Support Coordination Manual Developmental Disabilities

December 10, 2018

Support Coordination Manual
Developmental Disabilities
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Introduction

Manual's Targeted Audience

Support Coordination/Case Management is the core service that Virginians with developmental disabilities and behavioral health disorders use to help navigate and make the best use of Virginia's publicly funded system of services. It is the one service that is of critical importance to all dimensions of the services system. Strengthening the Support Coordinator's role is essential to assuring effective and accountable services and all Support Coordinator's must develop the knowledge and expertise needed to identify and strengthen natural support systems for each person they serve. (Workgroup report, 2011)

This manual was written for those professionals who provide this vital service: the Support Coordinators who serve people with developmental disabilities. The purpose of this manual is to guide Support Coordinators in all aspects of their work.

Terms Used in Manual

Although the terms Support Coordinator (SC), Case Manager (CM), and even Services Coordinator may be used interchangeably, Support Coordinator is the term most frequently used in regulations and in most of the material and guidance related to developmental disability Support Coordination/Case Management services developed by the Department of Behavioral Health and Developmental Services (DBHDS). It is also a term that suggests the centrality of the person who uses services and the variety of supports that need to be identified, accessed, and organized for the best outcomes for that person. Therefore, Support Coordinator (SC) and Support Coordination will be used throughout this manual. For a glossary of terms and their acronyms used in this manual, click here (link to at a glance).

Virginia's Public Behavioral Health and Developmental Disability System

The Department of Behavioral Health and Developmental Services (DBHDS) supports people by promoting recovery, self-determination, and wellness in all aspects of life. Their vision statement is, "A life of possibilities for all Virginians".

DBHDS oversees supports and services for Virginians with developmental disabilities (DD), mental health (MH) disorders and substance use disorders (SUD), and manages day to day operations for the Home & Community Based Services (HCBS) under Medicaid Waivers.

The state agency that administers the Developmental Disabilities (DD) Waivers in Virginia is the Department of Medical Assistance Services (DMAS). Locally, DD Waiver services are

coordinated by SCs employed by or contracted through the 39 Community Services Boards (CSBs) and one Behavioral Health Authority (BHA). The actual services are delivered by CSBs, the BHA and private providers across the state.

The following are entities that guide, inform, support, and dictate the role of the Support Coordinator:

- State Structure chart: the Big Picture at a glance
- Department of Behavioral Health & Developmental Services organizational chart at a glance
- Departments and people to know from the Department of Behavioral Health and Developmental Services (DBHDS)
    - **Community Resource Consultants (CRC)** The CRCs help guide SCs with problem solving and offer training and consultation. at a glance
    - **Regional Support Specialists (RSS)** The Regional Support Unit (RSU) oversees management and implementation of the DD Waivers Waitlist by CSBs, as well as all aspects of waiver slot assignments through the Waiver Slot Assignment Committee (WSAC) process. at a glance
    - **Service Authorization Consultants (SAC)** The SACs authorize requested waiver services. at a glance
    - **REACH** provides crisis stabilization, intervention, and prevention services. at a glance
    - **Regional Support Teams (RSTs)** provide recommendations in resolving barriers to the most integrated community settings consistent with a person's needs and informed choice. See chapter 7 for more information. Link chapt 7
    - **Office of Integrated Health (OIH): Community Integration Managers (CIMS)** OIH ensures quality supports and community integrated health services by building and improving new, innovative ways to effect change, and decrease inter and intradepartmental barriers across agencies. at a glance
    - **Behavioral Health Services Regional Housing Specialists (Cross Disability)** Housing Specialists are responsible for developing local, regional and statewide relationships and identifying potential resources necessary to increase the availability of and access to affordable and accessible housing for individuals with a developmental disability who are Medicaid Waiver recipients or those who are eligible for a Medicaid Waiver and possibly on the waiver waiting lists ("target population"). at a glance
    - **Office of Licensing(OL): Licensing Specialists** OL license providers that provide treatment, training, support and habilitation to those with mental illness, developmental disabilities, ~~or~~ substance use disorders, to people using services under the Medicaid DD Waivers, or those with brain injuries who use services in residential facilities. at a glance

- **Office of Human Rights (OHR): Human Rights Advocates** OHR assures and protects the human rights of people who use services in facilities or programs operated, licensed, or funded by DBHDS. at a glance mission; at a glance map

Brief History of Department of Justice Settlement Agreement in Virginia

In August 2008, the Department of Justice (DOJ) initiated an investigation of Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, the DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia's compliance with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court Olmstead ruling. The Olmstead decision requires that people be served in the most integrated settings appropriate to meet their needs consistent with their choice. In February 2011, the DOJ submitted a findings letter to Virginia, concluding that the Commonwealth failed to provide services to those with intellectual and developmental disabilities in the most integrated setting appropriate to their needs.

In March 2011, upon advice and counsel from the Office of the Attorney General, Virginia entered into negotiations with the DOJ in an effort to reach a settlement without subjecting the Commonwealth to an extremely costly and lengthy court battle with the federal government. On January 26, 2012, Virginia and the DOJ reached a settlement agreement. The agreement resolves the DOJ's investigation of Virginia's training centers and community programs and the Commonwealth's compliance with the ADA and Olmstead with respect to individuals with intellectual and developmental disabilities.

Use of the Manual

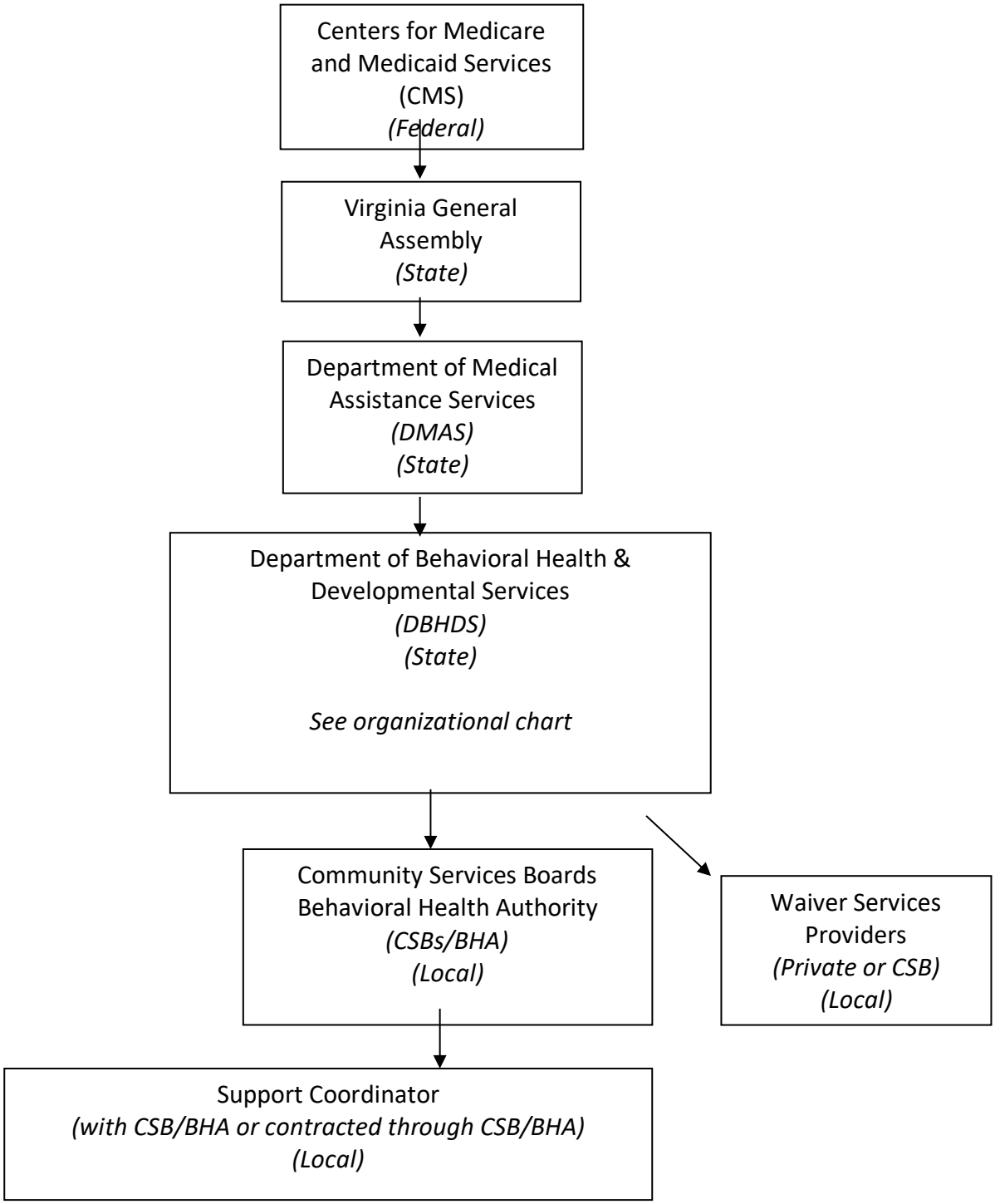
This manual is divided into chapters and sub-chapters as seen in the Table of Contents. If you wish to go to a particular chapter or sub-chapter, you can click on that topic in the Table of Contents and it will take you to the appropriate page. Each chapter has one or more At-a-Glance pages that summarize or enhance information covered in the chapter.

Glossary of Acronyms At a Glance

activities of daily living	ADL
Adult Protective Services	APS
American Association of Intellectual and Developmental Disabilities	AAIDD
Americans with Disabilities Act	ADA
Annual Risk Assessment	ARA
Association of People Supporting Employment First	APSE
Authorized Representative	AR
autism spectrum disorder	ASD
Behavioral Health Authority	BHA
Case Manager/Case Management	CM
Centers for Disease Control	CDC
Centers for Medicare and Medicaid	CMS
Central Virginia Training Center	CVTC
cerebral palsy	CP
Child Protective Services	CPS
Civil Rights of Institutionalized Persons Act	CRIPA
Community Consumer Submission	CCS
Commonwealth Coordinated Care Plus	CCC+
Community Integration Manager	CIM
Community Resource Consultants	CRC
Community Service Board	CSB
Consumer directed services	CD services
Critical Needs Summary	CNS
Department of Aging and Rehabilitative Services	DARS
Department of Behavioral Health and Developmental Services	DBHDS
Department of Justice	DOJ
Department of Medical Assistance Services	DMAS
developmental disability	DD
Diagnostic and Statistical Manual	DSM-5
Direct Support Professional	DSP
Early Intervention	EI
Enhanced Case Management	ECM
Fee for service	FFS
fetal alcohol spectrum disorder	FASD
Home & Community Based Services	HCBS
intellectual disability	ID
Intermediate Care Facility for people with an intellectual/developmental disability	ICF-ID/DD
Legal Guardian	LG

Local Human Rights Committee	LHRC
Long Term Care	LTC
Low Income Housing Tax Credit	LIHTC
Managed Care Organization	MCO
mental health	MH
National Core Indicators	NCI
National Institutes of Health	NIH
Omnibus Budget Reconciliation Act	OBRA
Office of Human Rights	OHR
Office of Integrated Health	OIH
Office of Licensing	OL
Person Centered Individual Support Plan	PC ISP
Person Centered Practices	PCP
Person Centered Review	PCR
Personal emergency response system	PERS
Plan for Support	PFS
Post Move Monitoring	PMM
Power of Attorney	POW
Quality Management Review	QMR
Regional Support Specialists	RSS
Regional Support Team	RST
Service Authorization Consultant	SAC
social communication disorder	SCD
Social Security Administration	SSA
Social Security Disability Insurance	SSDI
substance use disorders	SUD
Support Coordinator/Support Coordination	SC
Supports Intensity Scale	SIS
Supplemental Security Income	SSI
Treatment Episode Data Set	TEDS
Urinary Tract Infections	UTI
Virginia Individual Developmental Disability Eligibility Survey	VIDES
Waiver Management System	WaMS
Waiver Slot Assignment Committee	WSAC
Work Incentive Planning and Assistance	WIPA

VA Developmental Disabilities Service System At-a Glance



DBHDS New Organizational Structure (August 24, 2018)

Virginia Department of Behavioral Health & Developmental Services

Commissioner
Hughes Melton, MD, MBA

External Affairs Meghan McGuire (Communications, Constituent Services, Strategic Planning)

Settlement Advisor to the Commissioner Peggy Balak

Executive Assistant to the Commissioner An-Li Hoban

Internal Audit Randy Sherrod

Deputy for Compliance, Legislative, and Regulatory Affairs (Heidi Dix, Acting)

- Assistant Commissioner for Licensing and Compliance (Dev Nair): Licensing, Regulatory, Compliance, Human Rights*, Risk Management, Community Integration, Incident Management (CIT), Quality Assurance
- Assistant Commissioner, for Public Affairs (Heidi Dix): Policy, Legislative Affairs, State Board, Legal Affairs - FOIA, DI, adjudication, enforcement

Chief Clinical Officer (Alexis Aplasca, MD)

- Quality Improvement: Community
- Quality Improvement: Facilities
- Case Management
- Pharmacy
- Mortality Review
- Data Quality and Visualization

Chief Deputy for Community Behavioral Health Services (Mira Signer)

- Assistant Commissioner for Community Behavioral Health (Stacy Gill)
  - Recovery Support Services
  - Adult Community BH
  - Child and Family
  - Early Intervention
  - Wellness
- Housing: Cross Disability

Deputy Commissioner for Developmental Services (Heather Norton, Acting)

- Provider Development
- Waiver Operations
- Administrative Community Operations
- Office of Integrated Health
- Community Support Services

Deputy Commissioner for Facility Services (Daniel Herr)

- Assistant Commissioner for Forensic Services (Michael Schaefer): SVP and VCBR
- Architectural and Engineering
- Acute Care Services
- 9 mental health hospitals, HDMC, SEVTC

Deputy for Administrative Services (Connie Cochran, Acting)

- Human Resources* (Stacy Pendleton and Sue Ridout)
- Chief Information Officer/Information Security and Technology (Chris Sarandos)
- Reimbursement, Fiscal & Grants Mgmt, Budget Development and Budget Execution, Disaster Prep and Emergency Mgmt
- DataWarehouse
- Procurement and Administrative Services
- Office of Management Services for Outcomes, Performance Contracts, and Grants

Adult Crisis and Emergency Services- Deputy Commissioner for Facility Services

**Indicates office that also has a direct reporting structure to the Commissioner*

Provider Development CRC Assignments

Southeast	Central	Southwest	Western	Northern
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Office of Provider Development
Division of Developmental Services
Department of Behavioral Health and Developmental Services

DBHDS Regional Supports Unit

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DBHDS Regional Supports Unit

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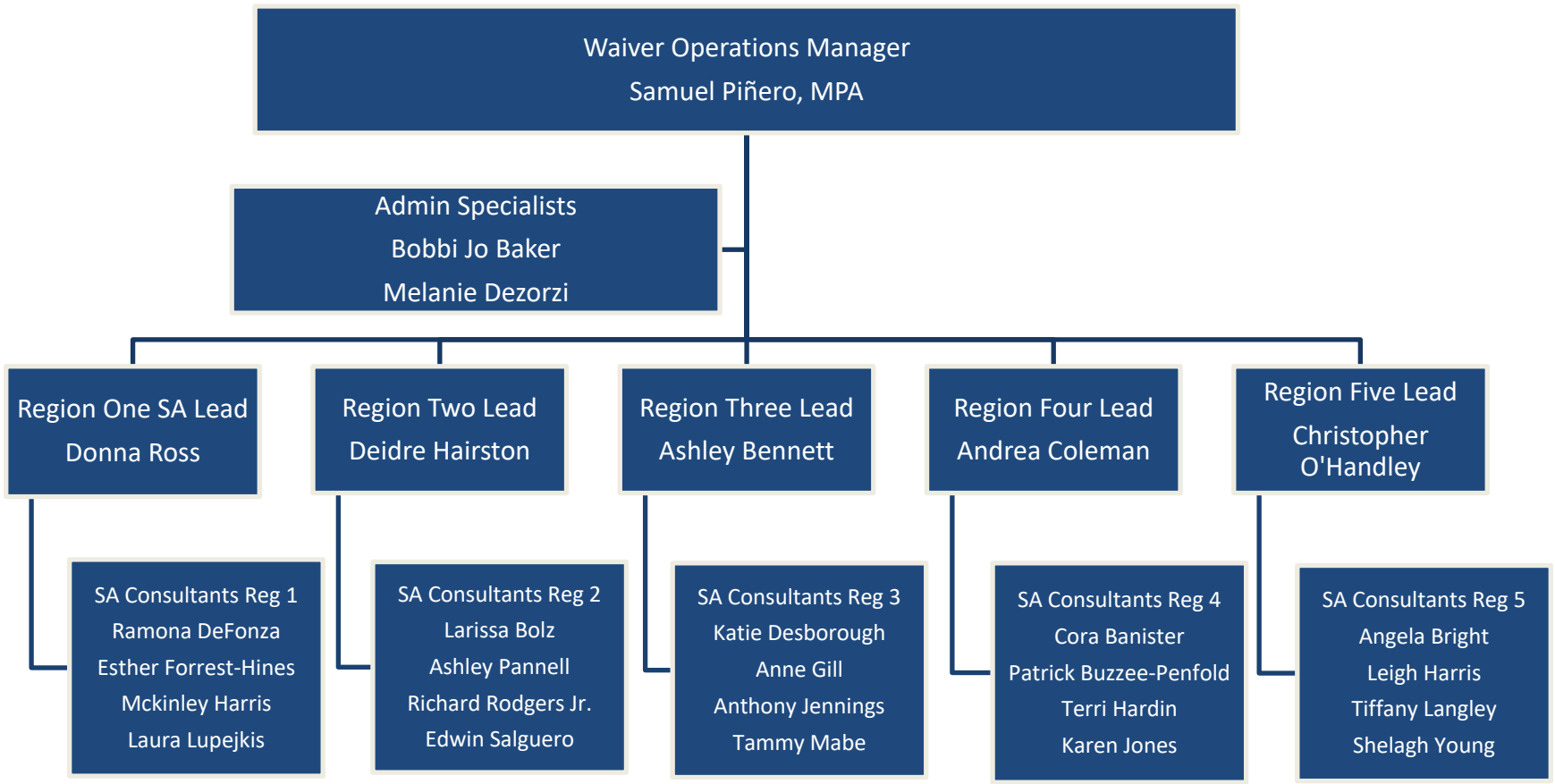
Service Auth. Helpline		804-663-7290	Central Office	

Division of Developmental Services
Service Authorization Organizational Chart
09/20/2017



Revised: 09/20/2017

Individuals with intellectual and/or developmental disabilities shall be supported with services that allow the individual to live the most inclusive life possible in his/her community which includes access to appropriate and effective crisis stabilization, intervention, and prevention services including mental health treatment services when indicated.

