modified**

1. Reasons for denying or terminating eligibility

Eligibility for services under the waiver may be denied or terminated for any of the following reasons:

- a. The unavailability of a waiver slot;
- b. The client has no waiver service need;
- c. The client's needs are being met by another source;
- d. The client does not meet priority ranking;
- e. The client/guardian has not supplied needed information to complete the eligibility process;
- f. The client fails to meet the specified eligibility criteria;
- g. A plan of services and supports cannot be developed/maintained which protects the client's health and welfare;
- h. The client/guardian has not signed necessary forms consenting to waiver services;
- i. The client/guardian voluntarily withdraws;
- j. The client moves out of Nebraska;
- k. The death of the client;
- l. The agency loses contact with the client and his/her whereabouts are unknown; or
- m. The need for Assistive Technology and Supports or Home Modifications has been addressed and no other waiver services are needed.

2. Situations when notice not required

No notice need be sent to the client/guardian in the following situations:

- a. The client/guardian reports that waiver service is no longer required and requests that his/her case be closed;
- b. The services coordinator learns of a client's death;
- c. The client is committed to an institution or admitted to a nursing facility on a long-term basis;
- d. The client's whereabouts are unknown;
- e. The services coordinator has verified that waiver services are being provided in another service area to which the client has moved;
- f. An authorization period is ending and the client/guardian has not acted upon a request for a level of care and plan of services and supports review; and
- g. The limited authorization for Assistive Technology and Supports or Home Modifications is ending and no other waiver services are authorized. **Moved to 480 NAC chapter 2, section 005.02 as modified**

3. Provider Notice

When a waiver client's services are being changed or terminated, the services coordinator shall provide written notice to the provider of the change in service provision or termination of payment for waiver services.

No provider notice is issued when service ends at the end of the service authorization period. **Moved to 480 NAC chapter 2, section 005.03 as modified**

D. APPEALING DECISIONS/ACTIONS

The Department of Health and Human Services shall provide opportunities for fair hearings as defined in 42 CFR 431, Subpart E, to clients or their legal representatives who are not given the choice of home and community-based services as an alternative to NF services or who are denied the services of their choice (see 465 NAC 2-001.02 and 6-000).

Waiver clients/guardians have the right to appeal the following services coordination decisions/actions:

1. Refusal to accept a request for waiver assessment;
2. Failure to act upon a request within the mandated time period;
3. Failure to offer the choice between Home and Community-Based Waiver Services and NF services;
4. Denial of eligibility;
5. Denial, termination, or reduction of services; and
6. Termination of the waiver case. Moved to 480 NAC chapter 2, section 006 as modified

5-004 SERVICES COORDINATION DOCUMENTATION

Services coordination documentation shall be maintained for each client, must be retained for four years, and may consist of either paper and/or computer data. Documentation must include:

1. Initial referral information;
2. Documentation related to waiver eligibility and authorization;
3. Determinations of NF level of care;
4. Assessment(s) and other functional information;
5. Plans of services and supports;
6. All written notices to, and other communication with, the client/guardian;
7. Interagency correspondence, including referrals;
8. Activities related to services delivery monitoring; and
9. Narrative documentation (e.g., communication with client/family/guardian and service providers; services coordinator decisions and actions; and other factual information and services coordination activity relevant to the case).

Narrative documentation must be objective and free from bias.

When a client moves from one service area to another, the services coordinator shall send to the receiving services coordinator pertinent documentation.

5-005 WAIVER SERVICES

Medicaid services available to persons eligible for this home and community-based waiver program are:

- A. Adult Day Health Care;
- B. Assisted Living Service;
- C. Assistive Technology and Supports;
- D. Child Care for Children with Disabilities;
- E. Home Care/Chore;
- F. Home-Delivered Meals;
- G. Home Modifications;
- H. Independence Skills Management;
- I. Nutrition Services;
- J. Personal Emergency Response System;
- K. Respite Care; and
- L. Transportation.

A. ADULT DAY HEALTH CARE

1. Description

Adult Day Health Care (ADHC) is a service which allows for structured social, habilitation, and health activities. It may (1) alleviate deteriorating affects of isolation; (2) aid in transition from one living arrangement to another; (3) provide a supervised environment while the regular caregiver is working or otherwise unavailable; and/or (4) provide a setting for receipt of multiple health services in a coordinated setting. ADHC is provided outside of the client's place of residence for a period of four or more hours daily, but less than 24 hours.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. ADHC definitions

Habilitation: Services which develop and/or retain capacity for independence, self care, and social and/or economic functioning.

Licensed Nurse: LPN or RN licensed in Nebraska.

3. ADHC conditions of provision

Service Components: Providers shall offer, or make available through arrangements with community agencies or individuals, each of the services required to meet the needs identified during the client's assessment. Depending on the client's assessed needs, these services include

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- a. Personal care services to address limitations in activities of daily living (ADL) (e.g., transferring, dressing, eating, toileting, and bladder and bowel continence. Assistance with ADL's must be provided by staff and supervised by a licensed nurse.
- b. ADL training, including training the client to increase independence in performing ADL's, the use of special aids, and accident prevention. This must be provided by staff under the supervision of a licensed nurse.
- c. Health assessment/nursing service, including observation of changes in client health and notification of family/doctors, health education and counseling, and administration of medications (either by staff or by the client), and skilled nursing care.
- d. Meal services, including preparation and serving of at least one daily meal. Menus must be planned by staff or a contracted individual who has knowledge of dietetic requirements and nutrition. If a dietitian is not on staff, one staff person must be designated as responsible for food service. Each client must be provided with a noon meal if s/he attends at mealtime. This meal must include at least one-third of the daily dietary allowance required for adults. Each participant who is in attendance for a full day must also be provided with two snacks daily which are controlled for sugar, salt, and cholesterol levels, as appropriate. Special diets must be provided according to the individual participant's plan.
- e. Recreational therapy, including social and recreational activities. Center staff must provide individual and group activity. The dignity, interests, and therapeutic needs of individual participants must be considered in the development of activity programs.
- f. Counseling, including individual and group counseling provided to participants and their families in the following areas: coping skills, and personal, social, family, and adjustment problems. Counseling may be provided only by a certified social worker, a certified master social worker, or a certified professional counselor.
- g. Other activities: The provider shall ensure that the program offers a balance of activities to meet each client's needs and interests. Clients are encouraged to participate in activities, but are free to decline.

Limitations: If the client will receive both Adult Day Health Care and Independence Skills Management (ISM), the services coordinator shall not authorize any component of ISM that will be duplicated by Adult Day Health Care.

School System Services: No service which is the responsibility of the school system may be provided under the waiver.

The services coordinator shall not authorize Adult Day Health Care services for the hours the client is attending school.

Adult Day Health Care Plan: The provider shall ensure that there is a written plan for each client. The written plan must be jointly developed with the client and services coordinator and must include the client's strengths, needs, and desired outcomes as they pertain to ADHC, a plan to meet the needs and desired outcomes, and ADHC components to be provided. The plan must also include an up-to-date listing of the client's current medications and treatments, any special dietary requirements, a description of any limitations to participate in activities, and any recommendations for special therapies. Center staff shall, together with the client and services coordinator, review and revise the plan as appropriate, but at least semiannually. A copy must be submitted to the client's services coordinator.

4. ADHC standards

The Department of Health and Human Services annually contracts with providers of Adult Day Health Care to ensure that all applicable federal, state, and local laws and regulations are met.

Provider Standards: Providers of ADHC shall obtain adequate information on the medical and personal needs of each client, if applicable; and observe and report all changes to the services coordinator.

