NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

September 27, 2021
10:00 a.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 404, of the Nebraska Administrative Code (NAC) – *Developmental Disabilities Services.* The purpose of the changes to Title 404 is to align the regulations with the recently promulgated Title 403 and the Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities waivers which were approved in 2019 by the Centers for Medicare and Medicaid Services (CMS). The proposed changes remove several chapters that outline outdated services or regulations, clarify language, and reorganizes the remaining regulations in to six chapters. The proposed changes will update definitions; outline eligibility and funding; update requirements for certification of agency providers; update core requirements for both agency and independent providers; provider data collection and reporting; set out appeal process; update specific crimes for employees and independent contractors; remove duplicative statutory language from the regulations; and update formatting.

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

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 in person or by participating via phone conference line by calling 888-820-1398; Participant code: 3213662#.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax or email written comments, 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) 471-8417. Individuals who are deaf or hard of hearing 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.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

TO: Executive Board
Room 2108 State Capitol
Legislative Council

FROM: Marge Respeliers, Paralegal I
Legal Services
Department of Health and Human Services (DHHS)

DATE: August 18, 2021

RE: Notice of Rulemaking under Neb. Rev. Stat. § 84-907.06

The Department of Health and Human Services (DHHS) will be holding a third public hearing on proposed amendments and repeal to the following regulations:

TITLE:	404	Developmental Disabilities Services
CHAPTER:	1	Scope and Authority
	2	Definitions
	3	Eligibility and Authorization
	4	Certification Requirements for Certified Providers of Services
	5	Core Requirements for All Certified and Independent Providers
	6	Provider Data Collection and Reporting
	8-11	REPEALED

These regulations are scheduled for public hearing on September 27, 2021.

The purpose of this hearing is to receive additional comments on proposed changes to Title 404, of the Nebraska Administrative Code (NAC) – *Developmental Disabilities Services.* The purpose of the changes to Title 404 is to align the regulations with the recently promulgated Title 403 and the Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities waivers which were approved in 2019 by the Centers for Medicare and Medicaid Services (CMS). The proposed changes remove several chapters that outline outdated services or regulations, clarify language, and reorganizes the remaining regulations in to six chapters. The proposed changes will update definitions; outline eligibility and funding; update requirements for certification of agency providers; update core requirements for both agency and independent providers; provider data collection and reporting; set out appeal process; update specific crimes for employees and independent contractors; remove duplicative statutory language from the regulations; and update formatting.

The following items are enclosed for your referral to the chair of the relevant standing committee of the Legislature:

1. A copy of the notice of public hearing;
2. A copy of the proposed regulations;
3. A copy of the Policy Pre-Review Checklist; and
4. The estimated fiscal impact of this rulemaking action on state agencies, political subdivisions or persons being regulated.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 404	Prepared by: Joe Dondlinger
Chapter: 1-11	Date prepared: 07/15/2021
Subject: Developmental Disabilities Services	Telephone: 402-471-7855

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

TITLE 404 DEVELOPMENTAL DISABILITIES SERVICES

CHAPTER 1 SCOPE AND AUTHORITY

001. SCOPE. This title governs services for individuals with developmental disabilities (DD).

002. LEGAL AUTHORITY. The following laws and regulations give legal authority to the Department of Health and Human Services for the establishment, administration, and implementation of these regulations:

(A~~1~~)Developmental Disabilities Services Act (DDSA) (Nebraska Revised Statutes [Neb. Rev. Stat.] §§ 83-1201 to 83-1226); and

(B~~2~~)The Health and Human Services Act (Neb. Rev. Stat. §§ 81-3110 to 81-3124).

003. ALTERNATIVE COMPLIANCE PROCEDURE. The Department has the discretion to authorize alternative methods of compliance with any standards or compliance procedures specified in these regulations when the method of compliance meets the purpose and intent of any regulation.

003.01 To apply for alternative compliance with a regulation, a provider or designee must submit a written request to the Department. The written request must include:

(A) The citation of the specific part of the regulation for which alternative compliance is being requested;

(B) The rationale supporting the request for alternative compliance;

(C) If appropriate, activities or performance criteria to replace the requirement of the regulation and the date the provider is expected to attain alternative compliance;

(D) The signature of the director; and

(E) Authorization from the provider's governing board or designee to request alternative compliance.

003.02 The Department may grant the request for alternative compliance when the provider's proposal meets the following conditions:

(A) It is consistent with the intent of the specified regulation;

(B) It conforms to good and customary administrative, management, and programmatic practices;

(C) It protects the rights, health, safety, and well-being of the persons receiving services; and

(D) It does not relieve the provider of the responsibility to comply with other pertinent regulatory requirements.

003.03 The Department will issue a written decision regarding a request for alternative compliance to the provider within 30 calendar days following the receipt of the request. When a request for alternative compliance is granted:

(A) It will be for a specified time period not to exceed the duration of the certification period for which the alternative compliance is requested;

(B) A provider must receive written authorization from the Department prior to implementing the proposal for alternative compliance; and

(C) A provider must meet all the conditions prescribed by the Department in granting the request for alternative compliance. Failure to comply with the specified conditions will automatically void the authorization for alternative compliance.

003.04 The Department's decision regarding a request of alternative compliance is not appealable.

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 1 SCOPE AND AUTHORITY

1-001 SCOPE: This title governs community-based services for individuals with developmental disabilities (DD). Remains in section 001 as modified

1-002 LEGAL AUTHORITY: The following state and federal laws and regulations give legal authority to the Department of Health and Human Services for the establishment, administration, and implementation of these regulations: Remains in section 002 as modified

1. Developmental Disabilities Services Act (DDSA) (Neb. Rev. Stat. §§ 83-1201 to 83-1226); Remains in section 002(1) as modified
2. Nebraska Medical Assistance Program (Neb. Rev. Stat. §§ 68-901 to 68-949);
3. Title XIX of the Social Security Act, including Section 1915(c) of the Social Security Act (Medicaid HCB Waiver);
4. 42 CFR 440.180 and Part 441, Subpart G; and
5. The Health and Human Services Act (Neb. Rev. Stat. §§ 81-3110 to 81-3124. Remains in section 002(2) as modified

1-003 ALTERNATIVE COMPLIANCE PROCEDURE: Unless otherwise specified in these regulations, the Department has the discretion to authorize alternative methods of compliance with any standards or compliance procedures specified in these regulations when the method of compliance meets the purpose and intent of any regulation. Remains in section 003 as modified

1-003.01 To apply for alternative compliance with a regulation, a provider/or designee must submit a written request to the Department. The written request must include:

1. The citation of the specific part of the regulation for which alternative compliance is being requested;
2. The rationale supporting the request for alternative compliance;
3. If appropriate, activities or performance criteria to replace the requirement of the regulation and the date the provider is expected to attain alternative compliance;
4. The signature of the director; and
5. Authorization from the provider's governing board/or designee to request a alternative compliance. Remains in section 003.01(A-E) as modified

1-003.02 The Department may grant the request for alternative compliance when the provider's proposal meets the following conditions:

1. It is consistent with the intent of the specified regulation;
2. It conforms to good and customary administrative, management, and programmatic practices;
3. It protects the rights, health, safety, and well-being of the persons receiving services; and
4. It does not relieve the provider of the responsibility to comply with other pertinent regulatory requirements. Remains in section 003.02(A-D) as modified

1-003.03 The Department will issue a written decision regarding a request for alternative compliance to the provider within 30 calendar days following the receipt of the request. When a request for alternative compliance is granted:

5. It will be for a specified time period not to exceed the duration of the certification period for which the alternative compliance is requested;
6. A provider must receive written authorization from the Department prior to implementing the proposal for alternative compliance; and
7. A provider must meet all the conditions prescribed by the Department in granting the request for alternative compliance. Failure to comply with the specified conditions will automatically void the authorization for alternative compliance. Remains in section 003.03(A-C) as modified

1-003.04 A provider aggrieved by a decision to deny a request for alternative compliance has the right to contest the decision. When a provider requests a hearing, the Department will hold a hearing in accordance with the Department's rules and regulations adopted and promulgated under the Administrative Procedure Act (APA).

TITLE 404 DEVELOPMENTAL DISABILITIES SERVICES

CHAPTER 2 DEFINITIONS

001. DEFINITIONS. For the purposes of these regulations, definitions found in the Developmental Disabilities Services Act (Nebraska Revised Statute [Neb. Rev. Stat.] §§ 83-1201 to 83-1226), the Public Guardianship Act (Neb. Rev. Stat. §§ 30-4101 to 30-4118), the Workforce Innovation and Opportunity Act 34 C.F.R. parts 361, 363, and 397), the Adult Protective Services Act (Neb. Rev. Stat. §§ 28-348 to 28-387), the Child Protection and Family Safety Act (Neb. Rev. Stat. §§ 28-710 to 28-727), and the following definitions apply:

001.01 APPLICANT FOR CERTIFICATION. The individual, governmental entity, corporation, partnership, limited liability company or other form of business organization who applies for certification as a provider of specialized services.

001.02 ASSESSMENT. The process of evaluating and identifying the preferences, skills, and needs of a participant and what services, interventions, and supports would facilitate the health, safety, and welfare of that participant.

001.03 CERTIFIED PROVIDER. The person or entity providing developmental disabilities services and to whom the Department has issued a certification.

001.04 DEPARTMENT. The Department has the same definition as set forth in Neb. Rev. Stat. § 83-1204.

001.05 DIRECTOR. The person hired by, reporting to, and authorized by the certified provider to direct the day-to-day activities of the provider agency. The director may also be identified as the administrator, executive director, chief executive officer, program administrator, or other similar terms.

001.06 EMERGENCY SAFETY SITUATION. Unanticipated behavior by a participant that places the participant or others at serious threat of violence or injury if no intervention occurs and that requires an emergency safety intervention.

001.07 EMERGENCY SAFETY INTERVENTION. Use of physical restraint or separation as an immediate response to an emergency safety situation.

001.~~05~~08 EMOTIONAL ABUSE. Humiliation, harassment, threats of punishment or deprivation, sexual coercion, or intimidation, resulting in emotional harm or emotional anguish.

001.~~06~~09 INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). Intermediate care facility for persons with developmental disabilities, has the same definition as that set forth at Neb. Rev. Stat. § 71-421.

001.~~07~~10 INDIVIDUAL SUPPORT PLAN (ISP). A written plan which identifies the supports, activities, and resources required for a participant to achieve and maintain personal goals and health and safety.

001.~~08~~11 INDIVIDUAL SUPPORT PLANNING TEAM. The team, consisting of the participant, legal representative, if applicable, service coordinator, provider representative, and other individuals chosen by the participant served, that develops the individual support plan (ISP).

001.~~09~~12 INFORMED CHOICE. An individual's voluntary, well-considered decision made on the basis of options, information, and understanding. The decision-making process should result in a free and informed decision by the individual about whether he or she desires supports and services and which services he or she needs.

001.~~10~~13 OBJECTIVE ASSESSMENT PROCESS (OAP). The process used by the Department to determine the amount of funding for any participant receiving services, which includes the Inventory for Client and Agency Planning (ICAP) and other assessments.

001.~~11~~14 PARTICIPANT. An individual receiving Waiver program services and supports. Where the right to receive notice, to participate in the individual support planning team process and development of the individual support plan (ISP), or informed choice are regulated in this Title, participant also means any competent person legally authorized to act on behalf of the individual receiving Waiver program services and supports.

~~001.12 PHYSICAL RESTRAINT. Any physical hold that restricts, or is meant to restrict, the movement or normal functioning of a participant.~~

001.~~13~~15 PLAN OF IMPROVEMENT. A written plan outlining the provider's strategies to address any areas found to be out of compliance with applicable standards found during certification or service reviews.

001.~~14~~16 POSITIVE BEHAVIORAL SUPPORTS. Supports that emphasize positive approaches directed towards maximizing the growth and development of each individual.

001.17 RISK ENDORSEMENT. An addendum for which a certified agency may apply in order to serve participants determined to meet the need for behavioral risk services.

001.18 SECLUSION. The involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from having contact with others or leaving. Seclusion is prohibited. Seclusion is not separation of a participant to a safe room or area in an emergency safety situation as part of an emergency safety intervention.

001.~~15~~19 SERVICE COORDINATION. Targeted case management services provided by Department staff to assist a participant in facilitating services and supports for which he or she qualifies.

001.20 SUBSTANTIAL FUNCTIONAL LIMITATION. A score that is two standard deviations or more below the mean on a properly administered and valid, norm-referenced assessment of adaptive functioning that is generally accepted within the field of psychology.

001.~~16~~21 VERBAL ABUSE. The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to individuals served.

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 2 DEFINITIONS

Abuse means adult and child abuse as follows which is the level that requires reporting to outside authorities.

1. Adult Abuse: In accordance with Neb. Rev. Stat. § 28-351, in regard to adults: Abuse means any knowing, intentional, or negligent act or omission on the part of a caregiver, a vulnerable adult, or any other person which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, exploitation, or denial of essential services to a vulnerable adult. In accordance with Neb. Rev. Stat. § 28-358, exploitation means the taking of property of a vulnerable adult by means of undue influence, breach of a fiduciary relationship, deception, or extortion, or by any unlawful means. Remains in section 001 as modified

2. Child Abuse: In accordance with Neb. Rev. Stat. § 28-710, in regard to children: Child abuse or neglect means knowingly, intentionally, or negligently causing or permitting a minor child to be: Remains in section 001 as modified

a. Placed in a situation that endangers his /her life or physical or mental health;
b. Cruelly confined or cruelly punished;
c. Deprived of necessary food, clothing, shelter, or care;
d. Left unattended in a motor vehicle if such minor child is six years of age or younger;
e. Sexually abused; or
f. Sexually exploited by allowing, encouraging, or forcing such person to solicit for or engage in prostitution, debauchery, public indecency, or obscene or pornographic photography, films, or depictions.

Adult means, for the purposes of these regulations, an individual age 21 or older.

Annual Supports Plan (ASP) means a written plan developed by the individuals with the other members of his/her team that describes the services and supports to be provided to assist the individual to achieve his/her plan for the future. An ASP is required when the individual is participating in the Community Supports Plan. The ASP may also be referred to as the Individual Program Plan (IPP).

Appeal means a process by which a person or provider aggrieved by a final decision in a contested case or hearing seeks judicial review of the decision by a court of law, in accordance with the Administrative Procedure Act and regulations adopted by the Department of Health and Human Services.

Applicant means the individual, government, corporation, partnership, limited liability company or other form of business organization who applies for certification as a provider of specialized services. Remains in section 001.01 as modified

Assessment means the process that identifies the preferences, skills, and needs of the person and the services, interventions, and support that would facilitate a healthy, safe and meaningful life. Remains in section 001.02 as modified

Aversive stimuli means procedures that are punishing, physically painful, emotionally frightening, or deprivational or that have the potential to be a health or safety risk to individuals when they are used to modify behavior.

Center for Persons with Developmental Disabilities (CDD), as defined in Neb. Rev. Stat. §71-408, means a facility where shelter, food, and care, including habilitation, advice, counseling, diagnosis, treatment, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have developmental disabilities.

Certified provider means the person, government, corporation, partnership, limited liability company, or other form of business organization legally responsible for the operation of the provider entity and to whom the Department of Health and Human Services has issued a certification. Remains in section 001.03 as modified

Certification means the approval by the Department of Health and Human Services to allow a Developmental Disabilities (DD) provider to deliver specialized services to individuals with developmental disabilities. Certification includes the approval process necessary to qualify a provider to receive public funding for the delivery of DD services.

CFR means the Code of Federal Regulations.

Child means, for the purposes of these regulations, an individual under the age of 21 years of age or an individual who will reach age 21 during the current school year.

Children's Waiver Family Services means services provided for individuals and families who are eligible for the Home and Community Based Waiver for Children with Developmental Disabilities and their Families. These services are respite services, homemaker services, habilitative child care, and home modifications, and may be provided by private individuals, community agencies, or specialized DD providers.

Choice means the individual's expression of preference, opportunity for, and active role in decision-making related to the selection of assessments, services, providers, goals and activities.

Complaint means an expression of concern or dissatisfaction.

Compliance means to act in accordance with the regulations.

Conflict of interest means a conflict between the private interests and the official responsibilities of a person in a position of trust.

Consensus means a decision to which all team members either agree or are willing to accept and support.

Contested case means a proceeding before an agency in which the legal rights, duties, or privileges of specific parties are required by law or constitutional right to be determined after an agency hearing. Also referred to as "administrative hearing" or "fair hearing".

Delegation, related to an unlicensed staff, means a registered nurse gives authority to unlicensed staff to perform non-complex nursing interventions. (See 404 NAC 4-004.07.)

Denial of essential services means essential services were denied or neglected to such an extent that actual physical injury or imminent danger of physical injury or death occurred. This includes, for example, denial or omission of providing food, clothing, toileting, essential medical treatment, or necessary supervision to keep an individual safe. Also see neglect.

Developmental disability, as defined in Neb. Rev. Stat. § 83-1205, means: Remains in section 001 as modified

1. An intellectual disability (mental retardation); or
2. A severe, chronic disability other than an intellectual disability or mental illness; which:
   a. Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness;
   b. Is manifested before the age of twenty-two years;
   c. Is likely to continue indefinitely; and
   d. Results in:
      (1) In the case of a person under three years of age, at least one developmental delay; or
      (2) In the case of a person three years of age or older, a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age:
         (a) Self-care;
         (b) Receptive and expressive language development and use;
         (c) Learning;
         (d) Mobility;
         (e) Self-direction;
         (f) Capacity for independent living; and
         (g) Economic self-sufficiency.

Department means the Division of Developmental Disabilities of Department of Health and Human Services. Remains in section 001.04 as modified

Director means the person hired by, reporting to, and authorized by the certified provider to direct the day-to-day activities of the provider agency/organization. The director may also be identified as the administrator, executive director, chief executive officer, program administrator, or other similar terms. Remains in section 001.05 as modified

Director of Developmental Disabilities means the Director of the Division of Developmental Disabilities.

Discovery, for purposes of hearings, means requests for disclosures of information by interrogatory, deposition, requests to admit or deny written statements of facts, and motions to produce documents.

Documentation means the provision of written, dated, and signed evidence.

Emergency safety situation means unanticipated behavior by an individual that places the individual or others at serious threat of violence or injury if no intervention occurs and that requires an emergency safety intervention. Remains in section 001.06 as modified

Emergency safety intervention means the use of physical restraint or separation as an immediate response to an emergency safety situation. Remains in section 001.07 as modified

Emotional abuse means humiliation, harassment, threats of punishment or deprivation, sexual coercion, intimidation, resulting in emotional harm or emotional anguish. Remains in section 001.08 as modified

Exploitation means to obtain by deception, intimidation, or undue influence with the intent to deprive the individual of: the individual's money, property, body, work, or sexually including taking pictures.

Extended Family Home means a residential living arrangement where an individual pays room and board, and the Department pays for residential services. The family may be an individual surrogate family who is an employee of the DD provider or who subcontracts with the DD provider to deliver residential services.

Family member means the parent, spouse, or child of the individual in services or a person of the same relation by marriage.

Foreign, when applied to a corporation, means one incorporated in a state other than Nebraska.

Governing board means the person or entity controlling the provider, when applicable.

Hearing means a process on matters related to the initiation, change, or termination or the refusal to initiate, change, or terminate the determination of eligibility for specialized services or the evaluation or placement of the person or the provision or specialized services or records relating to these issues.

Hearing officer means an individual appointed to preside at an administrative hearing.

Individual means the person receiving services. Remains in section 001.14 as modified

Individual Education Program (IEP) means the written statement, generated by the school system, for a child with a verified disability (see 92 NAC 51-007) which specifies the special education and related services necessary to assure that the child receive a free, appropriate public education.

Individual and Family Support Plan (IFSP) means a written plan developed by the interdisciplinary team with and for a child with a developmental disability which describes the services to be provided, the frequency of those services, and the type of provider for the services needed to support the family and maintain the child's placement with the family or in the community. An

IFSP is required when services are funded by the Home and Community-Based Waiver for Children with Developmental Disabilities and Their Families. The IFSP may be developed in conjunction with the IEP for children receiving special education or other community services. The IFSP may also be referred to as the Individual Program Plan (IPP).

Individual Program Plan (IPP) means a written plan developed by the individual with the other members of his/her interdisciplinary team, known as the IPP team, that describes the services to meet the assessed needs. The IPP may be developed in conjunction with the IEP for children receiving special education or other community services. The IPP may also include the IFSP or the ASP. Remains in section 001.10 as modified

Individual Support Options (ISO) means community-based supports that are defined as either Supported Living or Supported Day. Either or both may be offered to the same individual who is eligible for developmental disability services.

Informal dispute resolution means an informal meeting to provide an interested party including the individual receiving services or his/her legal representative and the Department an opportunity to exchange information specific to a contested decision.

Informed choice means an individual's voluntary, well-considered decision made on the basis of options, information, and understanding. The decision-making process should result in a free and informed decision by the individual about whether s/he desires supports and services and which services s/he needs. Remains in section 00112 as modified

Integrated community employment means a service that assists an individual in maintaining competitive employment in an integrated work setting with on-going support services.

Intellectual disability means mental retardation as defined in Neb. Rev. Stat. § 83-381(1).

Intrusive technique means any procedure or intervention that is imposed or enforced on an individual receiving services that is seen as undesirable by the individual or controls the individual's choices or actions.

Legal representative means any person who has been vested by law with the power to act on behalf of the person receiving services in making decisions as required by these regulations. This term includes a guardian appointed by a court of competent jurisdiction or a parent in the case of a minor.

Mechanical restraint means any mechanical device, material, object, or equipment that is attached or adjacent to an individual's body that the individual cannot easily remove or easily negotiate around that restricts freedom of movement or access to the individuals body. Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are excluded.

Medication means any prescription or nonprescription drug intended for treatment or prevention of disease or to affect body function in humans.

Mistreatment means behavior or provider practices that result in any type of individual exploitation such as financial, sexual, or criminal.

NAC means Nebraska Administrative Code.

Neglect means the failure or omission by one's self, a caregiver, or another person with a duty to supply or provide essential services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

Non-complex nursing interventions means those actions which can safely be performed according to exact directions, do not require alteration of the standard procedure, and for which the results and response of the individual receiving services are predictable. Unlicensed staff are allowed to perform these when delegated by a registered nurse.

Non-specialized services means services provided for individuals with developmental disabilities delivered by a provider of the individual's choosing.

Objective assessment process (OAP) means the method to determine the level of funding for services based on an individual's strengths and needs. The objective assessment process is designed and implemented by the Department to ensure equitable distribution of fiscal resources based on a standardized assessment. Remains in section 001.13 as modified

Physical injury means harm, pain, illness, impairment of physical function, or damage to body tissue.

Physical restraint means any manual physical holding of, or contact with an individual that restricts the individual's freedom of movement.

Plan of improvement means a written document outlining the provider's strategies to address any areas found to be out of compliance with applicable standards in 404 NAC found during certification or service reviews. Remains in section 001.15 as modified

Positive Behavioral Supports (PBS) means supports that emphasize positive approaches directed towards maximizing the growth and development of each individual. Remains in section 001.16 as modified

Provider operated setting means a location where day or residential services are provided to individuals. The setting is operated or controlled by a certified provider or the provider's employee or subcontractor or any entity owned or controlled by the provider. This is regardless of who owns or leases the property.

Provision of medication means the component of the administration of medication that includes giving or applying a dose of a medication to an individual and includes assisting an individual in giving or applying such medication to him/herself. "Provision of medication" are those components of administration of medication that include providing medications for another person according to the five rights. Provision of medication does not include observing, monitoring, reporting, and otherwise taking appropriate action regarding desired effects, side effects, interactions, and contraindications associated with the medication, or recording the provision of the medication.

PRN means an administration scheme in which a medication is not routine, is taken as needed, and requires assessment for need and effectiveness.

Psychotropic Medication means any medication prescribed specifically to treat mental illness and associated symptoms. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, antimania, stimulant, and sedative or hypnotic. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness.

Restraint means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal functioning of an individual. Includes medication used solely to control or alter behavior, physical intervention, or mechanical device used to restrict the movement, normal function of a portion of the person's body or control the behavior of a person receiving services. Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are excluded.

Rules of evidence means the rules of court procedure which govern the admissibility of evidence at trials and hearings.

Seclusion means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. See "emergency safety intervention". Seclusion is prohibited. Remains in section 001.18 as modified

Service coordination means activities conducted on behalf of individuals with developmental disabilities and their families to help them access developmental disability services and other services not funded by the Department. Service coordination ensures that services are responsive to the preferences and needs of the individual and that services promote the independence, interdependence, productivity, and inclusion of individuals receiving services. In Nebraska's home and community-based waivers for persons with developmental disabilities, service coordination is referred to as case management. Remains in section 001.19 as modified

Setting means a location where habilitation, services, and supports are delivered.

Sexual abuse means sexual harassment, sexual coercion, or sexual assault.

Slot means the waiver designation for the services received by a single individual.

Specialized services means services provided for individuals with developmental disabilities delivered by a certified provider under contract with the Department.

Supported day means day supports for three or fewer individuals as a non-facility based option. Supported day is defined as a setting where a majority of those present are other paid or non-paid adults without disabilities in a typical community setting. These include day supports including but not limited to integrated community and regular employment, volunteer or self-employment, and other inclusive non-facility participatory activities that bring monetary or social value to a person's life.

Supported living means supports provided in the community for an individual eligible for developmental disability services. Supported living services are provided to three or fewer persons in a residence that is under the control and direction of the individual(s). The residence must be in a community integrated setting. These community integrated settings are under the control of the individual or an entity that is separate from the provider of services. The services

and supports provided are person-centered and may range from intermittent to 24 hours/day intensive supports.

Supports means those services provided to the individual to meet identified needs that may not be met through programs, such as appointments, medication administration, further evaluations, assistance, supervision, and health services. The provision of these services, as well as the frequency and discipline responsible for providing the services, must be specified in the IPP.

Verbal abuse means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to individuals served. Remains in section 001.21 as modified

TITLE 404 DEVELOPMENTAL DISABILITIES SERVICES

CHAPTER 3 ELIGIBILITY AND AUTHORIZATION

001. ELIGIBILITY AND AUTHORIZATION FOR DD SERVICES. The Department authorizes funding for services to individuals determined to be eligible as set forth in 404 NAC.

001.01 The following apply to developmental disabilities services, regardless of whether the services are funded by state general funds or Medicaid waiver funds.

001.01(A) FAMILY MEMBERS. The Department will not pay a legally responsible adult to provide developmental disabilities services. A legally responsible adult is a person who has a legal obligation under the provision of state law to care for another individual including a parent (natural or adoptive) of a minor child, a spouse, or legal guardian.

001.01(B) EDUCATIONAL SERVICES. No service that is the responsibility of the school system will be authorized as a developmental disabilities service. The Department will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

001.02 ELIGIBILITY CRITERIA FOR DEVELOPMENTAL DISABILITIES SERVICES. To be eligible for funding under the Developmental Disabilities Services Act, the individual must:

(1) Be a citizen of the United States of America, or a qualified alien lawfully present in the United States and comply with all requirements set forth in Chapter 4 of the Nebraska Revised Statutes pertaining to alien eligibility for public benefits;
(2) Be a legal resident of the State of Nebraska; and
(3) Have a developmental disability as defined in the Nebraska Developmental Disabilities Services Act and any applicable definitions contained in this Title.

001.02(A) All individuals eligible for funding for specialized services under the Developmental Disabilities Services Act must apply for and accept any federal Medicaid benefits for which they may be eligible and benefits from other funding sources within the Department; the Department of Education, specifically including the Division of Rehabilitation Services; and other agencies to the maximum extent possible.

001.03 ELIGIBILITY DETERMINATION. A determination of eligibility is made without regard to whether the Department has sufficient funds to provide or obtain needed services for the individual.

001.04 STATEWIDE DATA REGISTRY. All individuals who have been determined eligible for developmental disabilities services are included in the statewide data registry. The Department will use the statewide data registry to:

(1) Track the specialized service and support needs of persons with developmental disabilities;
(2) Plan for future specialized support and service needs of persons with developmental disabilities; and
(3) Budget for future specialized support and service needs of persons with developmental disabilities.

Information in the registry is considered confidential and will not be released without proper authorization as provided by law.

001.04(A) Information for each eligible individual listed in the data registry system may include:

(i) Demographics;
(ii) Individual diagnosis;
(iii) Eligibility factors;
(iv) Financial information;
(v) Family and legal representative information; and
(vi) The objectively assessed needs for specialized supports and services, specifying amount and type.

001.05 DETERMINATION OF ELIGIBILITY. The Department determines eligibility for developmental disabilities services and notifies the individual in writing.

001.05(A) REASONS FOR INELIGIBILITY. An individual is ineligible if:

(i) The individual does not meet the criteria set forth in this Title; or
(ii) The individual or persons acting on his or her behalf have not supplied needed information. Upon supplying this information, eligibility will be determined.

001.05(B) SERVICE COORDINATION. Upon request, service coordination is provided to all eligible individuals when all statutory and regulatory requirements are fulfilled. Acceptance of service coordination is required to receive other developmental disabilities services.

001.06 AUTHORIZATION OF FUNDS FOR DEVELOPMENTAL DISABILITIES SERVICES. Funding for developmental disabilities services with State General Funds other than service coordination is authorized for eligible individuals contingent upon legislative appropriations and availability of funds.

001.06(A) The amount of funding for any person receiving services is determined using an objective assessment process (OAP).

001.06(B) Specialized services for an individual is authorized according to the individual's objective assessment.

001.06(C) The Department will authorize funding for services only when services and supports are not being provided through other available sources.

002. DEVELOPMENTAL DISABILITIES SERVICES FUNDED BY STATE GENERAL FUNDS. The following provisions govern services funded by State General Funds.