REACH Hotlines and Areas Served by Region:

Region I (Western):

Adult REACH Hotline: (855) 917-8278
Adult REACH Director: James Vann

Children's REACH Hotline: (888) 908-0486
Children's REACH Director: Amanda Cunningham

Areas Served Allegheny Highlands CSB: Alleghany, Covington, Clifton Forge City Harrisonburg-Rockingham CSB: Harrisonburg, Bergton, Bridgewater, Broadway, Dayton, Elkton, Grottoes, Keezletown, Massanutten, McGaheysville, Mt. Crawford, Mt. Solon, Penn Laird, Port Republic, Rockingham, Timberville Region 10 CSB: Crozet, Earlysville, Esmont, Greenwood, Keswick, North Garden, Scottsville, White Hall, Charlottesville, Fluvanna, Kents Store, Palmyra, Dyke, Graves Mill, Greene, Ruckersville, Arrington, Stanardsville, Bumpass, Louisa, Mineral, Trevilians, Afton, Colleen, Faber, Gladstone, Love, Lovingston, Massies Mill, Montebello, Nellsyvord, Nelson, Piney River, Roseland, Schuyler, Shipman, Tyro, Wingina, Wintergreen Valley CSB: Augusta , Augusta Springs, Fishersville, Ft. Defiance, Lyndhurst, Middlebrook, Mount Solon, Staunton, Stuarts Draft, Swoope, Verona, Weyer's Cave, Blue Grass, McDowell, Monterey, Waynesboro, Highland, Hightown Horizon BH: Clifford, Elon, Lowesville, Madison Heights, Monroe, Sweet Briar, Amherst , Pamplin, Spout Spring, Appomattox , Bedford City, Bedford , Big Island, Forest, Goode, Goodview, Hardy, Huddleston, Moneta, Montvale, Thaxton, Alta Vista, Brookneal, Campbell, Concord, Lynch Station, Rustburg, Lynchburg Rockbridge Area CS: Bath, Hot Springs, Millboro, Virginia , Warm Springs, Buena Vista, Lexington, Brownsburg, Fairfield, Glasgow, Goshen, Natural Bridge, Raphine, Rockbridge Baths, Rockbridge , Steeles Tavern, Vesuvius

Region II (Northern):

REACH Hotline: (855) 897-8278
Adult & Child REACH Director: Liv Salvador

Areas Served Alexandria CSB: City of Alexandria Fairfax Falls Church CSB: Annandale, Burke, Centreville, Clifton, Fairfax City, Fairfax , Fairfax Station, Falls Church, Great Falls, Herndon, Springfield, Vienna Loudon CSB: Aldie, Ashburn, Bluemont, Chantilly, Dulles, Hamilton, Hillsboro, Lansdowne, Leesburg, Lincoln, Loudoun, Lovettsville, Middleburg, Neersville, Paeonian Springs, Philimott, Purcellville, Round Hill, South

Riding, Sterling, Waterford, The Plains Arlington County CSB: Arlington Prince William County CSB: Manassas, Manassas Park, Bristow, Dale City, Dumfries, Gainesville, Haymarket, Montclair, Nokesville, Occoquan, Prince William, Quantico, Triangle, Woodbridge Northwestern CSB: Winchester, Clarke, Berryville, Boyce, Millwood, White Post, Clearbrook, Cross Junction, Frederick, Gainesboro, Gore, Stephens City, Luray, Page, Rileyville, Stanley, Basye, Edinburg, Fishers Hill, Fort Valley, Maurertown, Mt. Jackson, New Market, Orkney Springs, Quicksburg, Shenandoah, Strasburg, Toms Brook, Woodstock, Middletown, Bentonville, Front Royal, Linden, Warren Rappahannock Area CSB: Bowling Green, Carmel Church, Caroline , Ladysmith, Milford, Port Royal, Rappahannock Academy, Ruther Glen, Woodford, Fredericksburg, Dahlgren, King George, Lake Anna, Spotsylvania, Thornburg, Falmouth, Stafford Rappahannock-Rapidan CSB: Amissvile, Brandy Station, Culpeper, Elkwood, Fauquier, Griffinsburg, Jeffersonton, Reva, Richardsville, Stevensburg, Broad Run, Casanova, Catlett, Delaplane, Goldvein, Hume, Madison, Markham, Marshall, Midland, New Baltimore, Paris, Remington, Sumerduck, The Plains, Upperville, Warrenton, Brightwood, Crigslerville, Hood, Leon, Locust Dale, Madison, Pratts, Rochelle, Syria, Wolftown, Barboursville, Gordonsville, Locust Grove, Montpelier Station, Orange, Somerset, Bealton, Boston, Castleton, Flint Hill, Huntly, Rappahannock, Scrabble, Sperryville, Viewtown, Washington, Viewtown

Region III (Southwest):

REACH Hotline: (855) 887-8278
Adult and Children's REACH Director: Denise Hall

Areas Served: Blue Ridge BH: Botetourt, Buchanan Town, Daleville, Eagle Rock, Fincastle, Oriskany, Roanoke City, Troutville, Arcadia, Catawba, Craig, New Castle, Newport, Paint Bank, Bent Mountain, Roanoke , Vinton, Salem, Vinton Cumberland Mt CSB: Big Rock, Buchanan, Grundy, Pilgrims Knot, Vansant, Castlewood, Cleveland, Dante, Honaker, Lebanon, Rosedale, Russell, Tazewell Highland CS: Washington County, Abingdon, Clarksville, Damascus, Emory, Glade Spring, Meadowview and City of Bristol, Virginia New River Valley CS: Radford, Willis, Copper Hill, Floyd, Giles, Narrows, Pearisburg, Rich Creek, Staffordsville, Blacksburg, Christiansburg, Claudville, Montgomery, Riner, Shawsville, Pilot, Allisonia, Draper, Dublin, Hiwassee, New Bern, Pulaski , Pembroke, Meadows of Dan Danville-Pittsylvania CSB: Danville, Blairs, Callands, Chatham, Gretna, Pittsylvania, Ringgold, Sandy Level Dickenson County BHS: Birchleaf, Breaks, Clinchco, Clintwood, Dickenson , Haysi Mt. Rogers CSB: Bastian, Bland , Rocky Gap, Carroll , Atkins, Ceres, Chilhowie, Elk Creek, Fires, Galax, Grayson, Groseclose, Hillsville, Independence, Mouth of Wilson, Smyth, Sugar Grove, Troutdale, Whitetop, Saltville, Marion, Barren Springs, Crockett, Fort Chiswell, Foster Falls, Ivanhoe, Max Meadows, Wythe, Wytheville, Rural Retreat Piedmont CS: Martinsville, Boones Mill, Burnt Chimney, Callaway, Ferrum, Franklin , Glade Hill, Penhook, Rocky Mount, Smith Mountain Lake, Union Hall, Wirtz, Axton, Bassett, Collinsville, Fieldale, Henry, Ridgeway, Spencer, Stanleytown, Patrick Planning District One BHS: Dryden, Ewing, Jonesville, Lee, Middlesboro, Pennington Gap, Rose Hill, Stickleysville, Norton, Clinchport, Duffield, Dungannon, Gate City, Hiltons, Nickelsville, Scott, Weber City, Appalachia, Big Stone Gap, Coeburn, Pound, St. Paul, Wise

Region IV (Central):

REACH Hotline: (855) 282-1006
Adult and Children's REACH Director: Autumn Richardson

Areas Served: Richmond BHA: Richmond City Chesterfield CSB: Chester, Chesterfield , Ettrick, Matoaca, Midlothian, Mosely District 19 CSB: Hopewell, Dinwiddie, McKenney, Emporia, Greensville, Skippers, Disputanta, Fort Lee, Prince George, Claremont, Spring Grove, Surry, Wakefield, Jarrat, Stony Creek, Sussex,

Wakefield, Waverly, Colonial Heights, Petersburg Goochland/Powhatan CS: Crozier, Goochland, Gum Spring, Hadensville, Maidens, Manakin-Sabot, Oilville, Powhatan Hanover County CSB: Ashland, Beaverdam, Doswell, Hanover, Mechanicsville, Montpelier, Rockville Henrico Area MHDS: Charles City, Red House, Glen Allen, Henrico, Highland Springs, Sandston, Lanexa, New Kent , Providence Forge, Quinton Crossroads CSB: Amelia, Jetersville, Buckingham, Charlotte, Charlotte Court House, Drakes Branch, Keysville, Randolph , Red Oak, Cartersville, Cumberland , Dundas, Kenbridge, Lunenburg, Meherrin, Prince Edward, Victoria, Blackstone, Crewe, Nottoway, Farmville, Green Bay, Rice Southside CSB: Warfield, Alberta, Brunswick , Gasburg, Lawrenceville, Rawlings, Alaton, Boydton, Buffalo Junction, Chase City, Clarksville, Clover, Halifax, Mecklenburg, Nathalie, Scottsburg, Skipwith, South Boston, South Hill, Sutherlin, Virgilina, Bracey

Region V (Eastern):

REACH Hotline: (888)255-2989
Adult and Children's REACH Director: Brandon Rodgers

Areas Served: Middle Peninsula Northern Neck CSB: Wake, Saluda, Essex , Tappahannock, Dutton, Gloucester, Gloucester Point, Hayes, King and Queen, Aylett, King William, West Point, Irvington, Weems, White Stone, Burkeville, Church View, Cobbs Creek, Deltaville, Grimstead, Gwynn's Island, Hallieford, Hardyville, Hartfield, Locust Hill, Mathews, Middlesex, Port Haywood, Topping, Urbanna, Wake, Burgess, Callao, Heathsville, Kilmarnock, Lottsburg, Northumberland, Ophelia, Reedville, Wicomico Church, Farnham, Naylor's Beach, Richmond , Warsaw, Coles Point, Colonial Beach, Kinsale, Montross, Oak Grove, Stratford, Westmoreland, Achilles, Lancaster, Morattico Colonial BH: James City, Jamestown, Toano, Poquoson, Williamsburg, Grafton, York, Yorktown Eastern Shore CSB: Wachapreague, Accomac City, Accomack , Belle Haven, Bloxom, Chincoteaque, Grasonville, Hallwood, Harborton, Keller, Melfa, New Church, Onancock, Onley, Painter, Parksley, Pungoteague, Quinby, Sanford, Tangier, Tasley, Wachapreague, Wallops Island, Cape Charles, Capeville, Cheriton, Eastville, Exmore, Hacks Neck, Jamesville, Machipongo, Nassawadox, Northampton, Oyster, Townsend, Willis Wharf Western Tidewater CSB: Suffolk, Isle of Wight, Boykins, Capron, Courtland, Drewryville, Franklin City, Ivor, Sedley, Southampton, Smithfield, Windsor Hampton Newport News CSB: Newport News, Hampton Virginia Beach: City of Virginia Beach Portsmouth BHS: City of Portsmouth Chesapeake CSB: City of Chesapeake Norfolk CSB: City of Norfolk

Where can I learn more about crisis and behavioral services through DBHDS?

Heather Norton, Acting Commissioner, Division of Developmental Services, 804-786-5850 (office), 804-239-5155 (cell) heather.norton@dbhds.virginia.gov

Sharon Bonaventura, Regional Crisis Manager (Regions I and II), 434-947-2324 (office), 434-960-0427 (cell) Sharon.bonaventura@dbhds.virginia.gov

Nathan Habel, Regional Crisis Manager (Regions III, IV, and V), 804-495-5273 (cell) nathan.habel@dbhds.virginia.gov

Department of Behavioral Health and Developmental Services
Office of Integrated Health
Employee Directory

Mission: Supporting this life of possibilities by ensuring quality supports and a pathway to community integrated health services. To serve as a resource for information related to healthcare, wellness, healthcare providers, and health related services within the Commonwealth.

Acting-Director OIH

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REGIONAL HOUSING SPECIALISTS At a Glance

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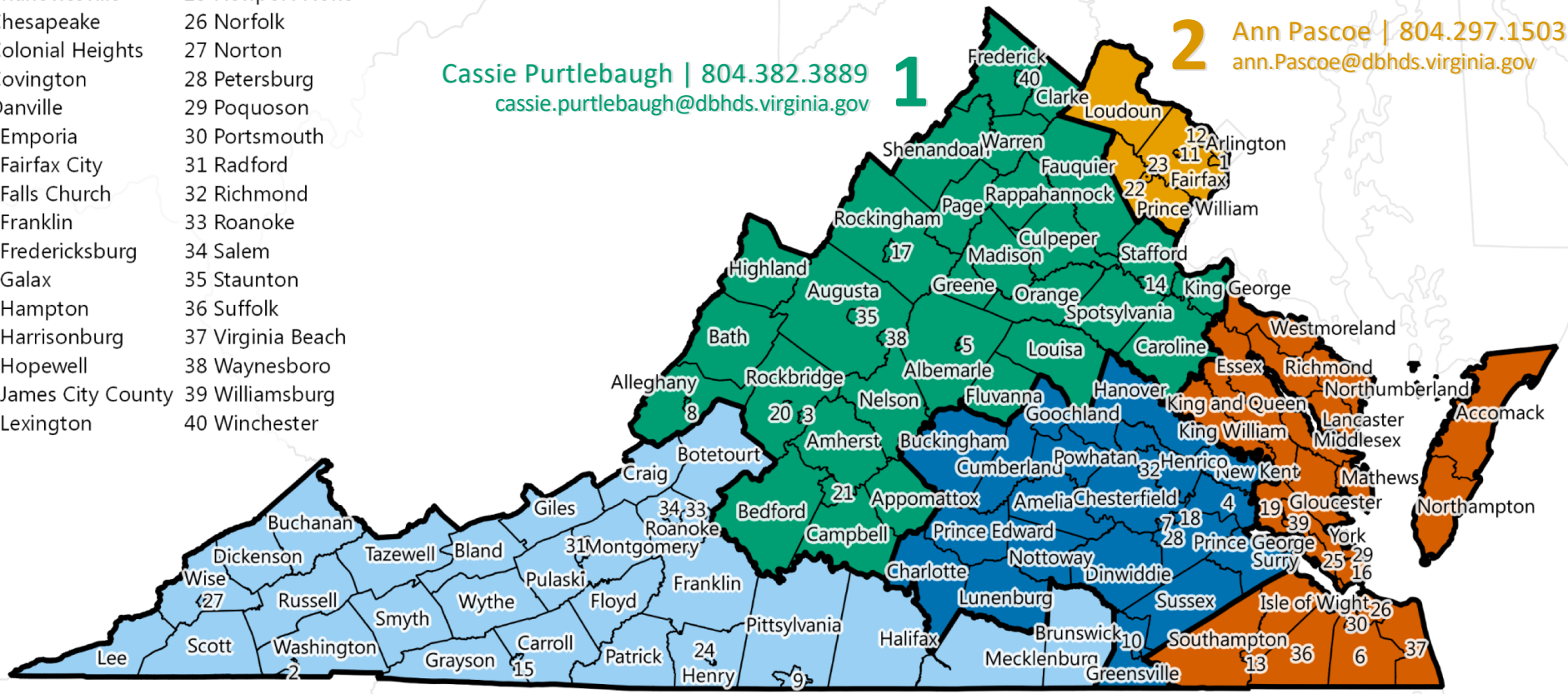
Anna Bowman	Housing Specialist	3 - Southwestern	anna.bowman@dbhds.virginia.gov	804-839-0476
Sheree Hilliard	Housing Specialist	4 - Central	sheree.hilliard@dbhds.virginia.gov	804-371-2154 or 804-629-1675
Kimberly Rodgers	Housing Specialist	5 - Eastern	kimberly.rodgers@dbhds.virginia.gov	804-629-1674

Office of Licensing Contact Information

This information is currently being updated.

Key

1 Alexandria
2 Bristol
3 Buena Vista
4 Charles City County
5 Charlottesville
6 Chesapeake
7 Colonial Heights
8 Covington
9 Danville
10 Emporia
11 Fairfax City
12 Falls Church
13 Franklin
14 Fredericksburg
15 Galax
16 Hampton
17 Harrisonburg
18 Hopewell
19 James City County
20 Lexington
21 Lynchburg
22 Manassas
23 Manassas Park
24 Martinsville
25 Newport News
26 Norfolk
27 Norton
28 Petersburg
29 Poquoson
30 Portsmouth
31 Radford
32 Richmond
33 Roanoke
34 Salem
35 Staunton
36 Suffolk
37 Virginia Beach
38 Waynesboro
39 Williamsburg
40 Winchester



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OHR Regional Manager Contact Information

Virginia Department of Behavioral Health & Developmental Services

Office of Data Quality and Visualization

Office of Human Rights At a Glance

The Office of Human Rights assists the Department in fulfilling its legislative mandate under §37.2-400 of the Code of Virginia to assure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed or funded by the Department (Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated By The Department of Behavioral Health and Developmental Services 2017).

The mission of the Office of Human Rights is to monitor compliance with the human rights regulations by promoting the basic precepts of human dignity, advocating for the rights of persons with disabilities in our service delivery systems, and managing the DBHDS Human Rights dispute resolution program.

Support Coordination Manual
Developmental Disabilities
Chapter 1
Person Centered Practices

- Definition
- Principles & Virginia's vision
- Supporting vs. Fixing
- Promises of Person Centered Practices
- Important to and Important for
- Values & Practices
    - Respect
    - Cultural Agility & Humility
    - Communication Considerations
    - Use of everyday Language
    - Personal Choice and Decision Making
    - Dignity of Risk
    - Individual Rights
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- Life Course tools
- Community
    - Definition
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    - PCP resources

Support Coordination Manual
Developmental Disabilities
Chapter 1
Person Centered Practices

Definition

Person centered practices is a term that embodies values and skills used to support and interact with people. Although the term is most often used in conjunction with the developmental disability field, Person centered practices can be used by all people in many different settings and areas of support need. This chapter will describe the values that underlie all person centered practices. Specific tools and skills are abundant and varied. The Person Centered Practices At-a-Glance resource page (link) found at the end of this chapter provides links to training and websites to learn specific person centered skills and obtain person centered tools.

Person Centered Practices encourages interaction with people with disabilities in much the same way one does with people who do not have disabilities. People with disabilities have the same wants and needs as anyone else. Their needs are not 'special.' Like most of us, people with disabilities want to feel a sense of belonging, they want to make contributions, feel useful and productive, and love and be loved, govern their own lives, including where and with whom they work, live, and play. People with disabilities are valuable members of the community. People who provide supports, including Support Coordinators, focus on promoting rich and fulfilling lives in the community.

Principles & Virginia's Vision

Many years ago, a group of people in Virginia came together to put forth a vision for Virginians with disabilities, along with principles to guide practice. This vision includes all people with disabilities, not just those who use the service system. With a few updates, these remain our principles today.

BOX

The vision of Virginia is that all people with disabilities are provided the opportunities and supports needed to live a good life in their own homes and communities.

Principles of Practice

Principle 1: Listening People are listened to and their choices are respected.

Principle 2: Community Relationships with families and friends and involvement in the community are supported.

Principle 3: Self-Direction People have informed choice and control over decisions that affect them.

Principle 4: Talents and Gifts People have opportunities to use and share their gifts and talents.

Principle 5: Responsibility There is shared responsibility for supports and choices.

This broader vision includes having a Virginia system of supports and services through which people with disabilities have opportunities for freedom, equality, and the opportunity to participate fully in public life. The extent of involvement in public life is defined by the person based on what is important to them.

In this system, people with disabilities…

- set their schedules, make decisions about how and where they live, and have opportunities for recreation that reflects their personal desires and interests;
- access their community with the same opportunity as people without disabilities;
- are employed, which increases integration and enables the pursuit of interests through increased income;
- have access to benefits counseling and financial planning services;
- routinely spend time with friends, family, and others not paid to support them;
- have access to home ownership or tenancy rights in affordable integrated settings where they live with whom they choose;
- have knowledgeable, person centered supports to explore and identify services and resources that lead to integration;
- have dependable transportation for community access when needed and desired; and
- choose their healthcare providers and have access to supports and activities that promote health, wellness, and safety.