Facility Standards: Each Adult Day Health Care facility must meet all applicable federal, state, and local fire, health, and other standards prescribed in law or regulation. This includes the following standards:

a. Atmosphere and design: This includes—

(1) The facility must be architecturally designed to accommodate the needs of the clients being served;

(2) Furniture and equipment used by clients must be adequate;

(3) Toilets must be in working order and easily accessible from all program areas; and

(4) A telephone must be available for client use.

b. Location and space: The facility shall ensure that the facility has sufficient space to accommodate the full range of program activities and services. This includes—

(1) Flexibility for large and small group and individual activities and services;

(2) Storage space for program and operating supplies;

(3) A rest area, adequate space for special therapies, and designated areas to permit privacy and isolate clients who become ill;

(4) Adequate table and seating space for dining;

(5) Outside space available for outdoor activities and accessible to clients; and

(6) Adequate space for outer garments and private possessions of the clients.

c. Safety and sanitation: The facility shall ensure that—

(1) The facility is maintained in compliance with all applicable local, state, and federal health and safety regulations;

(2) If food is prepared at the center, the food preparation area must comply with HHS regulations;

(3) At least two well-identified exits are available;

- (4) Stairs, ramps, and interior floor have non-slip surfaces or carpet;
- (5) The facility is free of hazards (e.g., exposed electrical cords, improper storage of combustible material);
- (6) All stairs, ramps, and barrier-free bathrooms are equipped with usable handrails; and
- (7) A written plan for emergency care and transportation is documented in the client's file.

Staffing: Each center must be staffed at all times by at least one full-time trained staff person.

The center shall maintain a ratio of direct care staff member to clients sufficient to ensure that client needs are met. The center shall develop written job descriptions and qualifications for each professional, direct care, and non-direct care position.

Provider Skills and Knowledge: Direct care staff members must —

- a. — Have training or one or more years' experience in working with adults in a health care/social service setting;
- b. Have knowledge of CPR and first aid;
- c. Be able to recognize distress or signs of illness in clients;
- d. Have knowledge of available medical resources;
- e. Have access to information on each client's address, telephone number, and means of transportation; and
- f. Know reasonable safety precautions to exercise when dealing with clients and their property.

The provider must have a licensed nurse on staff, or contract with a licensed nurse, who will provide the health assessment/nursing service component of ADHC and supervise ADL/personal care and ADL training component.

Counseling must be provided only by a certified social worker, a certified master social worker, or a certified professional counselor.

5. — ADHC rates and frequency: The frequency of service is a calendar day of at least four hours. In the event that a waiver client must leave the ADHC facility due to an unplanned need and has been there less than 4 hours, this is considered a full day for reimbursement purposes. DHHS Central Office establishes a statewide rate for ADHC.

6. — ADHC record keeping

The provider shall maintain the following in each client's file:

- a. Adult Day Health Care plan; and
- b. Phone numbers of persons to contact in case of emergency. Moved to 480 NAC chapter 5, section 003.01 as modified

B. ASSISTED LIVING SERVICE

1. Description

Assisted living is an array of support services that promote client self-direction and participation in decisions which incorporate respect, independence, individuality, privacy, and dignity in a home environment. These services include assistance with or provision of personal care activities, activities of daily living, instrumental activities of daily living, and health maintenance.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and support.

2. Definitions

Resident Service Agreement: An individualized contractual agreement between the facility and client. Clients who receive waiver assisted living service shall also have an individualized Plan of Services and Supports.

3. Assisted Living Service Conditions of Provision

The need for assisted living service is jointly determined by the client and services coordinator.

Service Components: Providers shall offer and make available each of the service components required to meet the needs identified during each client's assessment, and included in the individualized Plan of Services and Supports. The need for the following services is determined on an individual basis as specified in the plan of services and supports to promote or maintain the client's level of independence. These include—

a. Adult day care/socialization activities: Structured social, habilitative and health activities geared for the needs of the clients.

b. Escort services: Accompanying or personally assisting a client who is unable to travel or wait alone. This may include assistance to and from a vehicle and/or place of local destination. This may also include providing, or making arrangements for supervision and support to the client while away from the assisted living facility, as determined on an individual basis, and specified in the Resident Service Agreement.

c. Essential shopping: Obtaining clothing and personal care items for the client when the client is unable to do so for him/herself. This does not include financing the purchases of clothing and personal care items.

d. Health Maintenance Activities: Non-complex interventions which can safely be performed according to exact directions, which do not require alterations of standard procedure, and for which the results and client's responses are predictable (e.g., recording height and weight, monitoring blood pressure, monitoring blood sugar, and providing insulin injections as long as the client is stable and predictable). The need for health maintenance activities is determined on an individual basis.

e. Housekeeping Activities: Cleaning of public areas as well a client's private residence, such as dusting, vacuuming, cleaning floors, cleaning of bathroom and making and changing of the bed. Bed linens will be changed as soiled but at least weekly. Clean bath linens shall be made available daily.

f. Laundry services: Washing, drying, folding and returning client's clothing to his/her room. Dry cleaning is the responsibility of the client but the facility will assist the client in arranging for this service if needed.

g. Meal Service: Three meals per day, seven days per week, as well as access to between meal snacks. Each meal must consist of a variety of properly prepared foods containing at least one-third of the Minimum Daily Nutritional Requirements for adults, and take into account cultural and personal preference for foods served at specific times of day. Meals will be delivered to the client's room for those experiencing temporary illness.

h. Medication Assistance: Assistance with the administration of prescriptions and non-prescription medications.

i. Personal Care Services: Assistance with ADL's (e.g., transferring, dressing, eating, bathing, toileting, and bladder and bowel continence). The facility shall also provide assistance with eating. Assistance with eating includes opening packages, cutting food, adding condiments, and other activities which the client is unable to perform for his/herself in preparing to eat the food. If the client is unable to eat independently, the facility shall feed the client or shall assure other arrangements are made for this care. Personal care will be provided to the client in a manner in which the individual maintains as much independence and privacy as possible. The amount and degree of personal care services is determined on an individual basis.

j. Transportation Services: Transporting, or making arrangements for transporting a client to and from local community resources identified during client assessment and included in the Plan of Services and Supports as directly contributing to the ability of the individual to remain in an assisted living facility.

Resident Service Agreement: The provider shall ensure that there is a written plan for each client. The written plan must be jointly developed with the client, services coordinator, and facility staff, and must include the client's strengths, needs, and desired outcomes, and the service components to be provided. The plan must also include an up-to-date listing of the client's current medications and treatments, any special dietary requirements, and a description of any limitations to participate in activities. Assisted living staff shall, together with the client and services coordinator, review and revise the resident service agreement as appropriate, but at least annually. A copy must be submitted to the client's services coordinator.

When a facility or the services coordinator determines that a client's needs are beyond the facility's capabilities or capacities to meet the client's needs, the services coordinator and the client will initiate alternative arrangements.

4. Assisted Living Standards

HHS annually contracts with waiver providers of assisted living to ensure that all applicable federal, state, and local laws and regulations are met.

Facility Standards:

a. Each assisted living facility shall be licensed as an assisted living facility and certified as an Assisted Living Service waiver provider, as defined in 480 NAC, Chapter 5, by the HHS System.

b. Licensed nursing facilities in the State of Nebraska may apply to the Department for funding to convert all or a portion of their operation to assisted living under provisions of the Nebraska Health Care Trust Fund Act. Nursing facilities obtaining an assisted living license after utilizing funds granted under provisions of the Nebraska Health Care Trust Fund Act will not be required to meet the provisions of an independent living unit, independent bedroom, and independent toilet facilities for a period not to exceed six months from the effective date of the assisted living license.

c. The facility shall provide a private room with bath consisting of a toilet and sink for each client receiving waiver assisted living service. Any facility that receives funding through the Nebraska Health Care Trust Fund Act shall provide a private room with bath consisting of a toilet, sink, and tub or shower for each client receiving waiver assisted living service. Semi-private rooms shall be considered on an individual basis (e.g., couples), and require prior approval of the HHS System.

d. — Assisted living service provided in facilities also providing nursing facility care shall be separately licensed and separately located in another wing or section of the building, with separate dining and common areas. Individual facility exceptions to separate dining areas may be considered based on the facility's assisted living philosophy, and requires prior approval of the HHS central office.