002.01 DENIAL OF STATE GENERAL FUNDS. The Department may at any time deny or terminate funding for specialized services funded solely by State General Funds for one or more of the following reasons:

(A) The individual does not meet eligibility requirements;
(B) The Legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for specialized services;
(C) The eligible individual's needs may be met through the use of natural supports or other resources;
(D) Funding for requested specialized services is available from other sources;
(E) The eligible individual has not met prioritization criteria;
(F) The eligible individual has not met criteria for funding available through legislative mandates, or court decisions addressing specific population, groups, or order of services offered;
(G) The eligible individual or legal representative has failed to apply for and accept any federal Medicaid benefits for which she or he may be eligible; for benefits from other funding sources within the Department or the Nebraska Department of Education; and for benefits from other agencies to the maximum extent possible;
(H) The eligible individual is not eligible for Medicaid benefits or the eligible individual or legal representative has failed to comply with requirements for initial or continued eligibility of any federal Medicaid benefits for which she or he may be eligible;
(I) The eligible individual or legal representative failed to comply with the requirements for initial or continued benefits from other funding sources within the Department, the Nebraska Department of Education, and other agencies to the maximum extent possible;
(J) The eligible individual or legal representative has not signed documentation required by the Department;
(K) The eligible individual or legal representative has failed to cooperate with, or refused the services funded by the Department;
(L) The child under the age of 22 could receive educational services during a normal, regular, or adjusted school day;
(M) A plan of services and supports to protect the individual's health and welfare cannot be developed or maintained; or
(N) The eligible individual, legal representative, or representative payee has not supplied information requested by the Department including information regarding the individual's ability to pay a portion of the costs of services if required by applicable law.

002.02 FUNDING PRIORITIZATION. As State General Funds are available, the Department will authorize funding of specialized services to individuals on the basis of priority criteria as set forth in the Developmental Disabilities Services Act. Services provided under the Developmental Disabilities Services Act with State General Funds are:

(A) Habilitative Community Inclusion;

(B) Habilitative Workshop;
(C) Prevocational Service;
(D) Service Coordination;
(E) Supported Employment-Enclave;
(F) Supported Employment-Follow Along; and
(G) Supported Employment-Individual.

002.03 ABILITY TO PAY. Prior to entry into services and annually, the Department will assess the ability of an individual to pay all or part of the cost of services provided under this Title. This does not apply to persons receiving Medicaid Waiver services.

003. ANNUAL AND ONGOING ELIGIBILITY REVIEW FOR SERVICES. The Department will complete a review of eligibility on an annual basis or when changes in the individual's circumstances appear. If the individual is determined to be ineligible, the Department will notify the individual.

003.01 AUTHORIZATION OF SERVICES FUNDING. All State General Funds services funding must be authorized by the Department, prior to the service being provided.

003.02 PROHIBITED USES OF DEPARTMENT FUNDS. State General Funds will not be used to pay for:
(A) The care of individuals residing in a hospital, nursing facility, or intermediate care facility for individuals with developmental disabilities (ICF/DD);
(B) Room and board;
(C) Services currently covered under Nebraska Medicaid; or
(D) Services to a child when educational services could be provided during a normal, regular, or adjusted school day.

004. HEARINGS FOR ISSUES RELATED TO DEVELOPMENTAL DISABILITIES SERVICES FUNDED BY STATE GENERAL FUNDS. An individual has the right to appeal decisions made by the Department with respect to State General Fund services as follows:
(A) The denial, change, or termination of eligibility of the individual for specialized services;
(B) The evaluation of the individual;
(C) The provision of specialized services to the individual;
(D) The amount of the individual's authorized funding; or
(E) The records relating to the individual.

004.01 An individual is not entitled to appeal when state or federal law requires automatic changes adversely affecting some or all classes of persons applying for or receiving services under the Developmental Disabilities Services Act.

004.02 TIMELINESS OF APPEAL. In order to exercise the right to appeal, an individual must file a formal appeal, within 90 days of the mailing date of the decision being contested. If the individual does not file an appeal, the decision becomes final on the 90th day after the mailing date of the decision.

004.03 REQUESTING A HEARING. In order to exercise the right to a hearing, the individual must file an appeal with the Department. The appeal may be made on a form provided by the

Department for such purpose or in another writing that contains at least the following information:

(1) The name, address, and phone number of the appellant; the name, address, and phone number of the legal representative, if applicable; and the signature of the appellant or legal representative;
(2) The specific decision contested;
(3) The date of the decision contested; and
(4) Any other information that the individual wants to be included at the hearing.

004.03(A) If the appeal fails to include any of the above information, it will be ineffective to initiate the hearing process and the Department may either reject the appeal or request additional information from the individual.

004.03(B) In order to be effective, the appeal must be either mailed, sent via electronic mail, submitted by telephone or online portal, or hand delivered to the Department.

004.03(C) If mailed, the appeal will be deemed to be received by the Department on the date of the postmark. If hand delivered, emailed, or submitted via online portal or telephone, the appeal will be deemed to be received by the Department on the actual date of receipt.

004.04 STAYING THE DECISION OR ACTION. If an individual appeals within 10 days of a notice of decision being mailed, it is assumed that the individual is requesting that any ongoing assistance that is the subject of the appeal will continue during the pendency of the appeal unless the individual indicates a contrary intent.

004.05 HEARING OFFICER. Upon receipt of an appeal, the Director of the Division of Developmental Disabilities will assign the matter to a hearing officer who will receive all subsequent pleadings and will conduct the hearing.

004.05(A) Any party may challenge a hearing officer on the grounds that the hearing officer has a conflict of interest. The challenge may be made to the hearing officer on, or before, the date set for hearing. The hearing officer may hear and decide the challenge or may refer the matter to the Director of the Division of Developmental Disabilities. If the hearing officer does not hear the challenge immediately, the hearing on the appeal will be continued until the challenge is resolved. The hearing officer will notify all parties of the new hearing date by mail at least five business days before the date of the hearing.

004.05(B) The Director of the Division of Developmental Disabilities may substitute a hearing officer for good cause. The substitution of a hearing officer is reason for a continuance.

004.06 AUTHORITY AND DUTIES OF THE HEARING OFFICER. A hearing officer is assigned to each appeal and has the duty to:

(1) Conduct full, fair, and impartial hearings;
(2) Take appropriate action to avoid unnecessary delay in the disposition of proceedings; and
(3) Maintain order during the hearing.

004.06(A) The hearing officer has all the powers necessary to carry out his or her duties, including to:

(i) Administer oaths and affirmations;
(ii) Issue subpoenas as authorized by law to compel the appearance of witnesses and the production of relevant evidence;
(iii) Compel discovery and to impose appropriate sanctions for failure to make discovery;
(iv) Rule upon offers of proof and receive relevant, competent, and probative evidence;
(v) Regulate the course of the proceedings in the conduct of the parties and their representatives;
(vi) Hold conferences for simplification of the issues, settlement of the proceedings, or any other proper purpose;
(vii) Consider and rule orally or in writing, upon all procedural and other motions appropriate in adjudicative proceedings, including the application of, or exclusion from, the stay of an action or decision on appeal;
(viii) Establish the time for filing briefs;
(ix) Grant a specific extension of time, at the request of either party for good cause shown;
(x) Produce evidence on his or her own motion;
(xi) Exclude people from the hearing;
(xii) See that facts are fully developed including witness examination and cross examination, if needed; and
(xiii) Take any other action consistent with the purpose of the law and consistent with these rules.

004.07 THE HEARING. The hearing officer will set the date, time, and location of the hearing.

004.07(A) Unless as otherwise specified in these regulations or applicable statutes, the hearing officer and all parties may serve all motions, notices, pleadings, orders, or other papers personally or by mail.

004.07(B) The hearing officer and all parties must serve all parties who have entered their appearances with all notices, motions, pleadings, orders, or other papers filed. Service on an attorney of record is service on the party represented by the attorney.

004.07(C) PRESENTATION OF EVIDENCE. The Nebraska Evidence Rules, Neb. Rev. Stat. §§ 27-101 et seq., will not apply unless invoked in writing by either party at least ten business days before the hearing. However, the hearing officer will admit competent, relevant**,** and material evidence, but will exclude evidence that is incompetent, irrelevant, immaterial, or unduly repetitious.

004.07(C)(i) Any party invoking the Nebraska Evidence Rules is liable for the payment of all costs related thereto, including the cost of court reporting services, which the party is responsible for procuring for the hearing.

004.07(D) ORDER OF PRESENTATION. At the hearing, the parties will present evidence on the issues raised in the appeal and any subsequent pleadings.

004.07(D)(i) The order in which evidence and testimony is presented will be at the discretion of the hearing officer.

004.07(D)(ii) The appellant has the burden of persuasion throughout the hearing.

004.07(D)(iii) The appellant must prove his or her case by a preponderance of the evidence.

004.07(E) RIGHTS. A party at a hearing has the right to:

(i) Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to needs of persons with developmental disabilities, request subpoenas, and issue discovery as authorized by law to compel the appearance of witnesses and the production of relevant evidence;
(ii) Present evidence and confront, cross-examine, and compel the attendance of witnesses;
(iii) Prohibit the introduction of any evidence at the hearing that has not been disclosed to that party at least five calendar days before the hearing;
(iv) Obtain a written or electronic verbatim record of the hearing at his or her cost; and
(v) Obtain written findings of fact and decisions from the Director of the Division of Developmental Disabilities.

004.07(F) WITNESSES. The hearing officer may issue subpoenas to compel witnesses to attend or produce evidence. Witnesses are entitled to the fees and expenses as allowed in District Court.

004.07(F)(i) The Director of the Division of Developmental Disabilities may certify failure to respond to a subpoena to the District Court of Lancaster County for enforcement or for punishment for contempt of the District Court.

004.07(F)(ii) Each party is responsible for the payment of witness fees and mileage, including the fees and expenses of expert witnesses that the party calls.

004.07(F)(iii) The Department will provide personnel as witnesses when served with a subpoena without payment of witness fees or mileage fees.

004.07(G) At the completion of the proceedings, the hearing officer will prepare a report based on the evidence presented containing recommendations for the Director of the Division of Developmental Disabilities to make findings of fact and conclusions of law.

004.08 JUDICIAL REVIEW. Any party aggrieved by the final decision and order of the Director of the Division of Developmental Disabilities is entitled to judicial review under applicable state law.

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 3 ELIGIBILITY AND AUTHORIZATION

3-001 ELIGIBILITY AND AUTHORIZATION FOR DD SERVICES: The Department authorizes funding for services to individuals determined to be eligible. An individual needing developmental disabilities services as described in 404 NAC must go through this process: Remains in section 001 as modified

(A) Determination of the individual's eligibility for funding;
(B) Prioritization, which is the determination of the immediacy of the individual's need for specialized services; and
(C) Authorization of the funding for each individual for services.

In addition to state general funds, the Department uses federal Medicaid funds available for Home and Community Based Waiver (waiver) services. An individual must meet additional eligibility criteria to be authorized for this funding.

3-001.01 The following policies apply to DD services, regardless of whether the services are funded by state general funds or Medicaid waiver funds. Remains in section 001.01 as modified

3-001.01A Family Members: The Department will not pay family members to provide DD services. Family member means the parent, spouse, or child of the individual in services or a person of the same relation by marriage. Remains in section 001.01(A) as modified

3-001.01B Educational Services: No service that is the responsibility of the school system will be authorized as a DD service. The Department will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling. Remains in section 001(B) as modified

3-001.02 Eligibility Criteria for DD Services: To be eligible for funding under the Developmental Disabilities Services Act, the individual must: Remains in section 001.02 as modified

1) Be a citizen of the United States of America or a qualified alien under the federal Immigration and Nationality Act and be lawfully present in the United States: Remains in section 001.02(1) as modified
   a. Attestation: The applicant must attest that s/he is a citizen of the United States of America or that s/he is a qualified alien under the federal Immigration and Nationality Act, 8 USC 1101 et seq., as such act existed on January 1, 2009; and is lawfully present in the United States. The

applicant must provide his/her immigration status and alien number, and agree to provide a copy of his/her United States Citizenship and Immigration Services (USCIS) documentation upon request.

b. Verification: For any applicant who has attested that s/he is a qualified alien under 404 NAC 3-001.02, item 1.a., eligibility for benefits must be verified through the Systematic Alien Verification for Entitlements Program. Until verification of eligibility is made, the attestation may be presumed to be proof of lawful presence unless the verification is required before providing the public benefits under another provision of state or federal law.

2) Be a legal resident of the State of Nebraska; and Remains in section 001.02(2) as modified

3) Have a developmental disability as defined in 404 NAC 2. Remains in section 001.02(3) as modified

3-001.02A All individuals eligible for funding for specialized services under the Developmental Disabilities Services Act must apply for and accept any federal Medicaid benefits for which they may be eligible and benefits from other funding sources within the Department; the Department of Education, specifically including the Division of Rehabilitation Services; and other agencies to the maximum extent possible. Remains in section 001.02(A) as modified

3-001.03 Referral for Eligibility Determination: Service Coordination accepts referrals for eligibility determinations of all individuals and must make a determination of eligibility without regard to whether the Department has sufficient funds to provide or obtain needed services for the individual. Service Coordination must inform the individual or legal representative of findings of eligibility determination and the individual's right to contest the determination. Remains in section 001.03 as modified

3-001.04 Statewide Data Registry: All individuals who have been determined eligible for DD services are included in the statewide data registry. The Department will use the statewide data registry to:

1) Track the specialized service and support needs of persons with developmental disabilities;
2) Plan for future specialized support and/or service needs of persons with developmental disabilities; and
3) Budget for future specialized support and/or service needs of persons with developmental disabilities. Remains in section 001.04(1-3) as modified

Information in the Registry is considered confidential and will not be released without the proper authorization as provided by law. Remains in section 001.04 as modified

3-001.04A Information for each eligible individual listed in the data registry system may include:

(A) Demographics;
(B) Individual diagnosis;

(C) Eligibility factor(s);
(D) Financial information;
(E) Family/legal representative information; and
(F) The objectively assessed needs for specialized supports and/or services, specifying amount and type. Remains in section 001.04(A)(i-vi) as modified

3-001.05 Determination of Eligibility: The Department determines eligibility for DD services and notifies the individual in writing within 14 calendar days of the final decision. Remains in section 001.05 as modified

3-001.05A Reasons for Ineligibility: Service Coordination will find an individual to be ineligible if:

(A) The individual does not meet the criteria listed in 404 NAC 3-001.02; or
(B) The individual or persons acting on his/her behalf have not supplied needed information. Upon supplying this information, eligibility will be determined. Remains in section 001.05(A)(i-ii) as modified

3-001.05B Service Coordination: Upon request, service coordination is provided to all eligible individuals when all statutory and regulatory requirements are fulfilled. Acceptance of service coordination is required to receive other DD services. Remains in section 001.05(B) as modified

3-001.05C Application for Medicaid Waiver Services: See 404 NAC 3-003.01.

3-001.06 Authorization of Funds for DD Services: Funding for DD services other than service coordination is authorized for eligible individuals contingent upon legislative appropriations and availability of federal funds. Remains in section 001.06 as modified

3-001.06A Beginning July 1, 1995, persons determined to be eligible for specialized services who on or after September 6, 1993, graduate from high school, reach the age of twenty-one years, or are currently receiving services must receive services in accordance with the Developmental Disabilities Services Act. The amount of funding for any person receiving services must be determined using an objective assessment process.

3-001.06B Specialized services for an individual must be authorized according to the individual's objective assessment. Remains in section 001.06(A) as modified

3-001.06C Funding of services under pilot projects may require exceptions to the objective assessment process and will be utilized at the discretion of the Department.

3-001.06D The Department will authorize funding for services only when services and supports are not being provided through other available sources. Remains in section 001.06(C) as modified

3-002 DD SERVICES FUNDED BY STATE GENERAL FUNDS

3-002.01 Denial of State General Funds: The Department may deny funding for specialized services for one or more of the following reasons:

(A) The individual does not meet eligibility requirements;
(B) The Legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for specialized services;
(C) The eligible individual's needs may be met through the use of natural supports or other resources;
(D) Funding for requested specialized services is available from other sources;
(E) The eligible individual has not met prioritization criteria;
(F) The eligible individual has not met criteria for funding available through legislative mandates, or court decisions addressing specific population, groups, or order of services offered;
(G) The eligible individual or legal representative has failed to apply for, and accept any federal Medicaid benefits for which s/he may be eligible and benefits from other funding sources within DHHS, the State Department of Education, and other agencies to the maximum extent possible.
(H) The eligible individual or legal representative has failed to comply with requirements for continued eligibility of any federal Medicaid benefits for which s/he may be eligible and benefits from other funding sources within DHHS, the State Department of Education, and other agencies to the maximum extent possible;
(I) The eligible individual or legal representative has not signed documentation required by the Department;
(J) The eligible individual or legal representative has failed to cooperate with, or refused the services funded by the Department;
(K) The child under the age of 22 could receive educational services during a normal, regular, or adjusted school day;
(L) A plan of services and supports to protect the individual's health and welfare cannot be developed or maintained; and
(M) The eligible individual/legal representative/representative payee has not supplied information requested by the Department including information for the individual's ability to pay under 202 NAC 1. Remains in section 002.01(A-N) as modified

3-002.02 Funding Prioritization: As funding is available, the Department will authorize funding of specialized services for individuals who meet priority criteria. Priority is given to: Remains in section 002.02 as modified

(A) Individuals who need immediate intervention to prevent imminent physical harm caused by:
  a. Abuse or neglect;
  b. Lack of medical care;
  c. Lack of food, housing or clothing; or
(B) Individuals for whom immediate intervention by the Department is needed to prevent harm to themselves or others; or

(C) All other eligible individuals waiting the longest.

3-002.03 Ability to Pay: Prior to entry into services and annually, the Department will assess the ability of an individual to pay all or part of the cost of service coordination or services according to 202 NAC 1. This does not apply to Medicaid-eligible individuals. Remains in section 002.03 as modified

3-003 DD SERVICES FUNDED BY MEDICAID WAIVERS: The Nebraska Medical Assistance Program, also known as Medicaid, funds community-based services to individuals who have been determined eligible for Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) level of services.

The Department administers several Home and Community Based (HCB) Services Waivers for individuals with developmental disabilities.

3-003.01 Eligibility for Waiver Services

3-003.01A Application: An individual with developmental disabilities may apply for waiver services. To be eligible to receive waiver services:

(A) A slot must be available; and
(B) The individual must meet the criteria established for the adult or children's waiver, as appropriate.

3-003.01B Adult Waivers Eligibility Criteria: An individual is eligible for one of the adult home and community based services waivers if s/he:

(A) Is eligible for and currently receives DD services;
(B) Is 21 years old or older;
(C) Does not receive services under another 1915(c) home and community-based service waiver;
(D) Currently receives ICF/MR services, or meets the ICF/MR level of care criteria (see 404 NAC 3-003.01D);
(E) Is eligible for Medicaid;
(F) Has received an explanation of ICF/MR services and community-based waiver services;
(G) Has elected to receive waiver services;
(H) Has documentation of a physical exam within the past 12 months or, if the exam is waived, has written documentation from his/her physician;
(I) Has been assessed to benefit from habilitation;
(J) Has an Individual Program Plan (IPP) or Annual Supports Plan (ASP) developed by the individual and his/her team; and
(K) Has a waiver eligibility assessment current within the last 12 months.

3-003.01C Children's Waiver Eligibility Criteria: An individual is eligible for the children's waiver if s/he:

(A) Is eligible for and currently receives DD services;
(B) Is less than 21 years old unless s/he is 21 years old and in special education, with an active IEP;
(C) Does not receive services under another 1915(c) home and community-based service waiver;
(D) Currently receives ICF/MR services, or meets the ICF/MR level of care criteria (see 404 NAC 3-003.01D);
(E) Is eligible for Medicaid;
(F) Has received an explanation of ICF/MR services and community-based waiver services;
(G) Has elected to receive waiver services;
8. Has been assessed to benefit from habilitation;
9. Has an Individual and Family Support Plan (IFSP) developed by an interdisciplinary team; and
10. Has a waiver eligibility assessment current within the last 12 months.

3-003.01D ICF/MR Level of Care Criteria: The Department applies the following criteria to determine the need for ICF/MR services:

(A) As documented by an evaluation which was made no more than three years before the initial determination of waiver eligibility, the individual has an intellectual disability or meets the definition of developmental disability; or
(B) The individual has a severe, chronic disability other than an intellectual disability or mental illness which:
  a. Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness;
  b. Is manifested before the age of 22 years;
  c. Is likely to continue indefinitely; and
  d. Results in a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age:
    (1) Self-care'
    (2) Receptive and expressive language development and use;
    (3) Learning;
    (4) Mobility
    (5) Self-direction; and
    (6) Capacity for independent living; and
(C) Can benefit from habilitation directed toward:
  a. The acquisition, retention, and improvement of self-help, socialization, and adaptive skills for the individual's maximum possible independence; or
  b. For dependent individuals where no further positive growth is demonstrable, the prevention of regression or loss of current optimal functional status.
4. If an individual has a diagnosis of developmental disability and a diagnosis of mental illness, the diagnosis relating to developmental disability must be the primary disabling condition.

3-003.02 Determination of Eligibility for HCB Waiver Services: The individual is eligible if s/he meets eligibility requirements initially and on an ongoing basis. This determination is made annually by the Department. An individual who is eligible for waiver services will receive services if a slot and funds are available.

3-003.02A Annual and Ongoing Eligibility Review for Waiver Services: The Department must complete a review of eligibility on an annual basis or when changes in the individual's circumstances appear. If the individual is determined to be ineligible, the Department must notify the individual. Remains in section 003 as modified

3-003.02B Authorization of Waiver Services Funding: All waiver services funding must be prior authorized. Remains in section 003.01 as modified

3-003.02C Prohibited Uses of Department Funds: The Department must not use waiver services funds to pay for:

(A) The care of individuals residing in a hospital, nursing facility, or ICF/MR;
(B) Room and board, except when provided as part of respite in a facility, other than a private residence, approved by Medicaid;
(C) Services currently covered under Nebraska Medicaid;
(D) Services to an individual if it is reasonably expected that the aggregate cost of these services furnished to all individuals would exceed the cost of services provided in an ICF/MR, calculated by using the highest annual ICF/MR rate; and
5. Services to a child when educational services could be provided during a normal, regular, or adjusted school day. Remains in section 003.02(A-D) as modified

3-003.04 Denial of Authorization: The Department may deny authorization for waiver services for any of the following reasons:

(E) The individual fails to meet waiver eligibility criteria;
(F) The individual fails to meet the Department's eligibility criteria;
(G) A waiver slot is not available;
(H) The individual or legal representative has not consented to waiver services;
(I) The individual or legal representative has chosen to receive ICF/MR services;
(J) The individual, his/her legal representative or other person on his / her behalf has not supplied needed information;
(K) Intensity of services does not reflect the need for ICF/MR level of care;
(L) The individual's needs are not being met through waiver services;
(M) The IPP, IFSP, or ASP has not been implemented;
(N) In the children's waiver, the IFSP does not include an appropriate family involvement plan, if applicable; or

(O) A plan of services and supports to protect the individual's health and welfare cannot be developed or maintained.

3-003.05 Request for a Hearing regarding Waiver Eligibility or Waiver Services: An individual or his/her legal representative who disputes a Department decision regarding eligibility for waiver services may request a hearing on the decision as provided in 465 NAC 2-001.02 and 465 NAC 6. The disputed decisions must concern:

(P) Denial of eligibility for waiver services;
(Q) Not being given the choice of waiver services as an alternative to ICF/MR services; or
(R) Being denied waiver services of the individual's choice.

3-004 INFORMAL DISPUTE RESOLUTIONS AND HEARINGS FOR ISSUES RELATED TO DD SERVICES FUNDED BY STATE GENERAL FUNDS

3-004.01 Right to Appeal a Decision Regarding DD Services: An individual or the individual's legal representative has the right to appeal decisions made by the Division of Developmental Disabilities with respect to:

(S) The denial, change or termination of eligibility of the individual for specialized services;
(T) The evaluation or placement of the individual;
(U) The provision of specialized services to the individual;
(V) The amount of the individual's authorized funding; or
(W) The records relating to the individual. Remains in section 004(A-E) as modified

3-004.01A Commencement of Appeal: An individual or the individual's legal representative may choose to begin the appeal process by either:

(A) Requesting an Informal Dispute Resolution in writing or on a form provided by the Department; or
(B) Filing a petition for a formal appeal with the Department in writing or on a form provided by the Department.

3-004.02 Availability of Copies

3-004.02A Service Coordination will provide a copy of the statutes, regulations, and forms for Informal Dispute Resolution and formal hearings to individuals receiving or requesting services or the individual's legal representative upon the initial determination of eligibility and annually after the commencement of services.

3-004.02B An individual or individual's legal representative may request a copy of the statutes, regulations, and forms for Informal Dispute Resolution and formal hearings from any Service Coordination office. Service Coordination will mail the requested information within five days of receipt of the request.

3-004.03 Timeliness of Appeal: In order to exercise the right to appeal, an individual or the individual's legal representative must either request Informal Dispute Resolution or file a petition for a formal appeal, in either case within 90 days of the decision that is being contested. If the individual or legal representative does not request an IDR or file a petition, the decision becomes final on the 90th day after the notification. Remains in section 004.02 as modified

3-004.03A The 90-day period to exercise the right of appeal commences on the day immediately following the day on which the individual is notified of the decision by the Department. If the last day of the 90-day period is a Saturday, Sunday, or state holiday, the period will be deemed to continue until the close of business on the next day that the Department is open for business.

3-004.03B If an individual requests Informal Dispute Resolution, the 90-day period to file a formal appeal will be suspended, beginning on the day the Department receives the request for Informal Dispute Resolution until the day the Department notifies the individual or the individual's legal representative of the outcome of the IDR. At the conclusion of the IDR process, if the individual still wishes to dispute the Department's decision, the individual has the right to initiate a formal appeal, until the expiration of the 90-day period as calculated above.

3-004.03C If an individual files a petition for a formal hearing, the 90-day period to request Informal Dispute Resolution will not be suspended, except at the discretion of the Department. An individual will not have the right to request Informal Dispute Resolution at the conclusion of the formal hearing process.

3-004.04 Informal Dispute Resolution: Informal Dispute Resolution (IDR) is an opportunity for an interested party, including the individual or the individual's legal representative to request reconsideration of a decision of the Department without undergoing a formal hearing process before a hearing officer. Upon receiving a request for Informal Dispute Resolution, the Department will schedule a meeting between the individual or legal representative and the appropriate Department staff, which will be held at the soonest possible mutually convenient time for all necessary participants. An IDR may be held in person, by video, or by telephone.

3-004.05 Requesting a Hearing: In order to exercise the right to a hearing, the individual or the individual's legal representative must file a petition with the Department. The petition may be made on a form provided by the Department for such purpose, or in another writing that contains at least the following information:

(A) The name of the petitioner (the individual's or legal representative's name, address, and phone number, and signature);
(B) The specific decision contested;
(C) The date of the decision contested; and
(D) Any other information that the individual or legal representative wants to be included at the hearing. Remains in section 004.03(1-4) as modified

If the petition fails to include any of the above information, it will be ineffective to initiate the hearing process and the Department may either reject the petition or request additional information from the individual or the individual's legal representative. Remains in section 004.03(A) as modified

3-004.05A In order to be effective, the petition must be either mailed, sent via electronic mail or hand delivered to the Department. Remains in section 004.03(B) as modified

3-004.05B If mailed, the petition will be deemed to be received by the Department on the date of the postmark. If hand delivered, the petition will be deemed to be received by the Department on the actual date of receipt. Remains in section 004.03(C) as modified

3-004.06 Staying the Decision or Action: If an individual or the individual's legal representative makes a timely request for informal dispute resolution or makes a timely filing of a petition for a formal hearing, the related decision will be stayed until the final outcome of the appeal process. While the decision is stayed, the Department will not implement the decision and the individual must remain in his/her current placement unless: Remains in section 004.04 as modified

(X) The current placement is a temporary placement not to exceed 45 days made pursuant to a medical or other emergency and the emergency no longer exists;
(Y) A medical or other emergency arises necessitating a change in service or placement;
(Z) The health or safety of the individual would be endangered by the continued placement;
(AA) The health or safety of other persons would be endangered by the continued placement; or
(BB) The provider is no longer certified.

3-004.06A The hearing officer will rule on motions filed by parties disputing the application of and exclusion from the stay and the continuation of, or cessation of, current placement of the individual, pending the final decision on the petition.

3-004.07 Hearing Officer: Upon receipt of a petition for formal hearing, the Director of Developmental Disabilities will assign the matter to a hearing officer who will receive all subsequent pleadings and will conduct the hearing. Remains in section 004.05 as modified

3-004.07A Any party may challenge a hearing officer on the grounds that the hearing officer has a conflict of interest. The challenge may be made to the hearing officer on, or before, the date set for hearing. The hearing officer may hear and decide the challenge or may refer the matter to the Director of Developmental Disabilities. If the hearing officer does not hear the challenge immediately, the hearing on the petition will be continued until the challenge is resolved. The hearing officer will notify all

parties of the new hearing date by mail at least five days before the date of the hearing. Remains in section 004.05(A) as modified

3-004.07B The Director of Developmental Disabilities may substitute a hearing officer for good cause. The substitution of a hearing officer is reason for a continuance. Remains in section 004.05(B) as modified

3-004.08 Authority and Duties of the Hearing Officer

3-004.08A The hearing officer has the duty to:

(A) Conduct full, fair, and impartial hearings;
(B) Take appropriate action to avoid unnecessary delay in the disposition of proceedings; and
(C) Maintain order during the hearing. Remains in section 004.06(1-3) as modified

3-004.08B The hearing officer has all the powers necessary to carry out his/her duties, including to:

(A) Administer oaths and affirmations;
(B) Issue subpoenas as authorized by law to compel the appearance of witnesses and the production of relevant evidence;
(C) Compel discovery and to impose appropriate sanctions for failure to make discovery;
(D) Rule upon offers of proof and receive relevant, competent, and probative evidence;
(E) Regulate the course of the proceedings in the conduct of the parties and their representatives;
(F) Hold conferences for simplification of the issues, settlement of the proceedings, or any other proper purpose;
(G) Consider and rule orally or in writing, upon all procedural and other motions appropriate in adjudicative proceedings, including the application of, or exclusion from, the stay of an action or decision on appeal;
(H) Establish the time for filing briefs;
(I) Grant a specific extension of time, at the request of either party for good cause shown;
(J) Produce evidence on his/her own motion;
(K) Exclude people from the hearing;
(L) See that facts are fully developed including witness examination and cross examination, if needed; and
(M) Take any other action consistent with the purpose of the law and consistent with these rules. Remains in section 004.06(A)(i-xiii) as modified

3-004.09 The Hearing: The hearing officer will set the date, time, and location of the hearing. The hearing officer will attempt to arrange a time and place for the hearing that is convenient to all parties. Remains in section 004.07 as modified

3-004.09A Unless as otherwise specified in these regulations or applicable statutes, the hearing officer and all parties may serve all motions, notices, pleadings, orders, or other papers personally or by mail. Remains in section 004.07(A) as modified

3-004.09B The hearing officer and all parties must serve all parties who have entered their appearances with all notices, motions, pleadings, orders, or other papers filed. Service on an attorney of record is service on the party represented by the attorney. Remains in section 004.07(B) as modified

3-004.09C Presentation of Evidence: The Nebraska Evidence Rules, Neb. Rev. Stat. §§ 27-412 to 27-415, will not apply unless invoked in writing by either party at least three business days before the hearing. However, the hearing officer will admit competent, relevant, and material evidence, but will exclude evidence that is incompetent, irrelevant, immaterial, or unduly repetitious. Remains in section 004.07(C) as modified

3-004.09C1 Any party invoking the Nebraska Evidence Rules is liable for the payment of all costs related thereto, including the cost of court reporting services, which the party is responsible for procuring for the hearing. Remains in section 004.07(C)(i) as modified

3-004.09D Order of Presentation: At the hearing, the parties will present evidence on the issues raised in the petition and any subsequent pleadings:

(A) The individual who filed the petition or the individual's legal representative (the "petitioner") will present evidence first;
(B) The petitioner has the burden of persuasion throughout the hearing; and
(C) The petitioner must prove his or her case by a preponderance of the evidence. Remains in section 004.07(D)(i-iii) as modified

3-004.09E Rights: A party at a hearing has the right to:

(A) Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to needs of persons with developmental disabilities;
(B) Present evidence and confront, cross-examine, and compel the attendance of witnesses;
(C) Prohibit the introduction of any evidence at the hearing that has not been disclosed to that party at least five calendar days before the hearing;
(D) Obtain a written or electronic verbatim record of the hearing at his/her cost; and
(E) Obtain written findings of fact and decisions from the Director of Developmental Disabilities. Remains in section 004.07(E)(i-v) as modified

3-004.09F Witnesses: The hearing officer may issue subpoenas to compel witnesses to attend or produce evidence. Witnesses are entitled to the fees and expenses as allowed in District Court.