Supporting vs. Fixing

The Support Coordinator (SC) plays a significant role in planning with and supporting a person in meeting their goals in achieving their definition of a good life. All people need support regardless of ability. We may not always recognize the support we ourselves need/receive because we tend to see ourselves as competent, autonomous adults, But, we are all interdependent beings. It is important to remember that the type of support needed by someone is unique to that person. If someone needs guidance in one area of their life, say managing finances, does not mean they need assistance in all aspects of their life. (The International Learning Community for Person Centered Practices)

Sometimes people confuse support with ‘fixing’. The role of the SC is not to ‘fix’ a person; this has a coercive quality. Fixing is about ‘power over’ not ‘power with’. “When someone tries to fix another, it creates distance between themselves and the person they are fixing. Fixing is a form of judgment. All judgment creates distance, a disconnection, an experience of difference.” (Rachel Naomi Remen)

BOX

"In fixing, we see others as broken, and respond to this perception with our expertise. Fixers trust their own expertise but may not see the wholeness in another person or trust the integrity of the life in them" Rachel Naomi Remen

Box Below are two documents worth reading about supporting vs. fixing
https://themighty.com/2016/09/people-with-disabilities-dont-need-to-be-fixed-or-cured/

https://www2.gnb.ca/content/dam/gnb/Departments/pcsdp-cpmcph/pdf/docs/CredoforSupport.pdf

Promises of Person Centered Practices

According to the International Learning Community for Person Centered Practices, there are inherent promises made to a person when supporting them using person centered practices.

A Promise to listen
- To listen to what is being said and to what is meant by what is being said
- To keep listening

A Promise to act on what we hear
- To find something that we can do today or tomorrow
- To keep acting on what we hear

A Promise to be honest
- To let people know when what they are telling us will take time
- When we do not know how to help them get what they are asking for
- When what the person is telling us is in conflict with staying healthy or safe and we can't find a good balance between what is **important to** and **important for the person.**

Important to and Important for

At the core of all person centered practices is the ability to discover what is **important to** a person while balancing this with what is **important for** them. This is true about all people, not just those with a disability. All of us have things in our lives that are **important to** us and **important for** us. We all struggle to strike a balance between doing things that are good for our health/safety and having things in our lives that we cherish or just comfort us. Having what is **important to** us helps all of us handle stressors and issues that weigh on us.

BOX

Important To

Those things in life which help us to be satisfied, content, comforted, fulfilled, and happy. They include:

- People to be with/ relationships
- Status and control
- Things to do
- Places to go
- Rituals or routines
- Rhythm or pace of life
- Things to have

Box

Important For

Those things that keep a person healthy and safe. They include:

- Prevention of illness
- Treatment of illness/medical conditions
- Promotion of wellness (e.g. diet, exercise)
- Issues of safety: in the environment, physical and emotional well-being, including freedom from fear

Important For also includes what others see as necessary for a person to:

- Be valued and
- Be a contributing member of their community

Chapter ten (10) discusses health and safety in more detail.

Values & Practices

Respect

The term "respect" has many types of meanings. It includes a positive feeling towards another person or the person's skills, opinions or other characteristics and the honoring of a person's beliefs, ideas or culture. Respect requires seeing a person as a whole not as a disability. As a SC, respect may be demonstrated by

- listening
- developing an understanding of a person's background and their hopes and dreams
- presuming competence when meeting with and interacting with a person with a disability; maintaining high expectations
- practicing cultural agility and humility
- using everyday language
- supporting a person's dreams
- recognizing a person's talents and gifts
- facilitating ways a person can contribute to society

Cultural Agility & Humility

We are all multi-faceted human beings. For the people a SC serves, disability is just one part of who they are and the effects of one's disability in a person's life are varied and unique to that person. The same may be said about a myriad of other things including a person's age, socio-economic class, sexual orientation, race, ethnicity, religion, gender identity, and body weight.

Cultural agility and humility is about giving careful consideration to one's own assumptions and beliefs that are embedded in one's goals for a person. There are three tenants to cultural agility and humility:

The first is a lifelong commitment to self-evaluation and self-critique. Cultural agility and humility is not something that can be mastered, arriving at a point where learning is complete. Therefore, it is important to stay humble and flexible and maintain the willingness to look at oneself critically and to maintain the desire to learn more. Recognition that there is no finish line to learning is essential to cultural agility. (Tervalon & Murray-Garcia, 1998)

The second is a commitment to bring about change to power imbalances. This requires recognizing that each person brings something different to the "proverbial table of life" and that helps us see the value of each person. When a SC interviews a person, that person is the expert on their own life, abilities, and strengths. The SC holds a body of knowledge that the person does not; however, the person also has understanding outside the scope of the SC. Both people must collaborate and learn from each other for the best outcomes. "One holds power in scientific knowledge, the other holds power in personal history and preferences." (Tervalon & Murray-Garcia, 1998)

"The third commitment to practicing cultural agility requires developing partnerships with people and groups who advocate for others. We cannot individually commit to self-evaluation and fixing power imbalances without advocating within the larger organizations and systems in which we participate. Cultural agility, by definition, is larger than our individual selves — we must advocate for it systemically." (Tervalon & Murray-Garcia, 1998)

Reference: Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9, 117-125

BOX

View this video on Cultural Agility & Humility featuring Melanie Tervalon & Jann Murray-Garcia

https://www.youtube.com/watch?v=LLchs28ANj8

Ways to Grow in Cultural Agility

The most important thing a SC can do to become more culturally agile is to understand their own culture and assess their natural biases (the lens through which they view their world). Below are some ideas about how to expand awareness.

Take some time to learn about the cultures and languages of communities in the CSB service area. Attend cultural events, ask questions of people from other cultures, watch movies, listen to music, and read books from different cultures. Try ethnically diverse foods.

Take online tests that deepen your self-awareness. For example:

- Implicit Association Test (https://implicit.harvard.edu/implicit/)
- Quality and Culture Quiz (http://academicdepartments.musc.edu/gme/pdfs/Quality%20and%20Culture%20Quiz.pdf)
- Self-Assessment Checklist for Services to Children with Disabilities (file:///C:/Users/Dawn/Downloads/appc-fm1%20(3).pdf)

Communication Considerations

It is incumbent on the SC and the CSB as a whole to communicate effectively and convey information in a manner that is easily understood by diverse audiences including:

- Persons of limited English proficiency,
- Those who have low or no literacy skills, and
- Those whose disabilities limit their ability to communicate in typical ways.

Remember that SCs have a responsibility to support someone no matter what language they speak. If needed, ask a supervisor how to access interpreters.

Use of everyday Language

Choice of words in speaking and attitudes conveyed through tone of voice are very important. Language can act as a separator when a SC uses "special" language or professional jargon when talking about people with disabilities such as "client," or "consumer." Special language says people with disabilities are different and sets up an "us" versus "them" dynamic. Instead, use everyday language, words, and phrases you would use when talking about co-workers, friends, and family members. For example, instead of saying John was placed in a job, say, he found a job or instead of saying Jane transitioned from high school, say, she graduated. As a SC, how you talk will influence the attitudes and interactions others have with people with disabilities.

"Person First" language emphasizes the person and not the disability. The first choice is always to call someone by their name. If you have to refer to someone and mention disability, always put the person first. The phrase, "a disabled person," can be disrespectful and emphasizes the disability rather than the person. A SC should say, "a person with a disability." Instead of saying "someone with Down's," say, "a person who has Down syndrome." Referring to the person first lets others know that he or she is, first and foremost, a person who deserves respect.

There are some people with disabilities, especially those on the autism spectrum, who prefer to be referred to as 'autistic' rather than 'a person with autism'. They assert that autism is part of them and they cannot be separated from their autism as it might be with a person being cured of a disease. Therefore, they prefer to be called "autistics" in order to identify that this diagnosis and way of being is a permanent part of their personality. In instances such as these, it is important to respect and use the language an individual person prefers. To read more about this click on the following link. (http://autismmythbusters.com/general-public/autistic-vs-people-with-autism/)

According to the International Learning Community for Person Centered Practices, "How you say what you say matters as much as the actual words you say. Some other things to keep in mind regarding language are:

- **Tone** – The inflection or emotion in your voice. It should be age appropriate (no baby talk for adults), mild and respectful.
- **Volume** – Loudness of your voice. It should be appropriate for the situation. If you are in a noisy location, you may have to speak louder (not yell) to be heard. It can also be effective to lower the volume of your voice in order to draw someone's attention.
- **Context** – Where are you? Is it a comfortable, familiar location? Who else is around? Privacy is important. What is the intensity of emotion being expressed? Are you or others upset, frustrated, sad, happy, etc.?
- **Body Language** – Gestures and movements that accompany the words. Some experts say that 75% to 90% of *perceived* language is body language. Body language such as crossing your arms can show disinterest. Shaking your finger at a person can show anger. Rolling your eyes can show disbelief. You want your body language to match with what you are saying and how you are saying it.

Personal Choice and Decision Making

Personal choice means making decisions about all the details of our lives. Each day, as soon as we wake up we are engaged in making choices. We ask ourselves: "Should I hit the snooze button or get up?", "Should I call in or go to work?" and "What should I wear?" We also make major decisions about who to live with and what sort of work we want to do. We are in control and it feels good to be empowered and able to make our own decisions. Everyone is entitled to make decisions about their lives. However, it is rare that anyone makes major decisions in their lives in isolation from others. Most of us talk with those we are close to when making major decisions. SCs play a significant role in promoting choice when planning with a person and when evaluating whether a plan is working for them. Efforts should be made to include others in decision-making, *if the person wants to include others*. Individual choice drives the formulation of outcomes on the Individual Support Plans, the way provider agencies operate, the staffing patterns (what staff do and when they do it), and the daily actions of the Direct Support Professionals. Choice should occur naturally and should be expected without unnecessary restrictions. Many people entered supportive services with little to no choice. It is the SCs responsibility to promote personal choice by noticing likes, dislikes, and opinions as forms of choice.

Informed Choice refers to one's ability to make a decision based on a clear understanding of the facts, results of the choice, and possible future consequences. Some people do not show the capacity for informed consent and need supports from family members, an authorized representative, or a legal guardian. This is typically reserved for decisions or choices that might have an effect on a person's health and safety. This does not mean that the day-to-day choices or expression of hopes and dreams should be restricted. The role of legal guardians and authorized representatives are discussed in greater length in Chapter 3.

Dignity of Risk

The concept of dignity of risk is the right of a person to make an informed choice (or frankly, an uninformed choice) to engage in experiences meaningful to them and which are necessary for personal growth and development. Normal living often includes risks. Choice inherently involves risk, sometimes in a menial way, in other instances, in life threatening ways. Dignity of risk allows people to lead normal lives. Overprotecting people with disabilities keeps them from many life situations that they have the right to experience, and it may prevent meaningful connections and fulfillment of their hopes and dreams. Rather than protecting people with disabilities from disappointments and sorrows, which are natural parts of life, it is important to support them to make informed decisions. This enables them to experience the possibility of success and the natural risk of possible failure. Occasionally, a SC may believe they know the outcome for those who "dream too big." Dignity of risk demands we try to help people investigate and reach for their dreams.

Individual Rights

All people, no matter their ability, retain basic human rights. Like all U.S. citizens, people with disabilities are entitled to enjoy the rights and freedoms to privacy, to have personal possessions, to marry, to exercise free speech, to live in neighborhoods, to complain, to vote, etc. It is also the right of a person to be free from abuse, neglect, exploitation and not to have restrictions on his or her rights and freedoms. An SC is a "mandated reporter," and are required to report rights violations of anyone they support, including suspicion of abuse, neglect and/or exploitation. Mandated reporting is discussed in Chapter 2. Some people the SC supports may have had their legal rights limited through the appointment of a guardian, conservator, or another legal process. This does not mean they cannot make day-today choices and decisions or should have their dreams or plans go unheard. It is the SC's responsibility to seek guidance and help with decision making when appropriate and/or needed to preserve the health and safety of the person supported. As an employee of a community agency providing supports to people with developmental disabilities, it is the SC's responsibility to be knowledgeable of the *Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by DBHDS* (the Human Rights Regulations). The following links to these Regulations.

https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/

Confidentiality

Confidentiality is a right each of us has to privacy and respect of information given to and shared among professionals about us. People generally expect that their medical records, financial records, psychological records, criminal records, driving records, and other personal records are going to be kept in a confidential manner. SCs must remember to have this same respect for the private information about those they support. This includes health information that is covered by the Health Insurance Portability and Accountability Act (HIPAA) and substance use information that is more stringently covered under 42.CFR, Part 2. Your agency will provide additional information about confidentiality and requirements related to sharing information.

LifeCourse Beliefs and Tools

LifeCourse is a collection of person centered tools that may be useful when supporting someone to reach their dreams and goals. The core belief of Life Course is:
All people have the right to live, love, work, play and pursue their life aspirations in their community.

BOX

Principles of LifeCourse

- ALL people are considered in our vision, values, policies and practices for supporting people with intellectual and developmental disabilities.
- People exist and have reciprocal roles within a family system, defined by that individual. Roles adjust as the individual members change and age.
- Individuals and families can focus on a specific life stage, with an awareness of how prior, current and future life stages and experiences impact and influence life trajectory. It is important to have a vision for a good, quality life, and have opportunities, experiences and support to move the life trajectory in a positive direction.
- Individuals and families plan for present and future life outcomes that take into account all facets of life and have life experiences that build self-determination, social capital, economic sufficiency and community inclusion.
- People lead whole lives made up of specific, connected, and integrated life domains that are important to a good quality of life.
- Supports address all facets of life and adjust as roles and needs of all family members change.
- Individuals and families access an array of integrated supports to achieve the envisioned good life, including those that are publicly or privately funded and based on eligibility; community supports that are available to anyone; relationship-based Supports; technology; and that take into account the assets and strengths of the individual and family.
- Individuals and families are truly involved in policy making so that they influence planning, policy, implementation, evaluation and revision of the practices that affect them. Every program, organization, system and policymaker must always think about a person in the context of family.

Using Life Stages and Trajectory with people with DD and families can focus on a specific life stage, with an awareness of how prior, current and future life stages and experiences impact and influence life trajectory. It is important to have a vision for a good, quality life, and have opportunities, experiences and support to move the life trajectory in a positive direction.

The Integrated Delivery of Supports tool helps people with DD and families utilize an array of integrated supports to achieve the envisioned good life, including those that are publicly or privately funded and based on eligibility, community supports that are available to anyone, relationship based supports, technology, and that take into account the assets and strengths of the individual and family.

Once people have figured out the types of supports needed and/or existing, LifeCourse provides a calendar template as a way to apply the supports to a daily/weekly schedule. The worksheet includes instructions and an example on the back. The calendar is incorporated into the Waiver Management System (WaMS).

Information about LifeCourse and all of the their tools may be found at https://www.lifecoursetools.com/

Community

Definition

Community is a group of people who come together for a common reason. People may belong to several communities, of which are based on a common interest, such as bowling or bird watching; or geography, such as a neighborhood; or identity, such as religion or sexual orientation. Being part of a community brings people together, and people learn that although what brings them together is similar, there are many other factors that make us each unique. Positive and regular interactions within a community help people to get to know one another. Since people are, at times afraid of differences or the unfamiliar, it takes intentional effort to involve people with disabilities in their communities. If people with disabilities **only experience** segregated living environments, segregated work environments, and segregated social environments, they are separated from the larger community. This does not mean that a person should never be involved in a community of only people with disabilities especially if the organizing factor is one's identity as a person with a disability, such as People First or other advocacy groups. People First is an advocacy organization designed for and run by people with intellectual and developmental disabilities. The SC should explore ways a person may be involved in various communities that may be defined by where the person lives, their interests, their culture, religion or other parts of their identity.

BOX

Belonging in Community

Just because you live in a community or attend activities in a community does not mean you feel like you belong in that community. According to the International Learning Community for Person Centered Practices, there is a progression of involvement in a community with community connection being the goal.

- **Community presence** may include doing things in the community on a regular basis and being recognized by others who attend, but not really interacting with others. If a person is not there, they are not missed.
- **Community participation** may include doing things in the community on a regular basis, knowing several people by name and having conversations with them about personal lives. The person does things at the event that others depend on and they would be missed if they were not there on a particular day.
- **Community connection** may include a person being included in social gatherings outside of the primary connection, others recognizing and appreciating their contributions, and forming friendships that extend beyond the reason they are gathered. When a person is not there they are missed and people ask about them

With the focus on community life, there is no longer a need for specialized programs that exclude people from an ordinary or extraordinary life. Using paid supports does not mean a person with a disability has to participate in specialized programs with groups of people with similar disabilities, with little to no access to ordinary activities.

Alternatives to isolated programming refers to supporting a person in natural settings, with families and friends, by providing flexible supports that work well for them. People with disabilities should live in comfortable homes in safe neighborhoods. They should have the choice to work a regular job or to engage in other typical activities that they and the community value.

Contribution

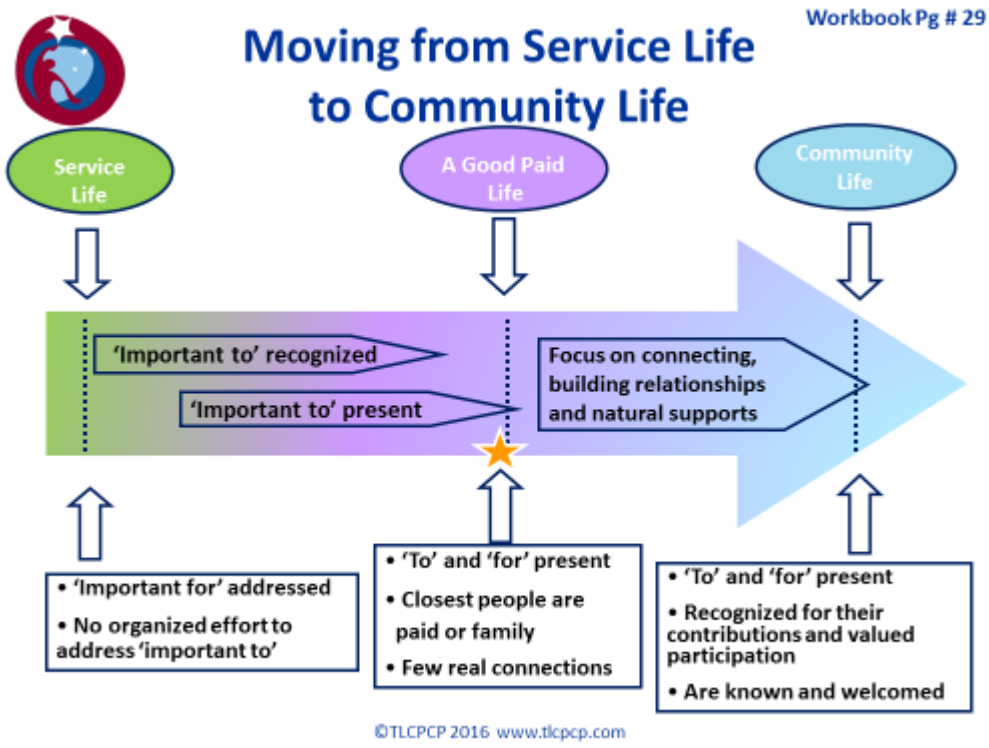
People feel better when they contribute to family, community, the world. Often our contributions come through the paid work we do, but there are many other ways in which a person may share their gifts and talents. ***Virginia is an Employment First state which means it is incumbent on SCs to offer and explore the option of integrated, community employment as the first choice of day activity for those they support.*** Employment and the Support Coordinator's role is described more in-depth in Chapter 12. However, whether we have paid employment or not, there are other ways to make contributions in life. For example, we contribute to family or roommates when we take a fair share of responsibility for the household chores and when we provide an empathetic ear. We may contribute to our communities by volunteering our time or resources for a cause we believe in. We may contribute to the world by changing living habits that affect our global environment. Along with employment, the topic of contribution needs to be explicitly discussed with people the SC supports, not with just one conversation, but in many conversations.