For general provider standards, see 480 NAC 5-006.

5. — Assisted Living Rates

The frequency of service is a month. Medicaid payment for assisted living service is through rates established by HHS Central Office. Variable rates may be utilized and may change annually.

6. — Assisted Living Record Keeping

The provider shall maintain the following in each client's file:

a. — The current Resident Service Agreement;

b. — The current Plan of Services and Supports; and

c. — Phone numbers of persons to contact in case of an emergency and the client's physician's name and phone number.

For general provider record keeping, see 480 NAC 5-011. Moved to 480 NAC chapter 5, section 003.02 as modified

C. ASSISTIVE TECHNOLOGY AND SUPPORTS

1. Description

Assistive technology and supports (ATS) are specialized medical equipment and supplies which include devices, controls, or appliances which enable a client to increase his/her abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which s/he lives. Approvable items are limited to those which are necessary to maintain the client in his/her home.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Assistive Technology and Supports conditions of provision

The need for ATS is jointly determined by the services coordinator and the client/family.

Consultation for ATS is provided by the Nebraska Department of Education Assistive Technology Project (ATP).

3. ATS standards

Consultation provided by ATP shall meet the contractual obligations and terms of the proposal as agreed upon by ATP and HHS.

All items/assistive equipment shall meet applicable standards of manufacture, design, and installation.

4. Assistive Technology and Supports rates

A frequency of service is per device/support, not to exceed the established annual cap. The established cap may change annually.

5. ATS record keeping

ATP shall maintain the following in each client's file:

a. The ATP Assessment Report which includes a summary of client's needs and current support, recommendations, cost estimate, cost coordination, if needed, and recommended vendor.

b. Notice of eligibility or ineligibility of ATS services.

c. Authorization of ATS services.

d. Documentation of the client's orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates.

e. Copy of signed vendor bill and signed Consumer Acceptance form.

f. Narrative summary. Moved to 480 NAC chapter 5, section 003.03 as modified

D. CHILD CARE FOR CHILDREN WITH DISABILITIES

1. Description: Child Care for Children with Disabilities (CCCD) is that portion of child care provided to children related to their medical or disability-related needs. Child care is provided to children from birth through age 17 on the average of less than 12 hours per day, but more than two hours per week on a regular basis, in lieu of caregiver supervision. Care is provided in a child's home by an approved provider or in a setting approved or licensed by the Department of Health and Human Services. The parent or primary caregiver is responsible for the basic cost of routine child care. The Aged and Disabled Medicaid Waiver is responsible for the payment of the service above the basic cost of routine child care.

The need for this service must be reflected in one or more assessment areas of the child's plan of services and supports.

2. CCCD conditions of provision: The services coordinator shall include Child Care for Children with Disabilities in the plan of services and supports only to allow the usual caregiver(s) to:

a. Accept or maintain employment. CCCD expenditures must be cost effective in comparison to employment wages and benefits received by the usual caregiver(s). Parent(s) who receive CCCD waiver service to maintain employment and are self-employed or employed part-time may be required to submit income documentation to show cost effectiveness. The average monthly income shown must meet or exceed the projected average CCCD Medicaid costs. An exception may be granted when there are extenuating circumstances, which may include but are not limited to self-employment income verified by an annual tax return which also reflects business expenses or losses. Goods or services received in place of wages are not considered in comparison of costs. Verification of the hours/schedule of employment is required. Persons who are self-employed shall provide a statement of hours worked.

b. Seek employment. To meet this need, CCCD may be authorized up to 12 hours per week for two consecutive months within any 12-month period. Each time a parent or usual caregiver loses employment, she/he is entitled to two months of child care to allow him/her to seek employment.

c. Enroll in and regularly attend vocational or educational training to attain a high school or equivalent diploma or an undergraduate degree or certificate which enables the caregiver(s) to increase future or maintain current earning power. This excludes students pursuing second undergraduate degrees, second certificates, any graduate degree, or classes to maintain a professional license or certificate. Verification of class schedule is required.

School System Services: No service which is the responsibility of the school system may be provided under the waiver. The services coordinator shall not authorize Child Care for Children with Disabilities for the hours the child is attending school.

3. CCCD standards: Waiver providers of CCCD must be approved or licensed through DHHS. Waiver providers of CCCD shall obtain adequate information on the medical and personal needs of each child, if applicable; and observe and report all changes to the services coordinator.

4. Child Care for Children with Disabilities Rates

CCCD rates shall be negotiated based upon the child's needs which affect staffing requirements (i.e., provider skill level or intensity of care provision), as identified through the assessment process.

The parent or primary caregiver of the child is responsible for the cost of routine child care. That amount is determined by the provider rates published by the Child Care Subsidy Program for care provided in the provider's home or a center. For care provided in the child's home, the license-exempt family child care home rate chart applies to individual providers and the child care center chart applies to agency providers. The Department is responsible for payment of the approved cost of the service above the basic cost of routine child care.

Services may be authorized in frequencies of hours and/or days. Six or more hours of care provided outside the child's home must be paid at a day rate, if that option is offered by the provider to private pay families. **Moved to 480 NAC chapter 5, section 003.05 as modified**

E. HOME CARE/CHORE

1. Home care/chore description

Home care/chore is a service for adults which includes general household activities necessary for maintaining and operating the individual's home when the individual is unable to perform these activities. Home care/chore activities provided are limited to those activities that are required to maintain the client in a healthy and safe environment.

Any or all home care/chore activities may be provided to the client as documented in the plan of services and supports. These include bill paying; errand service; essential shopping; food preparation; housekeeping activities; laundry service; personal care service; simple home repairs and maintenance; and supervision.

The need for home care/chore services must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Home care/chore activities and conditions

The following home care/chore activities are those which could normally be performed by the client, but which the client is presently unable to perform. The need for each activity must be identified during client assessment.

Full-Time/Live-In housekeeping: The services coordinator shall authorize full-time housekeeping only when the client is living alone or living with only minor children, or when the circumstances of eligible individuals residing together indicate this need. The housekeeper may live in. A full-time housekeeper shall—

a. Provide the following activities of home/care chore, as appropriate:

(1) Bill Paying: Assisting clients to organize and/or pay bills.

(2) Errand Service: Providing service in relation to needs described for escort service when not generally accompanied by the client. If the client does accompany the provider, the provider shall not bill an additional amount for transportation.

- (3) Essential Shopping: Obtaining food, clothing, housing, or personal care items.
- (4) Food Preparation: Preparing meals necessary to maintain independence. The client shall provide necessary meal preparation supplies.
- (5) Housekeeping Activities: In-home cleaning and care of household equipment, appliances, or furnishings. The client shall provide necessary supplies.
- (6) Laundry Service: Washing, drying, ironing, folding, and storing laundry in the client's home; or utilizing laundromat services on behalf of the client. The client shall provide soap and machine-use fees.
- (7) Personal Care Service: Limited to a non-legally responsible relative providing basic personal care and grooming including bathing, shaving, shampooing, assisting with dressing, ambulation, and toileting. This service is identical to what may be provided through Medicaid Personal Care Aide except that non-legally responsible relatives are allowed as waiver providers even though they are excluded as regular Medicaid Personal Care Aides (see 471 NAC 15-004.02). Natural, adoptive, and stepparents of a minor age client and the spouse of a client are prohibited as providers through both the regular Medicaid Personal Care Services and the Aged and Disabled Medicaid Waiver Personal Care Service.
- (8) Supervision: Staying with the client for part of a day when the client would otherwise be alone, and performing non-medical activities necessary to provide for the safety and comfort of the client.

- b. Provide service to only one household;
- c. Be available on a 24-hour basis to provide the authorized chore components; and
- d. Bill only for the days service is actually provided.

Note: If transportation service is provided by the housekeeper, s/he may be approved and bill for additional mileage as a transportation provider. Additional payment for time is not allowed.