(A) The Director of Developmental Disabilities will certify failure to respond to a subpoena to the District Court of Lancaster County for enforcement or for punishment for contempt of the district court.

(B) Each party is responsible for the payment of witness fees and mileage, including the fees and expenses of expert witnesses that it calls.

(C) The Department will provide personnel as witnesses when served with a subpoena without payment of witness fees or mileage fees. Remains in section 004.07(F)(i-iii) as modified

3-004.09G At the completion of the proceedings, the hearing officer will prepare a report based on the evidence presented containing recommendations for the Director of Developmental Disabilities to make findings of fact and conclusions of law. Remains in section 004.07(G) as modified

3-004.09H The report and final decision and order will be delivered to each party or attorney of record by certified mail.

3-004.10 Judicial Review: Any party aggrieved by the final decision and order of the Director of Developmental Disabilities is entitled to judicial review under Neb. Rev. Stat. §§ 83-1224. Any party to the hearing may seek enforcement of the final decision and order of the Director of Developmental Disabilities through the process of judicial review, if necessary. Remains in section 004.08 as modified

TITLE 404 DEVELOPMENTAL DISABILITIES SERVICES

CHAPTER 4 CERTIFICATION REQUIREMENTS FOR CERTIFIED PROVIDERS OF SERVICES

001. CERTIFICATION OF PROVIDERS. All agency providers of services under the Developmental Disabilities Services Act must meet the certification and accreditation requirements established by the Department of Health and Human Services.

001.01 OVERVIEW OF CERTIFICATION PROCESS. To become a certified provider, the provider applicant must:

(1) Submit a complete application;
(2) Be a United States citizen or qualified alien under applicable federal and state law;
(3) Provide all additional information the Department may require; and
(4) Comply with all provider requirements in this chapter.

001.01(A) APPLICATION. An applicant for certification as an agency provider of developmental disabilities services must apply for certification on the forms supplied by the Department. The applicant shall provide the following:

(i) The legal name of the applicant, address, and contact information;
(ii) The structure, such as partnership, corporation, government, or limited liability company;
(iii) A list of names and addresses of all persons with financial interest in the agency provider;
(iv) The preferred mailing address for receipt of official notices from the Department;
(v) The applicant's federal employer identification number;
(vi) The signature of the person of authority applying to be a certified agency provider;
(vii) A copy of the registration as a foreign corporation filed with the Nebraska Secretary of State, if applicable;
(viii) Program description for provision of services that includes:
  (1) A copy of the applicant's organizational chart identifying authority over the agency and the organization of management positions;
  (2) The developmental disabilities services to be provided;
  (3) The address, including street and city, and telephone number of each location for service delivery, including type of service to be provided at each location and planned capacity at each location;
  (4) Copies of current policies and procedures, as required by this chapter; and
  (5) A list of all subcontractors and proposed subcontracts that will provide services under this application; and

(ix) A disclosure of any criminal history or listing on the Department's Central Abuse and Neglect registries or the Nebraska State Patrol Sex Offender Registry for any management positions, including owners, directors, and managers.;

(x) At initial certification only, Ddocumentation showing the provider maintains a $10,000.00 minimum cash reserve or business line of credit ~~equal to three months of operating expenses or $10,000.00, whichever is greater~~; and

(xi) A statement of intent to seek a risk endorsement (if applicable).

001.01(B) INITIAL CERTIFICATION. For prospective providers, the Department will issue an initial certification for a six month period upon approval of the application. Before the expiration of initial certification, the Department will conduct an on-site review to determine compliance.

001.01(B)(i) Initial certification may be extended for up to six additional months when the provider has not been serving a participant for at least 90 days before the initial certification expires.

001.01(B)(ii) Following on-site review, the Department will:

(1) Issue a one or two year certification when the provider is found to be in compliance with applicable regulations;

(2) Extend initial certification on a one-time basis for up to six months when the on-site review shows the provider is not in compliance with applicable regulations, but there are no health or safety issues and the provider is making satisfactory progress towards compliance; or

(3) Deny certification when the on-site certification review shows the provider is not in compliance with applicable regulations and has not made progress in doing so, or there are serious health or safety issues identified.

001.01(C~~B~~) LENGTH OF CERTIFICATION. Provider certification is contingent upon compliance with applicable 404 NAC standards as required by the Department. Agencies, organizations, or individuals seeking certification will receive a two-year certification upon successful completion of the certification review. If the outcomes of the certification review show significant or repeated deficiencies, or if there is evidence that provider systems are not functioning properly, the Department may issue a one-year certification.

001.01(D~~C~~) DENIAL OF CERTIFICATION. The Department, in its discretion, may deny or terminate a provider's certification for good cause, which includes but is not limited to the following grounds:

(1) Violations of any of the provisions of Nebraska Administrative Code (NAC) Titles 172, 403, 404, 471, 480, 482 or other applicable law or regulation governing services provided;

(2) The provider or its owner is the respondent of a protection order;

(3) The provider or its owner committed a crime:

(a) Against a child or vulnerable adult;

(b) Involving the illegal use, possession, or distribution of a controlled substance; or

(c) That, if repeated, could injure or harm the Developmental Disabilities Services Waiver program or a developmental disabilities services participant;

(4) A provider's owner or administrative staff or management have been convicted of any of the crimes listed in this chapter; or

(5) The provider or its owner is listed as a perpetrator on the Nebraska Adult Protective Services Central Registry or the Child Abuse and Neglect Central Registry in a court-substantiated or agency-substantiated case, or is listed as a perpetrator on any comparable registry in any other state.

The Department deems a crime to have been committed when a conviction, admission, or substantial evidence of commission exists. In exercising its discretion, the Department considers the severity of the crime(s), the applicability of the crime(s) to the service of the provider, and the amount of time that has passed since the commission of the crime.

001.01(D~~C~~)(i) Failure to disclose requested information on the application, or providing incomplete or incorrect information on the application may result in the denial of a certification.

001.01(E~~D~~) Provider certification will be denied or terminated when any person with a 5% or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with a Medicare, Medicaid, or Title XXI program within the last ten years, unless the Department determines that denial or termination of enrollment is not in the best interest of the program.

001.02 EXTENSION OF CERTIFICATION. The Department may extend the certification for up to 60 calendar days, for good cause shown.

001.03 CERTIFICATION RENEWAL. Renewal applications must be submitted at least 90 calendar days prior to the expiration of the current certification. At any time, the Department may conduct an onsite review and request additional documentation.

001.03(A) ON-SITE CERTIFICATION REVIEW. Initial and renewal certifications will not be issued until the Department has conducted an on-site certification review to assess compliance.

001.03(B) RENEWAL APPLICATION. The provider must submit a complete renewal application which includes all requirements outlined in this chapter.

001.04 RISK ENDORSEMENT. In addition to all other certification requirements in this chapter, a certified agency seeking risk endorsement must meet specific qualifications including the following:

(A) Full-time employment of a clinician who is currently licensed in Nebraska as one of the following:
  (i) Licensed Independent Mental Health Practitioner (LIMHP);
  (ii) Licensed Clinical Psychologist; or
  (iii) Advanced Practice Registered Nurse (APRN);

(B) Two consecutive years operating as a certified, licensed, or accredited agency provider of Medicaid 1915(c) Waiver Home and Community-Based Services for individuals with developmental disabilities in Nebraska or another state;

(C) In good standing with the certification, licensing, or accrediting body in any and all states of operation; and

(D) Any other requirements as defined by and at the Department's discretion.

001.054 NOTIFICATION REQUIREMENTS. The provider must notify the Department, in writing, of any:

(1) Change of ownership or control within 10 business days of the effective date;

(2) Change in director within 10 business days of the effective date;

(3) Addition of a new service option at least 30 calendar days prior to the effective date;

(4) Termination of a service option currently being provided to participants at least 60 calendar days prior to the effective date;

(5) Addition of a new provider-operated or controlled service settingExpansion of services into another geographic area that was not included under the current provider certification at least 6015 calendar days prior to openingthe effective date. Expanded services in the new geographic area must not begin until the Department has issued a provisional certification for the new geographic area; and

(6) Change in contact information, including physical business address, phone number, mailing address, and e-mail address, within 10 business days of the effective date.; and

(7) For any provider with a risk endorsement, a change in clinician, change in clinician's employment status with the provider, or change in clinician's license status, within 5 business days of the effective date of the change.

001.054(A) CHANGE IN OWNERSHIP. A provider certification is issued only to the person named in the application as the certified provider. When a change of ownership occurs, the new owner must assume responsibility for correction of all previously cited deficient practices from the acquired provider.

001.065 CERTIFICATION AND SERVICE REVIEWS. The Department may, at any time, conduct unannounced on-site reviews. Providers must cooperate with site reviews and documentation requests.

001.065(A) RESULTS OF CERTIFICATION OR SERVICE REVIEWS. If the Department determines there are deficiencies or discovers non-compliance, the provider may:

(i) Be required to provide a plan of improvement;

(ii) Have a disciplinary action imposed; or

(iii) Have its certification terminated.

001.065(B) PLAN OF IMPROVEMENT. If the Department determines that a provider is in non-compliance with the provider requirements outlined in the Medicaid provider agreement or applicable law or regulation, a plan of improvement will be required from the provider. Within 20 days of receipt of the Department's written findings of non-compliance, the provider must submit an acceptable plan of improvement to address areas found to be out of compliance. The plan of improvement must:

(i) Be specific in identifying a planned action on how the areas found to be out of compliance have been or will be corrected for the individual cases included in the review and system wide within the provider organization;

(ii) Include an expected date for completion of the plan of improvement that is timely, taking into consideration the nature of the violation;
(iii) Identify a means to prevent a recurrence;
(iv) Identify who is responsible for implementing the plan of improvement and ensuring all areas are corrected and compliance is maintained; and
(v) Be signed and dated by the director ~~Chief Executive Officer~~ of the ~~Department~~ provider or designee.

001.07~~6~~ DISCIPLINARY ACTIONS. When a provider is out of compliance with the provider requirements outlined in the Medicaid provider agreement or applicable law or regulation, the Department may impose, in any order, one or more of the following types of disciplinary action:

001.07~~6~~(A) DIRECTED PLAN OF IMPROVEMENT. The provider will be required to implement a directed plan of improvement, within the specified period of time, developed by the Department, containing specific actions and timeframes.

001.07~~6~~(B) DIRECTED IN-SERVICE TRAINING. The provider will be required to train staff as required by the Department. The provider is responsible for the required training and the associated cost of the training.

001.07~~6~~(C) STATE MONITORING. The provider will be required to submit to monitoring by the Department or designee as a safeguard against further harm or injury to participants or serious risk to the safety of the participants.

001.07~~6~~(D) PROBATION. The provider will be placed on probation and be required to meet the terms and conditions of the probation in order to continue to operate.

001.07~~6~~(E) SUSPENSION OF SERVICES. The provider will be prohibited from:
(i) Accepting new participants;
(ii) Providing a specific service to any participants;
(iii) Providing a specific service at a specific site; or
(iv) Providing services as otherwise deemed appropriate by the department.

001.07~~6~~(F) TERMINATION OF THE PROVIDER CERTIFICATION. The provider's certification may be terminated when:
(i) The provider's non-compliance poses an immediate and serious threat to one or more participant's health and safety;
(ii) The provider's conduct or practices are detrimental to the health or safety of a participant or others;
(iii) The provider knowingly fails to report abuse, neglect, or exploitations as required by applicable law;
(iv) The provider has established a pattern of not maintaining compliance;
(v) The provider has not corrected previously identified areas of non-compliance;
(vi) The provider has established a pattern of not using internal quality improvement practices;
(vii) The provider commits, permits, aids, or abets~~, or fails to prevent the commission of~~ any unlawful act that would disqualify it from enrollment as a provider;

(viii) The provider failed to disclose information on the application or provided incomplete or incorrect information on the application;
(ix) The provider has failed to submit an acceptable plan of improvement; or
(x) The provider has failed to comply with any previously imposed disciplinary action directed by the Department.

001.076(G) NOTICE OF DISCIPLINARY ACTION TO PROVIDER. Notice of disciplinary action will be given to the provider in writing via mail or email.

001.076(H) IMMEDIATE AND SERIOUS THREATS TO HEALTH AND SAFETY. When situations involving immediate and serious threat to one or more participants' health and safety are identified, the provider:
(i) Upon discovery, must take immediate action to remove the risk to the identified individual and implement corrective measures to prevent further immediate and serious threat situations;
(ii) May have participants removed from its services, if the provider fails to remove the risk to identified participants and to implement corrective measures to prevent further immediate and serious threat situations;
(iii) May have its certification terminated unless the provider has eliminated the immediate and serious threat and is able to maintain corrective actions;
(iv) Must submit written evidence of correction or that the circumstances causing the immediate and serious threat no longer exist and that safeguards are in place to ensure the health and safety of participants; and
(v) May be required to submit to monitoring by the Department, including revisits, to verify compliance.

001.08 APPEAL RIGHTS. Any adverse action taken under Chapter 4 of this Title may be appealed to the Director of the Division of Developmental Disabilities by the person or entity against whom the action was taken.

001.08(A) HEARING REQUEST PROCEDURE. The person or entity appealing an adverse action under Chapter 4 of this Title must submit a written hearing request to the Director of the Division of Developmental Disabilities within 30 days of the date of the action.

001.08(B) HEARINGS. Appeal and hearing procedures are governed by 465 NAC.

002. ADMINISTRATION STANDARDS. All agency providers of services under the Developmental Disabilities Services Act must meet the administration standards and requirements in this section.

002.01 MEDICAID PROVIDERS. All providers must be an enrolled Medicaid provider pursuant to applicable laws and regulations relating to the Nebraska Medical Assistance Program.

002.02 DIRECTOR ~~CHIEF EXECUTIVE~~. Each provider must have a director ~~Chief Executive~~ who is responsible for overall management and compliance of the requirements in this Title,

establish policies and procedures as specified in this chapter, and ensure compliance with applicable laws and regulations.

002.03 PROVIDER POLICIES AND PROCEDURES. The provider must establish and implement written policies and procedures that:

(1) Describe the provider's operation and how systems are set up to meet participants' needs;
(2) Comply with all applicable regulations and laws governing providers;
(3) Are available to staff; and
(4) Are reviewed at least annually and revised if needed.

002.03(A) PROCEDURAL REQUIREMENTS REGARDING RIGHTS. The provider must establish procedures that:

(i) Specify participant rights and responsibilities and this specification does not conflict with Title 404 NAC;
(ii) Inform each participant served, and if applicable, the participant's parent if a minor, or the participant's legal representative, of the participant's rights and responsibilities;
(1) The information must be given at the time of entry to services, at the participant's annual individual support plan (ISP) review, and when significant changes occur; and
(2) The information must be provided in a manner that is easily understood, given verbally and in writing, in the native language of the participant, or through other modes of communication necessary for understanding;
(iii) Require the provision of supports to participants receiving services in exercising their rights;
(iv) Do not treat participants' rights as privileges; and
(v) Prohibit retaliation against participants' services and supports due to the participant, family members, or legal representatives advocating on behalf of the participant served. This includes initiating a complaint with outside agencies.

002.04 PSYCHOTROPIC MEDICATION. Psychotropic medications administered by the certified agency provider must:

(1) Only be given as prescribed by the participant's treating medical professional acting within his or her scope of practice;
(2) Be reviewed by the individual support planning team to determine if the benefits outweigh the risks and potential side effects;
(3) Be supported by evidence that a less restrictive and more positive technique has been systematically tried and shown to be ineffective, and that administration of the medications is part of the participant's person-centered plan as demonstrated by supporting data and outcome measures;
(4) Be reviewed by the rights review committee, unless all of the following are clearly documented:
(a) The psychotropic medication and dosage;
(b) The diagnosis for which the medication has been prescribed;
(c) The justification or reason for the medication; and
(d) Changes in the medication prescribed or dosage, if any;

(5) Be reviewed annually by the prescribing physician and semi-annually by the individual support planning team;
(6) Not be used as a way to deal with under-staffing; ineffective, inappropriate or other nonfunctional programs or environments;
(7) Also have a positive behavioral supports plan established and in place to address ~~those symptoms~~ problem behavior when ~~they~~ it occurs ~~if symptoms reappear and the ongoing use of medication is no longer effective~~; and
(8) Be monitored and documented on an ongoing basis by the provider to provide the individual support planning team and physician sufficient information regarding:
(a) The effectiveness of and any side effects experienced from the medication;
(b) Frequency and severity of symptoms; and
(c) The effectiveness of the positive behavioral supports plan.

002.04(A) No positive behavioral support plan is required when an individual is prescribed a medication that has the effect of behavior modification, but is prescribed for other reasons, as documented by a physician.

002.05 RIGHTS REVIEW COMMITTEE. The provider must establish a rights review committee to review any situation requiring an emergency safety intervention, the use of certain psychotropic medications, any restrictive measure, and any situation where violation of a participant's rights occurred.

002.05(A) MEMBERSHIP OF THE RIGHTS REVIEW COMMITTEE. The provider must appoint members of the committee that:
(i) Are free from conflict of interest; and
(ii) Will ensure the confidentiality of information related to participants served.

At least half of the committee members must be participants, family, or other interested persons who are not provider staff.

002.05(B) RECUSAL OF RIGHTS REVIEW COMMITTEE MEMBER. If the person responsible for approving the participant's program or any staff who provides direct services serves as a member of a rights review committee, he or she must recuse him or herself from participation in rights review committee proceedings pertaining to such participant.

002.05(C) MEETINGS. The committee must meet, at a minimum, semi-annually. The review may include obtaining additional information and gathering input from the affected participant and his or her legal representative, if applicable, to make recommendations to the provider.

002.05(D) SUB-COMMITTEES. The rights review committee may utilize sub-committees to complete its work. The sub-committee must document its activities and submit that documentation to the rights review committee, as evidenced in the rights review committee's meeting minutes.

002.05(E) INTERIM APPROVAL OF ~~PSYCHOTROPIC MEDICATIONS~~ RESTRICTIVE MEASURES. Interim approvals of ~~psychotropic medications and~~ restrictive measures are allowed in circumstances that require immediate attention. The interim approval may be done by a documented designee of the rights review committee, who must be a current member of the rights review committee and can be an employee of the certified provider, but must be free from conflict of interest. The meeting minutes must document final approval by the rights review committee at its next meeting.

002.05(F) ALLEGATIONS OF ABUSE OR NEGLECT. The rights review committee must evaluate all known allegations and investigations of abuse or neglect for any violation of a participant's rights.

002.06 PARTICIPANTS' PERSONAL FUNDS AND PROPERTY. The provider shall have written policies and procedures to protect the participant's funds and property. The provider must:

(1) Have a policy to address who is responsible for replacement or compensation when a participant's personal items are damaged or missing;
(2) Not use the participant's funds and personal property as a reward or punishment;
(3) Not assess the participant's funds and personal property as payment for damages unless approved by the individual support planning team, and written consent is received from the participant to make the restitution;
(4) Not use the participant's funds and personal property to purchase inventory or services for the provider; and
(5) Not allow the participant's funds and personal property to be used by provider staff or subcontractors for their personal use.

002.06(A) SUPPORT IN MANAGING FINANCIAL RESOURCES. When a participant does not have the skills necessary to manage his or her financial resources, the provider may, with the informed choice of the participant, offer services and supports that temporarily transfers some of the control of handling the participant's financial resources to the provider.

002.06(A)(i) The transfer of control of a participant's financial resources:

(1) Must not be for a convenience of staff, or as a substitute for habilitation;
(2) Must be temporary;
(3) Must be based on the choice of the participant and the extent to which the participant can participate; and
(4) Must not be transferred to another entity and the participant must not be charged for the service.

002.06(A)(ii) The participant's individual support planning team must determine and document in the individual support plan (ISP) the following regarding the temporary transfer of control of a participant's finances to the provider:

(1) The extent in which the participant can participate in management of his or her financial resources;
(2) The participant's informed choice; and
(3) The rationale for the transfer of control.

002.06(B) PROVIDER MANAGEMENT OF PARTICIPANTS' FINANCES. If the provider is responsible for handling participants' funds:

(i) The provider must maintain a financial record for each participant that includes:
  (1) Documentation of all cash funds, savings, and checking accounts, deposits, and withdrawals; and
  (2) An individual ledger which provides a record of all funds received and disbursed and the current balance;

(ii) The provider must provide account balances and records of transactions to each participant at least quarterly, unless otherwise requested;

(iii) Before the provider allows an ~~non-routine~~ expenditure exceeding $~~100~~150, the participant must review and prior authorize it.~~. The provider must~~ as well as notify the participant's individual support planning team;

(iv) The provider must have policies and procedures that outline how financial errors, overdrafts, late fees, and missing money will be handled when the provider is responsible for managing participants' funds. The policies and procedures must include that:
  (1) The provider is responsible for service charges and fees assessed due to staff errors;
  (2) The provider must replace missing money promptly if missing money is due to staff error; and
  (3) The provider is responsible for taking steps to correct a participant's credit history when it is affected by provider staff actions in managing the participant's finances; and

(v) When the provider is maintaining participants' personal funds in a common trust, a separate accounting is maintained for each participant or for the participant's interest in a common trust fund.

002.07 ENTRY TO SERVICE. Prior to accepting a participant into services, the provider must:

(A) Gather and review referral information regarding the participant, to the greatest extent possible, to make an informed determination as to whether the agency is capable of providing services to meet the participant's needs;

(B) Consider the safety of all participants in the decision to accept new participants to service or the location for the services;

(C) Consider whether the provider has the capacity, commitment, and resources necessary to provide supports to the participant for the long term. The provider must not admit a participant to services if it cannot reasonably assure that it has the ability to meet the participant's needs; and

(D) Participate in the transition process for a participant from one provider to another, whether the provider is ending services or beginning to provide services.

002.08 TERMINATION OF SERVICES. A provider may terminate services to a participant when the provider has determined that it can no longer effectively and appropriately serve the participant due to a lack of resources, skills, or capacity. Written notification outlining the reasons for termination of services must be given to the participant no less than 60 ~~calendar~~ days prior to the final day of services~~, outlining the reasons for termination of services.~~ unless the participant is served under a risk endorsement, in which case written notification outlining the reason for termination of services must be given to the participant no less than 90 calendar days prior to the final day of services.

002.08(A) If a provider or participant elects to terminate services, prior to terminating services, the provider must develop a transition plan in conjunction with the participant's individual support planning team. If another provider has been identified to serve the participant, that provider must be invited to the transition meeting. The individual support plan (ISP) must include:

(i) A primary focus on the participant's needs and preferences;
(ii) Timelines for the transition; and
(iii) Supports and strategies that are needed for the new and current provider that meet the needs of the participant during and after the transition from one provider to another.

002.08(B) If additional time is needed to transition the participant from one provider to another, the provider terminating services may be required to provide services for up to an additional 10 calendar days.

002.09 ACCESS TO RECORDS. The provider must provide access to or copies of all records or other documents relating to the operation of the provider, and all participants served by the provider, to the Department upon request.

002.10 PARTICIPANT RECORD KEEPING. The provider must maintain participant records that:

(A) Designate staff responsible for the maintenance of the individual's records;
(B) Develop and implement a systematic organization of records to ensure permanency, accuracy, completeness, and easy retrieval of information;
(C) Have a method to access the records by staff and other relevant persons as needed. The provider must ensure that current and applicable records relating to the participant are readily available to staff when providing services to participants. If there are changes in ownership, all participant records must be transferred to the current owner. Before dissolution of any provider agency, the administrator must notify the Department in writing of the location and storage of participant records;
(D) Govern access to, duplication, dissemination, and release of information from the participant's record;
    (i) The provider must ensure written consent is obtained from the participant or the participant's legal representative for the release of information specific to the participant, including release of photographs to persons not authorized under law to receive them. The consent must identify the specific information to be released and the time period the consent is in effect, except that no written consent to release or access information is necessary for Department representatives to review the records; and
    (ii) The provider must specify the method and frequency for obtaining authorizations for medical treatment and consents.

002.11 INCIDENT REPORTING. The provider must report incidents using the electronic system approved and used by the Department. The provider must implement a system for handling and reporting incidents that includes:

(A) Identification of incidents that require completion of an incident report to the Department that includes:

(i) Situations that adversely affect the physical or emotional well-being of a participant served;
(ii) Alleged or suspected cases of abuse, neglect, exploitation, or mistreatment; and
(iii) Emergency safety situations that require the use of emergency safety interventions;

(B) Recording the essential facts of the incident, including the results of the incident and any actions which might have prevented the incident;

(C) An action plan that includes the provider's immediate effort to address the situation and prevent recurrence;

(D) Timelines to ensure prompt reporting of incidents as appropriate, including reporting to:
(i) Provider management;
(ii) The individual who receives services involved in the incident;
(iii) Family member or legal representative as appropriate;
(iv) Child and Adult Abuse and Neglect in the Department; and
(v) Law enforcement;

(E) Reporting requirements including:
(i) A verbal report to the Department upon becoming aware of the incident;
(ii) A written report using the Department approved format within 24 hours of the verbal report;
(iii) A written summary submitted to the Department of the provider's investigation and action taken within 14 calendar days; and
(iv) An aggregate report of incidents must be submitted to the Department on a quarterly basis. Each report must be received by the Department no later than 30 calendar days after the last day of the previous quarter. The reports must include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that result in a reduction in the number of incidents over time; and

(F) A process to review and analyze information from incident reports to identify trends and problematic practices which may be occurring and take appropriate corrective actions to address problematic practices identified.

003. STAFF REQUIREMENTS. When recruiting, training, managing, and retaining staff, the provider must:

(1) Recruit, train, manage, and retain qualified staff with the skills necessary to meet the needs of participants and respond to emergencies;
(2) Comply with the employee verification requirements of Neb. Rev. Stat. § 4-114;
(3) Only hire staff who are at least 18 years of age if they will be providing direct services alone;
(4) Obtain a National Criminal background check ~~within 10 calendar days~~ prior to working alone providing direct support to a participant, and annually thereafter, on all staff members, and subcontractors, if providing direct support to a participant, and, if in provider owned or operated residential settings, on household members age ~~13~~ 18 and older;

(5) Obtain a check of the Central Registry of Child Protection cases and Adult Protective Services ~~within 10 calendar days~~ prior to working alone providing direct support to a participant, and annually thereafter, on all staff members, and subcontractors, if providing direct support to a participant, and, if in provider owned or operated residential settings, on household members age 13 and older;

(6) Obtain a check of the Nebraska State Patrol Sex Offender Registry ~~within 10 calendar days~~ prior to working alone providing direct support to a participant, and annually thereafter, on all staff members, and subcontractors, if providing direct support to a participant, and, if in provider owned or operated residential settings, on household members age ~~13~~ 18 and older; and

(7) Retain results of registry or background checks for one year following the termination of the staff person's employment.

003.01 EMPLOYEE BACKGROUND CHECKS. Employees who provide direct support services may not work alone with participants until the results of the registry checks and the criminal history background checks are reviewed by the provider. Background checks cannot be completed more than 180 calendar days before the staff person's hire date. Employees listed on the Central Abuse and Neglect Registry, Nebraska State Patrol Sex Offender Registry, or who have been charged pending disposition or convicted of crimes set forth in this chapter may not provide direct support services.