Natural Supports

The term natural supports refers to the resources that are already present and available to all persons in community environments. This includes family, friends, co-workers and neighbors, members of clubs or civic groups, and local merchants. Imagine for a minute what it would be like to wake up every morning knowing that the only people you will interact with all day will be those paid to be with you. This is not how most people live. Most people pay for some services and get assistance from others just because they care. It is part of the SCs role to uncover and set up flexible ways of supporting a person in community settings so they can develop natural relationships. The goal is to move away from dependence on paid supports and move towards

supports from friends, family, and others who are genuinely interested in the person. This not only benefits an individual, it benefits a system that cannot meet the all the needs of every person. Whether we like it or not, there is a limited amount of resources available to meet the needs of Virginians with disabilities.

The following diagram from The International Learning Community for Person Centered Practices, illustrates the movement from reliance on services to having a place in the community.



Person Centered Practices Resources At-a-Glance

Person Centered Thinking Training in Virginia www.personcenteredpractices.org

Support Development Associates http://sdaus.com/

Helen Sanderson Associates http://helensandersonassociates.co.uk/

The International Learning Community for Person Centered Practices
http://tlcpcp.com/

Cornell University Person Centered Planning Education Site
http://www.personcenteredplanning.org/

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Developmental Disabilities
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Support Coordination Manual
Developmental Disabilities
Chapter 2
Support Coordination Overview

Definition

The Administrative Code of Virginia defines Support Coordination as:

12VAC30-50-455. Support Coordination/Case Management (Support Coordination) for individuals with developmental disabilities (DD). A. Target Group. Individuals who have a developmental disability as defined in state law (§ 37.2-100 of the Code of Virginia) shall be eligible for support coordination.

1. An individual receiving DD Support Coordination shall mean an individual for whom there is a Person Centered Individual Support Plan (PC ISP) in effect which requires monthly direct- or in-person contact, communication or activity with the individual and family/caregiver, as appropriate, service providers, and other authorized representatives including at least one face-to-face contact between the individual and the Support Coordinator/Case Manager every 90-days. Billing shall be submitted for an individual only for months in which direct or in-person contact, activity or communications occur and the Support Coordinator's/Case Manager's (SC) records document the billed activity. Service providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

2. Individuals who have developmental disabilities as defined in state law but who are on the DD waiting list for waiver services may receive Support Coordination/Case Management services

Targeted Support Coordination services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted support coordination includes the following assistance:

An individual receiving DD Support Coordination shall mean an individual for whom there is an PC ISP in effect that requires monthly direct or in-person contact, communication, or activity with the individual and family/caregiver, as appropriate, service providers, and other authorized representatives including at least one face-to-face contact between the individual and the support coordinator/case manager every 90 days. Billing shall be submitted for an individual only for months in which direct or in-person contact, activity, or communication occurs and the SCs records document the billed activity. Service providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

For more detailed information on diagnostic eligibility for Support Coordination, please click here: (link to chapter 5 Diagnostic Eligibility)

Being a SC is a huge responsibility. Support Coordination is the core service that many Virginias with developmental disabilities and /or behavioral health depend upon to help navigate and make the best use of our publically funded system of services. In some ways SCs are the most important staff members in our entire system! They make sure individuals have access to services and ensure that those services are effective. When a need has been identified, SCs take the lead in problem solving and advocating in order to hold the system accountable.

Support Coordination is the management covered service for individuals to ensure that needs are met, covered services are not duplicated by the care-providing organization(s), and resources are used cost effectively. SCs either work directly for a CSB/BHA or contract with one. SCs usually work in a support coordination division or group within the CSB. Although Support Coordination is not a DD Waiver service, it is required for all DD Waiver recipients and paid for by Medicaid.

Types of Support Coordination

The type of Support Coordination provided may depend on the person's disability and age. Below are several examples of the type of Support Coordination services a person may use.

Developmental Disability (DD)

A person qualifying for DD Support Coordination has been diagnosed with a developmental disability but not an intellectual disability. For more specific information and full definition of developmental disability, see Chapter 3 of this manual (link to Chapter 3)

Intellectual Disability (ID)

A person qualifying for ID Support Coordination has been diagnosed with an intellectual disability. For more specific information and full definition of intellectual disability, see Chapter 3 of this manual (link to Chapter 3)

Part C

A child receiving Part C Support Coordination has been found eligible under the Infant & Toddler Connection of Virginia for early intervention supports and services to infants and toddlers from birth through age two, who are not developing as expected or have a medical condition that can delay normal development. For more specific information about Part C Support Coordination see this link. http://www.infantva.org/

Omnibus Budget Reconciliation Act (OBRA)

A person eligible for OBRA Support Coordination are those who meet the eligibility criteria for ID/DD Support Coordination and currently reside in a nursing home. They must be identified to need and benefit from specialized services.

For more specific information about specialized services available to a person receiving OBRA Support Coordination see this link https://www.vadars.org/cbs/nhos.htm

Mental Health (MH)

A person using mental health Support Coordination services has been diagnosed with a mental health disorder that significantly impacts their functioning in everyday living. Often times, a person using DD/ID SC services may also qualify for MH SC. In this instance it is important to determine from which program (DD/ID or MH) the person will receive primary Support Coordination.

Substance Use Disorders (SUD)

A person using SUD Support Coordination services has been identified as having a substance use disorder and is in need of medical, psychiatric, psychological, social, educational, vocational, recovery, and other supports essential to meeting the person's basic needs. Sometimes, a person using DD/ID SC services may also qualify for SUD Support Coordination. In this instance, it is important to determine from which program (DD/ID or SUD) the person will receive primary Support Coordination.

Targeted Case Management (State Plan Option)

If a person with a qualifying disability meets criteria for Medicaid, and has active service needs they are eligible for targeted Case Management (Support Coordination). This can include:

- A person who is a recipient of the DD Waiver
- A person with an intellectual disability on the waiting list for the DD Waiver who is eligible for Medicaid (in this instance the person may or may not be a recipient of one of the other Medicaid Waivers)
- A person with a developmental disability on the waiting list for the DD Waiver who is eligible for Medicaid AND has a short term special need (in this instance the person may or may not be a recipient of one of the other Medicaid Waivers)
- A person with an intellectual disability **not** on the waiting list for the DD Waiver, who is eligible for Medicaid and targeted case management, but **not** DD Waiver (in this instance the person may or may not be a recipient of one of the other Medicaid Waivers)

More detailed information about the service requirements for targeted Support Coordination/Case Management are provided in Chapter 5 of this manual.

Enhanced Case Management (ECM)

This more intensive level of Support Coordination is provided to people who are recipients of the DD Waiver who meet certain criteria that identifies certain situations that history and evidence based practice indicates increased risk for the individual. ECM requires more active support from a SC including more frequent face to face visits and monitoring of services to ensure that the individual remains stable and or does not further deteriorate.

ECM requirements apply to those on the DD Waiver wait list receiving the CCC Plus Waiver. In addition to meeting the ECM criteria, a person on the CCC Plus waiver can receive ECM if they are willing to accept services when offered.

It is important for SCs to understand the ECM criteria.
For more detailed ECM guidelines and criteria please click on the links provided.

BOX
ECM standards at a glance (link)
ECM flow chart at a glance (link)
DOJ Guidance on ECM

Consumer Monitoring/Follow Along

A person who is **not** eligible for Medicaid may still have a need for Support Coordination. Often times, individuals not eligible for Medicaid may be on the DD Waiver waiting list and have unmet needs that require SC.

Many CSBs or Support Coordination providers have protocols for how to provide support to a person who is **not** eligible for Medicaid. This may or may not include an option for the person to pay for SC services out of pocket *or* at a reduced fee. Some CSBs or SC providers may have different documentation and direct contact protocols for individuals **not** eligible for Medicaid.

Post Move Monitoring

Post move monitoring is required for anyone who previously resided in an Intermediate Care Facility, (ICF/IDD) or Training Center and is now living in the community. This type of monitoring is a requirement of the Department of Justice Settlement Agreement and involves a collaborative effort between training center staff, the Community Service Board (CSB), community providers and the Community Integration Manager (CIM) to ensure the health, safety and overall well-being of people discharged from Virginia Training Centers.

The training center post move monitoring (PMM) staff will conduct a minimum of three face to face visits with the person within the first 17 days following his/her move to the community to ensure essential supports are in place. These visits will occur in the home, at day support or the employment site. The PMM staff may review/request copies of: support logs/data collection sheets, progress notes, injury/illness/incident reports, medication administration records, new

physician orders, etc. PMM staff can make recommendations and assist in developing strategies and securing additional supports as needed to address any concerns identified during the post move monitoring process.

Box
Post Move Monitoring report (link)

Choice of Support Coordinator

Anyone seeking Support Coordination services should be offered a choice of Support Coordinator. Choice of providers is always an option and can be exercised at any time by a person using SC services and documented at a minimum on an annual basis. Each provider of Support Coordination shall implement a written policy describing how people are assigned SCs and how they can request a change of their assigned SC or SC provider.

Support Coordination Process Overview

Preparation and Engagement

The first step in the Support Coordination process is preparation and engagement. It is important for a SC to prepare by identifying documentation requirements and engaging the person, their family and service providers. A SC should always be aware of upcoming deadlines as they pertain to due dates for service plans and assessments. Organization and preparation is key to ensure positive outcomes for the person.

BOX

See chapter 4 for more detail regarding Preparation and Engagement **link**

Assessment

Assessment is the on-going process of gathering and summarizing information that guides the work between the SC and the person using services. It also refers to document(s) that synthesizes information that has been gathered. The assessment is a time for discovery and determining initial and ongoing eligibility for services.

The goal of assessment is to gather information to continually add to understanding those supported including their strengths, abilities, past successes, hopes, dreams, preferences, needs, and risks. In order to develop a plan that is effective, and in keeping with the person's values and goals, it is important to gather information about a person and their environment.

Effective assessments start where a person is, prioritizing their immediate concerns. Be sure to pay attention to any immediate health and safety issues, risk or risks of harm. The assessment should be precise and accurate and should identify support needs, stressors, goals, value, strengths, resources, health status, activities of daily living (ADL) and support networks.

Box
See chapter 5 for more detail regarding Assessment **link**

Plan Development

Planning is the bridge between the assessment and the services to be provided. The assessment process develops an understanding of the person's needs and the resources available. The planning process then translates the assessment information into desired outcomes and the means to reach them.

Person centered planning is a process-oriented approach to empowering people with disabilities. A person centered plan process recognizes that the person is the focus of planning, and those who know them. Learning through a shared collaborative process is the purpose of person centered planning. The person with whom a plan is being developed is always at the center of the planning process. The team may consist of the person using services, family members, friends, service providers and the Support Coordinator.

The Support Coordinator plays a vital role in ensuring that the information that is gathered puts the person's gifts, talents, goals, preferences, needs, and choices in the center of the planning process.

Box
See chapter 7 for more detail regarding Plan Development **link**

Plan Implementation

Support Coordination services help people work to improve their health and well-being, live a self-directed life, and strive to achieve their full potential. SCs assist people in accessing needed services. This process is known as plan implementation which can be divided into the following three categories.

Coordination ensures that activities between the person and service providers are implemented according to the PC ISP.

Linking people to needed resources and services by discussing options and referring as needed.

Advocating for a person by ensuring that their needs and preferences are being implemented and use problem solving when barriers arise. The SC has the knowledge and professionalism to represent the best interests of the person served.

Box

See chapter 7 for more detail regarding Plan Implementation **link**

Monitoring and Evaluation

Monitoring and evaluation is described as active observation, by the SC, of the person and service providers to make sure the plan is being properly implemented and being alert to changes that might indicate a modification in the plan is needed. Monitoring is conducted through periodic site and home visits to assess the quality of care and satisfaction of services. Making collateral contacts with the person's significant others, i.e. parent, authorized representative, guardian, etc. and assisting the person to identify problems and modifying the plan are also part of monitoring and evaluation. SCs can follow up with providers and other supports, provide or obtain instruction, education, and counseling to help ensure plan implementation. Regularly meeting with the person in their natural environment, for example their home, day program or workplace is an excellent way to monitor and evaluate. Monitoring and evaluating known risks and identifying new risks, needs and changes in status can help to ensure the person's safety and well-being.

Box
See chapter 8 for more detail regarding Monitoring and Evaluation **link**

Transitions, Transfers, Ending Services

There will be times when people will need Support Coordination services of indefinite duration while others will not. A person may need support in transitioning to new services because they have recently received a Waiver slot. Perhaps a person has moved to another catchment area and has requested that his case be transferred to the CSB of that new locality. Regardless of the reason why someone might need support during transition, transfer or ending services, the SC needs to ensure continuity of care in addition to participation and agreement from the person about how his services will be transitioned, transferred or ended.

Box
See chapter 9 for more detail regarding Transitions of Support **link**

Recognizing Limitations

Success as a SC requires a creative personality and good communication skills. SCs have to anticipate the unexpected and solve difficult problems on a daily basis. Flexibility and teamwork are top priorities as well as understanding individual perspectives in order to overcome barriers to service. When barriers to service have been identified it is important for the SC to be able to identify their limitations and seek support as needed. Supports can include, but not limited to the following:

- Support Coordination Supervisors
- Fellow Support Coordinators
- Community Resource Consultants (CRC) (link to contact list Intro)
- Regional Support Teams (RST) (Link to RST section chapter 7)

Support Coordinators must be knowledgeable of generic resources that are available in the community for those who use the DD Waiver as well as those who are on the waiting list or do not qualify for the DD Waiver. Additional resources may be found in Chapter 11. (link)

Mandated Reporting

The Code of Virginia states that mandated reporters who may have reason to suspect a child or disabled adult is being abused or neglected should immediately report to the local Department of social services. Support Coordinators are considered mandated reporters and are required to report all suspicions of abuse, neglect and exploitation to Adult Protective Services, if the person is an adult. If the person is under 18 years or up to 21 years old while in the care of a legal guardian, Child Protective Services should be notified. For DBHDS licensed providers, the offices of Licensing and Human Rights, as well as the Commonwealth Coordinated Care managed care organizations (MCO), if applicable, must also be notified.

Box
See chapter 10 for information about the signs of abuse and neglect. **link**

Department of Social Services/Child Protective Services (CPS)

The Department of Social Services operates a CPS Hotline 24/7 to support local departments of Social Services by receiving reports of child abuse and neglect and referring them to the appropriate local department of social services. The CPS Hotline is staffed by trained Protective Services Hotline Specialists.

Department of Aging and Rehabilitative Services (DARs) & Adult Protective Services (APS)

To report suspected financial exploitation or other kinds of abuse to elderly or adults with a disability, call the local department of Social Services or the Virginia Department of Social Services' 24-hour, toll-free APS hotline. APS investigates reports of abuse, neglect, and exploitation of adults aged 60 and over and incapacitated adults over 18 years of age, and provides services when persons are found to be in need of protective services.

BOX
To read a full description of the definition of mandated reporting for adults, click on the link for *Code of Virginia § 63.2-1603*
https://law.lis.virginia.gov/vacodefull/title63.2/chapter16/article2/

To read a full description of the definition of mandated reporting for children, click on the link for *Code of Virginia 63.2-1509*
https://law.lis.virginia.gov/vacode/title63.2/chapter15/section63.2-1509/

BOX

Reporting Abuse and Neglect: SC Responsibilities

- Immediately notify the local Department of Social Services (DSS) if abuse, neglect and/or exploitation is suspected. Follow CSB internal protocol regarding reporting abuse and neglect.
  - Virginia Department of Social Services 24-hour, toll-free Adult Protective Services (APS) hotline at: (888) 832-3858.
  - Virginia Department of Social Services 24-hour, toll-free Child Protective Services (CPS) Hotline at (800) 552-7096

Notify the DBHDS Offices of Human Rights/Licensing along with local DSS if there is suspicion of abuse, neglect or exploitation from a licensed DD Waiver provider. Please follow this link for contact for DBHDS Office of Human Rights. (link to contact list in intro)

Office of Licensing/Serious Incident Reporting

The Office of Licensing oversees the serious incident reporting side of the Computerized Human Rights Information System (CHRIS). A serious incident means any event or circumstance that causes or could cause harm to the health, safety, or well-being of a person using services. The term serious incident includes death and serious injury. Although SCs typically do not have access to enter information into the CHRIS system, each CSB will have one or more staff identified as users who have capability enter information and to run reports to view allegations and complaints, and a summary of provider reports for individuals who receive support coordination from the CSB.

More information on serious incident reporting can be found in the licensure regulations. http://dbhds.virginia.gov/assets/doc/QMD/OL/ch.105.full.wemergcompliance.9.01.18docx.pdf

BOX

Computerized Human Rights Information System (CHRIS): SC responsibilities

When a provider has identified and entered a serious injury, incident or death into CHRIS:

- Follow up with the provider in order to monitor the plan of correction
- Communicate with the individual and/or the family/guardian in order to determine their ongoing satisfaction with the provider
- Document ongoing monitoring and follow up as it relates to the incident

Office of Human Rights Allegations/Abuse, Neglect and Exploitation

Office of Human Rights

The Department's Office of Human Rights, established in 1978, has as its basis, the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by DBHDS. The Regulations outline the Department's responsibility for assuring the protection of the rights of individuals in facilities and programs operated funded and licensed by DBHDS.

Title 37.2-400, Code of Virginia (1950), as amended, and the Office of Human Rights assure that each individual has the right to:

- Retain his legal rights as provided by state and federal law;
- Receive prompt evaluation and treatment or training about which he is informed insofar as he is capable of understanding;
- Be treated with dignity as a human being and be free from abuse or neglect;
- Not be the subject of experimental or investigational research without his prior written and informed consent or that of his legally authorized representative;
- Be afforded an opportunity to have access to consultation with a private physician at his own expense and, in the case of hazardous treatment or irreversible surgical procedures, have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his health;
- Be treated under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint and isolation;
- Be allowed to send and receive sealed letter mail;
- Have access to his medical and clinical treatment, training, or habilitation records and be assured of their confidentiality but, notwithstanding other provisions of law, this right shall be limited to access consistent with his condition and sound therapeutic treatment;
- Have the right to an impartial review of violations of the rights assured under this section and the right of access to legal counsel;
- Be afforded appropriate opportunities, consistent with the individual's capabilities and capacity, to participate in the development and implementation of his individualized services plan; and
- Be afforded the opportunity to have a person of his choice notified of his general condition, location, and transfer to another facility.

OHR Advocates represent individuals receiving services from providers of mental health, developmental disabilities, or substance abuse services in Virginia whose rights are alleged to have been violated and perform other duties for the purpose of preventing rights violations. Each state facility has at least one advocate assigned, with regional advocates located throughout the State who provide a similar function for community programs. Their duties include investigating complaints, examining conditions that impact individuals'' human rights and monitoring compliance with the human rights regulations. At times, an individual served or anyone acting on their behalf may request to be linked with their regional Human Rights Advocate.