Simple Home Repairs and Maintenance: Providing minor repair of windows, screens, steps/ramps, furnishings, and household equipment. Mowing, raking, removing trash (to garbage pickup point), removing snow and ice, and cleaning water drains may also be provided. Mowing is limited to that necessary to meet the health and safety of the client and to meet local codes.

If the client lives in a rental property, the services coordinator shall investigate the lease agreement and determine the responsibilities of the landlord to provide repairs or maintenance.

3. Home care/chore standards

A home care/chore provider may be an individual or agency. HHS annually contracts with providers of home care/chore to ensure that all applicable federal, state, and local laws and regulations are met.

The provider shall have had training and/or experience in carrying out home care/chore services comparable to those which will be authorized.

The home care/chore provider shall obtain adequate information on the medical and personal needs of each client, if applicable, and observe and report all changes to the services coordinator.

Each home care/chore provider must be at least 19 years old and shall —

- a. Have knowledge of basic first aid skills and of available emergency medical resources, if providing supervision or full-time, live-in housekeeping, personal care, and escort services; and
- b. Exercise reasonable caution and care in the use and storage of clients' equipment, appliances, tools, and supplies.

Each agency provider shall —

- a. — Employ home care/chore staff based upon their qualifications, experience, and demonstrated abilities;
- b. — Provide training to ensure that home care/chore staff are qualified to provide the necessary level of care. Agree to make training plans available to the Department; and
- c. — Ensure adequate availability and quality of service.

4. Home care/chore rates

Home care/chore rates shall be established by HHS central office. These established rates may change annually.

Services may be authorized in frequencies of hourly, daily, or by the job. **Moved to 480 NAC chapter 5, section 003.04 as modified**

F. HOME-DELIVERED MEALS

1. Description

Home-Delivered Meals is a service for adults which provides a meal prepared outside the client's residence and delivered to his/her residence. Each meal must consist of a variety of properly prepared foods containing at least one-third of the Minimum Daily Nutritional Requirements for Adults.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Home-Delivered Meals conditions of provision

The need for home-delivered meals is jointly determined by the services coordinator and the client.

3. Home-Delivered Meals standards

HHS annually contracts with providers of Home-Delivered Meals to ensure that all applicable federal, state, and local laws and regulations are met. In addition, providers must meet the following standards:

a. Provider health and safety standards

Food preparation facilities and areas must conform to all established local, state, or federal fire prevention, sanitation, zoning, and facility maintenance standards. Food preparation personnel must be -

- (1) In good health and free from contagious disease; and
- (2) Skilled and instructed in sanitary food handling, preparation, and serving practices.

b. Home-delivered meal standards

Home-delivered meals must -

- (1) Be delivered on an established daily schedule;
- (2) Be transported and delivered using utensils and equipment which are sanitary and maintain proper food temperatures. Thermos-type containers and disposable or sterilizable serving dishes must be used;
- (3) Reflect the general dietary needs of persons who are aged or have disabilities, as well as the specific dietary needs of each client; and
- (4) Contain one-third of the minimum daily nutrition requirement per meal for adults using a variety of foods from day to day.

~~Providers of Home-Delivered Meals shall obtain adequate information on the medical and personal needs of each client, if applicable; and observe and report all changes to the services coordinator.~~

~~4. Home-Delivered Meals rates~~

~~Home-Delivered Meals rates shall be established by HHS central office. This established rate may change annually. A frequency is one meal.~~ Moved to 480 NAC chapter 5, section 005.07 as modified

G. HOME MODIFICATIONS

1. Description

~~Home modifications are those physical adaptations to the home which enable the client to function with greater independence in the home. Approvable modifications are limited to those which are necessary to maintain the client in his/her home.~~

~~Home modifications may include, but are not limited to, the installation of ramps and grab bars; widening of doorways; modification of bathroom facilities; or installation of specialized electric and plumbing systems which are necessary to support assistive equipment.~~

~~The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.~~

2. Home Modifications conditions of provision

~~The need for home modifications is jointly determined by the services coordinator and the client.~~

~~The consultation for home modifications is provided by the Nebraska Department of Education Assistive Technology Project (ATP).~~

~~Approved waiver home modifications shall not include adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the client, such as carpeting or roof repair.~~

3. Home Modifications standards

~~Consultation provided by ATP shall meet the contractual obligations and terms of the proposal as agreed upon by ATP and HHS.~~

~~All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate licenses and/or certifications.~~

~~Home modifications will be provided in accordance with applicable local and state building codes. All modifications must be made by or overseen by appropriately licensed/certified persons.~~

4. Home Modifications rates

Home modification rates shall be established through a bid process.

The frequency of the service is by the job, not to exceed the established annual cap. The established cap may change annually.

5. Home Modifications record keeping

ATP shall maintain in each client's file:

a. The ATP Assessment Report which includes the summary of the client's needs and current supports; recommendations, cost estimate, cost coordination, if needed, and recommended contractor.

b. Notice of the client's eligibility or ineligibility for home modifications.

c. Authorization of home modification services.

d. Documentation of the client's orientation and training on how to use or maintain the assistive equipment/support, which may include the delivery and/or installation dates.

e. Copy of the signed contractor bill and signed Consumer Acceptance form.

f. Narrative summary. Moved to 480 NAC chapter 5, section 003.03 as modified

H. INDEPENDENCE SKILLS MANAGEMENT

1. Description

Independence Skills Management (ISM) is training for adults and children in activities of daily living and training to overcome or compensate for the effects of physical disabilities. Training may occur in the client's home or in the community, and may be provided individually or in a group setting. The caregiver (non-Medicaid paid provider) may be included in this training to promote independence of the waiver client.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. ISM conditions of provision

ISM training must be provided to the client or his/her caregiver as indicated in the client's plan of services and supports. ISM training must be provided in the most appropriate setting to meet the client's needs. ISM providers shall provide training that is adaptable to the client's current residence. Individuals who reside with the client shall not be authorized as ISM providers.

ISM service components include the following:

a. Self-Care and Daily Living Skills: This includes training to increase independence in performing activities of daily living, such as dressing, grooming, personal hygiene, feeding, ambulation, and toileting;

- b. ~~Performing Essential Care and Home Management Activities: This includes training in-~~
- ~~(1) Basic home management, such as housekeeping, meal preparation, child care, cleaning, and related activities;~~
 - ~~(2) Mobility, such as using public transportation;~~
 - ~~(3) Shopping, including money management and meal planning;~~
 - ~~(4) Hiring and supervising attendants;~~
 - ~~(5) Financial management;~~
 - ~~(6) Health maintenance;~~
 - ~~(7) Social skills, including counseling to deal with feelings and problem solving for disability-related issues;~~
 - ~~(8) Accident prevention;~~
 - ~~(9) Communication, including services directed toward assisting the individual in acquiring new or improving techniques for communication; and~~
 - ~~(10) Accessibility, including housing relocation.~~

~~Other training, as identified in the client's plan of services and supports, may be included in each component.~~

~~Exclusions: The services coordinator shall not authorize ISM services -~~

- ~~a. When the public school system or rehabilitation services are responsible for providing training for independent living;~~
- ~~b. If the client will receive Adult Day Health Care and the components of ISM would be duplicated by Adult Day Health Care. Note: The services coordinator may authorize other ISM components as needed; and~~
- ~~c. When the training would fall in any of the following categories:~~
 - ~~(1) Basic education or academic remedial training to acquire the general educational background, knowledge, and skills to prepare for vocational training;~~
 - ~~(2) Work adjustment training to acquire work habits, work tolerance, or on-the-job behaviors essential to employment;~~
 - ~~(3) Vocational training to acquire knowledge and skills essential to performing tasks involved in an occupation; or~~
 - ~~(4) Training which can only be performed by licensed audiologists, hearing aid dealers, occupational therapists, optometrists, physical therapists, speech pathologists, and other related health care professionals.~~

~~ISM Plan: The provider shall ensure that there is a written plan for each client. The written plan must be jointly developed with the client and services coordinator and must include the client's strengths, needs, and desired outcomes as they pertain to ISM, a plan to meet the needs and desired outcomes, and the ISM components which will be provided. The ISM provider shall send a copy of the written plan to the client's services coordinator. Monthly progress reports must also be submitted.~~

Termination of ISM: ISM services must be terminated when -

- a. The outcomes identified in the client's plan of services and supports have been achieved; or
- b. The provision of services has demonstrated that the client is not benefitting from ISM services.