003.02 SPECIFIC CRIMES. The provider must not allow employees or independent contractors to work with participants served by the provider when charged pending disposition or convicted of ~~the following~~ a crime~~s to work with participants served by the provider~~:

(1) Against a child or vulnerable adult; ~~Any of the acts prohibited under the Child Pornography Prevention Act, Neb. Rev. Stat. §28-1463.01 et seq.;~~

(2) Of a nature, duration, or pattern that calls into question their regard for the law;~~Criminal child enticement;~~

(3) Involving the illegal use, possession, or distribution of a controlled substance; or ~~Abuse, neglect, or exploitation of a child or vulnerable adult;~~

(4) That, if repeated, could injure or harm a participant. ~~Felony domestic assault;~~

~~(5) Stalking, strangulation, or terroristic threats;~~

~~(6) Misdemeanor domestic assault within the last five years;~~

~~(7) Any of the theft offenses enumerated at Neb. Rev. Stat. §28-509 – 28-518 within the last three years;~~

~~(8) Felony fraud within the last ten years;~~

~~(9) Misdemeanor fraud within the last five years;~~

~~(10) Possession of any controlled substance within the last five years;~~

~~(11) Possession of any controlled substance with intent to deliver within the last ten years;~~

~~(12) Felony or misdemeanor assault without a weapon within the last ten years;~~

~~(13) Felony or misdemeanor assault with a weapon in the last 15 years;~~

~~(14) Prostitution or solicitation of prostitution within the last five years;~~

~~(15) Robbery or burglary within the last ten years;~~

~~(16) Rape or sexual assault, first, second, or third degree;~~

~~(17) Arson;~~

~~(18) Kidnapping or false imprisonment;~~

~~(19) Human trafficking or any other trafficking offense enumerated at Neb. Rev. Stat. § 28-831; or~~

~~(20) Homicide, murder, or manslaughter; or~~
~~(21) Any crime which, in the discretion of the Department, may endanger the health or safety of any person.~~

003.02(A) All employees must notify the provider immediately if charged or convicted of any of the crimes listed above or if placed on any of the Department's registries or State Patrol Sex Offender Registry.

003.03 STAFF TRAINING AND COMPETENCY. The provider must ensure that employees, including subcontractors and management, responsible for providing supports and services to individuals with developmental disabilities are trained on the minimum requirements necessary to address the individual's needs prior to working with individuals in services.

Staff responsible for providing direct services must demonstrate the competence to support individuals as part of a required and on-going training program. The provider must ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with individuals.

For staff responsible for providing direct services to participants served under a Risk Endorsement, the provider must ensure staff receive training from the provider-employed clinician on the participant's Individual Support Plan and any behavioral and safety plans and demonstrate competency in the implementation of these plans prior to working alone with a participant served under a risk endorsement.

The provider must document in the employee's personnel record that required orientation and training was completed and competency was demonstrated. It is the responsibility of the provider to ensure that training and verification of such is completed by persons with expertise who are qualified by education, training, or experience in those areas.

003.03(A) INITIAL ORIENTATION REQUIREMENTS. Initial orientation must be completed by all new employees prior to working alone with individuals. Employees must complete the following training requirements:

(i) Individual's choice;
(ii) Individual's rights in accordance with state and federal laws;
(iii) Confidentiality;
(iv) Dignity and respectful interactions with individuals; ~~and~~
(v) Individual support plan and any medical, behavioral, or safety protocols for all participants to whom the staff provides direct services; and
(vi) Abuse, neglect, or exploitation and state law reporting requirements and prevention.

003.03(B) REQUIRED TRAINING. Employees must be trained to respond to injury, illness, and emergencies, and competency verified within 30 calendar days of hire or before working alone with an individual. The following training areas must be completed:

(i) Emergency procedures;
(ii) Cardiopulmonary resuscitation (CPR);
(iii) Basic first aid; and
(iv) Infection control.~~; and~~

~~(v) Individual support plan and any medical, behavioral, or safety protocols for all participants to whom the staff provides direct services; Individuals' medical protocols as applicable; and~~

~~(vi) Individuals' safety protocols as applicable.~~

003.03(C) Employees must be trained and demonstrate competency within 180 calendar days of hire regarding the implementation of the provision of services to individuals. This training must include:

(i) Implementation and development of the individual support plan (ISP) and interdisciplinary process;

(ii) Positive support techniques;

(iii) Division ~~A~~ approved emergency safety intervention techniques;

(iv) Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the individual;

(v) Use of adaptive and augmentative devices used to support individuals, as necessary;

(vi) Other training required by the provider; and

(vii) Other training as required by the specific service options.

003.03(D) For employees providing direct services to individuals served under a risk endorsement, all training requirements outlined in 404 NAC 4-003.03 must be completed ~~within 30 days of employment and~~ prior to working alone with a participant served under a risk endorsement.

003.03(~~D~~E) Training and verification of competencies in the above areas must be conducted by persons with expertise who are qualified by education, training, or expertise in those areas.

003.03(~~D~~E)(i) Staff training and demonstration of competency must be documented and maintained by the provider, and must include:

(1) The training topic;

(2) Date staff attended training;

(3) Date competencies verified;

(4) Name of person conducting training; and

(5) Verification of competencies.

003.04 STAFF CREDENTIALS. The provider must maintain documentation of all current credentials of individuals providing services for which credentialing is required.

003.05 SUFFICIENT STAFF. The provider must at all times maintain enough persons providing services, supports, and supervision to meet the needs of each participant served.

003.06 STAFF RECORDS. All agency providers of services under the Developmental Disabilities Services Act must meet the staff records requirements in this section.

003.06(A) WORK RECORDS. The provider must maintain a record of hours worked by staff who provide direct services. The record must include the:

(i) Name of the staff person;

(ii) Staff person's position title;
(iii) Date and specific time period worked; and
(iv) Location the staff person worked for the specified period of time.

003.06(B) EMPLOYMENT RECORDS. The provider must maintain a current employment record for each staff person. Subcontractors of the provider must maintain their own record. The record must include:
(i) Date of hire;
(ii) Initial and ongoing training;
(iii) Credentialing information, if applicable;
(iv) Background checks;
(v) Job qualifications; and
(vi) Personnel actions, if applicable.

004. QUALITY ASSURANCE AND QUALITY IMPROVEMENT (QA/QI). The provider must have a quality assurance and quality improvement (QA/QI) process. This process must include:
(1) Ongoing proactive internal review of the quality and individualization of services;
(2) Continuous quality review of the services provided; and
(3) The provider must provide evidence that participants served and their families are involved in the quality assurance and quality improvement (QA/QI) process.

004.01 QUALITY ASSURANCE AND QUALITY IMPROVEMENT (QA/QI) STRUCTURAL COMPONENTS. The provider must create the structural components of the quality assurance and quality improvement (QA/QI) process. The process must be applied on a provider-wide basis and include:
(A) Areas of services to be monitored and evaluated to determine the quality of these services through identification of patterns and trends of the provider services; and
(B) Provisions for reviewing quality assurance and quality improvement (QA/QI) policies and procedures at least annually and revising as needed.

004.02 QUALITY ASSURANCE AND QUALITY IMPROVEMENT (QA/QI) ACTIVITIES. The quality assurance and quality improvement (QA/QI) activities must result in:
(A) Identification and correction of problems and noncompliance with applicable requirements in a timely manner and on a provider-wide basis; and
(B) Use of information from reviews, results, and recommendations to correct problems, improve services to participants served, and revise policies and procedures, if necessary.

004.03 DOCUMENTATION OF QUALITY ASSURANCE AND QUALITY IMPROVEMENT (QA/QI) ACTIVITIES. The provider must maintain documentation of all quality assurance and quality improvement (QA/QI) activities, including the results of reviews, recommendations, action taken, effectiveness of action taken, review by the director and certified provider, and other relevant information.

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 4 CORE REQUIREMENTS FOR SPECIALIZED PROVIDERS OF SERVICES

4-001 SCOPE: This chapter governs the certification of specialized providers of services for individuals with developmental disabilities and establishes core requirements. A specialized provider is an agency, organization, association, or other entity which provides specialized services and is certified by the Department.

A specialized provider who was certified before the effective date of these regulations will continue to be considered a certified provider under Title 404 NAC when the provider submits to the Department an updated application that includes all items described in 404 NAC 4-002.09A within 90 days of the effective date of these regulations. The current full certification will continue to be effective until the expiration date or terminated in accordance with 404 NAC 4-002.11F. The provider must continue to be in compliance with all applicable state statutes and regulations.

4-002 CERTIFICATION OF PROVIDERS: All specialized providers of services under this title must meet the core requirements in this chapter and the specific requirements in 404 NAC chapters 5, 6, or 8, as applicable to the services the provider plans to provide. Only a certified provider is eligible to provide specialized services under contract with the Department. Remains in section 001 as modified

4-002.01 Service Options: Certified providers may select the type of services they want to provide:

(i) Individual Support Options - Supported Day (see 404 NAC 5);
(ii) Individual Support Options - Supported Living (see 404 NAC 5);
(iii) Provider Operated - Residential Services (see 404 NAC 6);
(iv) Provider Operated - Day Services (see 404 NAC 6);
(v) Licensed Center for Persons with Developmental Disabilities (CDD) (see 175 NAC 3); and
(vi) Respite Services (see 404 NAC 8).

4-002.02 Anyone intending to become a certified provider must submit a letter of intent prior to submitting the application required in 404 NAC 4-002.05A to the Department which must include the type of service(s), as outlined in 404 NAC 4-002.01, that are proposed to be provided and the location(s) of the service(s).

4-002.03 The Department may prioritize the review of certified provider applications based on need.

4-002.04 Overview of Certification Process: To become a certified provider:

(i) The applicant submits a complete application as required in 404 NAC 4-002.05. A complete application means that all information and documents have been submitted and are acceptable; Remains in section 001.01 as modified

(ii) The Department will review the application to determine if the applicant has systems in place that will result in compliance with 404 NAC;

(iii) When a complete and acceptable application is received the Department will issue to the applicant a provisional certification as in 404 NAC 4-002.05C;

(iv) During the provisional certification period, the provider initiates services to individuals for the selected service options;

(v) After the initiation of services to individuals, the Department will conduct an unannounced on-site review;

(vi) Based on the on-site review, the Department will deny or issue a one- or two-year full certification;

(vii) An on-site review for compliance will be made prior to the expiration date of any current certification; and

(viii) Based on a submitted renewal application, the on-site certification review results and any applicable plans of improvement for any identified areas of non-compliance, the Department will make a final decision, in writing, to deny a renewal certification or to issue a one or two year full certification.

4-002.05 Certification Process: To become a certified provider:

4-002.05A Application: An applicant may construct an application or obtain an application from the Department. The application must include:

1. Full name of the entity to be certified, street and mailing addresses, telephone number and facsimile number, if any;
2. Name of director and members of the governing authority, if applicable;
3. Name and address of the owner(s) of the entity;
4. Ownership type, such as individual, partnership, corporation, government, or limited liability company;
5. List of names and addresses of all persons in control of the entity (The list must include all individual owners, partners, limited liability company members, members of board of directors owning or managing operations, and any other persons with financial interest or investments in the agency. In the case of publicly held corporations, only those stockholders who own 5% or more of the company's stock must be listed);
6. Mailing address of the owner;
7. The preferred mailing address for receipt of official notices from the Department;
8. The legal name of the individual or business organization (government, corporation, partnership, limited liability company, or other type) to whom the certification should be issued;
9. Applicant's federal employer identification number if not an individual;
10. Non-profit or for profit status;

11. Signature of the director of the provider and, as applicable, the chairperson of the governing authority;
12. A copy of the registration as a foreign corporation filed with the Nebraska Secretary of State, if applicable;
13. Anticipated date the applicant will be ready to initiate services to individuals;
14. Program description for provision of services that includes:
    a. Copy of the applicant's organizational chart identifying authority over the agency and the organization of management positions;
    b. Service options selected as outlined in 404 NAC 4-001;
    c. Address (including street and city) and telephone number of each location for service delivery, for day and residential services as specified in 404 NAC 6 and 7, including type of service to be provided at each location and planned capacity at each location;
    d. Copies of current policies and procedures, as specified in 404 NAC 4-003.04;
    e. List of all sub-contractors and proposed sub-contracts that will provide services under this application;
15. Signed attestation by the director of the entity that all assurances given in this application are to be considered accurate for the certification period unless changes are submitted, in writing; and
16. A disclosure of any criminal history or listing on the Department's registries or the Nebraska State Patrol Sex Offender Registry for any management positions, including owners, directors, and managers. The Department will not certify a provider whose administrative staff or management have been convicted of any of the crimes listed in 404 NAC 4-004.03F. Remains in section 001.01(A)(i-xi) as modified

4-002.05A1 Failure to disclose requested information on the application, or providing incomplete or incorrect information on the application may result in the denial of a certification. Remains in section 001.01(C)(i) as modified

4-002.05B The Department will review the application to determine if it is complete and make a decision to:

(1) Deny certification;
(2) Ask for revisions to the application; or
(3) Issue a provisional certification.

The Department will notify the applicant in writing of the decision.

4-002.05C Provisional Certification: Initial applicants are only eligible for a provisional certification. The Department will issue a provisional certification for a six-month period based on approval of the application.

4-002.05C1 If the provider has not provided services to an individual for at least 90 days before the expiration of the provisional certification, the provisional certification may be extended for a six-month period.

4-002.05C2 Initial Certification Review: Before expiration of the provisional certification, the Department will conduct an on-site review to determine compliance. Following the on-site review, the Department will:

1. Issue a full certification if the provider is found to be in compliance with 404 NAC; or
2. Extend the provisional certification on a one-time basis for up to six months when the on-site review shows:
   a. The provider has been unable to complete the certification requirements but is making satisfactory progress towards compliance;
   b. There were no health and safety issues involving provision of services to individuals identified; and
   c. The provider is capable of compliance within the six-month extension period; or

(3) Withdraw or deny certification when the on-site review shows:
   a. The provider is not in compliance with 404 NAC and has not made satisfactory progress towards compliance; or
   b. There were serious violations of health and safety identified.

4-002.06 Length of Full Certification: Provider certification is contingent upon compliance with applicable 404 NAC standards as required by the Department. Agencies, organizations, or individuals seeking certification will receive a two-year certification upon completion of the certification review. If the outcomes of the certification review show significant or repeated deficiencies, or if there is evidence that provider systems are not functioning properly, the Department may issue a one-year certification. Remains in section 001.01(B) as modified

4-002.07 Denial of Certification: A provider certification may be denied when an agency, organization, or individual has significant deficiencies in several areas of the standards, and there are serious threats to the health, safety, welfare, rights and habilitation of individuals receiving services; or if the agency, organization, or individual has failed, over time, to comply with the standards. Remains in section 001.01(C) as modified

4-002.08 Extension of Full Certification: The Department may extend the full certification for at least 60 days, as conditions warrant. Remains in section 001.02 as modified

4-002.09 Certification Renewal: All certified providers must submit a renewal application to the Department 90 days prior to the expiration date of the current certification. The Department will conduct an onsite review. Remains in section 001.03 as modified

4-002.09A Renewal Application: The provider must submit a complete renewal application which includes: Remains in section 001.03(B) as modified

(1) Full name of the entity to be certified, street and mailing addresses, telephone number and facsimile number, if any;
(2) Name of director and members of the governing authority, if applicable;

(3) Name and address of the owner(s) of the entity;
(4) Ownership type, such as individual, partnership, corporation, government, or limited liability company;
(5) List of names and addresses of all persons in control of the entity (The list must include all individual owners, partners, limited liability company members, members of board of directors owning or managing operations, and any other persons with financial interest or investments in the agency. In the case of publicly held corporations, only those stockholders who own 5% or more of the company's stock must be listed);
(6) Mailing address of the owner;
(7) The preferred mailing address for receipt of official notices from the Department;
(8) The legal name of the individual or business organization (government, corporation, partnership, limited liability company, or other type) to whom the certification should be issued;
(9) Applicant's federal employer identification number if not an individual;
(10) Non-profit or for profit status;
(11) Signature of the director of the provider and, as applicable, the chairperson of the governing authority;
(12) A copy of the registration as a foreign corporation filed with the Nebraska Secretary of State, if applicable;
(13) Program description for provision of services that includes:
a. Copy of the applicant's organizational chart identifying authority over the agency and the organization of management positions;
b. Service options selected as outlined in 404 NAC 4-001;
c. Address (including street and city) and telephone number of each location for service delivery, for day and residential services as specified in 404 NAC 6 and 7, including type of service to be provided at each location and planned capacity at each location;
d. Copies of current policies and procedures, as specified in 404 NAC 4-003.04;
e. List of all sub-contractors and proposed sub-contracts that will provide services under this application;
14. Signed attestation by the director of the entity that all assurances given in this renewal application are to be considered accurate for the certification period unless changes are submitted, in writing, as specified in 404 NAC 4-002.04; and
15. A disclosure of any criminal history or listing on the Department's registries or the Nebraska State Patrol Sex Offender Registry for any management positions, including owners, directors, and managers. The Department will not certify a provider whose administrative staff or management have been convicted of any of the crimes listed in 404 NAC 4-004.03F.

4-002.09A1 Failure to disclose requested information on the application, or providing incomplete or incorrect information on the application may result in the denial of a certification.

4-002.09B Prior to the expiration date of the current certification, the Department will conduct an on-site certification review to assess compliance. Remains in section 001.03(A) as modified

4-002.09C Based on review of the completed renewal application and the results of the on-site certification review, the Department will make a decision to deny a renewal certification or to issue a full certification in accordance with 404 NAC 4-002.06.

4-002.09D Notification Requirements: The provider must notify the Department, in writing, of any the following situations:

1. Change of ownership within 10 working days of the effective date;
2. Change in director within 10 working days of the effective date;
3. Any addition of a new service option at least 30 days prior to the effective date;
4. Ending a service option currently being provided to individuals at least 60 days prior to the effective date; and
5. Expanding services into another geographic area that was not included under the current provider certification at least 60 days prior to the effective date so the Department can issue a provisional certification. Remains in section 001.05 as modified

4-002.09D1 Change in Ownership: A provider certification is issued only to the person(s) named in the application as the certified provider. When a change of ownership occurs, the new owner must assume responsibility for correction of all previously cited deficient practices from the acquired provider. Remains in section 001.05(A) as modified

4-002.10 Certification and Service Reviews: The Department will determine provider compliance with 404 NAC by conducting certification reviews and service reviews to investigate complaints received by the Department or to follow up on incidents reported to the Department. On-site certification and service reviews may be unannounced. In addition to on-site reviews, the Department may request information from the provider prior to the review. Remains in section 001.06 as modified

4-002.10A Results of Certification or Services Reviews: The Department will notify the provider, in writing, of the results of the certification or service review including any areas found to be out of compliance with 404 NAC. Remains in section 001.06(A) as modified

4-002.10B Plan of Improvement: The provider must submit an acceptable plan of improvement to continue certification. Within 20 days of receipt of the Department's written results, the provider must submit an acceptable plan of improvement to address areas found to be out of compliance. The plan of improvement must:

(i) Be specific in identifying a planned action on how the areas found to be out of compliance have been or will be corrected, for the individual cases included in the review and system wide within the provider organization;

(ii) Include an expected date for completion of the plan of improvement that is timely, taking into consideration the nature of the violation;

(iii) Identify a means to prevent a recurrence;

(iv) Identify who is responsible for implementing the plan of improvement and ensuring all areas are corrected and maintained; and

(v) Be signed and dated by the director of the entity or designee. Remains in section 001.06(B) as modified

4-002.10C Upon receipt of an acceptable plan of improvement, the Department may conduct an on-site revisit or request information from the provider to follow-up on the plan of improvement.

4-002.11 Disciplinary Actions: The Department may impose a disciplinary action on a provider based on scope and seriousness of the immediate risk to individuals, the areas found to be out of compliance, or the compliance history of the provider. The Department may impose one or more of the following types of disciplinary action: Remains in section 001.07 as modified

4-002.11A Directed Plan of Improvement: The Department will develop the plan of improvement for the provider and require the provider to implement the specified actions within specified timeframes to achieve improvement. The provider is responsible for achieving compliance as outlined in the directed plan of improvement. Remains in section 001.07(A) as modified

4-002.11B Directed In-Service Training: The Department will require the provider to obtain specific training for staff. The provider is responsible for the required training and the associated cost of the training. Remains in section 001.07(B) as modified

4-002.11C State Monitoring: The Department will require monitoring by a Department employee or contractor as a safeguard against further harm or injury to individuals or when there is a serious risk to the safety of the individuals. The monitor must be a Department employee or contractor and cannot have an immediate family member receiving services with the provider or any other conflict of interest. Remains in section 001.07(C) as modified

4-002.11D Probation: The Department sets a period of time by which the provider may continue to operate under the terms and condition set by the Department. Remains in section 001.07(D) as modified

4-002.11E Limitation of Entry to Provider Service or Provision of Services: When the Department finds that the provider has areas found to be out of compliance that impact the provision of services to individuals, the Department may limit individuals' entry into service with the provider or limit the provision of services offered by the provider. This may include services offered at a specific service location(s). Once the provider has achieved compliance and has been determined to have the ability to

maintain compliance, the limitation will be lifted. Remains in section 001.07(E) as modified

4-002.11F Termination of the Provider Certification: The Department may terminate the provider certification when:

(i) Areas found to be out of compliance pose an immediate and serious threat to one or more individual(s) health and safety;
(ii) Conduct or practices are detrimental to the health or safety of an individual or other(s) occurs;
(iii) Failure to file a report of suspected abuse or neglect as required by Neb. Rev. Stat. §§28-372 and 28-711;
(iv) The provider has established a pattern of not maintaining compliance;
(v) The provider has not corrected previously identified areas found to be out of compliance on a provider-wide basis;
(vi) The provider has established a pattern of not utilizing internal quality improvement activities to ensure compliance on a provider-wide basis with 404 NAC 4-014;
(vii) The provider is found to have committed, permitted, aided, or abetted the commission of any unlawful act;
(viii) The provider failed to disclose information on the application or provided incomplete or incorrect information on the application;
(ix) The provider has failed to submit an acceptable plan of improvement; or
(x) The provider has failed to complete any imposed disciplinary action(s) in 404 NAC 4-002.11 as directed by the Department. Remains in section 001.07(F) as modified

4-002.11G Notice of Disciplinary Action to Provider: The Department will send a written notice by certified mail within 30 days of the decision to impose a disciplinary action to the provider. Remains in section 001.07(G) as modified

4-002.11H Immediate and Serious Threats to Health and Safety: When situations involving immediate and serious threat to one or more individual(s) health and safety are identified, the following will occur:

(i) The Department will notify the provider verbally of the situation involving immediate and serious threat during the certification or service review;
(ii) Upon verbal notification, the provider must take immediate action to remove the risk to the identified individual(s) and implement corrective measures to prevent further immediate and serious threat situations;
(iii) If the provider fails to remove the risk to identified individuals and to implement corrective measures to prevent further immediate and serious threat situations, the Department will notify the appropriate Department staff for consideration of individuals being removed from the provider's services;

(iv) The Department will notify the provider in writing of the circumstances of the immediate and serious threat situation and the decision to proceed with termination of the provider's certification unless the provider has eliminated the immediate and serious threat situation and is able to maintain corrective actions;

(v) The provider must submit written evidence of correction or that the circumstances causing the immediate and serious threat no longer exist and that safeguards are in place to ensure the health and safety of individual(s); and

(vi) Upon receipt of the provider's evidence of correction, the Department will make a determination regarding the provider's certification. The Department may conduct a revisit to verify compliance. Remains in section 001.07(H) as modified

4-002.12 Informal Dispute Resolution (IDR): The applicant or provider may request the Department conduct an IDR to review and evaluate findings that caused the Department's decision to deny a provisional, full, or renewal certification or to impose a disciplinary action. The applicant or provider must submit a written request for an IDR to the Department within 15 business days of receipt of the notice of the Department's action. The Department will:

(i) Hold an IDR within 30 business days of receipt of the request; and
(ii) Within 30 business days of the IDR, issue an affirmation, modification, or dismissal of the notice, in writing.

4-002.12A If the applicant or provider contests the result of the IDR, the applicant or provider must submit a request for hearing, in writing, to the Department within five business days after receipt of written decision from the Department.

4-002.13 Administrative Hearings in Contested Cases: An applicant or provider has the right to contest the Department's decisions regarding denial, non-renewal, or termination of certification and decisions related to disciplinary action. When an applicant or provider requests a hearing, the Department will hold a hearing in accordance with the Department's rules and regulations adopted and promulgated under the Administrative Procedure Act (APA) (Neb. Rev. Stat. §§. 84-901 to 84-920).

4-003 ADMINISTRATION STANDARDS

4-003.01 All specialized providers must be Medicaid providers as described in 471 NAC 2-000. Remains in section 002.01 as modified

4-003.02 Director: Each provider must have a director who is responsible for overall management of the provision of services, establish policies and procedures as specified in 404 NAC 4-003.04, and ensure compliance with applicable requirements in 404 NAC. The director must: Remains in section 002.02 as modified

1. Protect and promote the health, safety, and well-being of each individual; and
2. Ensure quality services are provided to meet the needs of all individuals whether services are provided directly by provider staff or through subcontract.

4-003.03 Local Governing Board or Advisory Committee: The specialized provider must comply with Neb. Rev. Stat. §§ 83-1217 and 83-1218.

4-003.04 Provider Policies and Procedures: The provider must establish and implement written policies and procedures that are:

3. Available to staff;
4. Describe provider's operation and how systems are set up to meet individuals' needs;
5. In compliance with 404 NAC; and
6. Reviewed at least annually and revised if needed. Remains in section 002.03 as modified

4-003.05 Entry to Service: The provider must:

7. Gather and review referral information regarding the individual, to the greatest extent possible, so the provider is aware of the individual's preferences, strengths, and needs to make a determination as to whether their agency is capable of providing services to meet the individual's needs;
8. Consider the safety of all individuals in the decision to accept new individuals to service or the location for the services; and
9. Consider whether the provider has the capacity, commitment, and resources necessary to provide supports to the individual for the long term. The provider must not admit an individual to services if it cannot reasonably assure that it has the ability to meet the individual's needs. Remains in section 002.07 as modified

4-003.06 Termination of Services

4-003.06A A provider may terminate services to an individual when the provider has determined that they can no longer effectively and appropriately serve the individual due to a lack of resources, skills, or capacity. Written notification must be given to the individual or his/her legal representative (if applicable) no less than 60 days prior to the final day of services outlining the reasons for termination of services. Remains in section 002.08 as modified

4-003.06A1 When an individual receives services funded through a contract addendum with enhanced rates, notification must be given no less than 90 days prior to the final day of services.

4-003.06A2 When the provider decides to terminate services, a transition plan must be developed in conjunction with the individual's IPP team and the new provider. The plan must be agreed upon by the IPP team and include:

a) A primary focus on the individual's needs and preferences;
b) Timelines;
c) Supports and strategies that are needed for the new provider; and
d) Supports and strategies that are needed for the current provider to continue to meet the needs of the individual during the transition

period prior to the termination date. Remains in section 002.08(A)(i-iii) as modified

If a suitable option for the individual has not been found, the Department may require the provider to continue to provide services to the individual for an additional ten days to allow more time to find another option. Remains in section 002.08(B) as modified

4-003.06B When an individual or legal representative (if applicable) decides to voluntarily terminate services with the provider, s/he must provide written notification to his/her current provider no less than 30 days prior to the final day of services. The individual must fulfill any housing lease agreement s/he holds. The individual's IPP team must develop a transition plan that includes:

(1) A primary focus on the individual's needs and preferences;
(2) Timelines;
(3) Supports and strategies that are needed for the new provider; and
(4) Supports and strategies that are needed for the current provider to continue to meet the needs of the individual during the transition period prior to the termination date.

4-003.07 Information Available to Public: The provider must make available to the public upon request any certification, licenses, and public inspection reports.

4-003.08 Access to DD Provider: The provider must allow access by Department staff to all records or other documents relating to the operation of the provider, and all individuals served, as the Department deems necessary. Remains in section 002.09 as modified

4-003.08A The Department will not authorize an alternative compliance procedure for 404 NAC 4-003.08 or any of its parts.

4-004 STAFF REQUIREMENTS: The provider must recruit, orient, train, manage, and retain qualified staff with the skills necessary to meet the needs of individuals and respond to emergencies. The provider must ensure and maintain evidence of the following: Remains in section 003(1) as modified

4-004.01 Specialized providers must comply with the employee verification requirements of Neb. Rev. Stat. § 4-114. Remains in section 003(2) as modified

4-004.02 Age Requirements: Staff providing direct services must be at least 18 years of age. Remains in section 003(3) as modified

4-004.03 Background Checks: The provider must ensure the safety of individuals served by complying with the following requirements for background checks: Remains in section 003(4) as modified

4-004.03A Register/Registry Check: The provider must:

1. Check the Central Register of Child Protection Cases and the Adult Protective Services Central Registry in the Department. The provider must initiate checks with the Department within ten calendar days of employment and as necessary to verify a staff person is not on the registry/register. The provider must initiate checks on all staff. The provider must initiate checks on household members (excluding individuals served) of a household in an extended family home or respite provider's home (if services are delivered in the provider's home) as follows: checks on the Central Register of Child Protection Cases for members age 13 or older and checks on the Adult Protective Services Registry for members age 18 or older;
2. Check the Nebraska State Patrol Sex Offender Registry; and
3. Retain results of registry/register checks for one year following the termination of the staff person's employment. Remains in section 003(5) and 003(6) as modified

4-004.03B Criminal History Check: The provider must:

1. Require a state and federal criminal history record information check completed by the Nebraska State Patrol and the Identification Division of the Federal Bureau of Investigation for all staff persons or subcontractors providing direct services hired on or after September 13, 1997, who work directly with individuals served and who are not licensed or certified as members of their profession;
2. Ensure that each new staff person subject to the criminal history check files two complete sets of his or her legible fingerprints, or fingerprint equivalent, and biographical information with the Department within ten calendar days of hire;
3. Not accept results and documentation of criminal history checks that are completed more than 180 days before the staff person's hire date; and
4. Retain results of each new staff person's criminal history checks for one year following the termination of employment. Remains in section 003.01 as modified

4-004.03C Employees who provide direct support services may not work alone with individuals served until the results of the registry checks and the criminal history background checks as specified in 404 NAC 4-004.03A and 4-004.03B are reviewed by the provider. Remains in section 003.01 as modified

4-004.03D The provider must determine whether employees found to be listed on the Central Register of Child Protection Cases or the Adult Protective Services Central Registry in the Department or the Nebraska State Patrol Sex Offender Registry or found to have with a criminal history present risk of abuse, neglect, exploitation, or sexual misconduct to individuals served. The provider must document any provider decision to maintain a staff person listed on a registry or found to have a criminal history as outlined in 404 NAC 4-004.03F, including how that decision was made and the provider's plan to reduce risks to individuals and to provide protections, as necessary.

4-004.03E Alternative Method of Criminal History Check: The provider may employ a person pending the results of the criminal history check if they have utilized an alternative method of criminal history checks at its own expense until the results of the required criminal history check are received. The alternative method of criminal history checks must be approved by the Department. If the results of the alternative method indicate that the person has not been convicted of any crimes listed in 404 NAC 4-004.03F, that person may work alone with individuals served by the provider. If the results of the required criminal history check in 404 NAC 4-004.03B indicate that the person has been convicted of any of the crimes listed in 404 NAC 4-004.03F, then the person may not work alone with individuals served by the provider.