Local Human Rights Committees (LHRCs) are comprised of community volunteers who are broadly representative of various professional and consumer interests. LHRCs play a vital role in the Department's human rights program, serving as an external component of the human rights system. LHRCs review individuals' complaints not resolved at the program level; review and make recommendations concerning variances to the regulations; review program policies, procedures and practices and make recommendations for change; conduct investigations; and review restrictive programming.

BOX

Office of Human Rights: SC responsibilities

If a person requests to be linked with their OHR advocate the SC can:

- Provide the contact information for the advocate
- Reach out to the advocate on behalf of the individual
- Document the person's request and the action taken
- A statewide listing of OHR staff can be found here (link to OHR contact sheet in Intro chapt)

Importance of Documentation

Documentation enhances the quality of service delivery. With heavy caseloads, referencing well documented records can assist SCs in remembering important aspects of a person's life. It provides information to colleagues and supervisors who must ensure continuity of care in the SC's absence.

Documentation ensures compliance with regulatory and funding requirements and standards. Records are audited by a variety of internal and external reviewers to ensure that guidelines are being followed and the quality of service delivery is optimal. Over a period of time, the SC may be able to see patterns or trends of effective and ineffective interventions and better assess other services that may be helpful.

An essential job responsibility of a SC is documentation which can include paperwork such as applications, pre-authorizations, documentation of choice, etc. Good documentation supports billing, data collection, and licensing standards.

The DBHDS Office of Licensing licenses public and private providers of community services throughout Virginia. DBHDS licenses services that provide treatment, training, support and habilitation to people with mental illness, developmental disabilities or substance use disorders, to people using services under the Medicaid DD Waiver, and to those with brain injuries using services in residential facilities. The licensing requirements for documentation

specific to support coordination can be found in Article 2 and Article 5 of the DBHDS licensure requirements
http://dbhds.virginia.gov/assets/doc/QMD/OL/ch.105.full.wemergcompliance.9.01.18docx.pdf

Data Collection

The Department of Behavioral Health and Developmental Services (DBHDS) developed the Community Consumer Submission (CCS) 3 Extract Specifications in collaboration with the Data Management Committee of the Virginia Association of Community Services Boards. In partnership with Community Services Boards (CSBs) and the Behavioral Health Authority (BHA), DBHDS uses CCS3to comply with federal and state reporting requirements, including those in the federal substance abuse Treatment Episode Data Set (TEDS) and federal mental health and substance abuse block grants. The CCS3 is used to submit data to state funding sources, including the General Assembly and Department of Planning and Budget and to produce data about the performance of the public mental health, developmental disabilities, and substance use disorder services system.

State and federal policymakers and decision makers and many others use this CCS3 data. It provides data for comparisons of and trends in the numbers and characteristics of people using direct and contracted mental health, developmental disabilities, and substance use disorder services from CSBs. The importance of correct coding is just as important as billing. SCs need to ensure that the correct codes have been utilized for a person using services and that CCS3 required data is kept up to date.

More information specific to CCS3 data collection can be found at this link

http://www.dbhds.virginia.gov/assets/doc/BH/oss/ccs-3-extract-specifications-version-7.4-june-2018.pdf

Waiver Management System (WaMS)

The Waiver Management System (WaMS) is a web hosted data management system used to manage waivers. WaMS interfaces with the Virginia Medicaid Management Information System (VAMMIS), and establishes the assessment levels of care based on a person's needs and automates the service authorization process. WaMS is customized to allow a single process for service authorizations for all three Waivers (Community Living, Family and Individual Supports, and Building Independence) supporting people with intellectual or developmental disabilities (ID/DD). WaMS interfaces with various Electronic Health Record (EHR) systems to transfer data into WaMS.

Support Coordinators use WaMS for a variety of documentation requirements including the PC ISP, VIDES survey, authorizations for Waiver services, and Waiver waiting list management.

WaMS CSB User Guide (http://vnppinc.org/wp-content/uploads/2016/08/WaMS-Provider-Manual-Final-7_8_2016.pdf

Appeal Rights

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the person's receipt of services. This includes, actions to deny a request for medical services, or an action to reduce or terminate coverage after eligibility has been determined.

An SC may need to assist a person to request an eligibility appeal in writing within 30 days of receipt of the notice about the action. The person may write a letter or complete an Appeal Request Form that would include:

- Name
- Medicaid ID number
- Phone number with area code, and
- a copy of the notice about the action
- Appeals are then mailed to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219

Telephone: (804) 371-8488
Fax: 804-452-5454

For reduction or termination of coverage, if the request is made before the effective date of the action and the action is subject to appeal, the coverage may continue pending the outcome of the appeal. The person may, however, have to repay any services received during the continued coverage period if the agency's action is upheld.

After the person files an appeal, they will be notified of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone. The Hearing Officer's decision is the final administrative decision rendered by the Department of Medical Assistance Services. However, if the person disagrees with the Hearing Officer's decision, they may appeal it at their local circuit court.

Box

DMAS Appeal Rights page
http://www.dmas.virginia.gov/#/appealsresources

DMAS Appeals form
http://www.dmas.virginia.gov/files/links/9/Client%20Appeal%20Request%20Form.pdf.

COMMONWEALTH of VIRGINIA
DEPARTMENT OF BEHAVIORALHEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond Virginia 23218-1797
Telephone (804) 786-3921
Fax: (804)371-6638
www.dbhds.virginia.gov

November 30, 2012 (Revised 14 April 2014)(Revised Jan 2017)
To: Community Services Board Executive Directors
Subject: Case Management Operational Guidelines Re: Settlement Agreement

UPDATE

As you are aware, the Settlement Agreement with the Department of Justice contains specific requirements related to the provision of case management/support coordination for those individuals with intellectual or developmental disabilities who receive DD waiver (Building Independence, Family and Individual Supports, Community Living) services. Effective March 6, 2013 CSBs were required to provide more frequent case manager/support coordinator face-to-face visits with individuals who met certain criteria. Specific operational guidance on how to implement the case management requirements of the Settlement Agreement, including the more frequent face-to-face case management visits (Enhanced Case Management) for certain individuals, were contained in the "Case Management Operational Guidelines," which was developed by a committee of CSB, DD Waiver and advocacy community representatives.

As a result of feedback in April 2014, three adjustments were made to the Enhanced Case Management (ECM) Criteria. The first change included moving the 5 day grace period to 10 days to coincide with DMAS regulations; the second change established criteria to exclude individuals considered stable in group homes of 5 or more (if this was the only ECM criteria met); and the third change included an exemption for individuals living in the family home with intense behavioral or medical needs as defined by the SIS.

The Case Management Operational Guidelines were again reviewed by a Case Management Workgroup, which included ID and DD support coordinators/case manager supervisors, beginning in Nov 2015. The intent of the review was to incorporate the April 2014 changes to Enhanced Case Management into the Case Management Operational Guidelines and to provide clarity and consistency throughout the document. Several reviews were made to provide more consistency in the two documents and to help clarify questions received from the field. Changes include:

- providing consistency in how long enhanced case management will continue (identified as 90 days after the individual is stabilized)
- reiterating the case manager/ support coordinator required actions to document and report, convene a team meeting, develop and implement safety and risk mitigation protocols if indicated, revise and update the ISP, monitor implementation of the ISP (including safety and risk mitigation protocols), and document resolution and
- clarifying exceptions
- clarifying that visits occur every 30 days, not monthly.

CASE MANAGEMENT OPERATIONAL GUIDELINES

The Settlement Agreement between the United States Department of Justice and the Commonwealth contains specific requirements regarding the provision of case management services, including face to face meetings at least every thirty (30) days with individuals who meet certain criteria. These requirements were implemented by March 6, 2013. These operational guidelines are intended to assist CSB DD case managers hereafter referred to as case manager/support coordinator in implementing the case management requirements of the Settlement Agreement. The Settlement Agreement requires the following related to Case Management/Support Coordination

1.For individuals receiving case management/support coordination services pursuant to this Agreement, the individual's case manager/support coordinator/case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs. (Section V.F.1).

2.At these face-to-face meetings, the case manager/support coordinator/case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether support sand services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager/support coordinator/case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution. (Section V.F.2)

3. The individual's case manager/support coordinator shall meet with the individual face-to-face every 90 days. The visit must occur **at least every 30 days**, and at least one such visit every two months must be in the individual's place of residence, for any individuals who:

A. Receive services from providers having conditional or provisional licenses;

B. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale® ("SIS") category representing the highest level of risk to individuals or by the Annual Risk Assessment (exceptions noted below);

C. Have an interruption of service greater than 30 days (excludes a break in employment when the individual is in Supported Employment and remains with the same supported employment provider);

D. **Encounter the crisis system**, (including risk triggers)as defined below;

E. **Have transitioned from a Training Center within the previous 12 months**; or

F. **Reside in congregate settings of 5 or more individuals** (exception described below). (Section V.F.3)

** Face to face visits must occur every 30 days **(not monthly)**. Example visit 2 March 2017. Next visit is due on or before 31 March 2017.

Explanation of Population Served:

All individuals with intellectual or developmental disabilities who receive HCBS waiver services shall receive case manager/support coordination pursuant to section III.C.5 of the Settlement Agreement. Such individuals who also meet any of the criteria in section V.F.3.a-f of the Settlement Agreement, set forth, above and below shall receive the more frequent face-to-face visits at least every thirty (30) days.

Individuals receiving HCBS waiver services include Building Independence (BI), Family and Individual Support (FIS), and Community Living (CL) waiver recipients, as well as individuals receiving services under the Elderly or Disabled with Consumer Directed Services (EDCD) or Assisted Technology (Tech) waivers. Thus, CSB DD case manager/support coordinator must provide the more frequent face-to-face visits at least every thirty (30) days to individuals who are on the DD waiver, DD waiver wait list, receiving EDCD or Tech waiver services, AND meet any of the criteria in section V.F.3. a-f of the Settlement Agreement.

Table 1 below shows which groups must receive face-to-face visits at least every thirty (30) days, if they meet any of the criteria in Section V.F.3.a-f. **Table 1: Population**	**30 day visits required IF any of the criteria V.F.3.a-f are met**
BI Waiver Recipients1	Yes
FIS Waiver Recipients	Yes
CL Waiver Recipients	Yes
Individuals on DD Waiver Wait List Who Are Receiving EDCD or Tech Waiver Services	Yes * **While these individuals receive ECM, onl individuals in DD Waivers (BI,FIS,CL) are code in CCS3**
Individuals on the DD Waiver Wait List Receiving No Other Waiver Services	No
Individuals in Training Centers	No
Individuals in Community-Based ICFs	No
Individuals in NFs	No

1 This includes individuals currently on the ID and DS Waiver and all those who receive a slot during the period of the Settlement Agreement.
2 This includes individuals currently on the DD Waiver and all those who receive a slot during the period of the Settlement Agreement.

Certain sections of the Settlement Agreement pertaining to case management/support coordination are set forth below, followed by operational guidelines for implementation:

1. For individuals receiving case manager/support coordination services pursuant to this Agreement, the individual's case manager/support coordinator shall meet with the individual face-to-face (FF) on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs." (Section V.F.1) (DMAS regulations for active case management)

"Regular basis" *means face-to-face visits every 90 days (with a 10 day grace period) consistent with the requirements of the ID and DD Targeted* case manager/*Support coordination (TCM) regulations. More frequent face-to-face visits are required if the individual meets the criteria of Section V.F.3.a-f of the Settlement Agreement.*

A. At these face-to-face meetings, the case manager/support coordinator/case manager shall:

1. observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status;
2. assess the status of previously identified risks, injuries, needs, or other change in status;
3. assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and
4. ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.

B. If any of these observations or assessments identifies:
1. previously unidentified or inadequately addressed risk, injury, or need,
2. a change in status;
3. a deficiency or discrepancy in the individual's individualized support plan (ISP) or services and the individual's strengths and preferences; or
4. a deficiency or discrepancy in the implementation of supports and services;

C. The case manager/ support coordinator/case manager shall:
1. **document and report** the issue,
2. **convene** the individual's service planning team to address it, and
3. **document resolution.** (Section V.F.2)

To "report and document the issue" and meet the other requirements of this section, case manager/ support coordinator/case managers should take the following actions in the situations listed:

a. If any face-to-face contact results in the identification of a previously unidentified or inadequately addressed risk, injury, need, or change in status, deficiency or discrepancy in the ISP

1) **Document in the record** the specific unidentified or inadequately addressed risk, injury, need, or change in status, including the report to and the response of the designated provider(s).

2) **Convene and mobilize Person-Centered Planning (PCP) team members** needed to address the issue and revise the ISP as needed. (Meeting will include individual, Guardian/AR, if applicable, Support coordinator/case manager, and applicable providers. Can be in person, conference call, and/or Support coordinator/case manager by phone to all parties)

3) **Report suspected abuse, neglect, or exploitation** to Adult Protective Services or Child Protective Services and the DBHDS Office of Human Rights.

4) **Report to the DBHDS Office of Licensing** serious incidents or injuries as defined in licensure.

5) **Document the issue and resolution** of the issue in the case manager/support coordinator/case manager record.

b. A **"change in status"** includes previously unidentified risk, injury, need or a change in service provider. When a change in provider occurs, the support coordinator/case manager/support coordinator/case manager should closely monitor the transition to the new provider to ensure there are not unnecessary gaps in services or delays and that services are provided in accordance with the individual's support plan.

c. If a deficiency in the individual's support plan or services and the individual's strengths and preferences **or** a deficiency or discrepancy between the implementation of supports **and services** is identified, the case manager/support coordinator/case manager shall:

1) **Document in the record** the specific deficiency or discrepancy, including the report to and the response of the designated provider(s).

2) **Convene and mobilize the individual's PCP team** members needed to address the issue and revise the ISP as needed (Meeting will include individual, Guardian/AR, if applicable, Support coordinator/case manager, and applicable providers. Can be in person, conference call, and/or Support coordinator/case manager by phone to applicable parties).

3) **Report** if the individual's PCP team cannot achieve resolution within a reasonable time (2 weeks), the case manager/support coordinator/case manager shall contact the CRC first and the DBHDS Office of Licensing second.

4) **Document the issue and resolution.** The Support coordinator/case manager will document the resolution of the issue in the record.

Enhanced Case Management

The individual's case manager/support coordinator/case manager shall initiate enhanced case management and meet with the individual face-to-face at least every 30 days, and at least one such visit every 60 days must be in the individual's place of residence, for any individuals who meet the below criteria (and further defined below):

1. **Receive services from providers having conditional or provisional licenses**

2. **Have more intensive behavioral or medical needs as defined by the Annual Risk Assessment category representing the highest level of risk to individuals (exceptions noted below)**

3. **Have an interruption of service greater than 30 days**

4. **Encounter the crisis system (includes admission or an assessment for admission)**

5. **Have transitioned from a Training Center (TC) within the previous 12 months**

6. **Lives in a 5 bed or larger group home (exceptions noted below)**

The case manager/ support coordinator/case manager shall:

1. **Document in the record the status of the current identified issues and any newly identified issues** to include the status of the individual related to current ECM criteria met and any newly identified ECM criteria met
2. **Convene and mobilize Person-Centered Planning (PCP) team members for any change in status** to address the issue and revise the ISP as needed. (Meeting will include the individual, Guardian/AR (if applicable), Support coordinator/case manager, and applicable providers. The planning meeting can be in person, via conference call, and/or by Support coordinator/case manager individual phone calls to all parties)
3. **Report suspected abuse, neglect, or exploitation** to Adult Protective Services or Child Protective Services and the DBHDS Office of Human Rights
4. **Report to the DBHDS Office of Licensing** serious incidents or injuries as defined in licensure
5. **Document support coordinator actions to address and resolve issues and resolution of identified issues** in the case manager/support coordinator record.

If an individual qualifies for enhanced case management, these face-to-face contacts must occur **every 30 days WITH A 10 DAY GRACE PERIOD** consistent with DMAS requirements and give CSBs more flexibility as to when to conduct the visits so the timing does not become predictable. This will avoid the problem of a literal interpretation that might require face-to-face contact on May 1st and May 31st, as well as avoid the problem associated with a "monthly" designation in which a contact could occur June 1st and the next one not until July 31st. **The use of the grace period does not alter the due date of the next face-to-face contact.**

If the case manager/support coordinator/case manager cannot complete the required face-to-face contact, he/she must document the reason(s) and all attempts. After two, consecutive 30-day

periods of no contact, the CSB case management/ support coordinator/case manager will advise supervisor and contact his/her regional CRC, who will determine if further steps are needed (such as contacting the Licensing Specialist, DMAS, etc.). This includes extended vacations individuals/families might take. The CSB case management support coordinator/case manager must also comply with the established Waiver "Request to Retain Slot" process as appropriate.

Compliance with these standards will be through routine Licensing reviews of case management services, Quality Service Reviews, and as part of the investigation review process for both Licensing and Human Rights.

Each ECM criteria is further defined below to include any exemptions allowed. If an individual meets an exception in one category but meets ECM in another category then ECM criteria is met and ECM face to face visits continue until NO ECM criteria is met and the individual has been stable (as defined below) for 90 days.

1) **Receive services from providers having conditional or provisional license**

   a. Case Manager/Support coordinator/case managers shall fulfill the above face-to-face obligation for the entire time a provider is on a **conditional** (i.e., new) license or **provisional** license. This level of face-to-face contact will continue for at least 90 days after a provider has been removed from the **conditional or provisional** status.

   b. This requirement for more frequent case management/support coordination visits applies to any individual recieving services in any of the DD Waivers (BI,FIS,CL) who receive services from any DBHDS licensed provider, that has been issued a conditional or provisional license.

   c. The DBHDS Office of Licensing (OL) will post information on the DBHDS website, updated monthly, about each provider that is operating under a conditional or provisional license.

2) **Have more intensive behavioral or medical needs as defined by the Annual Risk Assessment category representing the highest level of risk to individuals (exceptions noted below)**

   a. If any item in sections 3a or 3b of the **SIS Supplemental Risk Assessment** are scored "2" (i.e., extensive support needed), the individual shall receive enhanced case manager/support coordinator visits while those responses remain scored "2."

   b. **Exception(s)** to this requirement are defined below:

      i. A "yes" response to Annual Risk Assessment Item #5 (fall risk):

1. A yes to #5 fall risk does not automatically constitute a more intensive behavioral or medical need requiring more frequent case management/support coordination visits. **If the individual <u>has not</u> experienced an injury as a result of a fall in the past 90 days** then ECM is not required.

2. **If the individual <u>has</u> experienced an injury as a result of a fall in the past 90 days** then a "yes" to item #5 will require ECM visits 90 days after the individual is stablized.

ii. 3a #14 (lifting and/or transferring):

1. If the individual <u>has not</u> experienced an injury as a result of an adverse event in the context of lifting or transferring in the past 90 days, then ECM is not required
2. If the individual <u>has</u> experienced an injury as a result of an adverse event in the context of lifting or transferring in the past 90 days, **<u>then ECM is required</u>** and will continue 90 days after the individual is stabilized.

iii. 3a #15 (therapy services) only

iv. Enhanced case management/support coordination visits are not required for individuals who have more intensive behavioral or medical needs as defined by the **SIS 3A/3B or the Annual Risk assessment** (regardless of residential setting to include family homes and congregate settings of 5 or more individuals) **<u>if no other ECM criteria is met and</u>** their medical/behavioral condition has been well-controlled and well managed for the past year.