Related Transportation: The services coordinator shall authorize appropriate waiver transportation services for transportation related to ISM.

3. ISM standards

HHS annually contracts with providers of Independence Skills Management (ISM) to ensure that all applicable federal, state, and local laws and regulations are met.

Each provider must be age 19 or older and have three years experience in the components of independence skills management or be directly supervised by a person with three years experience. In addition, experience with formalized teaching methods is preferred.

The provider must have knowledge of any client-specific procedures as documented in the client's record. The provider must obtain adequate information on the medical and personal needs of each client. ISM providers must observe and report all changes to the services coordinator.

Any facility used in connection with the provision of ISM must meet the following environmental and fire and safety standards:

- a. Be architecturally designed to accommodate the needs of the clients being served;
- b. Have adequate equipment and furniture for use by the client;
- c. Have toilets in working order;
- d. Have a telephone available for clients' use.
- e. Have at least two well-identified exits;
- f. Have non-slip surfaces or carpets on stairs, ramps, and interior floors;
- g. Be free of hazards (e.g., exposed electrical cords, improper storage of combustible materials); and
- h. Have usable handrails for all stairs, ramps, and barrier-free bathrooms.

4. ~~ISM rates~~

~~ISM rates shall be negotiated at the lowest possible rate. A frequency of service is hourly.~~

5. ~~ISM record keeping~~

~~The provider shall maintain the following in each client's file:~~

- ~~a. The ISM plan and any recommended changes;~~
- ~~b. The monthly progress reports;~~
- ~~c. The name of the client's physician; and~~
- ~~d. Pertinent medical information (e.g., activity restrictions, medications and administration schedule, and special diets).~~ **Moved to 480 NAC chapter 5, section 003.08 as modified**

I. NUTRITION SERVICES

1. ~~Description~~

~~Nutrition Services (NS) are those which measure indicators of dietary or nutrition-related factors to identify the presence, nature, extent of impaired nutritional status of any type, and to obtain the information needed for intervention, planning, and improvement of nutritional care. The service includes assessment, intervention, including education/ counseling and follow-up.~~

~~The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.~~

2. ~~Nutrition Services conditions of provision~~

~~NS Plan: The need for nutrition services is jointly determined by the services coordinator and the client. The NS provider shall send a copy of the nutrition plan to the client's physician if there are specific physician-identified needs, and to the services coordinator. Evaluation of progress will be ongoing and will be reported to the services coordinator prior to the end of the authorization period.~~

~~Termination of NS: Nutrition services must be terminated when -~~

- ~~a. The outcomes identified in the client's nutrition plan have been achieved; or~~
- ~~b. The provision of NS has demonstrated that the client is not benefitting from nutrition services.~~

3. ~~Nutrition Services standards~~

~~HHS annually contracts with providers of nutrition services to ensure that all applicable federal, state, and local laws and regulations are met. NS providers must be a licensed medical nutrition therapist, or an individual certified in specific areas of nutritional expertise (e.g., certified diabetic educator) AND have training or experience in providing nutritional services to the population to be served.~~

~~The provider must obtain adequate information on the medical and personal needs of each client. NS providers must observe and report all changes to the services coordinator.~~

4. ~~Nutrition Services rates~~

~~NS rates shall be established by HHS central office. This established rate may change annually. The frequency of service is hourly.~~

5. ~~NS record keeping~~

~~The provider shall maintain the following in each client's file:~~

- ~~a. The nutrition plan and any recommended changes;~~
- ~~b. The progress reports;~~
- ~~c. The name of the client's physician; and~~
- ~~d. Any pertinent medical information (e.g., medications, special diets, medical restrictions).~~

J. PERSONAL EMERGENCY RESPONSE SYSTEMS

1. Description

Personal Emergency Response Systems (PERS) provides adults immediate access to emergency help at any time through communication connection systems.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. PERS conditions of provision

The need for PERS is jointly determined by the services coordinator and the client.

3. PERS standards

HHS annually contracts with providers of Personal Emergency Response Systems (PERS) to ensure that all applicable federal, state, and local laws and regulations are met. In addition, providers must—

- a. Instruct the client about how to use the PERS device;
- b. Obtain a client/client representative signature verifying receipt of the PERS unit;
- c. Ensure that response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days a week;
- d. Furnish a replacement PERS unit to the client within 24 hours of notification of malfunction of the original unit while it is being repaired;
- e. Update list of responder and contact names at a minimum of semi-annually to ensure accurate and current information;
- f. Ensure monthly testing of the PERS unit; and
- g. Furnish ongoing assistance when needed to evaluate and adjust the PERS device or to instruct clients in the use of PERS devices, as well as to provide for system performance checks.

4. PERS rates

A frequency of service is a monthly rental fee. Installation fees shall be authorized separately.

5. PERS record keeping

The provider shall maintain the following in each client's file:

- a. Documentation of service delivery including client orientation to the system and installation of PERS device;
- b. List of responder and contact names;
- c. Case log documenting client and responder contacts; and
- d. Record of monthly testing of the PERS unit. Moved to 480 NAC chapter 5, section 003.10 as modified

K. RESPITE CARE

1. Description

Respite Care is temporary care of an aged adult or adult or child with disabilities to relieve the usual caregiver from continuous support and care responsibilities. Components of respite care service are supervision, tasks related to the individual's physical needs, tasks related to the individual's psychological needs, and social/recreational activities.

Respite care may be provided in the individual's home or out of the home. If respite is provided by a hospital or other facility, the individual is not considered a facility resident.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Respite Care definitions

In-Home Care or Services: Care or services provided in the client's home.

Out-of-Home Care or Service: Care or services provided in a home or facility where the client does not reside.

Usual Caregiver: A person who resides with the client and is available on a 24-hour per day basis to assume responsibility for the care and supervision of the client. This may include a caregiver who is employed outside the home if s/he retains "on-call" responsibility while away from the client.

3. Respite Care conditions of provision

Respite Care may be authorized for one or more of the following situations:

- a. An emergency or crisis arises which
 - (1) Requires the usual caregiver's absence; or
 - (2) Places an unusual amount of stress on the usual caregiver;
- b. The usual caregiver requires health services (e.g., dental care, doctor appointments, hospitalization, temporary incapacity of caregiver);
- c. The usual caregiver needs relief for regular, prescheduled, personal activities (e.g., religious services, grocery shopping, or club meetings);
- d. The usual caregiver requires irregular periods of "time out" for rest and relaxation; or
- e. Usual caregiver vacations.

Respite care may not be used to allow the usual caregiver to accept or maintain employment or pursue a course of study designed to fit him/her for paid employment or professional advancement. (See instead Child Care for Children with Disabilities, 480 NAC 5-005.B.)