4-004.03F Specific Crimes: The provider must not allow employees found to be convicted of the following crimes to work alone with individuals served by the provider:

(1) Child pornography;
(2) Abuse of a child or vulnerable adult;
(3) Felony domestic assault;
(4) Misdemeanor domestic assault within the last five years;
(5) Shoplifting after age 19 and within the last three years;
(6) Felony fraud within the last ten years;
(7) Misdemeanor fraud within the last five years;
(8) Possession of any controlled substance within the last five years;
(9) Possession of any controlled substance with intent to deliver within the last ten years;
(10) Felony assault without a weapon within the last ten years;
(11) Felony or misdemeanor assault with a weapon in the last 15 years;
(12) Prostitution or solicitation of prostitution within the last five years;
(13) Felony or misdemeanor robbery or burglary within the last ten years;
(14) Rape or sexual assault; or
(15) Homicide. Remains in section 003.02(1-21) as modified

4-004.03G All employees must notify the provider immediately if charged or convicted of any of the crimes listed in 404 NAC 4-004.03F or if his/her name is placed on any of the Department's registries. Remains in section 003.02(A) as modified

4-004.04 Staff Training and Competency: The provider must ensure that employees, including subcontractors and management, responsible for providing supports and services to individuals with developmental disabilities are educated/trained on the minimum requirements necessary to address the individual's needs prior to working with individuals in services. Remains in section 003.03 as modified

Staff responsible for providing direct services must demonstrate the competence to support individuals as part of a required and on-going training program. The provider must ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with individuals. Remains in section 003.03 as modified

The provider must document in the employee's personnel record that required orientation and training was completed and competency was demonstrated. It is the responsibility of the provider to ensure that training and verification of such is completed by persons with expertise who are qualified by education, training, or experience in those areas. Remains in section 003.03 as modified

4-004.04A Initial Orientation Requirements: Initial orientation must be completed by all new employees prior to working alone with individuals. Employees must complete the following training requirements:

1. Individual's choice;
2. Individual's rights in accordance with state and federal laws;
3. Confidentiality;
4. Dignity and respectful interactions with individuals; and
5. Abuse, neglect, and exploitation and state law reporting requirements and prevention. Remains in section 003.03(A) as modified

4-004.04B Required Training: Employees must be trained to respond to injury, illness, and emergencies, and competency verified within 30 days of hire or before working alone with an individual. The following training areas must be addressed:

(1) Emergency procedures;
(2) Cardiopulmonary resuscitation;
(3) Basic first aid;
(4) Infection control;
(5) Individuals' medical protocols as applicable; and
(6) Individuals' safety protocols as applicable; Remains in section 003.03(B) as modified

4-004.04C Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to individuals. This training must include:

1. Implementation and development of the IPP and interdisciplinary process;
2. Positive support techniques;
3. Approved emergency safety intervention techniques;
4. Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the individual;
5. Use of adaptive and augmentative devices used to support individuals, as necessary;
6. Other training required by the provider; and
7. Other training as required by the specific service options. Remains in section 003.03(C) as modified

4-004.04D Training and verification of competencies in the above areas must be conducted by persons with expertise who are qualified by education, training, or expertise in those areas. Remains in section 003.03(E) as modified

4-004.04E The provider must document in the staff personnel record that training and demonstration of competency were successfully completed. Documentation must include:

(1) Topic;
(2) Date staff attended training;
(3) Date competencies verified;
(4) Name of person conducting training; and
(5) Verification of competencies. Remains in section 003(E)(i) as modified

4-004.05 Staff Credentials: Any person who provides a service for which a license, certification, registration, or other credential is required must hold the license, certification, registration, or credential in accordance with applicable state laws. The provider must maintain documentation of the staff credentials. Remains in section 003.04 as modified

4-004.06 Sufficient Staff: The provider must at all times maintain enough staff to provide services, supports, and supervision to meet the needs of each individual served. Remains in section 003.05 as modified

4-004.07 Direction and Supervision of Unlicensed Staff Providing Non-Complex Nursing Interventions: When the provider intends to have unlicensed staff provide non-complex nursing interventions to individuals served, the provider must comply with 172 NAC 99.

4-004.08 Medication Aides: When the provider is responsible for provision of medication to individuals as identified in the IPP and uses unlicensed staff, the provider must comply with 172 NAC 95 and 96.

4-004.09 Staff Records

4-004.09A Staff Work Records: The provider must maintain a record of hours worked by staff who provide direct services. The record must include the name of the staff person, position title, date and specific time period worked, and the location the staff person worked for the specified period of time. Remains in section 003.06(A) as modified

4-004.09B Staff Employment Records: The provider must maintain a current employment record for each staff person that includes:

(i) Date of hire;
(ii) Initial and ongoing training;
(iii) Certification or licensing information, if applicable;
(iv) Background checks as specified at 404 NAC 4-004.03;
(v) Job qualifications; and
(vi) Personnel actions, if applicable. Remains in section 003.06(B) as modified

4-005 SPECIALIZED PROVIDER SERVICE STANDARDS: The provider must ensure that all individuals receive habilitation, supports, health care, and other services consistent with the needs and preferences of the individual.

4-005.01 Habilitation: Each individual receiving services must receive habilitation services to acquire, retain, and improve the skills necessary so the individual is able to function with as much independence as possible; enhance choice and self management; and participate in the rights and responsibilities of community membership. Habilitation must be observable in daily practice and identifiable in the IPP and supporting documentation. Habilitation must be an ongoing planned process that includes: comprehensive assessments, an individualized plan, training and supports, service delivery, documentation of the service delivery, measuring progress of the plan; monitoring the service to determine if the services continue to meet the needs of the individual.

Habilitation requires that:

(i) The individual's program plan is developed based on the individual's preferences with input from the IPP team members, and strengths and needs that are accurately assessed.

(ii) The IPP team must prioritize needs so that:
a. The individual is challenged to overcome barriers that result in the need for specialized services; and
b. The highest level of independence in all areas of community living is achieved.

(iii) Strategies and supports must be developed that are:
a. Based on prioritized needs;
b. Relevant to the IPP;
c. Functional;
d. Tailored to individual needs, and respectful of individual choice; and
e. Documented in the IPP.

(iv) Training and supports are consistently implemented in all settings as the need arises and as opportunities occur. Incidental learning and appropriate behaviors are encouraged and reinforced.

(v) Activities and environments must facilitate acquisition of skills, appropriate behavior, greater independence, and personal choice.

(vi) Performance is accurately measured and training or supports or both are modified based on data and changes in individual circumstances;

(vii) Monitoring of service delivery must be provided and, if needed, cause actions to occur to ensure needs are addressed.

Individuals with conditions that make further growth or development unlikely must receive training and supports designed to maintain skills and functioning and to prevent further regression to the extent possible. Remains in section 404 5-001.01 as modified

4-005.01A Assessments: Assessments must be conducted for each individual to obtain accurate and complete information related to the individual's history, preferences, strengths, and abilities and needed services. The assessments must be the basis of development of the IPP. Assessments must be completed for each

individual within 30 calendar days of entry to services; at least annually, the assessments must be reviewed and updated to reflect the individual's current status. Remains in section 404 NAC 5-001.06 as modified

4-005.01B Individual Program Plan (IPP): The IPP must be an individualized person centered plan that specifies agreed upon services to be delivered to the individual to meet identified needs. The IPP must be a plan to offer habilitation services and supports to individuals. The IPP must be based on individual's preferences and the comprehensive assessments. The provider must participate in development of the annual IPP and take the necessary steps to ensure that the IPP documents the IPP team review, discussions, and decisions. Remains in section 404 NAC 5-001.07 as modified

4-005.01C Programs and Supports: Services such as supports and programs to learn new skills must be identified in the IPP. The provider must develop a specific written plan with enough detail to consistently implement these services. Remains in section 404 NAC 5-001.07 as modified

4-005.01C1 Supports are the assistance required by the individual to maintain or increase independence, achieve community participation, improve productivity, and for health and safety. Supports must be flexible and subject to change when circumstances change or the supports are no longer needed or effective.

4-005.01C2 Programs must be based on the goals identified in the IPP for the development of functional skills.

4-005.02 IPP Team Process: The IPP is developed through an IPP team process. The IPP team assigns responsibility for obtaining and providing services to meet the identified needs of the individual. Remains in section 404 NAC 5-001.07(A) as modified

4-005.02A The IPP team consists of the individual, legal representative, if applicable, service coordinator, provider representative(s), and other individuals chosen by the individual served. The individual may raise an objection to a particular provider representative. When an individual raises an objection, the IPP team must attempt to accommodate the objection while allowing participation by provider representatives.

4-005.02B The IPP team must utilize a team approach and work toward consensus development of a meaningful outcome driven IPP for the individual.

4-005.02A The Department will not authorize an alternative compliance procedure for 404 NAC 4-005.02 or any of its parts.

4-005.03 Positive Behavioral Supports: In addressing behaviors, the provider must develop and implement policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each individual.

The provider must ensure the following behavior supports and emergency safety interventions for emergency safety situations are in place:

1. The assessment must attempt to define the communicative function of the behavior for the individual;
2. The assessment must focus on what purpose the identified behavior serves in the individual's life;
3. A review of the individual's day supports, residential supports, and other relevant data must be incorporated in the assessment process;
4. A plan for the individual must be developed that emphasizes positive meaningful activities and options that are inconsistent with the behavior targeted for change;
5. There must be a combination of a planned meaningful day and individualized supports for the individual;
6. The plan must include a description of potential stressors and triggers that may lead to the individual experiencing a crisis. Once identified, there must be a comprehensive safety plan developed and implemented; and
7. There must be meaningful and individualized data collection and data analysis that track the progress of the individual. The data must be presented in a useful manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts. Remains in section 404 NAC 5-001.08 as modified

4-005.03A The Department will not authorize an alternative compliance procedure for 404 NAC 4-005.03 or any of its parts.

4-005.04 Notice of Costs to the Individual: The provider must develop and implement a system for notification to individuals and legal representatives of any associated cost to the individual for the service or items and terms of payment. Written notice must be given to the individual before initiation of service and before any change, giving adequate time for the individual or legal representative to respond to the notice. The notice must specify that individuals will not be charged for services or items that are covered through other funding sources, including items necessary to provide habilitation and transportation related to habilitation and provide information on policies for: Remains in section 404 NAC 5-001.09 as modified

1. Who is responsible for replacement or compensation when individuals' personal items are damaged or missing; and
2. How individuals will be compensated when staff or other individuals in service who do not reside in the location (i.e., respite) utilize the environment and eat food paid for by individuals. This excludes any visitors/guests invited by the individuals to socialize in the residence.

4-005.05 Individuals' Personal Funds and Property: The provider must develop and implement written policies and procedures to identify and detail the system to be used to protect individual's funds and property. These policies and procedures must include the following: Remains in section 002.06(B) as modified

4-005.05A General Requirements: The provider must ensure that:

(1) The provider must not use the individuals' funds and property as a reward or punishment;
(2) The provider must not assess the individuals' funds and personal property as payment for damages unless the IPP team reviews, on a case by case basis, whether it is appropriate for the individual to make restitution, the rationale is documented on the IPP, and the individual or legal representative gives written informed consent to make restitution for damages;
(3) The provider must not assess the individuals' funds and personal property for damages when the damage is the result of lack of appropriate supervision or lack of programmatic intervention;
(4) The provider must not use the individuals' funds and personal property to purchase inventory or services for the provider; and
(5) The individuals' funds and personal property are not borrowed by staff. Remains in section 002 as modified

4-005.05B Support in Managing Financial Resources: When an individual does not have the skills necessary to manage his/her financial resources, the provider may, with the informed choice of the individual, offer services and supports that temporarily transfers some of the control of handling the individual's financial resources to the provider. Remains in section 002.06(A) as modified

4-005.05B1 The transfer of control of an individual's financial resources:

(1) Must not be for a convenience of staff, or as a substitute for habilitation;
(2) Must be temporary;
(3) Must be based on the choice of the individual and the extent to which the individual can participate;
(4) Must not be transferred to another entity and the individual must not be charged for the service. Remains in section 002.06(A)(i) as modified

4-005.05C The individual's IPP team must determine and document in the IPP the following regarding the temporary transfer of control of an individual's finances to the provider:

(1) The extent in which the individual can participate in management of his/her financial resources;
(2) The individual's informed choice;
(3) The rationale for the transfer of control;
(4) The support plan that leads to returning control of the finances to the individual; and
(5) The frequency in which the IPP team will review the temporary transfer of control and support plan, but at least annually. Remains in section 002.06(A)(ii) as modified

4-005.05D Provider Management of Individuals' Finances: When the provider is responsible for handling individuals' funds:

(1) The provider must maintain a financial record for each individual that includes:
   (1) Documentation of all cash funds, savings, and checking accounts, deposits, and withdrawals; and
   (2) An individual ledger which provides a record of all funds received and disbursed and the current balance.
(2) The provider must provide account balances and records of transactions to each individual or legal representative at least quarterly, unless otherwise requested;
(3) The provider must ensure that all non-routine expenditures exceeding $100 are reviewed and prior authorized by the individual or legal representative. The individual's IPP team is notified;
(4) The provider must ensure that policies and procedures outline how financial errors, overdrafts, late fees, and missing money will be handled when the provider is responsible for managing individuals' funds. The policies and procedures must include that:
   (1) The provider is responsible for service charges and fees assessed due to staff errors;
   (2) The provider must replace missing money promptly if missing money is due to staff error; and
   (3) The provider is responsible for taking steps to correct an individual's credit history when it is affected by provider staff actions in managing the individual's finances;
(5) When the provider is maintaining individuals' personal funds in a common trust, a separate accounting is maintained for each individual or for his/her interest in a common trust fund. Remains in section 002.06(B) as modified

4-005.06 Health Services: Unless otherwise assigned in the IPP, the provider must take reasonable steps to assist and support individuals in obtaining health services consistent with his/her needs. Individual health services include medication administration and monitoring, medical services, dental services, nutritional services, health monitoring and supervision, assistance with personal care, personal health care and education, exercise, and other therapies. The provider must meet the following requirements. Remains in section 404 NAC 5-001.10 as modified

4-005.06A Evaluations/Services: Unless otherwise assigned in the IPP, the provider must arrange for or assist the individual in obtaining evaluations and services based on the individual's need, such as physical exams, dental services, psychological services, physical and occupational therapy, speech therapy, audiological services, vision services, nutrition therapy, and other related evaluations and services. Each individual must receive the following evaluations:

1. A medical evaluation every 12 months. Exception: The medical practitioner has identified the need for these evaluations on an alternate schedule; and

2. A dental evaluation every 12 months. Exception: The dentist has identified the need for the evaluation on an alternate schedule.

4-005.06B Observing and Reporting: The provider must ensure that the health status and physical conditions are observed, reported, and responded to in a timely and appropriate manner as needed. For those individuals where the responsibility for obtaining health services has been assigned to someone other than the provider, the provider is responsible to observe, report, and respond to the individual's health service needs to ensure needs can be appropriately met. Remains in section 404 NAC 5-001.10(A) as modified

4-005.06C Orders/Recommendations: The provider must ensure individuals receive care, treatment, and medications in accordance with orders from a medical practitioner. Recommendations from other health care professionals must be reviewed by the IPP team and incorporated into the IPP as determined by the IPP team.

4-005.06D Assistive Devices: The provider must assist individuals with the utilization of assistive and adaptive devices as needed and as identified on the IPP.

4-005.06E Health Records: The provider must maintain health-related records on each individual to document the provision of services and the individual's response to services. The records must include:

1. Any health related assessments;
2. Documentation of an illness, injury, and other health concerns of care, treatment, and medication administration;
3. Documentation of provision of health-related services, including observations of the individual's response, such as lack of progress in provision of service;
4. Current physician orders for medication, treatments, and therapies;
5. Records of visits to the physician or other health care professionals and their recommendations and any other consultation or therapy provided; and
6. Information related to hospitalization, nursing facility stays, or other types of health care providers.

4-005.07 Disaster Preparedness and Management: The provider must establish and implement disaster preparedness plans and procedures to ensure that individual's care, safety, and well-being are provided and maintained during and following instances of natural (tornado, flood, etc.) or other disasters, disease outbreaks, or other similar situations. These plans and procedures must address and delineate:

10. How the provider will maintain the proper identification of each individual to ensure that care coincides with the individual's needs;
11. How the provider will move individuals to points of safety or provide other means of protection when all or part of the building is damaged or uninhabitable due to natural or other disaster;

12. How the provider will protect individuals during the threat of exposure to the ingestion, absorption, or inhalation of hazardous substances or materials;
13. How the provider will provide food, water, medicine, medical supplies, and other necessary items for care in the event of a natural or other disaster; and
14. How the provider will provide for the comfort, safety, and well-being of individuals served in the event of 24 or more consecutive hours of:
    a. Electrical or gas outage;
    b. Heating, cooling, or sewer system failure; or
    c. Loss or contamination of water supply. Remains in section 404 NAC 5-001.11 as modified

4-006 TRANSPORTATION: When the provider transports individuals, the provider must ensure that all individuals are transported in a safe and comfortable manner that meets the needs of each individual. The provider must ensure that:

1. Vehicles are adapted to meet the needs of all individuals served. Individuals must not be denied transportation services due to the lack of adaptation of vehicles;
2. Adequate measures are taken to provide a sufficient number of staff in the vehicle to ensure safety and to meet the needs of each individual being transported; and
3. That each person transporting individuals served:
   a. Has a valid driver's license with the appropriate class code;
   b. Has knowledge of state and local traffic rules;
   c. Is capable of assisting individuals in and out of vehicles and to and from parking places, when required; and
   d. Has received training in first aid, CPR, and in meeting the needs of the specific individuals for whom transportation is provided. Remains in section 404 NAC 5-002(A-C) as modified

4-007 RIGHTS OF INDIVIDUALS RECEIVING SERVICES: Each individual receiving services has the same legal rights and responsibilities guaranteed to all other individuals under the federal and state constitutions and federal and state laws. These rights can only be modified or suspended according to state or federal law.

4-007.01 Procedural Requirements Regarding Rights: The provider must ensure that:

(i) Rights and responsibilities are specified and this specification does not conflict with Title 404.
(ii) Each individual served, parent if a minor, or legal representative is informed of the individual's rights and responsibilities:
   (i) The information must be given at the time of entry to services, annually thereafter, and when significant changes occur; and
   (ii) The information must be provided in a manner that is easily understood, given verbally and in writing, in the native language of the individual, or through other modes of communication necessary for understanding.
(iii) The provision of supports to individuals receiving services in exercising their rights;
(iv) Rights must not be treated as privileges; and

(v) Prohibit retaliation against individuals' services and supports due to the individual, family members, or legal representatives advocating on behalf of the individual served. This includes initiating a complaint with outside agencies. Remains in section 002.03(A) as modified

4-007.02 The Department will not authorize an alternative compliance procedure for 404 NAC 4-007 or any of its parts.

4-008 INCIDENT REPORTING SYSTEM: The provider must implement a system for handling incidents.

4-008.01 The incident reporting system must include:

1. Identification of incidents that require completion of an incident report to the Department that includes:
   (i) Situations that adversely affect the physical or emotional well-being of an individual served;
   (ii) Suspected cases of abuse, neglect, exploitation, and mistreatment; and
   (iii) Emergency safety situations that require the use of emergency safety interventions;
2. Recording the essential facts of the incident, including the results of the incident and any actions which might have prevented the incident;
3. An action plan that includes the provider's immediate effort to address the situation and prevent recurrence;
4. Establish timelines to ensure prompt reporting of incidents as appropriate, including reporting to:
   a. Provider management;
   b. The individual who receives services involved in the incident;
   c. Family member/legal representative as appropriate;
   d. Child and Adult Abuse/Neglect in the Department; and
   e. Law enforcement.
5. Reporting requirements;
   a. A verbal report to the Department upon becoming aware of the incident;
   b. A written report using the Department approved format within 24 hours of the verbal report;
   c. A written summary submitted to the Department of the provider's investigation and action taken within 14 days; and
   d. An aggregate report of incidents must be submitted to the Department on a quarterly basis. Each report must be received by the Department no later than 30 days after the last day of the previous quarter. The reports must include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that result in a reduction in the number of incidents over time.

(vi) Review and analyze information from incident reports to identify trends and problematic practices which may be occurring and take appropriate corrective actions to address problematic practices identified. Remains in section 002.11 as modified

4-009 COMPLAINTS AND GRIEVANCES: The provider must promptly addresses complaints and grievances filed with the provider on behalf of individuals served:

1. The process must be made available to individuals, legal representatives, staff, and other representatives. Utilization of the provider's process is voluntary and is not meant to deny or delay an individual's right to file a complaint elsewhere or to access the legal system;
2. The process must be convenient to the individual;
3. The process must include time frames and procedures for review of complaints and grievances and the provision of a response;
4. The provider must review the complaint and grievance process, including the right to go to court, with each individual receiving services and the legal representative at the time the individual enters services and annually thereafter; and
5. The provider must maintain documentation of the receipt of all complaints and grievances, the resolution, and the response to the complainant. Remains in section 404 NAC 5-003(A-E) as modified

4-009.01 The Department will not authorize an alternative compliance procedure for 404 NAC 4-009 or any of its parts.

4-010 ABUSE AND NEGLECT: The provider must develop a system to detect and prevent abuse and neglect and to handle allegations of abuse, neglect, and exploitation. The provider must ensure:

1. The provider's definition of abuse and neglect is consistent with these regulations;
2. The description of the process and timelines for prompt and accurate reporting of allegations or suspicion of abuse or neglect to appropriate outside authorities in accordance with Neb. Rev. Stat. §28-372 of the Adult Protective Services Act or, in the case of a child, in accordance with Neb. Rev. Stat. §28-711;
3. Description of measures and timelines for reporting of suspicion of abuse and neglect to appropriate provider administrative staff; the legal representative, if appropriate, and service coordinator;
4. Description of the process to conduct a timely, thorough, and objective investigation of all allegations or suspicions of abuse and neglect, including protection of individuals during the investigation;
5. Description of the process for disciplinary action taken when staff are found to have engaged in abusive or neglectful behavior;
6. Appropriate corrective or disciplinary action is taken in response to the investigation;
7. Review by the director of the entity, or designee, of all allegations and investigations and make decisions on the action to be taken;
8. Identification of the means to lessen the likelihood of further incidents if the allegation is substantiated;
9. Documentation of the allegation, investigation, conclusion, action taken, and means to prevent further incidents; and
10. The rights review committee must evaluate all allegations and investigations of abuse and neglect for any violation of an individual's rights. Remains in section 404 NAC 5-004(A-F) as modified

4-011 RIGHTS REVIEW COMMITTEE: The provider must establish a rights review committee that meets no less than semi-annually. The function of this committee is to review any situation requiring an emergency safety intervention, the use of psychotropic medication as outlined in 404 NAC 5-003.02E and 404 NAC 6-005, any restrictive measure as outlined in 404 NAC 6-004, and any situation where violation of an individual's rights occurred. The review may include obtaining additional information and gathering input from the affected individual and his/her legal representative, if applicable, to make recommendations to the provider. The rights review committee may utilize sub-committees to complete its work, but must document reports of the sub-committees to the overall committee in the minutes of meetings held. Interim approvals of psychotropic medications and restrictive measures are allowed in circumstances that require immediate attention. The interim approval may be done by a documented designee of the committee, who must be a current member of the rights review committee, and the meeting minutes must document final approval by the overall committee at its next meeting. Remains in section 002.05 as modified

4-011.01 Membership of the Rights Review Committee: The committee members must be persons free from conflict of interest and who will ensure the confidentiality of information related to individuals served. The person responsible for approving the individual's program and any staff who provides direct services to the individual cannot participate as decision makers. At least half of the committee members must be individuals, family, or other interested persons who are not provider staff. Remains in section 002.05(A) as modified

4-012 CONFIDENTIALITY: The provider must ensure protection of the confidentiality of each individual's information, including verbal, electronic, and written form. Individual information must be protected regardless of the form or storage method of the records. Remains in section 404 NAC 5-005 as modified

4-012.01 The Department will not authorize an alternative compliance procedure for 404 NAC 4-012 or any of its parts.

4-013 RECORD KEEPING: The provider must maintain records in such a manner to ensure accurate, current, and complete records specific to the individual and for administrative records. Remains in section 404 NAC 5-006 as modified

4-013.01 Individual Record: The provider must develop and maintain a record keeping system that includes a separate record for each individual that contains sufficient, current, and accurate information. The individual's records must contain information that includes, but is not limited to:

15. Date of entry into services with the provider;
16. Name, gender, and birth date of the individual;
17. Current physical description or current photo of the individual;
18. The language or means of communication utilized by the individual;
19. Legal status of individual, and name, telephone number, and address of legal representative, if applicable;
20. Name, phone number, and address of persons to contact in an emergency;

21. Name, phone number of the individual's current personal physician and other health care professionals, if applicable;
22. Relevant medical information; including history of seizures, illness, physician orders, treatments, medications, medication history, immunizations; physician contacts, emergency room visits, dental visits, counseling visits, and hospitalizations;
23. Records of incidents and accidents;
24. Consents as appropriate;
25. Records of emergency safety intervention usage and the rationale for use;
26. IPP;
27. Documentation of delivery of services and supports;
28. The individual's rights notification;
29. Notice of charges;
30. Name of service coordinator and phone number;
31. Accounting of the individual's funds, if managed by provider;
32. Notification of termination of services with the provider, if applicable; and
33. Social history information. Remains in section 404 NAC 5-006.01 as modified

4-013.02 General Record Keeping Requirements

4-013.02A Time Frames: The provider must establish time frames for the completion, routing, and filing of all record documents as required and as appropriate to the individual. Remains in section 404 NAC 5-006.02(A) as modified

4-013.02B Documentation: The provider must ensure sufficient, current, and accurate documentation to verify the delivery of services and compliance with applicable requirements in 404 NAC. Remains in section 404 NAC 5-006.02(B) as modified

4-013.02C Maintenance: The provider must designate staff responsible for the maintenance of the individual's records.

4-013.02D Organization: The provider must develop and implement a systematic organization of records to ensure permanency, accuracy, completeness, and easy retrieval of information.

4-013.02E Retention/Destruction: The provider must develop a process relating to retention, safe storage, and safe destruction of the individual's records to ensure retention of necessary information and to protect confidentiality of records. The provider must retain records relating to the individual and the provision of services for at least six years, including HIPAA health-related records. Remains in section 404 NAC 5-006.03 as modified

4-013.02F Location: The provider must have a method to access the records by staff and other relevant persons as needed. The provider must ensure that current and applicable records relating to the individual are readily available to staff when providing services to individuals. If there are changes in ownership, all individual records must be transferred to the current owner. Before dissolution of any provider

agency, the administrator must notify the Department in writing of the location and storage of individual records.

4-013.02G Access: The provider must govern access to, duplication, dissemination, and release of information from the individual's record.

4-013.02G1 The provider must ensure written consent is obtained from the individual or the individual's legal representative for the release of information specific to the individual, including release of photographs to persons not authorized under law to receive them. The consent must identify the specific information to be released and the time period the consent is in effect, except that no written consent to release or access information is necessary for Department representatives to review the records.

4-013.02G2 The provider must specify the method and frequency for obtaining authorizations for medical treatment and consents.

4-013.02H Record Entries: The provider must ensure that all record entries are dated, legible, and clearly identify the person making the entry. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent. Remains in section 404 NAC 5-006.02(C) as modified

4-013.02I Inspection of Records: The provider must ensure that all administrative records and records relating to the individual served are made available for review by authorized representatives of the Department.

4-014 QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI): The provider must have a process for:

1. Ongoing proactive internal review of the quality and individualization of services;
2. Continuous quality review of the services provided;
3. The provider must provide evidence that individuals served and their families are involved in the QA/QI process. Remains in section 004(1-3) as modified

4-014.01 QA/QI Structural Components: The provider must create the structural components of the QA/QI process. The process must be applied on a provider-wide basis and include:

34. Areas of services to be monitored and evaluated to determine the quality of these services through identification of patterns and trends of the provider services.
35. Provisions for reviewing QA/QI policies and procedures at least annually and revising as needed. Remains in section 004.01 as modified

4-014.02 The QA/QI activities must result in:

36. Ensuring compliance with applicable requirements in Title 404;

(vii) Identification and correction of problems in a timely manner and on a provider-wide basis; and

(viii) Use of information from reviews, results, and recommendations to correct problems, improve services to individuals served, and revise policies and procedures, if necessary. Remains in section 004.02 as modified

4-014.03 Documentation of QA/QI Activities: The provider must maintain documentation of all QA/QI activities, including the results of reviews, recommendations, action taken, effectiveness of action taken, review by the director and certified provider, and other relevant information. Remains in section 004.03 as modified

TITLE 404 DEVELOPMENTAL DISABILITIES SERVICES

CHAPTER 5 CORE REQUIREMENTS FOR ALL CERTIFIED AND INDEPENDENT PROVIDERS OF SERVICES

001. PROVIDER SERVICE STANDARDS. All certified agency providers and independent providers of services under Medicaid Home and Community-Based Services waivers must meet requirements established by the Department of Health and Human Services in this chapter.

001.01 Provider services are based on goals and needs identified in the participant's individual support plan (ISP). The provider must:

(A) Participate in the individual support planning team;
(B) Provide services in accordance with the participant's individual support plan (ISP);
(C) Prioritize the needs of the participant, such that:
  (i) The participant is challenged to overcome barriers that result in the need for specialized services; and
  (ii) The highest level of independence in all areas of community living is achieved;
(D) Develop strategies and supports that are:
  (i) Based on prioritized needs;
  (ii) Relevant to the individual support plan (ISP);
  (iii) Functional;
  (iv) Tailored to individual needs, and respectful of participant choice; and
  (v) Documented in the individual support plan (ISP);
(E) Implement training and supports consistently in all settings, as the need arises and as opportunities occur;
(F) Encourage and reinforce incidental learning and appropriate behaviors;
(G) Provide activities and environments that facilitate acquisition of skills, appropriate behavior, greater independence, and personal choice;
(H) Accurately measure performance and modify training, supports, or both based on data and changes in the participant's circumstances; and
(I) Monitor service delivery and address needs as they occur.