1. Individuals who have been identified as being at risk for serious injury and/or death due to a specific condition or event and medical and behavioral conditions are well controlled **<u>due in part to safety protocols and mitigation plans being in place</u>**

2. Safety protocols/mitigation plans (health and safety outcomes/risk protocols/behavior plans) are in place as evidenced by:

a. No serious injuries or crisis has occurred in the last year

b. The ISP includes safety protocols and mitigation plans for the identified intensive medical and behavioral need

c. Safety protocols/mitigation plans are followed by the provider and or family member

d. SC reviews provider documentation of safety protocols and mitigation plans as evidence that safety protocols and mitigation plans are in place and implemented as written

3. The safety protocols/mitigation plans (health and safety outcomes/risk protocols/behavior plans) are reviewed quarterly and revised as needed. The ISP is updated as appropriate

4. **No other risks triggers or changes in medical or behavioral conditions have been identified that would put the individual at risk** (*includes diagnosis of aspiration pneumonia, bowel obstruction, decubitus ulcer (pressure sore), Urinary Track Infection (UTI), seizure, falls with injury, sepsis)*) Examples of significant changes in conditions or events related to an individual's risk include **any change in health or behavioral status**, change in medications especially as the side effects may impact the risk (dizziness may contribute to falls), dental work as it relates to someone who is already at risk for choking as it may lead to aspiration pneumonia, dehydration, or constipation as it may lead to bowel obstruction.

c. Stable is defined as pre injury/illness condition/functioning or the individual has reached post injury/illness, condition or optimum functioning as determined by a licensed medical professional (Primary Care Provider (PCM), Nurse Practioner (NP), Registered Nurse (RN), Physician Assistant (PA)).

d. If the individual were to meet any ECM criteria, this exemption does not apply.

3) **<u>Have an interruption of service greater than 30 days</u>**

a. This means an interruption of any of the following waiver service

i. Congregate residential (including supervised and sponsored residential)

ii. In-home residential

iii. Personal Assistance (agency-directed or consumer-directed)

iv. Supported Employment (Change in SE job site but not provider does not constitute interruption in service)

v. Day Services

vi. Ongoing **or inability to access** therapeutic services, assistive technology, environmental modification, behavioral consultation.

b. The case management/support coordinator/case manager shall meet with the individual face-to-face at least every thirty (30) days, with at least one such visit every 60 days in the individual's residence, until either services have resumed or the individual has lost his/her slot

c. An extended vacation, when the individual and his or her family are out of town, does not constitute an interruption of service. Extended vacations must be clearly documented in the individual's record.

4) **Encounter the crisis system (includes admission or an assessment for admission)**

a. Crisis includes behavioral/psychiatric and medical events and serious incidents:

i. Crisis means **admission or assessment for admission** to:

1. Crisis Stabilization Unit (CSU), unplanned crisis stabilization services

2. Emergency Services, Children's Crisis or REACH services
3. Hospital (other than for routine or elective procedures) and ER visits

4. Hospital followed by admission to a Long Term Rehab or skilled nursing facility

5. Risks triggers (diagnosis of aspiration pneumonia, bowel obstruction, seizures, decubitus ulcer (pressure sore), UTI, seizure, falls, sepsis)

ii. APS/CPS involvement

iii. Involvement with the criminal justice system or incarceration

b. The case management/ support coordinator/case manager shall:.

i. **Document in the record** the specific crisis event or incident and any change in status

ii. **Convene and mobilize Person-Centered Planning (PCP) team members** needed to address the issue (meeting will include individual, Guardian/AR, if applicable, Support coordinator/case manager, and applicable providers. Can be in person, conference call, and/or Support coordinator/case manager by phone to all parties)

iii. **Revise the ISP** to include safety and risk mitigation protocols as indicated

iv. **Report suspected abuse, neglect, or exploitation** to Adult Protective Services or Child Protective Services and the DBHDS Office of Human Rights

v. **Report to the DBHDS Office of Licensing** serious incidents or injuries as defined in licensure

vi. **Document resolution** of the issue in the case manager/support coordinator/case manager record

c. The support coordinator/case manager shall monitor implementation of the ISP (including safety and risk mitigation protocols) to ensure the ISP is implemented as written to reduce the potential of a future crisis event.

d. **ECM visits will be initiated and continue for 90 days after the individual is stable (not 90 days after the crisis event)**

e. Stable is defined as pre injury/illness condition/functioning or the individual has reached post injury/illness, condition or optimum functioning as determined by a licensed medical professional (Primary Care Provider (PCM), Nurse Practioner (NP), Registered Nurse (RN), Physician Assistant (PA)).

f. Exception:

i. In some individual situations, an individual may meet one of the above crisis system criteria (ex.; the family member routinely uses the ER for non-emergent care rather than the primary care physician dispite repeated efforts by the support coordinator/case manager to encourage the family member to use the primary care physician for routine care). In these

situations, the support coordinator/case manager may review this with the supervisor to determine the need for an exception to enhanced case management.

1. It is expected that these situations will be infrequent and should clearly document supervisory review and why an exception is being made.

2. **If any other ECM criteria is met, no exception to enhanced case management will be made.**

5) **Have transitioned from a Training Center (TC) within the previous 12 months**

a. The support coordinator/case manager shall meet face-to-face with the individual at least every thirty (30) days, with at least one such visit every 60 days in the individual's residence, for twelve (12) months post TC discharge

b. The support coordinator/case manager shall ensure Post Move Monitoring reports are sent to DBHDS Post Move Monitor for 30, 60 and 90 day visits

c. Any change in provider requires a team meeting to ensure that the Post Move Monitor is aware of the change in provider and the new provider is aware of the individual specific transition plan provided by the initial post move monitoring visit.

6) **Lives in a 5 bed or larger group home (exceptions noted below)**

a. Enhanced case management/support coordination visits are required for individuals who live in a 5 bed or greater group home

b. **Exception:**

i. **If no other ECM criteria is met** except that the individual lives in a 5 bed or larger group home **and the individual's medical/behavioral condition is well-controlled and well managed** for the past year as described below, ECM is not required

ii. Individuals who have been identified as being at risk for serious injury and/or death due to a specific condition or event and medical and behavioral conditions are well controlled **due**

in part to safety protocols and mitigation plans being in place

1. Safety protocols/mitigation plans (health and safety outcomes/risk protocols/behavior plans) are in place as evidenced by:

    a. No serious injuries or crisis has occurred in the last year

    b. The ISP includes safety protocols and mitigation plans for identified intensive medical and behavioral needs

    c. Safety protocols/mitigation plans are followed by the provider

    d. SC reviews provider documentation of safety protocols and mitigation plans as evidence that safety protocols and mitigation plans are in place and implemented as written

    e. The safety protocols/mitigation plans (health and safety outcomes/risk protocols/behavior plans) are reviewed quarterly and revised as needed. The ISP is updated as appropriate

    f. **No other risks triggers or changes in medical or behavioral conditions have been identified that would put the individual at risk** (*includes diagnosis of aspiration pneumonia, bowel obstruction, decubitus ulcer (pressure sore), Urinary Track Infection (UTI), seizure, falls with injury, sepsis)*) Examples of significant changes in conditions or events related to an individual's risk include **any change in health or behavioral status**, change in medications especially as the side effects may impact the risk (dizziness may contribute to falls), dental work as it relates to someone who is already at risk for choking as it may lead to aspiration pneumonia, dehydration, or constipation as it may lead to bowel obstruction.

c. Stable is defined as pre injury/illness condition/functioning or the individual has reached post injury/illness, condition or optimum functioning as determined by a licensed medical professional

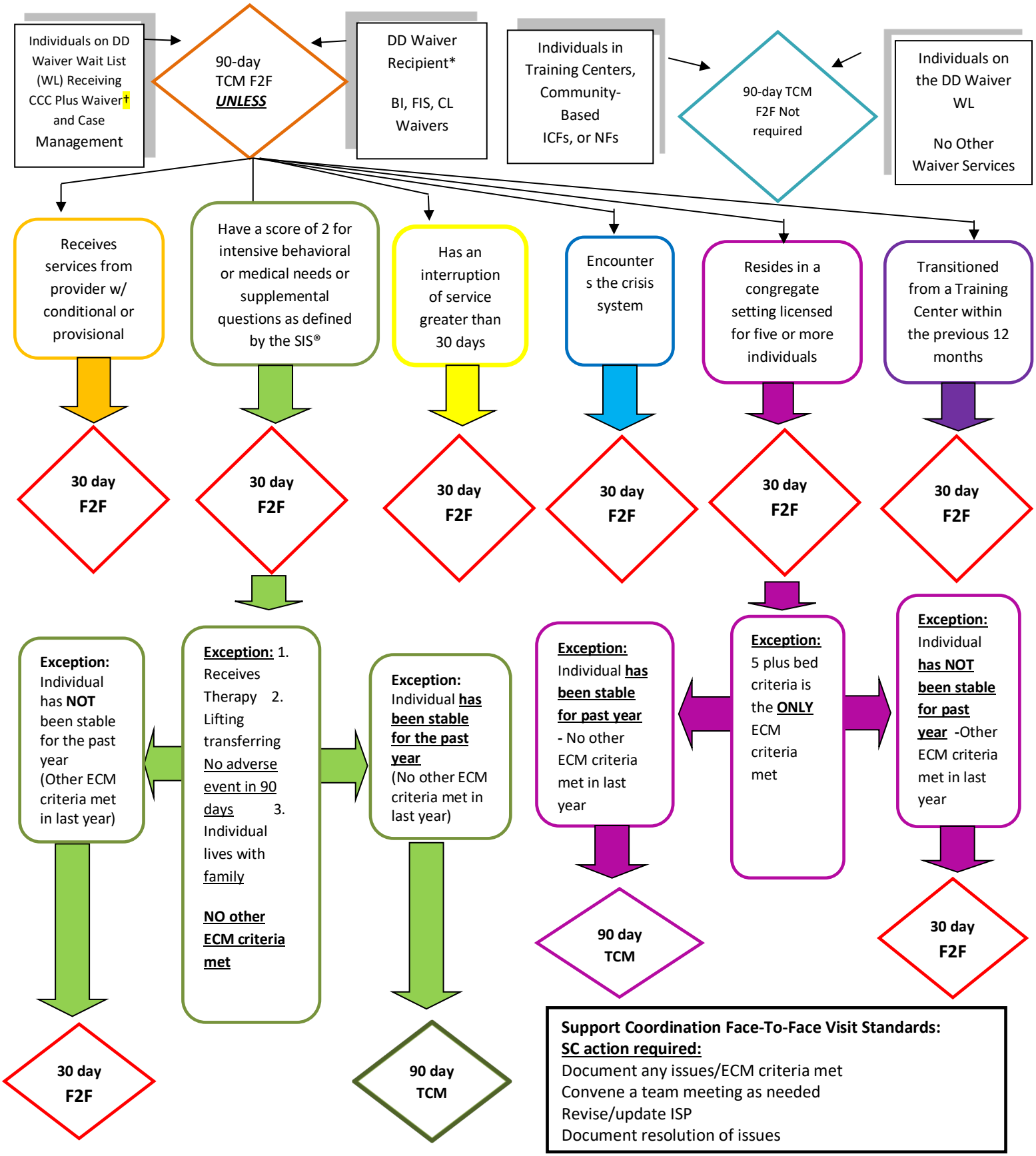
(Primary Care Provider (PCM), Nurse Practioner (NP), Registered Nurse (RN), Physician Assistant (PA)).

d. **ECM visits will continue for 90 day after the individual is stable (not 90 days after the incident)**

e. If the individual were to meet any other ECM criteria, this exemption does not apply.

**OL will post on the DBHDS website, a current list of congregate settings licensed for five or more individuals.*

Enhanced Case Management Flowchart Rev: July 2017



*This includes individuals currently on the BI, FIS and CL Waivers.

WL-†Offer 90-day TCM FF, repeat at least annually. If declined, document. ECM not required for individuals on the WL except as indicated.

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Virginia Department of Behavioral Health and Developmental Services
Enhanced Case Management Criteria
Instructions and Guidance

(April 2014)

As a result of feedback from meeting with ID CM CSBs last May, DBHDS requested 3 adjustments to Enhanced Case Management (ECM) criteria:

The first change included moving the 5 day grace period to 10 days to coincide with DMAS regulations and was approved effective May 1, 2014.

The second change requested establishing criteria to exclude those individuals currently considered stable in group homes of 5 beds or more from automatically requiring ECM.

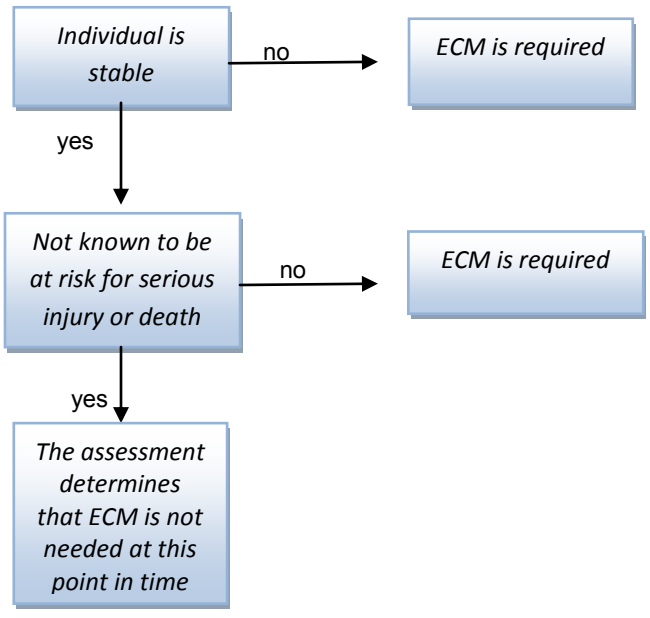
Prior to an individual being designated as not needing enhanced case management visits, an individual has to be stable for at least one year. Stable is defined as living in the same placement for at least one year prior to the ECM determination without significant events that threaten serious injury or death such as founded abuse and/or neglect; bowel obstruction; aspiration pneumonia; falls resulting in serious injury; or encounters with the crisis system for a serious crisis or for multiple less serious crisis within a three month period.

For those individuals who are currently living in a congregate setting with 5 or more beds, the Case Manager/Support Coordinator needs to determine:

- *Whether the individual is known to be at risk for serious injury or death*
- *Whether the individual has been stable for one year (living in the same place for one year without significant events that threaten serious injury or death*

Decision Tree

Starting Point for Assessment – Lives in a congregate setting of 5 or more individuals



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If the individual were to encounter any of these triggers, then enhanced case management visits would be provided and continue until the person was stable, as defined above.

There are individuals living in congregate settings of 5 or more who have been identified as being at risk for serious injury and/or death due to a specific condition or event. Some of these individuals are stable as defined above due in part to safety protocols being in place. When they experience any event or significant changes in the condition(s) related to their risk, enhanced case management visits would be required and would continue until the individual is once again stable. In addition, the safety protocols will be reviewed by staff when increased risks are identified and revised as needed. Examples of significant changes in conditions or events related to an individual's risk include any change in medications especially as the side effects may impact the risk (dizziness may contribute to falls), dental work as it relates to someone who is already at risk for choking, and constipation as it may lead to bowel obstruction.

The third change included establishing criteria for those who have more intensive behavioral or medical needs as defined by SIS when they live in the family home and their medical/behavioral condition is well-controlled and well-managed and the individual is stable (living in the family home for at least one year without significant events that threaten serious injury or death such as founded abuse and/or neglect; bowel obstruction; aspiration pneumonia; falls resulting in serious injury; or encounters with the crisis system for a serious crisis or for multiple less serious crises within a three month period).

For those individuals having more intensive behavioral or medical needs as defined by the SIS, the case manager/service coordinator needs to determine:

- *Whether the individual lives in their family's home with care and supports provided primarily by family members, and*
- *Whether medical/behavioral condition(s) is well controlled and well managed, and*
- *Whether the individual is stable (living in the family home for at least one year without significant events that threaten serious injury or death)*

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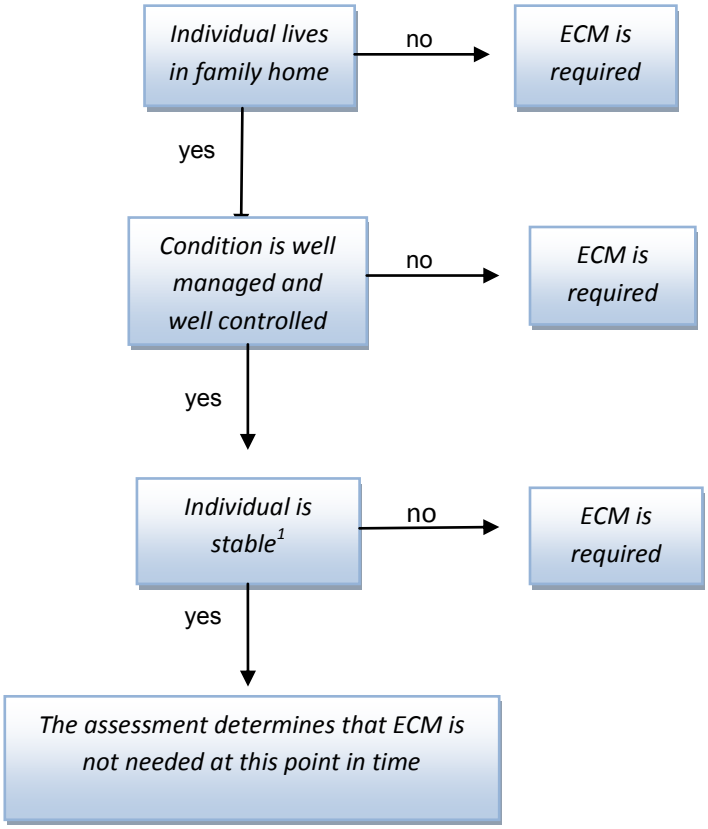
Decision Tree:

Starting point: Has at least one "yes" on the SIS Supplemental Risk Assessment or a score of 2 or higher in 3a or 3b on the SIS Exceptional Medical and Behavioral Supports Needs



If it is determined that ECM is not needed at this point in time, Case Managers/Support Coordinators would be required on a quarterly basis to assess whether the family member/caregiver is following medical orders and/or behavior treatment plan recommendations. If the individual were to encounter any of these triggers then enhanced case management would be provided and continue until the person was stable, as defined above.

There are individuals living with family who have been identified as being at risk for serious injury and/or death due to a specific condition or event. Some of these individuals are stable as defined above due in part to safety protocols being in place. When they experience any event or significant changes in the condition(s) related to their risk related to their risk, enhanced case management visits would be required and would continue until the individual is once again stable. In addition, the safety protocols would be reviewed by a provider or the CM/SC with family when increased risks are identified and revised as needed. Examples of significant changes in conditions or events related to an individual's risk include

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any change in medications especially as the side effects may impact the risk (dizziness may contribute to falls), dental work as it relates to someone who is already at risk for choking, and constipation as it may lead to bowel obstruction.

Expectations

The importance of on-going assessing of individuals needs cannot be stressed enough. Assessments are “snapshots in time” and the level of risk and conditions can change very quickly. When determining whether an individual should be receiving enhanced case management (based on the change in criteria) assessing the risk and potential of risk is necessary. Each individual who is moving in or out of enhanced case management should be assessed and the outcome of the assessment should be well documented either in a progress note or on an assessment “form”.

This instruction and guidance does not specify a specific assessment, but it is suggested that a review of current medical conditions, current medications, and any recent changes to medications, falls, recent changes in behaviors and recent medical procedures be reviewed. Upcoming medical procedures or any changes in living arrangements should also be reviewed. As previously stated the assessment needs to be clearly documented as this will demonstrate to Licensing and Human Rights in their reviews, that appropriate action was taken.