~~Respite Care for a Live-in Housekeeper: Respite care may be used to relieve a live-in housekeeper. However, if respite care is provided for a full day, no live-in housekeeper payment may be approved for that day. Respite care paid for a portion of a day will not change that day's live-in housekeeper rate.~~

~~4. Respite Care standards~~

~~A provider may be an individual or agency. HHS annually contracts with providers of respite care to ensure that all applicable federal, state, and local laws and regulations are met.~~

~~Respite providers must agree never to leave the client alone while providing the service.~~

~~Respite providers shall obtain adequate information on the medical and personal needs of each client. The provider shall observe and report all changes to the services coordinator.~~

~~Agency provider standards~~

~~Each agency provider shall —~~

- ~~a. Employ respite care staff based upon their qualifications, experience, and demonstrated abilities;~~
- ~~b. Provide training to ensure that respite staff are qualified to provide the necessary level of care. Agree to make training plans available to the Department; and~~
- ~~c. Ensure adequate availability and quality of service.~~

Out-of-home provider standards

If respite care is to be provided outside of the client's home, the provider must-

- a. — Ensure that the facility or home is architecturally designed to accommodate the needs of the clients being served;
- b. — Have available an operable telephone;
- c. — Post emergency phone numbers by the telephone;
- d. — Ensure that the home/facility is accessible to the client, clean, in good repair, free from hazards, and free of rodents and insects;
- e. — Ensure that the facility or home is equipped to provide comfortable temperature and ventilation conditions;
- f. — Ensure that toilet facilities are clean and in working order;
- g. — Ensure that the eating areas and equipment are clean and in good repair;
- h. — Ensure that the home/facility is free from fire hazards;
- i. — Ensure that the furnace and water heater and any firearms, medications, and poisons are inaccessible to the client; and
- j. — Ensure that any household pets have all necessary vaccinations.

5. — Respite Care rates

Respite Care rates shall be established by HHS central office. This established rate may change annually. Frequency of service is hourly and/or daily.

The rate for Respite Care may include the cost of three full meals per day only when respite care is provided on a 24-hour basis in a facility that is not a private residence. Moved to 480 NAC chapter 5, section 003.11 as modified

L. TRANSPORTATION

1. Description

~~Transportation service is transporting a client to and from community resources identified during client assessment as directly contributing to the ability of the individual to remain at home. Service may be provided by an individual, agency (exempt provider), or by common carrier.~~

~~The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.~~

2. Transportation definitions

Common Carrier: ~~Any person who transports passengers by motor vehicle for hire and is licensed as such with the Public Service Commission (PSC).~~

Escort: ~~A person who accompanies or personally assists a client who is unable to travel or wait alone. This may include assistance to and from a vehicle and/or place of destination, supervision, or support.~~

Exempt Provider: ~~Carriers exempted from PSC licensure by law including those which—~~

- ~~a. Transport persons who are aged and their spouses and dependents under a contract with a municipality or county;~~
- ~~b. Are owned and operated by a nonprofit organization which has been exempted from the payment of federal income taxes as provided by Section 501(c)(4), Internal Revenue Code, and transporting solely those persons over age 60, their spouses and dependents and persons experiencing disabilities;~~
- ~~c. Are operated by a municipality or county as authorized by law in the transportation of persons who are aged;~~
- ~~d. Are operated by a governmental subdivision or a qualified public purpose organization having motor vehicles with a seating capacity of 20 or less and are engaged in the transportation of passengers in the state; or~~
- ~~e. Are engaged in the transportation of passengers and are operated by a transit authority created under and acting pursuant to the laws of the State of Nebraska.~~

3. Transportation conditions of provision

Non-medical transportation is covered by this waiver program for the following assessed needs:

1. ~~Apply for Benefits: To allow the client to apply or be recertified for benefits and services from programs when a face-to-face interview is required for:~~
 - a. ~~Nebraska Department of Health and Human Services;~~
 - b. ~~Social Security Administration; or~~
 - c. ~~Veteran's Administration.~~
2. ~~Shop for Food and Essential Items: To allow a client to shop for food and essential items a maximum of one round trip per calendar week.~~
3. ~~Obtain Legal Services: To allow the client to receive legal counsel from legal aid societies, private attorneys, county attorneys and other professional legal sources for non-criminal matters a maximum of one round trip per calendar month.~~
4. ~~Obtain Financial Services: To allow the client to take care of financial matters at a banking institution a maximum of one round trip per calendar month.~~
5. ~~Access Waiver Services: To allow the client transportation to and from Adult Day Health Services or Independence Skills Building.~~
6. ~~Secure Housing: To allow a client to tour and secure adequate housing or an independent living arrangement. Authorization is allowed for a maximum of five round trips in any twelve-month period. Additional trips may be authorized if the client's health and safety is jeopardized.~~

Exclusion: ~~Transportation may not be authorized to obtain educational services for children.~~

5. ~~Transportation rates~~

~~Transportation rates shall be negotiated according to statutory limits.~~

~~Frequency of service is by mileage or trip or hourly for escort service.~~

6. ~~Authorization of individual transportation providers~~

~~Staff shall contract with and authorize payments for individual providers only if-~~

~~a. The proposed provider is the individual who will personally drive the vehicle;~~

~~b. There is no common carrier serving the area in which the client needs transportation; or the common carrier is incapable of providing the specific service in question. (An individual cannot be authorized unless the carrier(s) serving the area provides a written statement that they are incapable. If the provider refuses to provide such a statement, the staff shall contact Central Office for possible intervention by the Public Service Commission.); and~~

~~c. The provider is registered with the PSC, certifying that all provider requirements are met.~~

5-005.M Home Again (HA) Service

1. Description: HA Service is available to support and enable Medicaid-eligible nursing facility residents to move to a more independent living situation of their choice. Items and services covered include but are not limited to:

1. Furniture, furnishings, and household supplies;
2. Security deposits, utility installation fees or deposits; and
3. Moving expenses.

2. Need for Service: All items and services covered must be essential to:

1. Ensure that the person is able to transition from the current NF; and
2. Remove identified barriers or risks to the success of the transition to a more independent living situation.

3. Persons Eligible: To receive this service, a person aged 18 or older must be a current NF resident whose NF services have been paid by Medicaid for at least six months. Persons whose NF stay is rehabilitative are not eligible for this service.

4. Items and Services Covered: The Services Coordinator and client must jointly determine the need for specific Home Again Services. Services must be identified in one or more assessment areas and reflected in the client's Plan of Services and Supports. The Services Coordinator may authorize services in one or more of the following areas:

1. Essential furniture, appliances, furnishings, and household supplies;
2. Security deposits and utility installation fees and deposits;
3. Moving expenses;
4. Assistance from a Home Again Sponsor; and
5. Expenses for other services or items related to the move which are essential to remove barriers to the transition or its success.

Once purchased, all items become the property of the client. Any prior-authorized transition expenses incurred in good faith will be covered by the program even if the transition does not ultimately occur (for example, the client has a medical emergency).

5. Items and Services Not Covered: Medicaid funds may not be used to pay rent. In addition, the Services Coordinator must not authorize items and services which:

1. Are not essential to supporting the move or ensuring its success;
2. Are available through the Medicaid state plan or through another service of this Waiver program;

3. _____ Are available at no cost from relatives, friends, or any other source; or
4. _____ Relate to a move to an assisted living facility and are the responsibility of the AL facility or included in the client's public assistance budget. Examples are a rental deposit, monthly payment, utilities provided for all residents, or basic furniture.

6. Service Duration: HA services may be authorized only once during a twelve month period. The authorization period for HA Services may begin as soon as the client, Services Coordinator, and NF staff agree that a discharge plan indicates a move to a more independent setting. The Services Coordinator may authorize expenditures made up to 60 days in advance of the planned move date and for 30 days after the actual move date.

7. Home Again Sponsor: Each client eligible for Home Again Service must have a designated HA Sponsor. The role of the Sponsor includes but is not limited to:

1. _____ Assisting the client as necessary to locate and procure accessible, affordable housing;
2. _____ Providing support in dealing with the changes related to the transition move; and
3. _____ Providing the up-front funding to obtain the essential items and services included in the Plan of Services and Supports.

If the client has no family or friend available to fill the Sponsor role at no cost, the Services Coordinator may authorize the payment to a paid Sponsor. A relative or friend assuming the role of Sponsor must also meet provider standards to receive reimbursement of actual transition expenditures made on behalf of the client.