Participants with conditions that make further growth or development unlikely must receive training and supports designed to maintain skills and functioning and to prevent regression to the fullest extent possible.

001.02 NON-RESIDENTIAL LOCATION REQUIREMENTS. When a service is provided in a provider-controlled or operated setting outside of the participant's home, the provider must provide services in a facility or location that:

(A) Is architecturally designed to accommodate the needs of the participant being served;
(B) Is accessible to the participant, clean, in good repair, free from hazards, and free of rodents and insects;
(C) Is equipped to provide comfortable temperature and ventilation conditions;
(D) Has an operable telephone and emergency numbers available;
(E) Has toilet facilities that are clean and in working order;
(F) Has eating areas and equipment that are clean and in good repair;
(G) Is free from fire hazards and contains working smoke detectors;
(H) Has the furnace and water heater located safely;
(I) Ensures any firearms on site are in a locked unit and inaccessible to the participant;
(J) Has an area that is inaccessible to participants in which medications, harmful chemicals, and poisons are stored; and
(K) If it has household pets, keeps the necessary vaccinations current.

001.03 RESPITE PROVIDERS. In addition to general provider standards, providers of respite services must:
(A) Be 18 years old or older, if certified provider staff, and 19 or older if an Independent Provider;
(B) Hold a current certification in basic first aid and cardiopulmonary resuscitation (CPR);
(C) Agree to never leave a minor participant alone; and
(D) Prepare and serve any appropriate meals and snacks to meet the participant's dietary needs, as explained by the usual caregiver.

001.04 HOMEMAKER SERVICE PROVIDERS. In addition to general provider standards, providers of homemaker service must:
(A) Be 19 years old or older. If no provider age 19 or older is available and acceptable to the family, and the participant requests a younger provider, the Department may authorize a younger provider, considering the following:
(i) The capacity of the provider to meet the child's needs in the case of an emergency; and
(ii) Which of the homemaker tasks will be authorized;
(B) Exercise reasonable caution and care in the family's home and in the use of the family's equipment, appliances, and supplies;
(C) Have training or home experience in carrying out homemaker services;
(D) Provide any tools or equipment necessary to perform authorized tasks or duties, if the family does not provide them; and
(E) If he or she is less than 19 years old and not emancipated, have the service provider agreement signed by his or her parent or legal guardian.

001.05 HOME MODIFICATION PROVIDERS. In addition to general provider standards, providers of home modification service must:
(A) Comply with applicable local and state building codes;
(B) Be appropriately licensed or certified persons, when applicable;
(C) Ensure all products and materials installed conform to specifications, unless blemished or reused building materials are stated in the cost estimate and prior approval;

(D) Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, and equipment and fixtures affected during the course of constructions, to original or better condition;
(E) Warranty all work, materials, and products for a minimum of one year;
(F) Ensure any and all subcontractors' work will conform to the terms and conditions of the home modification service contract;
(G) Accept sole responsibility for all work performed pursuant to the home modification service contract; and
(H) Have the service provider agreement signed by his or her parent or legal guardian, if the provider is less than 19 years old and not emancipated.

001.06 ASSESSMENTS. The provider must conduct assessments for each participant to obtain accurate and complete information related to the participant's history, preferences, strengths, abilities, and needed services. The assessments must be the basis of development of the individual support plan (ISP). Assessments, as assigned to the provider, must be completed for each participant within 30 calendar days of entry to services. At least annually, the assessments must be reviewed and updated to reflect the participant's current status.

001.07 INDIVIDUAL SUPPORT PLAN. The provider must participate in development of the annual individual support plan (ISP) and review the individual support plan (ISP), discussions, and decisions for accuracy. The provider must develop and implement programs and supports based on the individual support plan (ISP).

001.07(A) INDIVIDUAL SUPPORT PLAN TEAM PROCESS. The individual support plan (ISP) is developed through an individual support planning team process. The individual support planning team assigns responsibility for obtaining and providing services to meet the identified needs of the participant. The individual support planning team will get input from the participant and provider.

001.08 POSITIVE BEHAVIORAL SUPPORTS. In addressing the participant's behaviors, the provider must:
(A) Develop and implement policies and procedures that emphasize positive approaches directed towards maximizing the growth and development of each participant;
(B) Develop an assessment that defines the communicative function of the behavior for the participant and focuses on what purpose the identified behavior serves in the participant's life;
(C) Review the participant's day supports, residential supports, and other relevant data and incorporate it in the assessment process;
(D) Develop a plan for the participant that emphasizes positive meaningful activities and options that are inconsistent with the behavior targeted for change;
(E) Plan a meaningful day that has individualized supports for the participant;
(F) Document potential stressors and triggers that may lead to the participant experiencing a crisis. Once identified, there must be a comprehensive safety plan developed and implemented;
(G) Conduct meaningful and individualized data collection and data analysis that tracks the progress of the participant. The data must be presented in a useful manner and

collected through a range of methods that are valid and meaningful for planning and evaluation efforts; and

(H) Utilize data analysis and progress to adjust services to meet the participant's needs.

001.09 NOTICE OF COSTS TO THE PARTICIPANT. The provider must develop and implement a system for notification to participants of any associated cost to the participant for services or items not funded by developmental disabilities services, and terms of payment. Written notice must be given to the participant before initiation of service and before any change, giving adequate time for the participant to respond to the notice. The notice must specify that participants will not be charged for services or items that are covered through other funding sources, including but not limited to, items necessary to provide habilitation and transportation related to habilitation.

001.10 HEALTH SERVICES. Unless otherwise assigned in the individual support plan (ISP), the provider must assist and support participants in obtaining health services and arrange for or assist the participant in obtaining evaluations consistent with ~~their~~ his or her needs. Participant health services and evaluations include, but are not limited to:

(1) Physical exams;
(2) Dental services;
(3) Psychological services;
(4) Physical and occupational therapy;
(5) Speech therapy;
(6) Audiological services;
(7) Vision services;
(8) Nutrition therapy;
(9) A medical evaluation at the frequency determined appropriate by the participant's treating medical provider;
(10) A dental evaluation at the frequency determined appropriate by the participant's treating dental provider.
(11) Medication administration and monitoring;
(12) Medical services;
(13) Nutritional services;
(14) Health monitoring and supervision;
(15) Assistance with personal care;
(16) Personal health care and education;
(17) Exercise; and
(18) Other therapies.

001.10(A) OBSERVING AND REPORTING. Regardless of whether the provider has been assigned the responsibility of obtaining health services for the participant, the provider must observe, report, and respond to the participant's health status and physical conditions, in a timely and appropriate manner, as needed.

001.11 DISASTER PREPAREDNESS AND MANAGEMENT. The provider must establish and implement disaster preparedness plans and procedures to ensure that participants' care, safety, and well-being are provided and maintained during and following instances of natural

or other disasters, disease outbreaks, or other similar situations. These plans and procedures must address and delineate:

(A) How the provider will maintain the proper identification of each participant to ensure that care coincides with the participant's needs;

(B) How the provider will move participants to points of safety or provide other means of protection when all or part of the building is damaged or uninhabitable due to natural or other disaster;

(C) How the provider will protect participants during the threat of exposure to the ingestion, absorption, or inhalation of hazardous substances or materials;

(D) How the provider will provide food, water, medicine, medical supplies, and other necessary items for care in the event of a natural or other disaster; and

(E) How the provider will provide for the comfort, safety, and well-being of participants served in the event of 24 or more consecutive hours of:

(i) Electrical or gas outage;

(ii) Heating, cooling, or sewer system failure; or

(iii) Loss or contamination of water supply.

002. TRANSPORTATION. If the provider transports participants, the provider must ensure that all participants are transported in a safe and comfortable manner that meets the needs of each participant. The provider must:

(A) Use vehicles adapted to meet the needs of the participants;

(B) Take adequate measures to provide a sufficient number of staff in the vehicle to ensure safety and to meet the needs of each participant being transported; and

(C) Only have people transporting participants served that:

(i) Have a valid driver's license with the appropriate class code;

(ii) Assist participants into and out of vehicles and to and from parking places, as appropriate; and

(iii) Have received training in first aid, cardiopulmonary resuscitation (CPR), and in meeting the needs of the specific participants for whom transportation is provided.

003. COMPLAINTS AND GRIEVANCES. The provider must promptly address complaints and grievances filed with the provider on behalf of participants served. The provider's process to address complaints and grievances must:

(A) Be made available to participants, legal representatives, staff, and other representatives. Utilization of the provider's process is voluntary and is not meant to deny or delay a participant's right to file a complaint elsewhere or to access the legal system;

(B) Be convenient to the participant;

(C) Include time frames and procedures for review of complaints and grievances and the provision of a response;

(D) Be reviewed by the provider with the participant and his or her legal representative, where applicable; and

(E) Include the right to access the court system.

The provider must maintain documentation of the receipt of all complaints and grievances, the resolution, and the response to the complainant.

004. ABUSE AND NEGLECT. The provider must develop and implement a system to detect and prevent abuse or neglect and to handle allegations or suspicions of abuse, neglect, or exploitation. The provider must:

(A) Establish a definition of abuse or neglect that is consistent with these regulations;
(B) Establish a process and timelines for prompt and accurate reporting of allegations or suspicions of abuse or neglect to appropriate outside authorities that is in accordance with applicable law;
(C) Have measures and timelines for reporting of allegations or suspicions of abuse or neglect to appropriate provider administrative staff; the legal representative, if appropriate; and the service coordinator;
(D) Conduct a timely, thorough, and objective investigation of all allegations or suspicions of abuse or neglect, including protection of participants during the investigation;
(E) Establish a process for disciplinary action taken when staff are found to have engaged in abusive or neglectful behavior; and
(F) Take appropriate corrective or disciplinary action in response to the investigation. As part of this action, the provider must:
(i) Complete a review, by the director of the entity or designee, of all allegations or suspicions, and investigations and make decisions on the action to be taken;
(ii) Identify the means to lessen the likelihood of further incidents if the allegation or suspicion is substantiated; and
(iii) Document the allegation or suspicion, investigation, conclusion, action taken, and means to prevent further incidents.

005. CONFIDENTIALITY. The provider must protect the confidentiality of each participant's information, including verbal, electronic, and written forms. Participant information must be protected regardless of the form or storage method of the records. Participant information may not be released without valid legal consent except as otherwise provided by law.

005.01 The provider must specify the method and frequency for obtaining authorizations for medical treatment and consents.

006. RECORD KEEPING. The provider must maintain accurate, current, and complete administrative records and records specific to participants in services.

006.01 PARTICIPANT RECORDS. The participant's records must contain information that includes, but is not limited to:

(A) Date of entry into services with the provider;
(B) Name, gender, and birth date of the participant;
(C) Current physical description or current photo of the participant;
(D) The language or means of communication utilized by the participant;
(E) Legal status of participant, and name, telephone number, and address of guardian, if applicable;
(F) Name, phone number, and address of persons to contact in an emergency;
(G) Name, phone number, and address of the participant's current personal physician and other health care professionals, if applicable;
(H) Relevant medical information including but not limited to: history of seizures, illness, physician orders, treatments, medications, medication history, known allergies,

immunizations, physician contacts, emergency room visits, dental visits, counseling visits, and hospitalizations;

(I) Records of incidents and accidents;
(J) Consents as appropriate;
(K) Records of emergency safety intervention usage and the rationale for use;
(L) Individual support plan (ISP);
(M) Documentation of delivery of services and supports;
(N) The participant's rights notification;
(O) Notice of charges;
(P) Name of service coordinator and phone number;
(Q) Accounting of the participant's funds, if managed by provider;
(R) Notification of termination of services with the provider, if applicable; and
(S) Social history information.

006.02 ADMINISTRATIVE AND PARTICIPANT RECORD KEEPING REQUIREMENTS. The provider must keep administrative and participant records that:

(A) Have time frames for the completion, routing, and filing of all records or documents as required and as appropriate to the participant;
(B) Are sufficient, current, and accurate to verify the delivery of services and comply with state and federal laws and regulations; and
(C) Are dated, legible, and clearly identify the person making the entry. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent.

006.03 RECORD MAINTENANCE REQUIREMENTS. Providers must maintain, for six years, records relating to the participant and the provision of services.

007. RESTRICTIVE MEASURES. To the fullest extent possible, a participant's rights may not be suspended or restricted. If a restrictive measure is necessary:

(A) The restrictive measure determined necessary for one participant must not unreasonably affect other individuals who receive services in that setting;
(B) The restrictive measure must not be used as punishment, for the convenience of staff, due to a shortage of staff, as a substitute for habilitation, or as an element of a positive behavior support plan;
(C) The restrictive measure must be the least restrictive and least intrusive possible;
(D) There must be a goal of reducing and eliminating the restrictive measure;
(E) Prior to proposing a restrictive measure, there must be documented evidence that other less restrictive methods had been applied by trained staff and failed, unless a participant's behavior resulted in an immediate and serious threat to the health and safety;
(F) The participant or their legal representative, if applicable, must give consent to the restrictive measure; ~~and~~
(G) The restrictive measure must be safe for the participant~~.~~; and
(H) The restrictive measure ~~and the requirements in this section~~ must be documented in the participant's individual support plan (ISP).

007.01 REVIEW AND APPROVAL OF RESTRICTIVE MEASURE. Prior to implementation of a restrictive measure, the provider must ensure review and approval by the individual support planning team and rights review committee, except where the provider is not required under this Title to have a rights review committee.

007.02 RESTRAINTS. The use of mechanical and physical restraints is prohibited unless required by law.

007.02(A) EMERGENCY SAF~~T~~ETY INTERVENTION. An emergency safety intervention is allowed to respond to an emergency safety situation. The provider must document all incidents of emergency safety interventions and give the documentation to the participant's individual support planning team and provider rights review committee to review that the emergency safety intervention was appropriate rather than an instance of mechanical or physical restraint.

007.02(B) EXCEPTION. Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are not considered restraints.

007.02(C) PROHIBITED METHOD. The provider must prohibit the use of:

(i) Mechanical ~~or physical~~ restraint~~s, except as noted above~~;
(ii) Physical restraint, except when used as emergency safety intervention;
(iii) Chemical restraint;
(iv~~ii~~) Aversive stimuli;
(v~~iii~~) Corporal punishment;
(vi~~iv~~) Seclusion;
(vii~~v~~) Verbal abuse;
(viii~~vi~~) Physical abuse;
(ix~~vii~~) Emotional abuse;
(x~~viii~~) Denial of basic needs;
(xi~~ix~~) Discipline;
(xii~~x~~) Implementation of an intervention of a participant in services by another participant in services; or
(xiii~~xi~~) Other means of intervention ~~with the behavior~~ that result~~s~~ in, or is likely to result in injury to the participant.

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 5 INDIVIDUAL SUPPORT OPTIONS (ISO)

5-001 SCOPE: This chapter governs:

1) Provider requirements for Individual Support Options (ISO) services for adults with developmental disabilities;
2) The initial certification of Individual Support Options providers; and
3) The certification of Individual Support Options providers on an ongoing basis.

5-002 PURPOSE: There are two major types of supports that fall under this Individual Support Options: Supported Living (SL) and Supported Day (SD).

5-002.01 Individual Support Options means that services can be provided for as long as 24 hours a day and can include both continuous and intermittent supports. There must be flexibility of services that change, as the person's needs change, without the individual having to move elsewhere for services. These services must:

(A) Be person centered;
(B) Demonstrate that the individual is in charge of his/her services and supports;
(C) Promote the freedom for an individual to live a meaningful life and participate as a member of the community as any other citizen;
(D) Promote the individual's rights and autonomy;
(E) Promote the use of generic services, natural supports, and options;
(F) Assist the individual in acquiring, retaining, and improving the skills and competence necessary to live successfully in his/her residence and as a member of the larger community; and
(G) Promote well planned and proactive opportunities for the individual and his/her family to determine the type and amount of support desired with meaningful direction from the individual, the individual's family or guardian (where appropriate) and the proposed or current provider (as appropriate and desired).

5-002.02 Individual Support Options includes the provision of the following:

(A) Habilitation, staff support, professional services, and any related support services necessary to ensure the health, safety, and welfare of the individual(s) receiving services;

(B) A combination of lifelong or extended duration support, training, and other services essential to daily living; and

(C) Protective oversight to do, to whatever degree necessary, what is required to ensure that basic health and safety are always provided and readily available.

5-002.03 Supported Living: Supported Living is defined as supports provided in the community for an individual eligible for developmental disability services, with no more than two other individuals with developmental disabilities in a residence that it is under the control and direction of the individual(s). The residence must be in a community integrated setting.

Supported Living means that the individual(s) have control and choice over where and with whom they live. Providers may suggest potential roommates for individuals, but the recommendation must not be based on diagnosis alone but by the individuals' preferences and compatibility.

The number of individuals with developmental disabilities alone does not define Supported Living. Supported Living is an option that can be considered by the individual receiving support and offered by providers as an option in their menu of services. If an individual chooses Supported Living, or if the provider chooses to offer Supported Living as a service option, the requirements of this chapter must be met for this option to be exercised.

Supported Living options are for a maximum of three individuals with developmental disabilities (not including staff) who choose to live together in this type of arrangement. The provider of specialized DD services must be able to document that the individual(s) chose the supported living residence and that the lease or mortgage is under the control of the individual(s). The owner or lessee of the property must be unrelated, directly or indirectly, to the provider of specialized services.

5-002.03A An Extended Family Home (EFH) situation may qualify as a Supported Living option if the requirements of Individual Support Option services described in this chapter are met. To be considered, it must be a residence for no more than two individuals with developmental with disabilities, owned or leased by the subcontractor providing supports. The individual, who is his/her own payee or representative payee, pays room and board directly to the subcontractor. Agency owned housing when the EFH provider is engaged as a subcontractor does not qualify as a Supported Living option.

5-002.04 Supported Day: Supported Day is defined as day supports provided for three or fewer individuals as part of an array of supports in a non-facility based option. This is an option where a majority of the non-paid adults present are individuals without developmental disabilities who are part of the typical community.

Supports offered may include, but are not limited to, supported employment, self-employment, regular work, and other inclusive non-facility, participatory activities that bring monetary or social value to a person's life. These are all part of what may be considered a meaningful day.

5-003 CERTIFICATION OF INDIVIDUAL SUPPORT OPTIONS PROVIDERS: Only a certified, specialized DD provider is eligible to provide Individual Support Options services under contract with the Department. To become certified, and to maintain certification, the provider must:

1) Comply with the applicable provider requirements in 404 NAC;
2) Designate the choice to become a provider of Individual Support Options services and obtain certification as described in 404 NAC 4 and 5;
3) Comply with all applicable federal and state laws and regulations;
4) Support individuals with developmental disabilities who have chosen Individual Support Options to increase independence, productivity, and community integration; and
5) Ensure that the type and intensity of services specified in the Individual Program Plan (IPP) are commensurate with identified strengths and preferences that enhance community membership.

5-003.01 Certified Provider Responsibilities: Once certified as an Individual Support Options provider in good standing, the provider must meet all of the certification requirements of this section to remain certified by the Department.

5-003.02 Certification Requirements: The Individual Support Options provider must develop and implement policies and procedures that encompass the following:

5-003.02A Administrator: Each provider must identify an administrator who is responsible for overall management of the provision of Individual Support Options services, and ensure compliance with applicable requirements in 404 NAC 5.

5-003.02B Rights: Inherent in Individual Support Options is that supports and services are delivered in the individuals' homes, or in the community. The same rights and responsibilities of any citizen apply in Individual Support Options.

5-003.02C Restriction of rights, person, or property is not allowed in Individual Support Options services.

5-003.02D Restraints are prohibited, but an emergency safety intervention can be used in a situation where the individual is in danger of immediate jeopardy or harm. If there are disruptive or challenging behaviors displayed by an individual, then a safety and support plan must be developed utilizing the principles of positive behavioral supports (see 404 NAC 4-005.03).

5-003.02E Psychotropic medications taken by the person due to diagnosed mental illness (a dual diagnosis of a severe and persistent mental illness in conjunction with a developmental disability) must be prescribed by a physician, who has authority in his/her scope of practice to determine the diagnosis, and used only with the consent of the individual in services. If symptoms reappear and the ongoing use of medication is no longer effective, a positive behavioral supports plan must be established and in place to address those symptoms when they occur. No specific plan is required to reduce or eliminate the medication.

Psychotropic medications used solely for the purpose of modifying behaviors may be used only with the consent of the individual, with a plan to reduce and eliminate the medication, and in conjunction with a positive behavioral supports plan. There must be evidence that a less restrictive and more positive technique had been systematically tried and shown to be ineffective.

No positive behavioral supports plan is required when an individual is prescribed a medication that has the effect of behavior modification, but is prescribed for other reasons, as documented by a physician.

All psychotropic medications must be reviewed by the rights review committee as outlined in 404 NAC 4-011. There must be an annual review by the prescribing physician and a semi-annual review by the IPP team of all psychotropic medications utilized. There must be clear and convincing evidence that the individual has a person-centered plan demonstrated by data and outcome measures.

5-003.03 Residence Safety: An individual receiving Individual Support Options services must agree to keep his/her residence safe. This must be addressed in the IPP; this is not the provider's responsibility. The individual must ensure his/her residence has operable smoke detectors properly installed. The individual smoke detectors must be tested at least quarterly.

TITLE 404 DEVELOPMENTAL DISABILITIES SERVICES

CHAPTER 6 PROVIDER DATA COLLECTION AND REPORTING

001. DATA COLLECTION AND REPORTING. Each provider must maintain data, statistics, schedules, reports, and other information as required by the Department.

001.01 PROVISION OF INFORMATION. The provider must, upon request, submit data, statistics, schedules, reports, and any other requestedired information to the Department.

002. DEPARTMENT ACCESS. Each provider must allow access to records, must provide copies of documents upon request, and must allow access to the provider's operations for on-site review by the Department.

003. FISCAL ACCOUNTABILITY. Each provider must have fiscal and budgetary financial systems that provide accounting for funds received from the Department. Fiscal accountability must be consistent with generally accepted accounting principles and standards acceptable to the Department.

003.01 ACCOUNTING RECORDS. The provider must maintain accounting records that allow the provider to:

(A) Produce a complete annual financial report in a format specified by the Department;
(B) Provide copies of source documents and work papers;
(C) Maintain records for each employee that:
  (i) Are prepared at the end of each pay period;
  (ii) Show the employee's:
    (1) Name;
    (2) Position title or description;
    (3) Gross salary;
    (4) Taxes; and
    (5) All other deductions or contributions;
  (iii) Are the final, approved copies;
  (iv) Document when personnel are compensated in whole or in part with room and board; and
  (v) Show charges for employee benefits;
(D) Maintain itemized records of:
  (i) Expenditures for technical assistance;
  (ii) Cost of the operation of programs;
  (iii) Rent;
  (iv) Equipment leasing expenses; and
  (v) Maintenance costs for facilities and services; and

(E) Maintain accounting records in sufficient detail to allow for the calculation of the cost of each service provided;.

(F) Identify costs that are not allowed for consideration by Center for Medicaid and Childrens Health Insurance Program (CHIP) Services for rate setting purposes, including costs associated with the provision of room and board for participants; and

(G) Identify transactions between the provider and a related party.

004. MINIMUM CASH RESERVE. Each provider must maintain a minimum cash reserve or business line of credit equal to three months of operating expenses or $10,000.00, whichever is greater. Providers shall submit evidence of meeting this requirement upon application for initial certification and any renewal applications, as set forth in 404 Nebraska Administrative Code (NAC) 4, as well as upon Department request at its sole discretion.

0054. ANNUAL AUDIT OF CERTIFIED PROVIDERS. The certified provider must contract with a certified public accountant licensed to practice in the State of Nebraska for an annual independent audit of its financial operations. This audit must be conducted using generally accepted auditing standards acceptable to the Department. A certified provider is exempt from the annual audit requirement described in this paragraph if the certified provider's gross receipts from Medicaid Home and Community Based Services developmental disabilities waiver program payments for its fiscal year are less than $1,500,000.00. A certified provider must comply with the annual audit requirement for any fiscal year in which its gross receipts from Medicaid Home and Community Based Services Developmental Disabilities Waiver program payments equal or exceed $1,500,000.00.

0054.01 AUDIT REPORT. The certified provider must submit the required audit report, if any, must be submitted to the Department within 180 calendar days ofafter the end of the provider's first full fiscal year, and for every fiscal year thereafter unless otherwise exempt. At a minimum, the audit report must include:

(A) A review of receipts and disbursements;

(B) A review of cash control procedures;

(C) An audit of the provider's income statement, balance sheet, source, and use of funds statement;

(D) An accounting of all lease agreements and mortgages and, if requested by the Department, a copy of any such documents;

(E) A review of the cash balance on hand at the beginning and at the end of the fiscal year;

(F) A disclosure of all related party transactions, or a statement attesting that no such transactions were found; and,

(G) A disclosure of all deficiencies in internal control over financial reporting identified during the audit.; and

(H) An accounting of all business lines of credit for which the provider is approved at the end of its fiscal year.

0065. COMPLIANCE AUDITS. All providers must permit the Department, the U.S. Department of Health and Human Services, and any other duly authorized agent or governmental agency to perform audits or inspections, or both, of its records.

006~~5~~.01 The provider must retain all financial records, supporting documents, statistical records, and all other records as directed by the Department . The provider must retain such records in a format acceptable to the Department.

~~005.02 Compliance audits may result in:~~

~~(A) Reduction in or reimbursement of funds;~~
~~(B) Probationary status;~~
~~(C) Termination, in whole or in part, of a contract, or~~
~~(D) Any combination of the above.~~

006~~5~~.02~~3~~ The provider may be required to prepare and submit a plan to the Department to address audit findings.

005~~6~~.03 The certified provider may establish a fiscal year for accounting purposes, but if the provider does not establish a fiscal year the Department will presume the provider's fiscal year is July 1 through June 30 for purposes of enforcing the requirements of this chapter

005~~6~~.04 Failure to comply with the requirements imposed upon certified providers in this chapter may result in reduction in or reimbursement of funds, or disciplinary action or termination of certification as provided for in 404 NAC 4, or other applicable law or regulation.

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 6 PROVIDER OPERATED/CONTROLLED COMMUNITY BASED RESIDENTIAL AND DAY SERVICE OPTION

6-001 SCOPE: This chapter governs the requirements for residential and day community based services for persons with developmental disabilities delivered at provider operated/controlled settings.

6-001.01 Only a certified specialized provider is eligible to provide day or residential services under this option. The specialized provider must:

1. Comply with the requirements in this chapter;
2. Comply with core requirements in 404 NAC 4; and
3. Comply with all applicable federal and state laws and regulations and local codes.

6-001.02 Day and residential services in this chapter are provided at various integrated community settings that are operated or controlled by a certified provider or the provider's employee or subcontractor or any entity owned or controlled by the provider. This is regardless of who owns or leases the property.

6-001.02A Each residential setting must:

1. Have no more than 3 individuals with developmental disabilities residing at the setting;
2. Be operated as a single setting and demonstrate that each residence operates independently; and
3. Be staffed when the residence offers continuous services.

6-001.03 These services may be continuous or intermittent, based on the individual's needs.

6-002 Inherent throughout all of the services and supports offered under this chapter, the provider must ensure:

1. Individuals are free from abuse, neglect, mistreatment, and exploitation;
2. Health, safety, and well-being of the individual is a priority;
3. Individuals are treated with consideration, respect, and dignity;
4. Individuals' preferences, interests, and goals are honored;
5. Individuals have daily opportunities to make choices and participate in decision making;
6. Activities are meaningful and functional for each individual;

7. Services are directed towards maximizing the growth and development of each individual for maximum community participation and citizenship;
8. Individuals live in a manner that is most inclusive;
9. Individuals experience being part of the community; and
10. Individuals are able to express their wishes, desires, and needs.

6-003 RESIDENTIAL AND DAY SERVICES: Residential and Day services offer habilitation, including services and supports and supervision as needed, designed to assist the individual in acquisition, improvement, and retention of skills necessary to enable him/her to live and work successfully and independently as possible in his/her home and the community.

6-003.01 Residential Services: Residential services take place where the individual lives or in the community and are directed at developing, improving, or maintaining the individual's health and personal skills that would typically occur in one's home.

6-003.02 Day Services: Day services are directed at developing, improving, or maintaining skills to maximize employment and inclusion.

6-003.02A An individual's day services must not be provided at a residential site, except in the following situations:

1. Due to health concerns documented by a physician that must be approved by the Department and time-limited;
2. If the individual is receiving retirement services; or
3. If the individual is preparing to participate in community work experiences and competitive employment.

6-004 GENERAL STANDARDS: In addition to the standards in 404 NAC 4, the provider must follow these standards.