TRAINING CENTER
POST MOVE MONITORING REPORT

SECTION A:

Individual: **Monitoring Staff:** **Monitor Date:**

Discharge Date: Time Frame: ☐ 1-3days ☐ 4-10days ☐ 11–17days ☐ Other

Discharge Coordinator: **CIM:** **Social Worker:**

Residential Support: **Vocational/Day Program:**

Authorized Representative: **CSB Support Coordinator:**

SECTION B:

Source of Information and Name of Contact:	Contact Date	Method of Contact	Person Responsible	Others Involved
Individual		☐ Face-to-Face		
CSB Support Coordinator		☐ By Phone ☐ Face-to-Face		
Residential Provider/staff		☐ By Phone ☐ Face-to-Face		
Supported Employment/Day Provider		☐ By Phone ☐ Face-to-Face		
AR/Guardian		☐ By Phone ☐ Face-to-Face		

Contact Notes:

SECTION C:

Describe type of Employment or Day Support Activities:

1. **Are all of the Essential Supports identified in the Discharge Plan being provided?**

Essential Support	Document Observation and/or Evidence	Observed		Additional Training		
		YES	NO	Needed	Date Completed	Person Responsible
		☐	☐	☐Yes ☐No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		

Follow Training Center Protocol for reporting emergencies and health and safety concerns to ensure compliance with mandated reporting.

		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
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		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		

Follow Training Center Protocol for reporting emergencies and health and safety concerns to ensure compliance with mandated reporting.

Please describe any 1) outstanding issues or concerns under each question, 2) list evidence reviewed to verify information 3) request related documentation and attach:

2. Does the Individual and/or AR express satisfaction with his/her new life? ☐ Yes ☐ No

3. Are there any relationship or family concerns? ☐ Yes ☐ No

4. Are there any medical needs that require further support? ☐ Yes ☐ No

5. Has the individual remained free of injury/illness? ☐ Yes ☐ No
   (If no, request incident reports and/or ID Notes)

6. Were the medical and other provider appointments kept as stated in the discharge plan? ☐ Yes ☐ No

   Please provide written documentation verifying the appointment.

Medical Appointment	Date of Appointment	Medical Provider

7. Are there any behavioral needs that require further support? ☐ Yes ☐ No

8. Were there any behavioral incidents? ☐ Yes ☐ No
   (If yes, request incident reports and/or ID Notes)

9. If so, did staff feel equipped to manage them? ☐ N/A ☐ Yes ☐ No

10. Additional Areas of concern: ☐ Yes ☐ No

11. Have there been any medication changes? ☐ Yes ☐ No

    (If response is yes, list the medications changed, date of change and reason for changes, request copy of Physicians Orders **regardless review individuals MAR**)

Medications Changed	Date of change	Reason for Change

12. Are there additional supports that can be provided for the individual or provider? ☐ Yes ☐ No
13. Do they require a Community Resource Consultant Referral? ☐ Yes ☐ No

Support requested/needed	Date requested	Target Date	Date completed	Person/s Responsible	Additional information

Follow Training Center Protocol for reporting emergencies and health and safety concerns to ensure compliance with mandated reporting.

SECTION D:

ACTION PLAN FOR AREAS OF CONTINUED MONITORING OR FOLLOW-UP

Action Item ***Note: If this is an action item from previous monitoring report**	**Target Date**	**Date Completed**	**Person Responsible**	**Others Involved**

Additional Comments:

Signature of Person Completing Monitor

Date

Follow Training Center Protocol for reporting emergencies and health and safety concerns to ensure compliance with mandated reporting.

Waiver Management System (WAMS) Community Services Boards User Guide

January 2018

Version 2.0

Virginia Department of Behavioral Health & Developmental Services (DBHDS)

Created and customized for you by Dee Dee Thomas, WaMS Training Services on January 3, 2018.

Table of Contents

1 Navigating the WaMS Environment

1.1 About WaMS

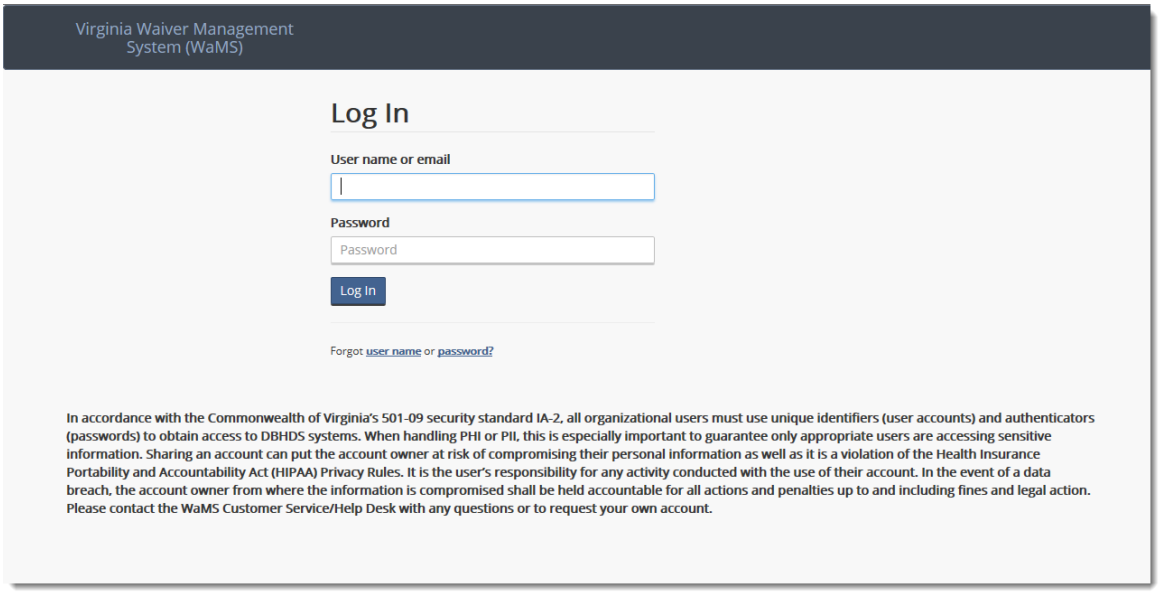
The **Waiver Management System** (WaMS) is a web hosted data management system used to manage waivers. WaMS interfaces with the **Virginia Medicaid Management Information System** (VAMMIS), and establishes the assessment levels (of care) based on an individual's needs and automates the authorization process. WaMS is customized to allow a single process for service authorizations for all three waivers (Community Living, Family and Individual Supports, and Building Independence) supporting individuals with intellectual or developmental disabilities (ID/DD).

1.2 Become familiar with the WaMS environment

The options and view that is available in WaMS is based on the assigned role. Take time to use the various tabs and tools in WaMS to determine how to best support your workstyle by using the *Dashboard*, *Alerts*, *My Lists*, *Assignments* and *Service Authorization* tabs. See more information on using these tabs below.

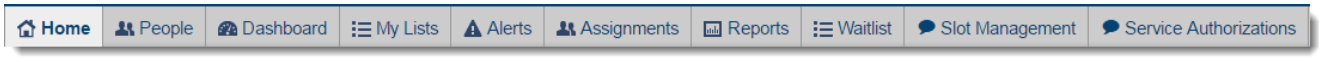
1.3 Log In to WaMS

1. From an internet browser type: ***https://www.wamsvirginia.org*** in the address bar.
2. Type in your **User name** or **Email**.
3. Type in your **password**.
4. Click on **Log In**. *WaMS opens to the Home page. What you see in WaMS is based on the role that has been assigned.*



1.4 Navigating WaMS

The tabs at the top of the WaMS window are useful for high-level navigation through the system. The following tabs are included in the top-level navigation:



1.4.1 Home Tab

The **Home** tab is the landing page upon logging in to WaMS and consists of the following sections:

- Announcements: This section provides important announcements as needed
- Recent Alerts: This section describes systems alerts for WaMS
- Recent System Updates: This section displays announcements regarding WaMS system enhancement based on user requirements.
- Upcoming Events: This section displays information regarding any upcoming events such as training.
- Technical Support: This section contains contact information, such as the helpline number and email for WaMS technical support.
- Training Manuals, Webinars, and FAQs: This section provides detailed instructional materials, user guides, presentations and video recordings on how to use WaMS.

1.4.2 People Tab

The **People** tab is used to search for and add new individuals to the WaMs environment.

1.4.3 Dashboard Tab

The **Dashboard** provides a snapshot of what should be worked on in WaMS. It is divided in to three sections to provide a quick glance of *Calendar* events (manually added and system generated), your 10 most recent *Alerts* and *To-Do List* in WaMS.

1.4.4 My Lists Tab

The **My Lists** tab allows for locating a subset of persons based on a specific criteria or category as defined in the drop down list. For example, view a list of all persons based on the status of *Enrollment, Retain Slot*, *Individual Support Plan* and *Service Authorization*. Lists are available based on the agency and role of the user logged in.

1.4.5 Alerts Tab

Alerts are notifications sent of actions and updates that have been made to a specific person's file.

1.4.6 Assignments Tab

The **Assignments** tab is where the *Support Coordinator* is assigned to a person.

> **Note**: The only information another Support Coordinator or other member of the organization can access for a person who is not assigned to them is the *Personal Summary*, *Personal Profile* and *CSB Assignment*.

1.4.7 Reports Tab

The **Reports** tab provides access to a variety of canned reports available in WaMS based on the staff member's role. Reports can be quickly created. For example, *Waitlist by CSB Detail, Waitlist by CSB Summary* and *Statewide Summary and Detailed Waiver* reports.

> **Note**: Data for all the canned reports is for the day before and is "real time" data for that date.

1.4.8 Waitlist Tab

The **Waitlist** tab is used to view Waitlist status based on search criteria. Search options include searching for a specific individual, individuals with a particular waitlist status, date and/or service requested.

1.4.9 Slot Management Tab

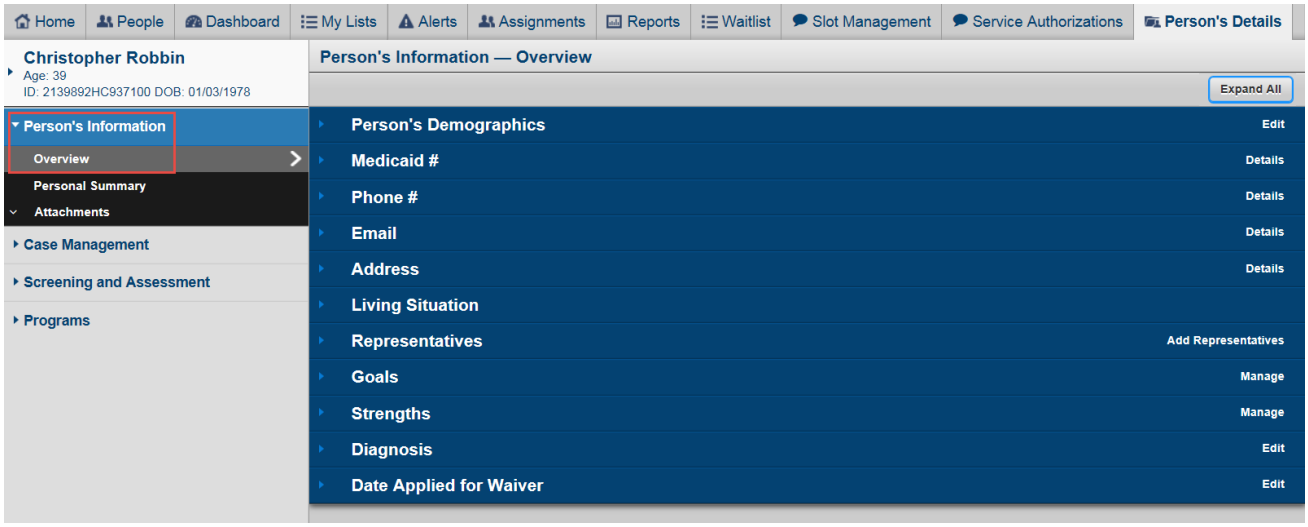
The **Slot Management** tab is used to see if a slot is available by Waiver type. View the slot for a specific individual by typing in their information into the search criteria.

1.4.10 Service Authorizations Tab

The **Service Authorizations** tab provides a more direct access to Service Authorizations. Search by the person's name, the provider, status or by any other available options.

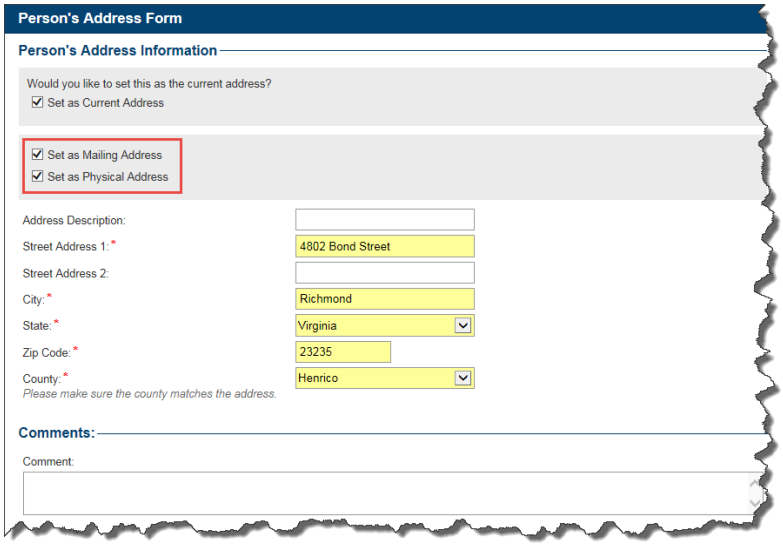
IMPORTANT: While certain features are *required* components of WaMS (i.e., denoted with red asterisks and/or yellow highlights) it is essential that ALL individuals in WaMS (including those currently assigned to a waiver or assigned to active status on the Waitlist) have the following elements completed in their WaMS record for successful Waiver Enrollment:

Each of the following elements can be found and modified under *Person's Information*, *Overview* section in WaMS. (*See Section2.2.9: Update Person's Information/Overview Page, for additional details*).

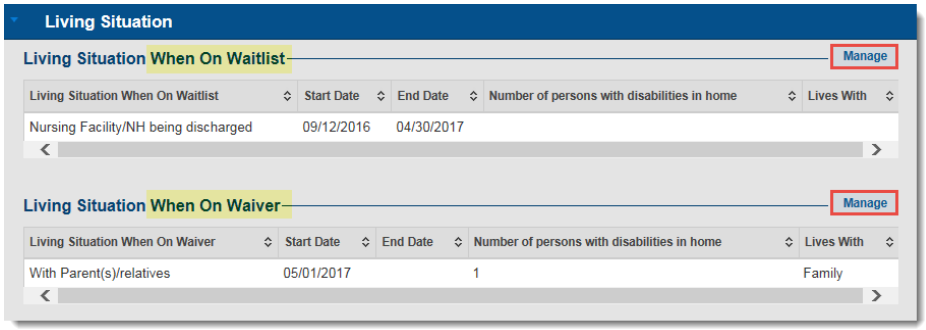


Medicaid #: The Medicaid number is mandatory for all NEW enrollments..

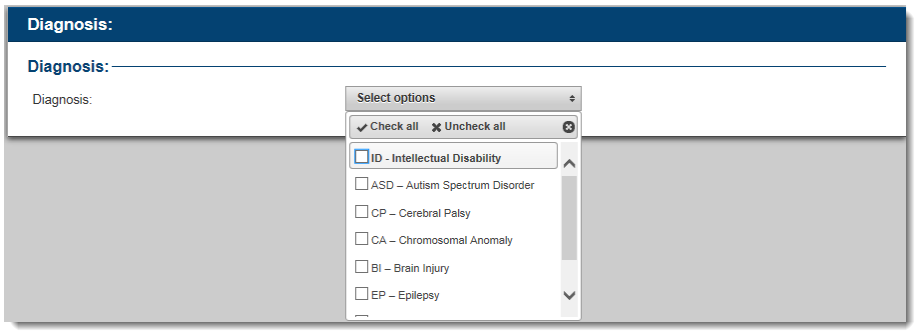
Address: The physical address of where the person resides. This address should be updated when the individual moves to a new residence. (*See Section 2.2.4: Add Person's Address, for additional information).*



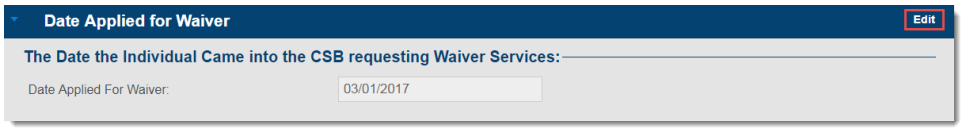
Living Situation: Click on **Manage** to update the person's *Living Situation when on Waitlist* or their *Living Situation when on Waiver*.



Diagnosis: A *diagnosis* is required in WaMS for each individual on the Waitlist and for those individuals that are receiving a Waiver. The diagnosis can be updated in the *Diagnosis* section. *(See Section2.2.6: Add Diagnosis, for additional detail).*



Date Applied for Waiver: Click on **Edit** to add the date the individual came to the CSB to request service.

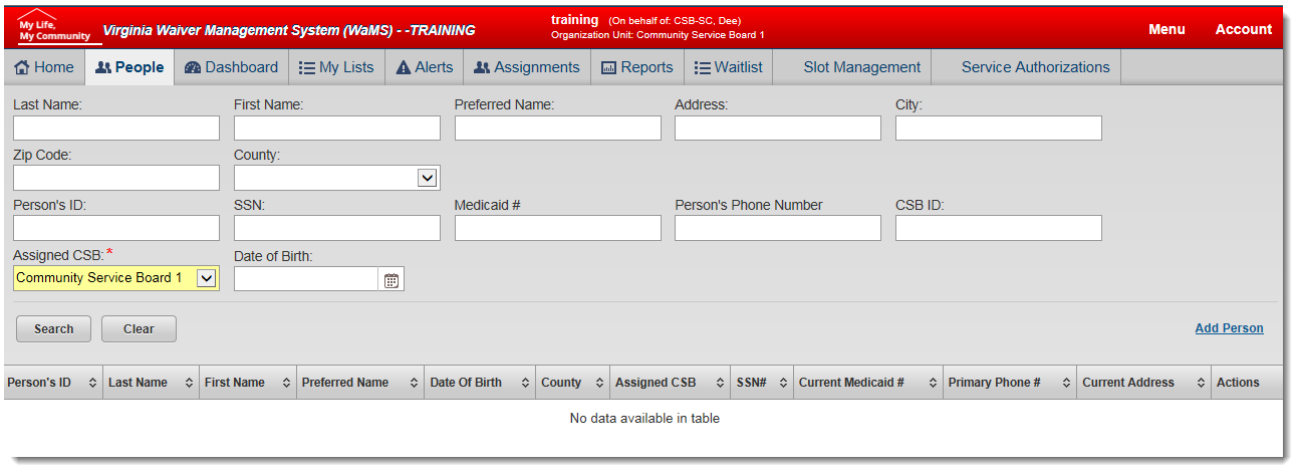


2 The People Tab

The *People* tab is used for searching for current *and* adding new individuals to the WaMs environment.