8. HA Sponsor Standards: A HA Sponsor may be an individual, a business, an organization or an agency. In addition to the general standards for all waiver providers, a HA Sponsor must:

1. _____ Be age 19 or older;
2. _____ Recognize and support the client choice in selection of items and services provided through this service;
3. _____ Have experience in carrying out activities related to locating housing and setting up a household;
4. _____ Be free of communicable disease;
5. _____ Be able to recognize distress and/or signs of illness in clients;
6. _____ Observe and report all changes in client functioning to the services coordinator and/or to the NF staff; and
7. _____ Assure that any vehicle and driver transporting a client to look for housing or other transition need meets applicable licensing and safety laws and regulations. **Moved to 480 NAC chapter 5, section 003.06 as modified**

~~9. Home Again Rates: The Home Again rate consists of payment for the actual cost of items and services necessary for the client's move and any payment to the sponsor. The maximum amount allowed for the Home Again service is a one-time payment of \$1500, of which up to \$300 may be allowed for the payment to the sponsor. This amount may be subject to annual adjustment as allowed by the Legislature (see 480-000-209). Payment for the Home Again service is not counted in the client's monthly cost for waiver services.~~

~~10. Home Again Services Provider Billing: HA Sponsors must bill for services by:~~

- ~~1. _____ Totaling and submitting dated receipts for purchases made on behalf of the client;~~
- ~~2. _____ Totaling and submitting receipts or other written documentation of the financial obligation incurred by the Sponsor on behalf of the client for security deposits, utility installation, and/or fees;~~
- ~~3. _____ Providing a detailed listing of the dates and activities performed if payment for the Sponsor's time is authorized; and~~
- ~~4. _____ Submitting a billing request for the total amount of expenses incurred. Moved to 480 NAC chapter 4, section 003.06 as modified~~

5-006 GENERAL PROVIDER STANDARDS

GENERAL STANDARDS FOR ALL WAIVER PROVIDERS: All home and community-based services (HCBS) waiver providers are Medicaid providers (see 471 NAC 2-000). All HCBS waiver providers shall meet the following general provider standards:

1. Follow all applicable Nebraska Health and Human Services policies and procedures (Nebraska Administrative Code Titles 465, 471, 473, 474, and 480).
 - a. Bill only for services which are authorized and actually provided.
 - b. Submit billing documents after service is provided and within 90 days.
2. Accept payment as payment in full for the agreed upon service(s) unless the client has been assigned a portion of the cost. Provider will not charge clients any difference between the agreed upon rate and private pay rate.
3. Agree not to provide services, if s/he is the legally responsible relative (i.e., spouse of client or parent of minor child who is a client).
4. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60.
5. Retain financial and statistical records for four years from date of service provision to support and document all claims.
6. Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20 – 74.24; and 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site.
7. Keep current any state or local license/certification required for service provision.
8. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State.
9. Agree and assure that any false claims (including claims submitted electronically), statements, documents, or concealment of material fact may be prosecuted under applicable state or federal laws (42 CFR 455.18).
10. Respect every client's right to confidentiality and safeguard confidential information.
11. Understand and accept responsibility for the client's safety and property.
12. Not transfer this agreement to any other entity or person.
13. Operate a drug-free workplace.
14. Not use any federal funds received to influence agency or congressional staff.
15. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect.
16. Allow Central Registry checks on himself/herself, family member if appropriate, or if an agency, agree to allow Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place.
17. Have the knowledge, experience, and/or skills necessary to perform the task(s).
18. Report changes to appropriate Department staff (e.g., no longer able/willing to provide service, changes in client function).
19. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate HHS staff.
20. Be age 19 or older if an individual provider; or assure that agency staff who assume the following roles are age 19 or older: director, administrator, agency representative for signing legal documents, or provider of in-home client services. **Moved to 480 NAC chapter 4, section 002.06 as modified**

Reports of Abuse or Neglect: If the provider is an agency, HHS staff shall review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse or neglect are in place.

If the provider is an individual, HHS staff shall check the Central Registries to determine if any substantiated reports of abuse or neglect by the provider exist. If the provider provides services in his/her own home, HHS staff shall also check the Central Registries to determine if any substantiated reports of abuse or neglect by household members exist. If a report of abuse or neglect has been substantiated, HHS staff shall not contract with the individual provider.

If a report of abuse or neglect concerning a current waiver provider (or household member) as perpetrator is substantiated, staff shall immediately terminate the provider contract and notify the services coordinator. **Moved to 480 NAC chapter 4, section 002.08 as modified**

Reports of Convictions, Unacceptable Behaviors: Before approval, the provider shall provide a statement to HHS staff, giving information concerning any felony and/or misdemeanor arrests and convictions and pending criminal charges. Any other adult regularly present in the home must also provide such a statement if services will be provided in the provider's home. These statements must be signed and dated.

If additional information is needed to determine whether the provider meets this standard (e.g., the statement shows a questionable history or the staff has reason to question the validity of the statement), HHS staff shall obtain a release of information and request information available from law enforcement. Releases must also be obtained from household members, as applicable. Refusal to sign a release of information is grounds for immediate denial or termination of provider approval.

No provider approval will be issued or remain in effect if there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the illegal use of a controlled substance, or crimes involving moral turpitude on the part of the provider or any other household members. The provider and household members shall not engage in or have a history of behavior injurious to or which may endanger the health or morals of the client. **Moved to 480 chapter 4, section 002.07 as modified**

5-007 PROVIDER APPROVAL PROCESS

Designated HHS staff use the following policies and procedures when evaluating and approving providers of waiver services.

A. DEFINITIONS

Agency Provider: Providers who have one or more employees or will be subcontracting any one or part of the service(s) for which they are requesting approval.

Individual Provider: Providers who have no employees and will not normally be subcontracting any service(s) for which they are requesting approval. Individual providers are independent contractors and not employees of HHS or the State of Nebraska. (For the purpose of FICA withholding, the provider is considered an employee of the client.)

Provider Identification Number: A nine-digit federal identification (FID) number or a nine-digit Social Security number (SSN).

Service Provider Agreement: A legally binding document which may include an addendum and all applicable provider checklists, describing the service(s) to be provided, and the maximum rate(s) allowed for each provider. The responsibilities of the provider and of HHS are stated in the agreement.

Subcontracting: Occurs when a service provider pays someone other than an employee to provide the contracted service.

B. EVALUATING A POTENTIAL PROVIDER

HHS staff shall conduct an in-person interview with each potential provider.

If the provider does not meet standards at the time of the initial visit or interview, but is willing to correct the deficiency within a reasonable period of time, staff shall continue the evaluation process when proof of compliance is received.

All waiver providers must have a Social Security number or FID number, whichever is appropriate, and provide it to HHS before contracting.

Conflict of Interest: No employee of HHS or its subdivisions may be approved as a service provider if s/he is in a position to influence his/her own approval or utilization.

HHS Staff Relatives as Providers: HHS staff shall not approve, reapprove, evaluate, or negotiate provider agreements with, or authorize service provision from, providers to whom they are related. In situations where a HHS staff person's relative is the only resource, staff shall obtain approval from the Service Area Administrator or designee.

Client Relatives as Providers: Legally responsible relatives (i.e., spouses of clients or parents of minor children who are clients) shall not be approved as service providers for their relatives.