6-004.01 Restrictive Measures: To the fullest extent possible, an individual's rights may not be suspended or restricted. In the event where a restrictive measure is considered:

1. The restrictive measure determined necessary for one individual must not affect other individuals who receive services in that setting;
2. The restrictive measure must not be used as punishment, for the convenience of staff, due to shortage of staff, as a substitute for habilitation, or as an element of a positive behavior support plan;
3. The restrictive measure must be the least restrictive and intrusive possible;
4. There must be a goal of reducing and eliminating the restrictive measure;
5. Prior to proposing a restrictive measure, there must be documented evidence that other less restrictive methods had been regularly applied by trained staff and failed; and
6. The individual or their legal representative, if applicable, must give consent to the restrictive measure;

7. The restrictive measure must be safe for the individual; and
8. The restrictive measure and these considerations must be documented in the IPP. Remains in section 404 NAC 5-007(A-G) as modified

6-004.01A Review and Approval of Restrictive Measure: Prior to implementation of a restrictive measure, the provider must ensure review and approval by the IPP team and rights review committee as outlined in 404 NAC 4-011. Remains in section 404 NAC 5-007.01 as modified

6-005 PSYCHOTROPIC MEDICATION

6-005.01 Psychotropic medications taken by the person due to diagnosed mental illness (a dual diagnosis of a severe and persistent mental illness in conjunction with a developmental disability) must:

1. Only be given as prescribed by a physician who has authority in his/her scope of practice to determine the diagnosis. PRN (as needed) psychotropic medications are prohibited;
2. Be reviewed by the IPP team to determine if the benefits outweigh the risks and potential side effects;
3. Be supported by evidence that a less restrictive and more positive technique had been systematically tried and shown to be ineffective;
4. Be reviewed by the rights review committee in accordance with 404 NAC 4-011. There must be an annual review by the prescribing physician and a semi-annual review by the IPP team of all psychotropic medications utilized. There must be clear and convincing evidence that the individual has a person-centered plan demonstrated by data and outcome measures;
5. Not be used as a way to deal with under-staffing; ineffective, inappropriate or other nonfunctional programs or environments;
6. Also have a positive behavioral supports plan established and in place to address those symptoms when they occur if symptoms reappear and the ongoing use of medication is no longer effective; and
7. Be monitored and documented on an ongoing basis by the provider to provide the IPP team and physician sufficient information regarding:
   a. The effectiveness of and any side effects experienced from the medication;
   b. Frequency and severity of symptoms; and
   c. The effectiveness of the positive behavioral supports plan. Remains in section 404 NAC 4-002.04 as modified

6-005.02 Psychotropic medications used solely for the purpose of modifying behaviors may only be used if in accordance with 404 NAC 6-005.01 (above) and:

1. There is a plan to reduce and eliminate the medication; and

2. The drug is used in conjunction with a positive behavioral supports plan as outlined in 404 NAC 4-005.03;

6-005.03 No positive behavioral supports plan is required when an individual is prescribed a medication that has the effect of behavior modification, but is prescribed for other reasons, as documented by a physician. Remains in section 404 NAC 4-002.04(A) as modified

6-006 RESTRAINTS: The use of mechanical restraints is prohibited. If the provider agrees to serve an individual under 404 NAC 6 who has a physical restraint program in place at the time of the enactment of these regulations, then a program must be implemented within 180 days of enactment of these regulations which eliminates the use of such restraints. The use of physical restraints will be prohibited one year from the enactment of these regulations. Remains in section 404 NAC 5-007.02 as modified

An emergency safety intervention utilized pursuant to a safety plan is allowed to respond to an emergency safety situation. This is different than physical restraint because it is not used as a behavioral consequence. In instances where the individual must be kept from harm (i.e., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the individual), the provider must use their reasonable and best judgment to intervene to keep the individual from injuring him/herself or others. This may include hands-on guidance to safely protect the individuals and others from immediate jeopardy or physical harm. Remains in section 404 NAC 5-007.02(A) as modified

These situations are not predictable, are unusual, and are usually not reoccurring. In any instances other than these, there must be a positive behavioral supports program in place to work with the individual on alternative positive displays of behavior that are incompatible with other negative behaviors.

All such incidents must be documented and reviewed by the individual's IPP team and rights review committee to ensure that the emergency safety intervention was appropriate rather than an instance of mechanical or physical restraint. Remains in section 404 NAC 5-007.02(A) as modified

6-006.01 Prohibited Methods: The provider must prohibit the use of mechanical or physical restraints (except as noted above), aversive stimuli, corporal punishment, seclusion, verbal abuse, physical abuse, emotional abuse, denial of basic needs, discipline, or implementation of an intervention of an individual in services by another individual in services, or other means of intervention with the behavior that result in, or is likely to result in injury to the individual. Remains in section 404 NAC 5-007.02(C)(i-xiii) as modified

6-007 PHYSICAL LOCATION REQUIREMENTS: The provider must ensure that locations comply with the codes and regulations of the local jurisdiction and meet the needs of the individuals receiving services in those locations. Residence

TITLE 404 COMMUNITY BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 8 (Repealed)

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 8 RESPITE SERVICES

8-001 Respite Services: Respite is defined as intermittent, temporary relief to the usual non-paid caregiver from the continuous support and/or care of the individual. Respite components are supervision, tasks related to the individual's physical and psychological needs, and social/recreational activities and are documented in the IPP.

The term "usual non-paid caregiver" means a person who resides with the individual, is not paid to provide services, and is responsible on a 24-hour per day basis for the care and supervision of the individual.

8-002 Eligibility for Respite Services: For services governed by this chapter, the individual must be eligible for funding for DD services.

8-002.01 Eligibility for Respite Services for Adults:

1. To be eligible to receive respite, an adult must live with a non-paid caregiver. When the caregiver is paid to deliver services, respite is not available.
2. Only specialized DD providers may deliver adult respite services to individuals.

8-002.02 Eligibility for Children's Respite Services:

1. To be eligible to receive respite, a child must live with a non-paid caregiver. When the caregiver is paid to deliver services, respite is not available.
2. Specialized DD providers may deliver children's respite services.
3. Children living in their family home may also receive respite services from a non-specialized provider. See 404 NAC 10.

8-003 Funding for Respite: The Department will authorize respite from one program source only. The authorized amount of respite is not determined using the objective assessment process. Individuals may be authorized for up to 30 days of respite services per state fiscal year.

8-003.01 Conditions for Authorization: Respite funding for 720 hours or 30 days per state fiscal year is available under the following conditions:

1. An individual must be determined eligible for DD services;
2. An individual lives with his/her family or unpaid caregiver;

3. An individual must be receiving DDD Service Coordination; and
4. The need for respite is documented in the person's IPP/IFSP/ASP.

8-003.02 Limitations: Respite funding is not available when the usual caregiver is employed or attending classes. Respite does not take the place of special education, childcare, or adult day care. Respite cannot be provided by members of the individual's immediate household.

8-004 Providers of Respite Services: The provider must develop and implement written policies and procedures for providing respite services when the provider chooses to provide respite services.

8-004.01 Certified Providers: Certified providers of specialized services may provide respite services. If the certified provider chooses to provide respite services, this must be identified on the certification application.

8-004.02 The provider may deliver respite services in the individual's home or in another location.

8-004.03 The provider must meet provider standards in 404 NAC 4 except for habilitation (404 NAC 4-005.01). When respite services are provided in a DD provider-managed location, the provider must be certified under 404 NAC 6.

8-004.04 Respite services are not available for the specialized DD provider.

8-004.05 The provider must ensure documentation in the IPP of the plan for the provision of respite services including the amount of respite time needed for the individual served.

8-004.06 Respite services do not require the provision of habilitation; however, the provider must ensure that the individual's needs are met and that intervention techniques and/or supports are consistent with those delivered as habilitation.

8-004.07 The provider must implement the services and supervision identified on the IPP/IFSP during the respite period.

8-004.08 The provider must ensure that individuals who are receiving respite services in a DD provider-managed location do not utilize the bed or other personal items of an individual who resides at this location.

8-004.09 Non-Specialized Providers: See chapter 10 for standards for non-specialized providers for children's respite services.

8-005 AUTHORIZATION: The following applies to the authorization for the provision of respite services:

1. A unit is an hour when less than 8 hours are provided in a calendar day;
2. A unit is a day if eight or more hours are provided in a calendar day;
3. Respite cannot exceed 30 days per waiver year (waiver year begins with the month the individual begins receiving waiver services);
4. Unused respite hours/days are not carried over into the next year;
5. Respite cannot be authorized when a household member is paid to deliver services to the child who is receiving waiver services; and
6. Respite funding is available from one Department program source only.

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CHAPTER 9 (Repealed)

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 9 NON-SPECIALIZED SERVICES

9-001 OVERVIEW OF COMMUNITY SUPPORTS PROGRAM

9-001.01 Purpose: The Department offers a system of supports and services intended to allow individuals with developmental disabilities to maximize their independence as they live, work, recreate, and participate in their communities.

The Community Supports Program (CSP) is designed to offer alternatives to the traditional model of services available through the Department. The traditional model provides for services consisting of day and residential habilitation and respite care, provided only by agencies certified as specialized providers of developmental disabilities services. The CSP allows for a broader array of services to be provided by developmental disability service providers and/or other community (individual or agency) providers. This is intended to give the individual more control over the type of services received and providers of those services, as well as allowing individuals to purchase services other than habilitative training.

The underlying philosophy of the Community Supports Program is to build upon the individual and family strengths and to strengthen and support informal and formal services already in place. The CSP utilizes a self-directed philosophy, designed to provide choice when determining the services and supports that are needed to maximize the independence of the person with a developmental disability. The individual has the right and responsibility to participate to the greatest extent possible in the development and implementation of his/her plan. The CSP is a funding stream that may be utilized either alone or in conjunction with other Department funded services and supports, as appropriate for the individual.

9-001.02 CSP services are not intended to duplicate or replace other services or supports (paid or unpaid) that are available to the individual, including Medicaid State Plan services, Social Services Block Grant services, or services/supports available from other sources.

9-001.03 Amount: Community Support Program services may be authorized and funded at the actual cost of the services, but limited to the amount of the individual's current funding authorization for respite, day, and/or residential services or an annual cap determined by the Department, whichever is less. The annual cost cap will begin with the month the individual begins receiving community supports.

Individuals enrolled in the Community Supports Program will be subject to the same Ability to Pay requirements in 202 NAC 1 as all others in the DD System.

The cost of Service Coordination is not deducted from the annual funding amount.

9-002 Community Supports Services

9-002.01 Types: CSP services include:

1. Personal Emergency Response System (PERS):
2. Community Living and Day Supports (CLDS);
3. Respite;
4. Assistive Technology and Supports;
5. Home Modifications; and
6. Vehicle Modifications.

9-002.02 Authorization: CSP services may be authorized if:

1. The individual is eligible for services;
2. The individual has a funding amount authorized; and
3. The need and the amount for the specific service(s) are documented in the Annual Supports Plan (ASP). Individuals eligible for the Community Supports Program design their system of services and supports, based upon their preferences and needs as identified in their support plan.

9-002.03 The ASP is developed by the individual, in cooperation with his/her Service Coordinator and other appropriate persons as identified.

9-003 DESCRIPTIONS OF COMMUNITY SUPPORTS PROGRAM SERVICES: The following supports are available under the Community Supports Program to individuals who live in a residence that is under the control and direction of that individual or who reside with an unpaid usual caregiver (family member).

9-003.01 Personal Emergency Response Systems (PERS): PERS is an electronic device which enables individuals to secure help in an emergency.

The individual may also wear a portable PERS button to allow for mobility.

9-003.01A PERS services are limited to those individuals who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

9-003.02 Community Living and Day Supports (CLDS): CLDS provides the necessary assistance and supports to meet the daily needs of the individual. These services and supports are provided to ensure adequate functioning in the individual's home, as well as assisting the individual to participate in a wide range of activities outside the home. CLDS also provides the necessary assistance and supports to meet the employment and/or day service needs of the individual in integrated, community settings.

9-003.02A Assistance with personal care needs or household activities is available only to those individuals who do not live with a paid caregiver. A paid caregiver is an individual or agency paid to provide services to meet the individual's daily needs. Immediate family members and other family members living in the same household cannot be approved as paid caregivers. Immediate family members are parents, spouse, or children. This does not include payments made for room and board.

9-003.02B The Community Living and Day Supports service is intended to provide necessary supports for the individual, but is not intended to duplicate or replace other supports available to the individual. Household activities and home maintenance activities are for the purpose of fulfilling duties the individual would be expected to do to contribute to the operation of the household, if it were not for the individual's disability.

9-003.02C Transportation to and from community activities is not covered as a separate component under this service. Fees, membership costs, and equipment costs related to social, leisure, and recreational outings are not covered under this service.

9-003.02D The Community Living and Day Supports service includes the following components:

1. Individual assistance with hygiene, bathing, eating, dressing, grooming, toileting, menstrual care, transferring, or basic first aid. Routine health care supports may be furnished to the extent permitted under Nebraska state law.
2. Supervision and monitoring for the purpose of ensuring the individual's health and safety.
3. Supports to enable the individual to access the community. This may include someone hired to accompany and support the individual in all types of community settings. Individual assistance with money management and personal finances may be provided, but the provider cannot act as the representative payee.
4. Supports to assist the individual to develop self-advocacy skills, exercise rights as a citizen, and acquire skills needed to exercise control and responsibility over other support services, including managing generic community resources and informal supports.
5. Supports to assist the individual in identifying and sustaining a personal support network of family, friends, and associates.

6. Household activities necessary to maintain a home living environment on a day-to-day basis, such as meal preparation, shopping, cleaning, and laundry.
7. Home maintenance activities needed to maintain the home in a clean, sanitary, and safe environment. This may include heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement and as required by law, will be examined prior to any authorization of service. The individual must supply necessary cleaning products and equipment when a provider cleans or cares for household equipment, appliances, or furnishings in the individual's home.
8. Supports to enable the individual to maintain or obtain employment. This may include someone hired to accompany and support the individual in an integrated work setting. Integrated settings are those considered as available to all members of the community. Payment for the work performed by the individual is the responsibility of the employer. Covered services do not include those provided in specialized developmental disability provider settings, workstations, or supported employment services.
9. Supports to enable the individual to access services and opportunities available in community settings. This may include accessing general community activities, performing community volunteer work, and accessing services provided in community settings such as senior centers and adult day centers. Supports provided under CLDS must be those that are above and beyond the usual services provided in such a setting and not duplicate services expected to be the responsibility of the center.

9-003.03 Respite: Respite is the temporary, intermittent relief to the usual non-paid caregiver from the continuous support and care of the individual. This service is available only to those individuals who live with the usual non-paid caregiver(s). The term "usual non-paid caregiver" means a person who resides with the individual, is not paid to provide services, and is responsible on a 24-hour per day basis for the care and supervision of the individual. Respite cannot be provided by members of the individual's immediate household. These services may be provided in the individual's living situation and/or in the community.

9.003.03A Components of the respite service are:

1. Supervision;
2. Tasks related to the individual's physical and psychological needs; and,
3. Social/recreational activities.

Respite funding is available from one Department program source only.

9-003.04 Assistive Technology and Supports (ATS): ATS includes devices, controls, or appliances that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment they live in, thus decreasing their need for assistance from others. The Department has final authority to determine coverage of ATS.

9-003.04A Approvable items are limited to those necessary to support an individual in his/her home and must be appropriate to the needs of the individual as a result of limitations due to disability. An assessment will be completed to assist the individual to find an appropriate ATS solution. All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design, and installation.

Examples of ATS include the following items: reachers, magnifiers, hand-held showers, trouser pulls, built-up shoe horns, bowl holders, pan holders, suction brushes, jar and bottle openers, and spring scissors.

9-003.04B Items that are not covered include: items covered or coverable by Medicaid, recreational and/or exercise items, security items, devices or modifications already purchased or completed, computers (some exceptions may apply), furniture or appliances, air conditioners, clothing or bedding, or disposable medical or hygiene supplies.

9-003.05 Home Modifications: Home Modifications are those physical adaptations to the individual's home that are necessary to ensure the health, welfare, and safety of the individual, and/or which enable the individual to function with greater independence in the home.

9-003.05A Approvable modifications are limited to those necessary to maintain the individual in his/her home. Examples of approvable home modifications include:

1. Installing ramps, lifts, door levers, and grab-bars;
2. Building an accessible entrance into the home;
3. Widening interior doors to provide accessible routes of travel within the home to the bedroom, bathroom, and kitchen;
4. Modifying existing bathrooms to add roll-in showers, raised toilets, roll-under sinks; and
5. Adapting electric and plumbing systems to support assistive equipment, such as chair lifts and bathroom facilities.

9-003.05B Approvable modifications do not include adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual. Examples of home modifications that may not be approved include:

1. Home maintenance and repair such as carpeting or roof repair;

2. Access to the basement for use as a storm shelter or recreation;
3. Recreational pools and decks;
4. Remodeling not related to accessibility or disability-related needs;
5. New construction (exception may be made in cases where the existing bathroom cannot be modified for accessibility);
6. Restrictive modifications that replace supervision, such as half-doors, fences, and security items. Items which assist in supervision and are specifically related to the individual's needs due to disability may be considered, if necessary to ensure safety;
7. Central air conditioning; and
8. Adaptations which add to the total square footage of the home.

9-003.05C Conditions of Approval:

1. The Department will not approve home modifications if the adaptations are available under the Medicaid State Plan or from a third party source.
2. The provider of home modifications must comply with applicable state or local building codes and/or applicable standards of manufacturing, design, and installation.
3. The individual's home must not present a health and safety risk to the individual other than that corrected by the approved home modifications.
4. If the family resides in a rental unit, the family must obtain written assurance from the landlord that the property will be made available to an individual with a disability for a period of at least three years after the funding of approved home modifications by listing the property for rent on www.housing.ne.gov.

9-003.06 Vehicle Modifications: Modifications to vehicles may be made for purposes of accessibility when the vehicle is privately owned by the individual or his/her family and is used to meet the individual's transportation needs. The vehicle must be in good operating condition and modifications must be made in accordance with applicable standards of manufacturing, design, and installation. An assessment will be completed to determine the appropriate vehicle modification solution for the individual.

9-004 ANNUAL SUPPORTS PLAN (ASP)

9-004.01 Self-Directed Plan: Persons eligible for the Community Supports Program must have an Annual Supports Plan developed before the initiation of services. This person-centered and self-directed plan must be individually tailored to address the unique preferences and needs of the person.

9-004.02 Annual Supports Plan Team Members: The individual or the legal representative, if applicable, must determine who will be participants in the planning process. This must include at least the individual, the Service Coordinator, and the legal representative if there is one.

9-004.03 Contents of ASP: The Annual Supports Plan must identify the needs and preferences of the individual and specify how those needs will be addressed. This must include identification of services and supports to be provided within the cost caps of the Community Supports Program, as well as services and supports to be provided by other non-DDD funded resources.

9-004.04 Development of ASP: Requests for Community Supports Program funding will likely be for diverse and varied services and supports, some of which may never have been purchased under past service models. The following must be considered and documented when developing the individual's support plan.

These considerations will assist Department staff before authorizing services to determine whether the requested services/supports are a sound and valid use of the Community Supports Program. Additionally, these considerations will bring consistency and cost efficiency to the types of services/supports purchased. Considerations include:

1. Whether reasonable attempts have been made to meet the individual's needs through natural supports;
2. Whether alternate sources of funding could be utilized to meet the individual's needs before utilizing Community Supports funding;
3. Whether the Community Supports Program "with reasonable expectation" could be expected to meet the health and safety needs of the individuals;
4. Whether the request enhances the individual's ability to live, work, and recreate in his/her community;
5. Whether safeguards or back-up plans are in place in the event of failure of the plan to meet the individual's needs. The individual and/or legal representative must be aware of and willing to assume the risks and responsibilities associated with the CSP; and
6. Whether there is a reasonable alternative to the request. (That is, is the request "reasonable and prudent" in its use of public funds?)

If a request is denied, attempts should be made to offer reasonable alternatives or help in developing natural or other supports to meet the need.

9-004.05 Semi-annual Review: The ASP team (see 404 NAC 9-004.02) must review the Supports Plan at a minimum semi-annually.

9-004.06 Service Coordination Monitoring: The Service Coordinator must monitor the implementation and effectiveness of the ASP.

9-005 SERVICE AUTHORIZATION PROCESS

9-005.01 Following the development of the Annual Supports Plan, the individual, legal representative, and family, as appropriate, will work with the Service Coordinator and other designated Department staff to locate providers to deliver the services. See Provider Contracting section at 404 NAC 9-006.11 for further information regarding this process. Department staff will use program standards and guidelines to develop appropriate service authorizations based upon the funding authorization.

9-006 PROVIDER STANDARDS

9-006.01 CSP Providers: Providers of CSP services may be individuals or agencies. All providers of CSP services must be Medicaid providers as described in 471 NAC 2-000. Providers must meet all other established standards and complete the Department enrollment process in order to be authorized to receive payment for the provision of those services.

9-006.02 Family Members as Providers: The Department will not pay a family member as a provider under this waiver. Family member means the parent, spouse, or child of the individual in services or a person of the same relation by marriage.

9-006.03 Contracts: Provider contracts are established for a maximum of one year. To continue as a provider, each contract must be renewed annually. Contracts may be terminated at any time it is determined that the provider no longer meets the program standards.

9-006.04 General Standards: All providers of CSP services who have direct contact with the individual receiving CSP services must:

1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people with developmental disabilities;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with developmental disabilities;
6. Exhibit the capacity to:
   a. Assume responsibility;
   b. Follow emergency procedures;

c. Maintain schedules; and
d. Adapt to new situations.

7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property to the extent applicable for the scope of service being provided;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement that the provider is able to perform the services, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

9-006.05 General Conditions: All providers of CSP services must:

1. Not be the usual responsible caregiver or legally responsible guardian;
2. Not be a member of the immediate household.
3. Not assign or transfer duties, responsibilities or payment for the authorized service to any entity or person other than the provider named in the service provider agreement;
4. Not provide service before receiving a provider authorization for each service for each individual;
5. Provide services only as authorized in accordance with Department standards;
6. Accept Medicaid reimbursement as payment in full for the authorized waiver service, with no additional charges made to the individual or family for the authorized waiver service;
7. Accept a rate which does not exceed the amount charged to private-paying persons;
8. Not discriminate in service provision between individuals receiving CSP services and other individuals;
9. Meet applicable licensure or certification requirements and maintain current licensure or certification;
10. 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;
11. Be a United States citizen or an alien who is authorized by the federal government to work in the United States;
12. Provide a Social Security number or federal identification (FID) number to the Department before contracting;
13. Submit claims for service only after the service has been provided and within 90 days;
14. Furnish all financial records at the request of the Department;
15. Permit the Department to monitor and evaluate services by:
    a. Inspecting the setting;
    b. Observing service delivery;
    c. Interviewing the provider or other staff members; or
    d. Similar methods;
15. Permit the Department to recover funds paid erroneously; and

16. Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of any CSP service.
17. Must be a citizen of the United States of American or a qualified alien under the federal Immigration and Nationality Act and be lawfully present in the United States. The applicant must attest that s/he is a citizen of the United States of America or that s/he is a qualified alien under the federal Immigration and Nationality Act, 8 USC 1101 et seq., as such act existed on January 1, 2009;and is lawfully present in the United States. The applicant must provide his/her immigration status and alien number, and agree to provide a copy of his/her United States Citizenship and Immigration Services (USCIS) documentation upon request.
    a. Verification: For any provider who has attested that s/he is a qualified alien under item 17, eligibility must be verified through the Systematic Alien Verification for Entitlements Program. Until verification of eligibility is made, the attestation may be presumed to be proof of lawful presence unless the verification is required before providing the public benefits under another provision of state or federal law.

9-006.06 Record Keeping: Providers of CSP services must maintain for six years the following material:

1. Documentation which supports selection and provision of services under the ASP to each individual, including dates of service provision and identification of provider;
2. Financial information necessary to allow for an independent audit;
3. Documentation which supports requests for payment; and
4. Provider agreements.

9-006.07 Reports of Neglect or Abuse: The Department will complete an annual check of the Central Register of Child Protection Cases, the Adult Protective Services Central Registry, and the Nebraska State Patrol Sex Offender Registry before entering into an annual provider agreement with individuals providing Community Living and Day Supports service and Respite.

9-006.07A Required Checks: The following persons must sign a statement agreeing to a check of the Central Register of Child Protection Cases, the Adult Protective Services Central Registry, and the Nebraska State Patrol Sex Offender Registry:

1. A person applying to be a provider of CSP services, before approval;
2. A provider of CLDS or Respite services, annually;
3. Any members (excluding individuals served) of provider's household (if services are delivered in the provider's home) as follows: checks on the Central Register of Child Protection Cases for members age 13 or older and checks on the Adult Protective

Services Registry for members age 18 or older, before approval, and annually thereafter.

9-006.07B Denial of Authorization: The Department must not authorize a person with a substantiated report on the Adult Protective Services Central Registry or a substantiated report on the Central Register of Child Protection to provide CSP services. If the Department receives substantiated report on the Adult Protective Services Central Registry or a substantiated report on the Central Register of Child Protection on a current provider or household member when services are in the provider's home, the Department must immediately terminate the provider authorization. The Department must not authorize a person on the Nebraska Sex Offender Registry to provide CSP services.

9-006.08 Criminal History

9-006.08A Felony/Misdemeanor Statements: The following persons must sign a statement giving information about current charges, pending indictments, and convictions regarding felony or misdemeanor actions:

1. A person applying to be a provider of CSP services, prior to approval;
2. A provider of CSP services, annually;
3. Any member of the provider's household if services will be provided in the provider's home, prior to approval and annually thereafter.

9-006.08B Follow-up Information: If additional information is needed to evaluate the criminal history of the provider or household member, the Department will:

1. Obtain a release of information from the provider or household member; and
2. Request information available from law enforcement.

The Department DHHS may deny or terminate provider approval of an applicant or provider who refuses to sign a release of information.

9-006.09 Denial/Termination of Provider Agreement: The Department will not approve or will terminate as a provider of CSP services any person who:

1. Has been convicted of, has admitted to, or against whom there is substantial evidence of crimes:
   a. Against a child or vulnerable adult;
   b. Involving intentional bodily harm;
   c. Involving the illegal use of a controlled substance; or
   d. Involving moral turpitude; and

2. Has as a household member a person who has been convicted of, has admitted to or against whom there is substantial evidence of crimes (if services are to be provided in the provider's home):
   a. Against a child or vulnerable adult;
   b. Involving intentional bodily harm;
   c. Involving the illegal use of a controlled substance; or
   d. Involving moral turpitude.

9-006.10 Provider's Right to Contest a Decision: A provider of CSP services has the right to appeal for a hearing on an action that has a direct adverse effect on the provider (see 471 NAC 2-003). Hearings are scheduled and conducted according to the procedures in 465 NAC 6-000.

9-006.11 Specific Service Provider Standards: These are the specific standards that persons who provide particular types of CSP services must meet whether operating independently or through an agency. Service providers must meet general provider standards and conditions and standards specific to each service provided.

9-006.11A Personal Emergency Response Systems (PERS): A provider of PERS must:

1. Instruct the individual about how to use the PERS device;
2. Obtain the individual's or authorized representative's signature verifying receipt of the PERS unit;
3. Ensure that response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days per week;
4. Furnish a replacement PERS unit to the individual within 24 hours of notification of malfunction of the original unit while it is being repaired;
5. Update list of responder and contact names at a minimum semi-annually to ensure accurate and correct information;
6. Ensure monthly testing of the PERS unit; and
7. Furnish ongoing assistance when needed to evaluate and adjust the PERS device or to instruct the individual in the use of PERS devices, as well as to provide for system performance checks.

9-006.11B Community Living and Day Supports (CLDS): A provider of CLDS must:

1. Be age 18 or older;
2. Have knowledge of basic first aid skills and of available emergency medical resources, if providing components other than household activities or chore services;
3. If providing services in the individual's home, exercise reasonable caution and care in the home and in the use and storage of the individual's equipment, appliances, tools, and supplies;
4. Have knowledge and understanding of the needs of persons with developmental disabilities; and

5. Have training and/or experience in the performance of the service or similar services.

9-006.11C Respite: A provider of Respite must:

1. Be age 18 or older;
2. Have knowledge of basic first aid skills and of emergency responses;
3. Agree never to leave the individual alone; and
4. Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as explained by the usual caregiver.

Remains in section 404 NAC 5-001.03 as modified

9-006.11C1 Agency Providers: If Respite is provided by an agency, the agency must be licensed and:

1. Employ respite staff based upon their qualifications, experience, and demonstrated abilities;
2. Provide training to ensure that respite staff are qualified to provide the necessary level of care and agree to make training plans available to the Department, if requested; and
3. Ensure adequate availability and quality of service.

9-006.11C2 Out of Home Providers: If Respite is provided outside of the family home, the family is requested to visit the facility or home in which the service is to be provided for agreement to the provision of services in that location. The provider must ensure that:

1. The home/facility is architecturally designed to accommodate the needs of the individuals being served;
2. An operable telephone and emergency phone numbers are available;
3. The home/facility is accessible to the individual, clean, in good repair, free from hazards, and free of rodents and insects;
4. The home/facility is equipped to provide comfortable temperature and ventilation conditions.
5. The toilet facilities are clean and in working order;
6. The eating areas and equipment are clean and in good repair;
7. The home/facility is free from fire hazards;
8. The furnace and water heater are located safely;
9. Firearms are in a locked unit;
10. Medications and poisons are inaccessible; and
11. Household pets have all necessary vaccinations.

Remains in section 404 NAC 5-001.02 as modified

9-006.11D Assistive Technology and Supports (ATS): A provider of ATS must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation.

9-006.11D1 The Nebraska Department of Education Assistive Technology Partnership (ATP) provides consultation for ATS.

9-006.11D1a Consultation provided by ATP must meet the contractual obligations and terms of the proposal as agreed upon by ATP and the Department.

9-006119D1b: ATP must maintain the following in each individual file:

1. The ATP Assessment Report which includes a summary of needs and current support, recommendations, cost estimate, cost coordination, if needed, and recommended vendor;
2. Notice of eligibility or ineligibility of ATS services;
3. Authorization of ATS services;
4. Documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
5. Copy of signed vendor bill and signed consumer acceptance form; and
6. Narrative summary.

9-006.11E Home Modifications: A provider of home modification services must:

1. Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
2. Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;
3. Ensure all products and materials installed conform to specifications. The provider must not use "blemished," "seconds," or reused building materials unless otherwise noted in the quote and approved before installation;
4. Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;
5. Warrant all work, materials, and products for a minimum of one year; and

6. Ensure any and all subcontractor's work will conform to the terms and conditions of this contract and accept sole responsibility.

Remains in section 404 NAC 5-001.05 as modified

9-006.11E1 The Nebraska Department of Education Assistive Technology Partnership (ATP) provides consultation for home modification services.

9-006.11E1a Consultation provided by ATP must meet the contractual obligations and terms of the proposal as agreed upon by ATP and the Department.

9-006.11E1b ATP must maintain the following in each individual file:

1. The ATP Assessment Report which includes a summary of needs and current support, recommendations, cost estimate, cost coordination, if needed, and recommended vendor;
2. Notice of eligibility or ineligibility of home modification services;
3. Authorization of home modification services;
4. Documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
5. Copy of signed vendor bill and signed consumer acceptance form; and
6. Narrative summary.

9-006.11F Vehicle Modifications: A provider of vehicle modification services must:

1. Ensure that the vehicle is in good operating condition;
2. Perform modifications in accordance with applicable standards of manufacturing, design, and installation.

9-006.11F1 The Nebraska Department of Education Assistive Technology Partnership (ATP) provides consultation for vehicle modification services.

9-006.11F1a Consultation provided by ATP must meet the contractual obligations and terms of the proposal as agreed upon by ATP and the Department.

9-006.11F1b ATP must maintain the following in each individual file:

1. The ATP Assessment Report which includes a summary of needs and current support, recommendations, cost estimate, cost coordination, if needed, and recommended vendor;
2. Notice of eligibility or ineligibility of vehicle modification services;
3. Authorization of vehicle modification services;
4. Documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
5. Copy of signed vendor bill and signed consumer acceptance form; and
6. Narrative summary.

9-006.12 Provider Rates: The Department establishes a range of rates, including a maximum rate for each CSP service. Rates will be individually negotiated within the established maximum with each provider for each service. Agreed-upon rates will be contingent upon the service to be performed, availability of qualified providers, and the qualifications and experience of the provider. The rates paid to providers of these services must be usual and customary or less for similar services in the community. The rates and amount of services must take into consideration the annual cap amount available to the individual.

9-006.13 Provider Contracting: The following process must be utilized when enrolling providers:

9-006.13A Provider Identification: The individual or legal representative, as appropriate, must identify potential providers for the CSP services. Assistance in locating providers may be given by others such as family members, the Service Coordinator, community members, etc. as appropriate and as needed. Other Department staff may also serve as resources to assist in identifying providers.

9-006.13B Background Checks: Once a potential provider has been identified, a request will be made for the initial background checks as required by the CSP provider standards to be completed by the designated Department or Service Area staff.

9-006.13C Negotiation: After it has been determined that the potential provider meets the general and specific provider standards, the individual or legal representative will work with that provider to determine the specific tasks to be performed, schedule for provision of services, and the rate requested to be paid to the provider (within the established rate structure). This may be done with the assistance of and must be approved by the Service Coordinator or other Department staff.

9-006.13D Department Approval: When the individual/legal representative and the provider have reached agreement on the services to be provided,

schedule, and rate, the contracting process will be completed by designated Department or Service Area staff. This will involve final determination that the provider meets the provider standards, understands the program requirements, and has agreed to provide the services as specified by the support plan for the agreed-upon rate.

9-006.14 Provider Billing and Payment

9-006.14A Billing For Services Delivered: Providers must submit claims and a service calendar, when applicable, for services rendered, to the individual or legal representative for their review and approval.

9-006.14B Department Approval: Once approved and signed by the individual or designated family member, claims must be submitted to the designated Department staff for verification, approval, and processing.

9-006.14C Provider Social Security Tax Withholding: The Department withholds Social Security taxes (Federal Insurance Contribution Act, FICA) when:

1. An in-home service is provided by an individual not affiliated with an agency;
2. Services are provided in each calendar year in which the provider is paid a federally determined amount or more for services to one individual. If earnings do not reach this annual amount for FICA service per individual, the amount withheld for that year is refunded.

The Department remits to the Internal Revenue Service 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 individual employer.

9-006.14D Income Taxes: The Department does not withhold amounts for personal income tax purposes.

9-007 APPEAL PROCESSES

9-007.01 Individual's Right to Contest a Decision: Individuals in the Community Support Program may appeal decisions made by the Department as specified in 404 NAC 3-002.05.

9-007.02 Individuals in the Community Support Waiver may appeal decisions made by the Department as specified in 465 NAC 2-001.02 and 465 NAC 6-000.

TITLE 404 COMMUNITY BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 10 (Repealed)

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 10 CHILDREN'S WAIVER FAMILY SERVICES

10-001 OVERVIEW OF FAMILY SERVICES

10-001.01 Purpose: The Department authorizes family services under the Home and Community Based Medicaid Waiver for Children with Developmental Disabilities and Their Families (the children's waiver) to promote the child's independence and integration into the community and to allow the child's family to support him/her in the family home. Note: Family, as used in this chapter, means the usual non-paid caregiver with whom the child or adolescent resides.

10-001.01A Application: A child with developmental disabilities may apply for waiver services. To receive waiver services:

1. A slot must be available; and
2. The child must meet the criteria established for the children's waiver.

10-001.02 Waiver Eligibility: A child is eligible the children's waiver if s/he:

1. Is eligible for DD services;
2. Is less than 21 years old unless s/he is 21 years old and in special education, with an active IEP;
3. Does not receive services under another 1915(c) Home and Community-Based Service Waiver;
4. Currently receives ICF/MR services, or meets the ICF/MR level of care criteria (See 404 NAC 3-003.01D);
5. Is eligible for Medicaid;
6. Has received an explanation of ICF/MR services and community-based waiver services;
7. Has elected to receive waiver services;
8. Meets the priority criteria in 404 NAC 3-002.04E;
9. Has been assessed to benefit from habilitation;
10. Has an Individual and Family Support Plan (IFSP) which:
    a. Has been developed by an IPP team;
    b. Identifies a plan for DD services that will be implemented within 30 days; and
11. Has an eligibility assessment current within the last 12 months.

10-001.03 Types: Family waiver services include:

1. Respite;
2. Homemaker services;
3. Home modifications; and
4. Habilitative child care services.

10-001.04 Authorization: Family waiver services may be authorized if:

1. The child has been determined to be eligible for the children's waiver;
2. The child resides in his/her family home; and
3. The need and the amount for the specific service(s) are documented in the Individual and Family Support Plan (IFSP).

10-001.05 The Department will not authorize any funding or service for which the child's school system is responsible. Children's waiver services are not available during "regular" school hours and days for children receiving shortened school days, special education services in the family home or away from the school building, or for children who are home schooled.

10-001.06 Waiver services will not be furnished to a child while s/he is an inpatient of a hospital, nursing facility, or ICF/MR. Room and board is not included as a cost that is reimbursed under the children's waiver.

10-002 DESCRIPTIONS OF FAMILY WAIVER SERVICES

10-002.01 Respite: Respite is the temporary, intermittent relief to the non-paid family member from the continuous support and care of the child. Respite may be provided in the child's living situation or in the community in the non-specialized provider's home. If a hospital, ICF/MR, or nursing facility provides respite, the child is not considered a facility resident under the children's waiver. Components of respite service are:

1. Supervision;
2. Tasks related to the child's physical and psychological needs; and
3. Social/recreational activities.

10-002.02 Homemaker: Homemaker services are the general household activities necessary for maintaining and operating the child's family home to allow the usual caregiver to attend to and nurture the individual. The following specific services may be authorized as homemaker services.

10-002.02A Escort Service: A child receiving escort services is accompanied to obtain services, other than education, such as medical, dental, therapies, and behavioral health counseling because the child is unable to travel or wait alone.

10-002.02B Errand Service: Generally, the child does not accompany the provider on errand services, such as picking up the child's prescription or specialized equipment.

10-002.02C Essential Shopping: A provider of essential shopping services buys clothing or personal care items for the child, or food for the family.

10-002.02D Food Preparation: The family must supply the necessary food and kitchen equipment when a provider of food preparation services prepares meals.

10-002.02E Housekeeping Activities: The family must supply necessary cleaning products and equipment when a provider of housekeeping services cleans or cares for household equipment, appliances, or furnishings in the child's home.

10-002.02F Laundry Services: The family must supply necessary laundry products and equipment or machine use fees when a provider of laundry services washes, dries, irons, folds, or stores laundry for the child or the child's family.

10-002.03 Home Modifications: Home modifications are the physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the individual or which enable the child to function with greater independence in the home.

10-002.03A Approvable modifications are limited to those necessary to maintain the child in the family's home. Examples of approvable home modifications include:

1. Installing ramps, lifts, door levers, and grab bars;
2. Building an accessible entrance into the home;
3. Widening interior doors to provide accessible routes of travel within the home to the bedroom, bathroom, and kitchen;
4. Modifying existing bathrooms to add roll-in showers, raised toilets, roll-under sinks; and
5. Adapting electric and plumbing systems to support assistive equipment, such as chair lifts and bathroom facilities.

10-002.03B Approvable modifications do not include adaptation or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the child. Examples of home modifications that are not approvable include:

1. Home maintenance and repair such as carpeting or roof repair;
2. Access to the basement for use as a storm shelter or recreation;
3. Recreational pools and decks;
4. Remodeling not related to accessibility or disability-related needs;
5. New construction (exception may be made in cases where the existing bathroom cannot be modified for accessibility);
6. Restrictive modifications that replace supervision, such as half-doors, fences, and security items. Items that assist in supervision and are specifically related to the child's needs due to disability may be considered, if necessary to ensure safety;
7. Central air conditioning; and
8. Adaptations that will add to the total square footage of the home (exception may be made in cases where the existing bathroom cannot be modified for accessibility).

10-002.03C Conditions of Approval

10-002.03C1 The Department will not approve home modification under the children's waiver if the adaptations are available under the Medicaid State Plan or from a third party source.

10-002.03C2 The provider of home modifications must comply with applicable state or local building codes and applicable standards of manufacturing, design, and installation.

10-002.03C3 The family home must not present a health and safety risk to the child other than that corrected by the approved home modifications.

10-002.03C4 If the family resides in a rental unit, the family must obtain written assurance from the landlord that the property will be made available to an individual with a disability for a period of at least three years after the funding of approved home modifications.

10-002.04 Habilitative Child Care: Habilitative child care is authorized to allow the child's usual non-paid caregiver(s) to accept or maintain employment. Note: The term "usual non-paid caregiver" means a person(s) who resides with the child, is not paid to provide services, and is responsible for the care and supervision of the child on a 24-hour basis. Any interventions provided as a component of habilitative childcare must be:

1. Consistent with any habilitation provided by the habilitation services provider;
2. Consistent with interventions provided by the educational services provider; and
3. Monitored by the service coordinator.

10-003 PROVIDER STANDARDS: These are the standards and conditions that all persons who provide children's waiver family services must meet.

10-003.01 General Standards

10-003.01A All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

10-003.01B All providers of family services who have contact with the child receiving waiver services must:

1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the services(s) being provided and be able to perform the tasks required for the child and family's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of each child;
4. Observe and report all changes which affect the child and/or the child's plan to the service coordinator, taking action as necessary;

5. Have knowledge and understanding of the needs of individuals with developmental disabilities;
6. Exhibit the capacity to:
   a. Assume responsibility;
   b. Follow emergency procedures;
   c. Maintain schedules; and
   d. Adapt to new situations;
7. Protect the confidentiality of the child's and family's information;
8. Accept responsibility for the child's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

10-003.01C Family Members as Providers: The Department will not pay a family member as a provider under this waiver. Family member means the parent, spouse, or child of the individual in services or a person of the same relation by marriage.

10-003.02 General Conditions: All providers of family waiver services must:

1. Not be the usual non-paid caregiver or legally responsible relative;
2. Not be a member of the immediate household;
3. Not assign or transfer duties, responsibilities, or payment for the authorized service to any entity or person other than the provider named in the service provider agreement;
4. Not provide service before receiving a provider authorization for each service to each child;
5. Provide services only as authorized in accordance with Department standards;
6. Accept Medicaid reimbursement as payment in full for the authorized service with no additional charges made to the child or family for the authorized service;
7. Accept a rate which does not exceed the amount charged to private-paying persons;
8. Not discriminate in service provision between individuals receiving waiver services and other individuals;
9. Meet applicable licensure or certification requirements and maintain current licensure or certification;
10. 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;
11. Be a citizen of the United States or an alien who is authorized by the federal government to work in the United States;
12. Provide a Security number or federal identification (FID) number to the Department before contracting;
13. Submit a claim to the Department after service is provided and within 90 days;
14. Retain financial and statistical records for six years to support and document all claims;
15. Furnish all financial records at the request of the Department;
16. Permit the Department to monitor and evaluate services by:

a. Inspecting the facility;
b. Observing service delivery;
c. Interviewing the provider or the staff members; or
d. Similar methods;

16. Permit the Department to recover funds paid erroneously; and
17. Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of any waiver service.
18. For individual providers, attest that s/he is a citizen of the United States of American or a qualified alien under the federal Immigration and Nationality Act and is lawfully present in the United States:
    a. Attestation: The applicant must attest that s/he is a citizen of the United States of America or that s/he is a qualified alien under the federal Immigration and Nationality Act, 8 USC 1101 et seq., as such act existed on January 1, 2009; and is lawfully present in the United States. The applicant must provide his/her immigration status and alien number, and agree to provide a copy of his/her United States Citizenship and Immigration Services (USCIS) documentation upon request.
    b. Verification: For any applicant who has attested that s/he is a qualified alien under item 18.a. (above), eligibility must be verified through the Systematic Alien Verification for Entitlements Program. Until verification of eligibility is made, the attestation may be presumed to be proof of lawful presence unless the verification is required under another provision of state or federal law.

10-003.03 Record Keeping: Providers of waiver services must maintain for six years the following material:

1. Documentation which supports selection and provision of services under the IFSP to each child, including dates of service provision and identification of provider;
2. Financial information necessary to allow for an independent audit;
3. Documentation which supports requests for payment; and
4. Provider agreements.

10-003.04 Reports of Neglect or Abuse

10-003.04A Before entering into an annual provider agreement with individuals providing homemaker services involving direct individual contact, respite, or habilitative child care, the Department will complete a check of the:

1. Central Register of Child Protection Cases;
2. Adult Protective Services Central Registry;
3. The Department's License Information System; and
4. Nebraska State Patrol Sex Offender Registry.

10-003.04B The following persons must sign a statement agreeing to a check of the sources listed in 404 NAC 10-003.04A:

1. A person applying to be a provider of family services, before approval;
2. A provider of homemaker, respite, or habilitative child care services, annually;
3. Any member of the provider's household if services will be provided in the provider's home, before approval, and annually thereafter.

10-003.04C The Department will not authorize a person to provide children's waiver family services if the person has a substantiated report on the Adult Protective Services Central Registry or a substantiated report on the Central Register of Child Protection Cases.

10-003.04D If the Department receives a substantiated report on the Adult Protective Services Central Registry or a substantiated report on the Central Register of Child Protection Cases on a current waiver provider or household member when services are in the provider's home, the Department will immediately terminate the provider authorization.

10-003.04E The Department will not authorize a person on the Nebraska Sex Offender Registry to provide children's waiver family services services.

10-003.05 Criminal History

10-003.05A Felony or Misdemeanor Statements: The following persons must sign a statement giving information about current charges, pending indictments, and convictions for felony or misdemeanor actions:

1. A person applying to be a provider of family services, before approval;
2. A provider of children's waiver family services, annually;
3. Any member of the provider's household if services will be provided in the provider's home, before approval, and annually thereafter.

10-003.05B Follow-up Information: If additional information is needed to evaluate the criminal history of the provider or household member, the Department will:

1. Obtain a release of information from the provider or household member; and
2. Request information available from law enforcement.

10-003.05B1 The Department will deny or terminate the provider approval of an applicant or provider who refuses to sign a release of information.

10-003.05C Denial or Termination of Provider Agreement: The Department will not approve or will terminate as a provider of children's waiver family services any person who:

1. Has been convicted of, has admitted to, or against whom there is substantial evidence of crimes:
   a. Against a child or vulnerable adult;
   b. Involving intentional bodily harm;
   c. Involving the illegal use of a controlled substance; or
   d. Involving moral turpitude;
2. Has as a household member a person who has been convicted of, has admitted to, or against whom there is substantial evidence of crimes:
   a. Against a child or vulnerable adult;
   b. Involving intentional bodily harm;
   c. Involving the illegal use of a controlled substance; or
   d. Involving moral turpitude.

10-003.05D Provider's Right to Contest a Decision: A provider of children's waiver family services has the right to appeal for a hearing on an action that has a direct adverse effect on the provider (see 471 NAC 2-003 ff.). Hearings are scheduled and conducted according to the procedures in 465 NAC 6-000.

10-004 SPECIFIC SERVICE PROVIDER STANDARDS: These are the specific standards that persons who provide particular types of family services must meet whether operating independently or through an agency. Providers must meet general waiver provider standards and conditions and standards specific to each service provided.

10-004.01 Respite Provider Standards

10-004.01A: Respite providers must:

1. Be 19 years old or older. If no provider age 19 or older is available and acceptable to the family, and the child and family requests a younger provider, the Disability Services Specialist may authorize a younger provider, considering the following:
   a. The functioning level of the child;
   b. The availability of back-up assistance; and
   c. The capacity of the provider to meet the child's needs in the case of an emergency;
2. Have knowledge of basic first aid skills and of emergency responses;
3. If s/he is less than 19 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian;

4. Agree to never leave the child alone; and
5. Prepare and serve meals and snacks, as applicable.

10-004.01A1: If respite is provided by an agency, the agency must:

1. Employ respite staff based upon their qualification, experience, and demonstrated abilities;
2. Provide training to ensure that respite staff are qualified to provide the necessary level of care and agree to make training plans available to the Department, if requested;
3. Ensure adequate availability and quality of service; And
4. Ensure that individuals who are receiving respite services in a DD provider-managed location do not utilize the bed or other personal items of an individuals who resides at this location.

10-004.01B Out of Home Respite: When respite is provided outside the family home, the following conditions apply.

10-004.01B1 The child's parent is requested to visit the facility or home and agree to the provision of services in the facility or home.

10-004.01B2 The provider must ensure that:

1. The facility or home is architecturally designed to accommodate the needs of the individuals being served;
2. An operable telephone and emergency phone numbers are available;
3. The home/facility is accessible to the child, clean, in good repair, free from hazards, and free of rodents and insects;
4. The facility or home is equipped to provide comfortable temperature and ventilation conditions;
5. The toilet facilities are clean and in working order;
6. The eating areas and equipment are clean and in good repair;
7. The home/facility is free from fire hazards;
8. The furnace and water heater are located safely;
9. Firearms are in a locked unit;
10. Medications, harmful chemicals, and poisons are inaccessible; and,
11. Household pets have all necessary vaccinations.

10-004.02 Homemaker Provider Standards: A provider of homemaker services must:

1. Be 19 years old or older. If no provider age 19 or older is available and acceptable to the family, and the child and family requests a younger provider, the Disability Services Specialist may authorize a younger provider, considering the following:
   a. The capacity of the provider to meet the child's needs in the case of an emergency; and
   b. Which of the homemaker tasks will be authorized;

2. Exercise reasonable caution and care in the family's home and in the use of the family's equipment, appliances, and supplies;
3. Have training and/or home experience in carrying out homemaker services;
4. Provide any tools or equipment necessary to perform authorized tasks or duties, if the family does not provide them; and
5. If s/he is less than 19 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian. Remains in section 404 NAC 5-001.04 as modified

10-004.03 Home Modification Provider Standards: A provider of home modification services must:

1. Comply with applicable local and state building codes;
2. Be appropriately licensed/certified persons, when applicable;
3. Ensure all products and materials installed conform to specifications, unless blemished, seconds, or reused building materials are stated in the cost estimate and prior approval;
4. Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment and fixtures affected during the course of constructions, to original or better condition;
5. Warrant all work, materials, and products for a minimum of one year;
6. Ensure any and all subcontractors' work will conform to the terms and conditions of this contract and accept sole responsibility; and
7. If s/he is less than 19 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian.

10-004.04 Habilitative Child Care Provider Standards: A provider of habilitative child care services must:

1. Be 19 years old or older. If no provider age 19 or older is available and acceptable to the family, and the child and family requests a younger provider, the Disability Services Specialist may authorize a younger provider, considering the following:
    a. The functioning level of the child;
    b. The availability of back-up assistance; and
    c. The capacity of the provider to meet the child's needs in the case of an emergency;
2. If outside of the individual's home, provide care at a site licensed, certified, or approved by the Department;
3. Meet child care provider standards as specified in state regulations; and
4. If s/he is less than 19 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian.

10-005 ANNUAL ENROLLMENT OF CHILDREN'S WAIVER FAMILY SERVICES PROVIDERS: A person proposing to provide family services must enroll annually.

10-005.01 Proposal: To submit a children's waiver family services provider proposal:

1. The family must choose a provider; and
2. The chosen provider must submit a completed Waiver Services Provider Proposal form to the Department.

10-005.02 Service Provider Agreement: If the chosen provider meets the required applicable standards in 404 NAC 10-004, the Department will enter into a provider agreement with the provider using the:

1. Service Provider Agreement ;
2. Service Provider Addendum ;
3. Approved Family Child Care Home Self-Certification Checklist and/or In-Home Child Care Self-Certification Checklist , when applicable;
4. IRS Form W-9, "Request for Taxpayer Identification Number and Certification";
5. Range of rates established by the Department.

10-005.03 Department Staff Relatives as Providers: Department staff must not approve, reapprove, evaluate, or negotiate provider agreements with, or authorize service provision from, providers to whom the Department staff person is related. In situations where a Department staff person's relative is the only resource, staff must obtain approval from the Service Area administrator or designee.

10-005.04 Renewal: Before expiration of the provider agreement, the provider must submit a new proposal and felony / misdemeanor statement(s).

10-006 AUTHORIZATION OF CHILDREN'S WAIVER FAMILY SERVICES

10-006.01 Respite Services: The following applies to the authorization for the provision of respite services:

1. A unit is an hour when less than 8 hours are provided in a calendar day;
2. A unit is a day if eight or more hours are provided in a calendar day;
3. Respite can not exceed 30 days per waiver year (waiver year begins with the month the individual begins receiving waiver services);
4. Unused respite hours/days are not carried over into the next year;
5. Respite cannot be authorized when a household member is paid to deliver services to the child who is receiving waiver services; and
6. Respite funding is available from one the Department program source only.

10-006.02 Homemaker Services: The following applies to the authorization for the provision of homemaker services:

1. A unit is an hour;
2. Homemaker services cannot exceed 10 hours per week or 520 hours per waiver year; and
3. Unused homemaker hours are not carried over into the next year.

10-006.03 Home Modifications: The following applies to the authorization for the provision of home modifications:

1. A unit is a job; and
2. Costs for initial modifications, maintenance, and further modifications cannot exceed those established by the Department.

10-006.04 Habilitative Child Care: The following applies to the authorization for the provision of habilitative child care services:

1. A unit is an hour when less than 6 hours are provided in a calendar day;
2. A unit is a partial day when 6 to 12 hours are provided in a calendar day;
3. The daily maximum is 12 hours of habilitative child care, or a combination of child care and respite; and
4. The Disability Services Specialist will consider parents' work schedules, child's school schedule, and estimated school absences, such as illness or medical appointments in the authorization of units.

10-006.05 General Provisions: The following applies to the authorization for the provision of family services:

1. The beginning date of authorization is the date that each family provider is approved to begin, or the date services begin;
2. The ending date of authorization is the ending date of the child's waiver year,
3. The maximum authorization period is 12 months; and
4. The Disability Services Specialist will consider the location (in home or out of home) in the authorization of services.

10-007 BILLING AND PAYMENT: Providers of children's waiver family services must submit claims and a service calendar, when applicable, for services rendered, to the individual or legal representative for review and approval. Once approved, claims will be submitted to Department staff for payment. The rates paid to providers of these services specified in the provider agreement must be usual and customary or less for similar services in the community.

10-007.01 Social Security Tax Withholding: The Department withholds Social Security taxes (Federal Insurance Contribution Act, FICA) when:

1. An in-home service is provided by an individual not affiliated with an agency; and
2. Services are provided in each calendar year in which the provider is paid a federally determined amount or more for services to one child. If earnings do not reach this annual amount for FICA service per child, the amount withheld for that year is refunded.

The Department remits to the Internal Revenue Service 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 F & S on behalf of the individual employer.

10-007.02 Income Taxes: The Department does not withhold amounts for personal income tax purposes.

TITLE 404 COMMUNITY BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 11 (Repealed)

TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 11 SPECIALIZED DEVELOPMENTAL DISABILITIES PROVIDER CONTRACTING

11-001 BILLING AND PAYMENT PROCEDURES: The Department determines and publishes billing and payment procedures for delivery of specialized community-based DD services. Providers are paid by rates set by the Department.

11-001.01 If the provider identifies an error by either the provider or the Department, the provider must submit a request for correction within 90 days after the end of the state fiscal year.

11-002 SUBCONTRACTS: Only agencies and programs certified by the Department may enter into subcontracts for specialized services.

11-002.01 Provider Responsibility Regarding Subcontracts: The provider must ensure that:

1. The services to be delivered through a subcontract are permitted under 404 NAC;
2. Policies and procedures include a section that addresses development, training, oversight, and service monitoring components for subcontracted services;
   a. Subcontractors will have the same qualifications, staff training and service provision expectations as employees of the provider.
   b. Service provision monitoring of the subcontractor's performance is completed on-site at a minimum of one time per month;
3. Copies of subcontracts are submitted to the Department prior to utilization of the subcontractor's services; and
4. Subcontracts are subject to the requirements of relevant statutes, regulations, and other policies and procedures of the Department.

11-002.01A The Department will consider noncompliance with state and federal statutes and regulations regarding services on the part of a subcontractor as noncompliance on the part of the provider.

11-002.02 Subcontractor Responsibility Regarding Subcontracts

11-002.02A The subcontractor has no independent, contractual relationship with the Department. The Department is not responsible for withholding.

11-002.02B The subcontractor does not serve as the legal guardian of the individual served. The subcontractor must not be an immediate family member of the individual served.

11-003 DATA COLLECTION AND REPORTING: Each specialized DD provider must maintain data, statistics, schedules, reports, and other information as required by 404 NAC and the contract. Remains in section 404 NAC 6-001 as modified

11-003.01 Provision of Information: The provider must, upon request, submit data, statistics, schedules, reports, and other required information to the Department or other regulatory entities, whether federal, state, or local. Remains in section 404 NAC 6-001.01 as modified

11-003.02 Payroll: The provider must maintain documentation of front line staff and supervisors payroll.

11-004 DEPARTMENT ACCESS: Each provider must allow access to records, must provide copies of documents upon request, and must allow access to the provider's operations for on-site review by the Department or other regulatory entities, whether federal, state, or local. Remains in section 404 NAC 6-002 as modified

11-004.01 The Department will not authorize an alternative compliance procedure for 404 NAC 11-004 or any of its parts.

11-005 FISCAL ACCOUNTABILITY: Each provider must have fiscal and budgetary financial systems that provide accounting for funds administered by and disbursed from the Department. Fiscal accountability must be consistent with generally accepted principles and standards set by the American Institute of Certified Public Accountants (AICPA). Remains in section 404 NAC 6-003 as modified

11-005.01 Accounting System: The accounting system must:

1. Produce a complete, annual financial report;
2. Permit ready accountability of all sources of funding from the respective funding source;
3. Effect proper control of salaries and wages;
4. Produce payroll vouchers or statements for salaries and wages which:
   a. Are prepared at the end of each pay period;
   b. Show the employee's:
      (1) Name;
      (2) Position number;
      (3) Gross salary;
      (4) Taxes; and
      (5) All other deductions or contributions; and
   c. Are approved by the appropriate authority of the provider;

5. Maintain itemized records of:
   a. Personnel compensated in whole or in part with room and board;
   b. Charges for benefits;
   c. Expenditures for technical assistance;
   d. Cost of the operation of programs;
   e. Rent;
   f. Equipment leasing expenses; and
   g. Maintenance costs for of facilities and services;
6. Maintain accounting records in sufficient detail to allow for the calculation of the cost of services provided. Remains in section 404 NAC 6-003.01 as modified

11-005.02 Annual Audit: The provider must contract with a certified public accountant licensed to practice in the State of Nebraska for an annual independent audit of its financial operations. This audit must be conducted using generally accepted auditing standards set by the AICPA Government Auditing Standards (Yellow Book), single Audit Act, and Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations as applicable as determined by the provider and its auditor. Remains in section 404 NAC 6-005 as modified

11-005.02A Audit Report: The audit report must be submitted to the Department within 180 days of the end of the provider's fiscal year. At a minimum, the audit report must include:

1. A review of receipts and disbursements;
2. A review of cash control procedures;
3. An audit of the provider's income statement, balance sheet, source and use of funds statement;
4. An accounting of lease agreements or mortgages;
5. A review of the cash balance on hand at the beginning and at the end of the fiscal year; and,
6. Any and all written communications received by the provider from an auditor related to the provider's internal control over financial reporting requirements and communication with those charged with governance, including those in compliance with or related to Statement of Auditing Standards (SAS) 112 *Communicating Internal Control related Matters Identified in an Audit* and SAS 114 *The Auditor's Communication with Those Charged With Governance.* Remains in section 404 NAC 6-005.01(A-H) as modified

11-005.02B The provider must prepare and submit a plan to the Department to address audit exceptions

11-005.02C Exception: In lieu of the independent, detailed audit, a provider with a total annual operating budget of less than $200,000 may submit a detailed financial statement providing a review of receipts and disbursements, including a statement explaining the source and use of funds, and a statement of fund balances. The format of the financial statement will be determined by the Department. An audit by the Department may be conducted to verify this statement. The provider must make

available to the Department, upon request, financial records supporting the detailed financial statement.

11-005.02D Failure To Comply: The Department will arrange for an independent audit of the provider's operations if the provider fails to comply with this section. In that event, the provider must pay the cost of the audit.

11-005.03 The Department will not authorize an alternative compliance procedure for 404 NAC 11-005 or any of its parts.

11-006 COMPLIANCE AUDITS: All providers must permit the Department, the U.S. Department of Health and Human Services, and any other duly authorized agent or governmental agency to perform audits and/or inspections of its records. Remains in section 404 NAC 6-006 as modified
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11-006.01 The provider must retain financial records and the contract for a period of six years following the termination of a contract to assure compliance with its terms, and/or to evaluate the provider's performance. Remains in section 404 NAC 6-006.01 as modified

11-006.02 Compliance audits may result in:

1. Continuation of the contract;
2. Reduction in or reimbursement of funds;
3. Probationary status;
4. Termination, in whole or in part, of a contract, or;
5. Any combination of the above. Remains in section 404 NAC 6-006.04 as modified

11-006.03 The provider may be required to prepare and submit a plan to the Department to address audit findings. Remains in section 404 NAC 6-006.02 as modified

11-007 REQUESTS FOR HEARING: The provider, by filing a petition in accordance with the Department's rules and regulations adopted and promulgated under the Administrative Procedure Act (APA) (Neb. Rev. Stat. §§ 84-901 to 84-920), may seek administrative review and adjudication of any decision, which directly affects the provider that has been rendered by the Department. A provider may appeal decisions related to the delivery of specialized services, decisions regarding state or federal funding levels, reporting or records, or the administration, interpretation, application, suspension, or termination for cause of the current contract. The provider may also appeal the Department's application of the Developmental Disability Services Act and Title 404 as it applies to the provider's contract.