Moved to 480 NAC chapter 4, section 004.01 as modified

C. DENYING A POTENTIAL PROVIDER

Denial of Application: ~~If HHS staff determine that the potential provider does not comply with all the provider standards for the service(s) to be provided, s/he shall -~~

- ~~1. Document the regulation(s) on which the denial is based and the reason(s) why the potential provider does not comply with the cited regulations; and~~
- ~~2. Send a letter of notice to the potential provider including -~~
 - ~~a. Explanation of the reasons for HHS's determination that the potential provider does not comply with the cited regulations, or that HHS and the potential provider have failed to agree on contracting issues;~~
 - ~~b. Citation of the regulations on which the denial was based; and~~
 - ~~c. Notification of the potential provider's right to appeal HHS's decision/action.~~

Voluntary Withdrawal: ~~Written notice to the potential provider is not required if s/he voluntarily withdraws from the evaluation process.~~

D. COMPLETING A PROVIDER AGREEMENT

~~When a potential provider has met all necessary requirements, HHS staff shall complete a Services Provider Agreement. Staff shall explain that monitoring visits will occur.~~

~~If the provider is a non-emancipated minor, the signature of his/her parent or legal guardian must be obtained on the provider agreement.~~

Agreement Policies: ~~The following policies govern service provider agreements:~~

- ~~1. Each provider must have a service provider agreement in effect before service can be authorized for purchased;~~
- ~~2. Resource development staff shall evaluate and approve or disapprove all service providers located within the office's jurisdiction;~~
- ~~3. Service provider agreements are effective up to 12 months, are never back-dated, and must be agreed upon and signed by all parties on or before the effective date; and~~
- ~~4. Changes in service provider agreements require agreement and new signatures of the contract. Address changes which do not affect the service location must be reported to HHS staff and do not require a new agreement.~~

Monitoring: ~~Staff assigned services coordination or resource development responsibilities shall provide ongoing monitoring of the quality of services provision. Staff monitoring must also be done any time there is reason to believe a provider is not fulfilling his/her responsibilities. Staff shall report any suspected abuse or neglect to law enforcement and/or the appropriate HHS staff.~~

E. NOTIFYING OF PROVIDER TERMINATION

Either HHS or the provider may terminate an agreement by giving at least 30 days advance written notice. The 30-day requirement may be waived in case of emergencies such as illness, death, injury, or fire. If the provider violates or breaches any of the provisions of the Service Provider Agreement, then the agreement may be terminated immediately at the election of HHS.

When an agreement is to be terminated by HHS, staff shall-

1. Document the reason(s) for the termination and provide written notice.
2. Provide written notice which includes:
 - a. Explanation of the reasons for the termination;
 - b. Citation of the regulations on which the termination was based; and
 - c. Notification of the provider's right to appeal HHS's decision/action.

Resource development staff shall notify services coordination staff of the provider termination.

F. APPEALING DECISION/ACTIONS

A provider of waiver services has the right to appeal any decision/action that has a direct adverse effect on the provider (see 471 NAC 2-003). Hearings are scheduled and conducted according to the procedure in 465 NAC 2-001.02 and 6-000. Moved to 480 chapter 4, section 004.05 as modified

~~5-008 PROVIDER AGREEMENT RENEWAL~~

~~HHS staff shall use established standards to re-evaluate each service provider before the expiration of a provider agreement. Provider agreements must be renewed based on the same procedures used for initial approval, including conducting an in-person interview and completing provider checklists.~~ Moved to 480 NAC chapter 4, section 002.09 as modified

5-009 RESOURCE DEVELOPMENT DOCUMENTATION

~~Resource development documentation shall be maintained for each provider, and retained for four years. Documentation must include:~~

- ~~1. Provider agreements, addendums, and checklists;~~
- ~~2. Verification of Central Registry checks;~~
- ~~3. Felony and/or misdemeanor statements;~~
- ~~4. Written notices to, and other communication with, the provider;~~
- ~~5. Activities related to services delivery monitoring;~~
- ~~6. Narrative documentation (e.g., resource development staff decisions and actions; and other factual, relevant information); and~~
- ~~7. Billing and payment records.~~

5-010 PROVIDER SOCIAL SECURITY TAX WITHHOLDING

Affected Providers: In some situations, HHS withholds Social Security taxes (Federal Insurance Contribution Act, FICA) from provider payments. The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not affiliated with an agency. HHS, upon receiving a signed "Employer Appointment of Agent," acts on behalf of clients who receive in-home services to withhold mandatory FICA taxes from individual providers and pays the client's matching tax share to the Internal Revenue Service (IRS).

Earnings Taxed for Social Security: Affected providers are subject to Social Security tax payment for each calendar year in which they are paid a federally determined amount or more for services provided to one client. (For example, for calendar year 1995 the base amount was \$1,000 paid for FICA-covered services per client.) HHS shall withhold this tax from all payments to affected providers. If a provider's earnings do not reach this annual amount for FICA services per client, the amount withheld for that year is refunded.

Social Security Tax Rates: HHS remits to the IRS an amount equal to the current Social Security tax rate for specified "in-home" services. Half of this amount is withheld from the provider as the employee's share; the other half is provided by HHS on behalf of the client employer. **Moved to 480 NAC chapter 4, section 002.11 as modified**

5-011 PROVIDER RECORD KEEPING

Providers of waiver services must retain for four years the following material:

1. Documentation which supports provision of services to each client served under the waiver;
2. Any other documentation determined necessary by HHS to support selection and provision of services under a plan of services and supports;
3. Financial information necessary to allow for an independent audit under the waiver;
4. Documentation which supports requests for payment under the waiver; and
5. Provider agreements with HHS. Moved to 480 NAC chapter 4, section 002.12 as modified

TITLE 480 HOME AND COMMUNITY-BASED SERVICES

CHAPTER 6 TRAUMATIC BRIAN INJURY (TBI) WAIVER SERVICE REQUIREMENTS

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 68-901 Et seq. (the Medical Assistance Act).

002. PARTICIPANT ACCESS AND REQUIREMENTS.

002.01 PARTICIPANT ELIGIBILITY. In addition to the criteria outlined in 480 Nebraska Administrative Code (NAC) 3-000, to be eligible for Traumatic Brain Injury (TBI) Waiver services, an individual must:

- (A) Be an adult, ages 18 - 64 years old, with a medically documented diagnosis of traumatic brain injury (TBI);
- (B) Have needs which require the type of care necessary to treat the conditions and criteria identified in the definition of a Specialized Assisted Living (SAL); and
- (C) Utilize available waiver capacity. If a statewide waiting list is required due to limited statewide capacity, the next available opening is assigned based upon this priority order:
 - (i) The participant has been residing in a nursing facility, hospital, or other institution for longer than 90 days;
 - (ii) The participant is in a crisis or high stress situation and is at risk for institutional placement;
 - (iii) The participant is a person who has had a substantiated report of abuse or neglect, and it is determined that the applicant can be appropriately supported with waiver services; and
 - (iv) Any other situation where the participant is eligible for waiver services.

002.02 PERSON-CENTERED PLAN (PCP). The person-centered plan (PCP) must be developed and managed in accordance with the provisions of 480 NAC 3-000 and additionally, will identify specialized assisted living (SAL) service components and select a qualified provider to meet the participant's assessed needs.

003. SPECIALIZED ASSISTED LIVING (SAL) PROVIDER REQUIREMENTS. In addition to all requirements applicable to an assisted living provider in 480 NAC Chapters 2-000, 4-000 and 5-000, each assisted living (AL) provider providing traumatic brain injury (TBI) services will be licensed as a specialized assisted living (SAL) provider per 175 NAC Chapter 4-000.

003.01 SPECIALIZED ASSISTED LIVING (SAL) PROVIDER RATES. Specialized assisted living (SAL) providers are provided an increased rate relative to the rates outline in 480 NAC 4-000. This increased rate is based on participant condition and complexity of providing services.

004. SERVICE REQUIREMENTS. The service available to eligible persons under Nebraska's traumatic brain injury (TBI) Waiver is described in this section. The need for each Waiver service must be identified in one or more assessment areas and addressed in the participant's person-centered plan (PCP).

004.01 SPECIALIZED ASSISTED LIVING (SAL) SERVICE.

004.01(A) SERVICE DESCRIPTION. Specialized assisted living (SAL) is an array of support services for the Home and Community-Based Services (HCBS) Waiver population which includes assistance with or provision of personal care activities, activities of daily living (ADL), instrumental activities of daily living (IADL), and health maintenance activities.

004.01(B) SERVICE COMPONENTS. Specialized assisted living (SAL) providers must offer and make available each of the service components identified and outlined in 480 NAC 5-000.