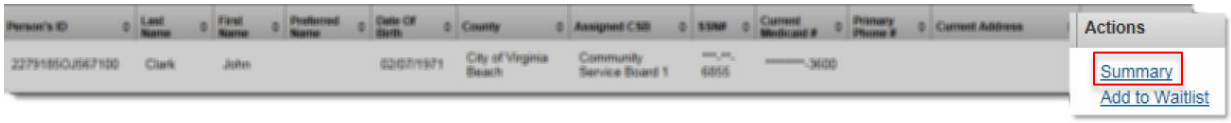
2.1 Locate an Existing Individual's Profile

Use the **People** tab to locate individuals in WaMS:



1. Click the **People** tab.
1. Type in the criteria for the individual you are looking for (i.e., **Last Name**, and **First Name)**.
2. Click **Search**. *The search results will display a list of individuals that meet the search criteria. If there is no match, the **Create Person Notice** box will appear indicating that a profile does not currently exist.*
3. Click on **Summary** link under *Actions* to open the person's record.

> **Note**: Input as much information as you know in each field to retrieve the most accurate search.

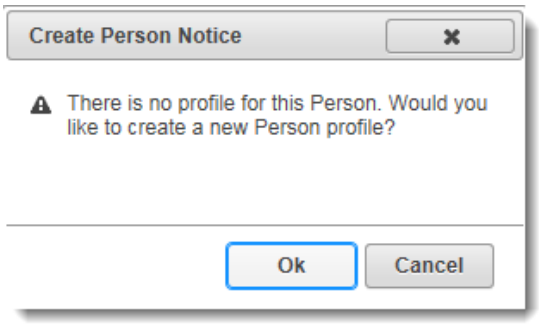


2.2 Add a New Individual to WaMS

Use the **People** tab to add new individuals in WaMS:

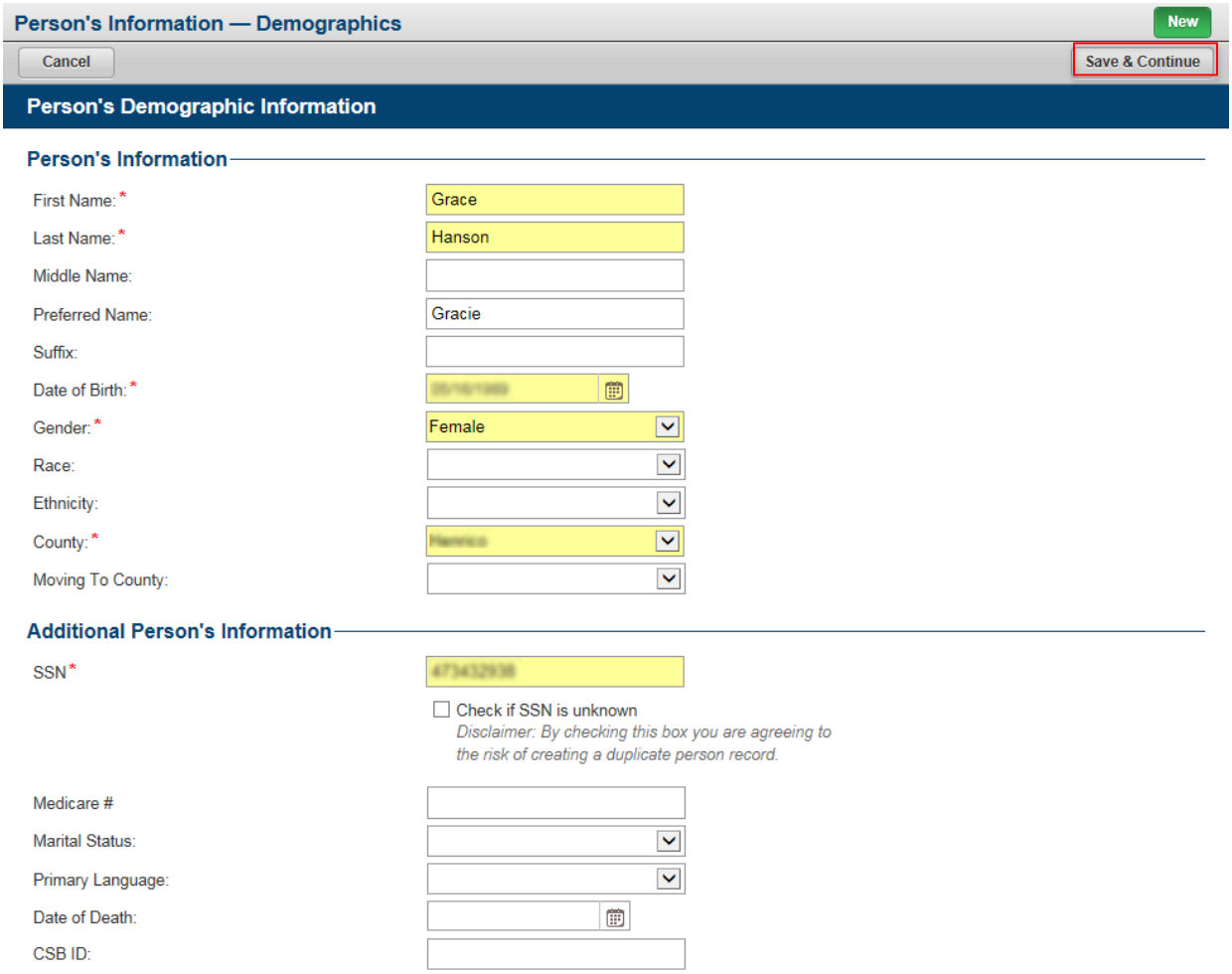
1. Click the **People** tab.
4. Type in the criteria separately in each field for the individual you are looking for (i.e., **Last Name**, **First Name** or **Social Security)**.
5. Click **Search.** If there is no match, the **Create Person Notice** box will appear indicating that a profile does not currently exist.

> **Note**: Search for an individual first before adding to ensure that person is not already in WaMS.



6. Click **OK**. *The New Person's Demographic Information page appears.*

> **Note**: The **Add Person** link on the *People* tab can also be used to add a new individual (without searching).



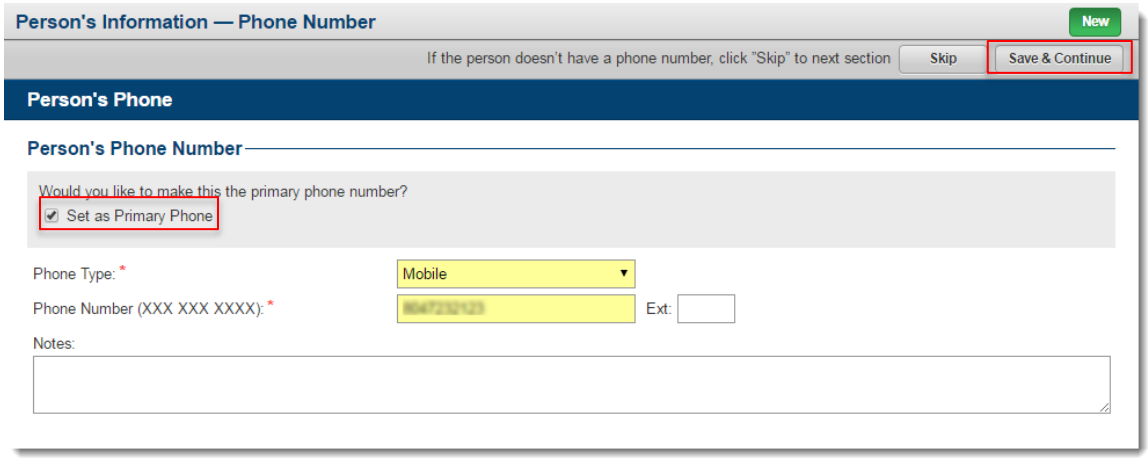
2.2.1 Add Person's Demographics Information

Complete the new person's demographic information. Fields that are *yellow* with a *red* asterisk (*) are required.

1. Complete all required fields (*First Name, Last Name, Date of Birth, Gender, County* and *SSN*).
2. Input as much optional information as possible.
3. Click **Save & Continue**.

> **Note**: If the individual SSN is not known click the checkbox to accept the risk of creating a duplicate person record.

2.2.2 Add Person's Phone



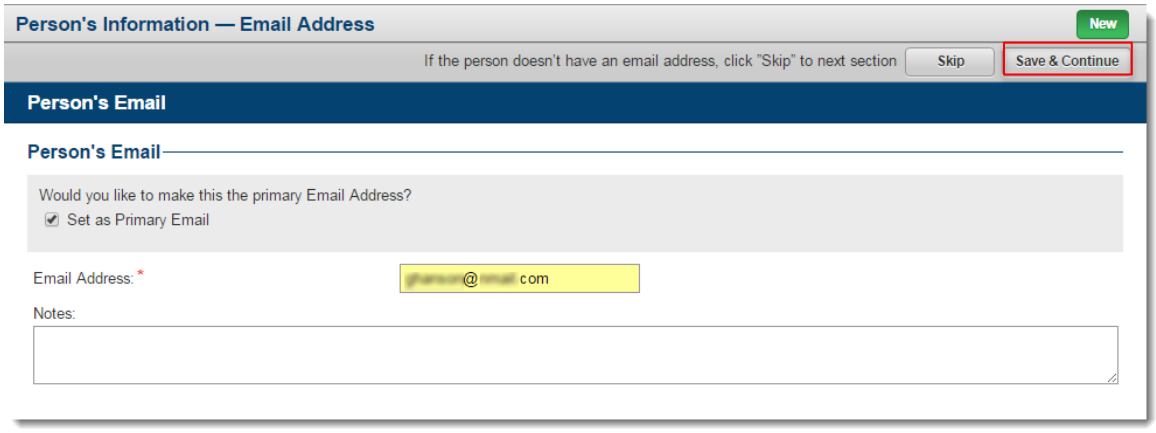
1. Complete all required fields (*Phone Type* and *Phone Number*). If the person does not have a phone number, click **Skip.**

> **Note**: Place a check in the "**Set as Primary Phone**" checkbox in order for the phone number to be visible in the *Overview* section of the person's profile

2. Add Notes if necessary.
3. Click **Save & Continue**.

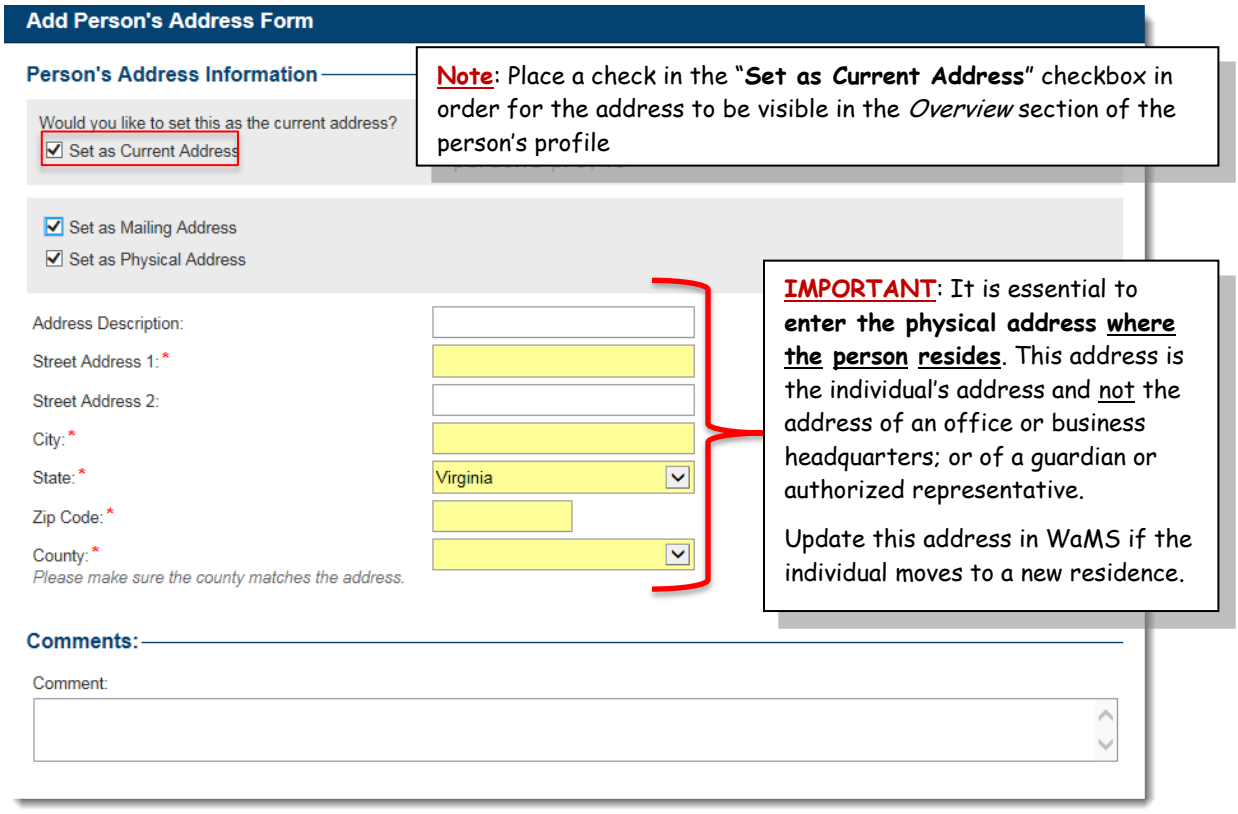
> **Note**: Additional phone number(s) may be added from the Person's Overview page. 1) Choose *Overview -> Phone # ->* 2) Click **Details**, 3: Click **Add Person's Phone Number**.

2.2.3 Add Person's Email



1. Complete all required fields (*Email Address*). If the person does not have an email, click **Skip.**
2. Add Notes if necessary.
3. Click **Save & Continue**.

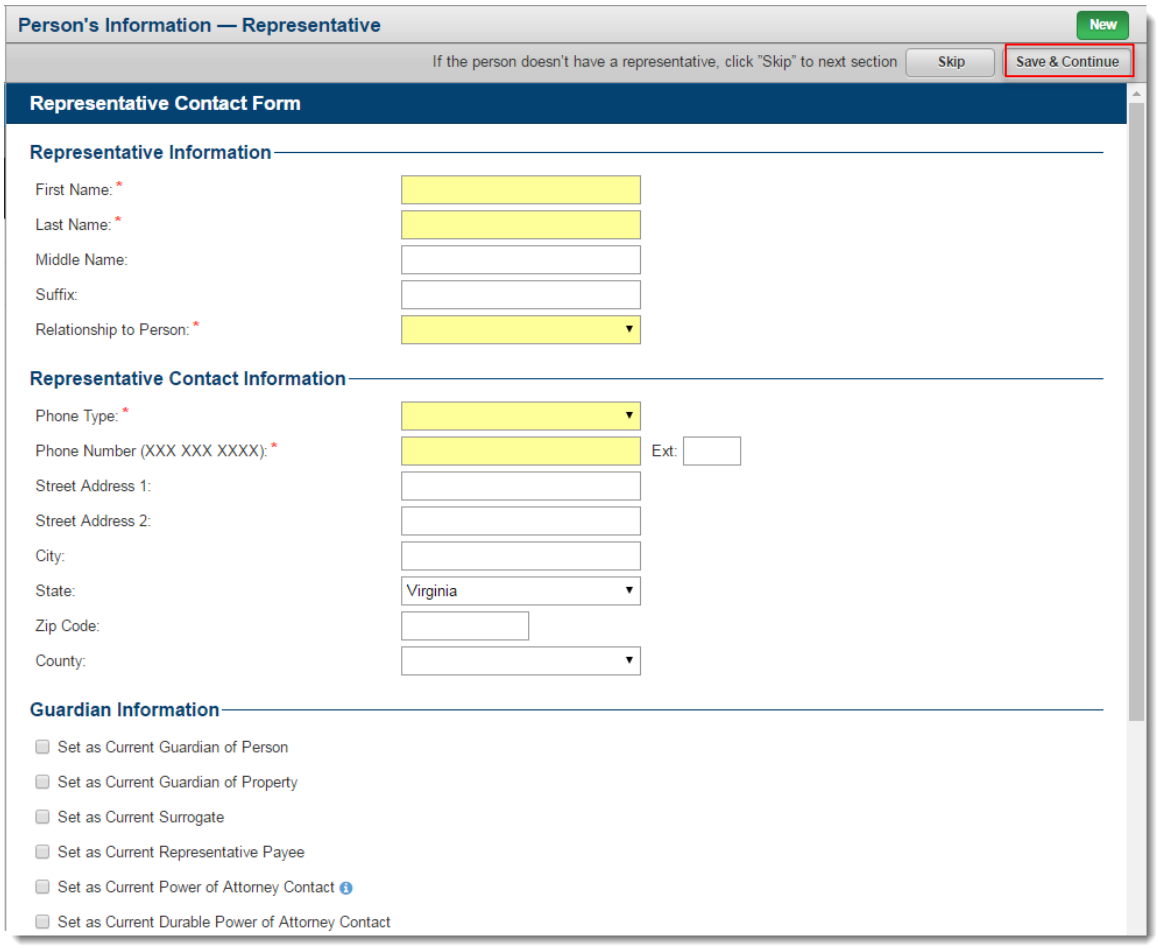
2.2.4 Add Person's Address



1. Complete all required fields (*Street Address 1, City, State, Zip Code, County*). If the person's address is unknown, click **Skip**.
2. Add **Comments** if necessary.
3. Click **Save & Continue**.

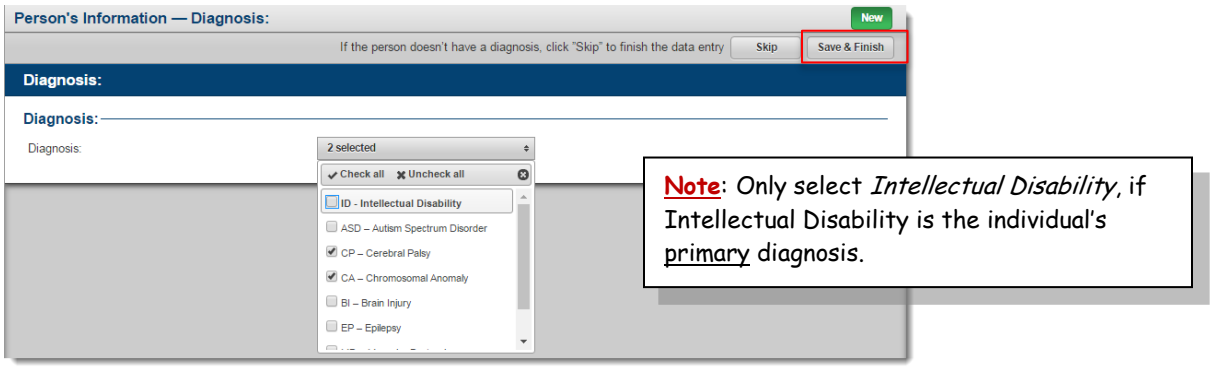
> **Note**: Additional address(es) may be added from the Person's Overview page. 1) Choose *Overview* -> *Phone #* -> 2) Click **Details**, 3: Click **Add Person's Phone Number**.

2.2.5 Add Representative Contact



1. Complete all required fields for contact (*First Name, Last Name, Relationship to Person, Phone Type, Phone Number*). If the person does not have a known representative, click **Skip**.
2. Input as much optional information as possible.
3. Add Comments if necessary.
4. Click Save **& Continue**.

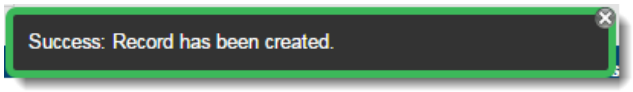
2.2.6 Add Diagnosis



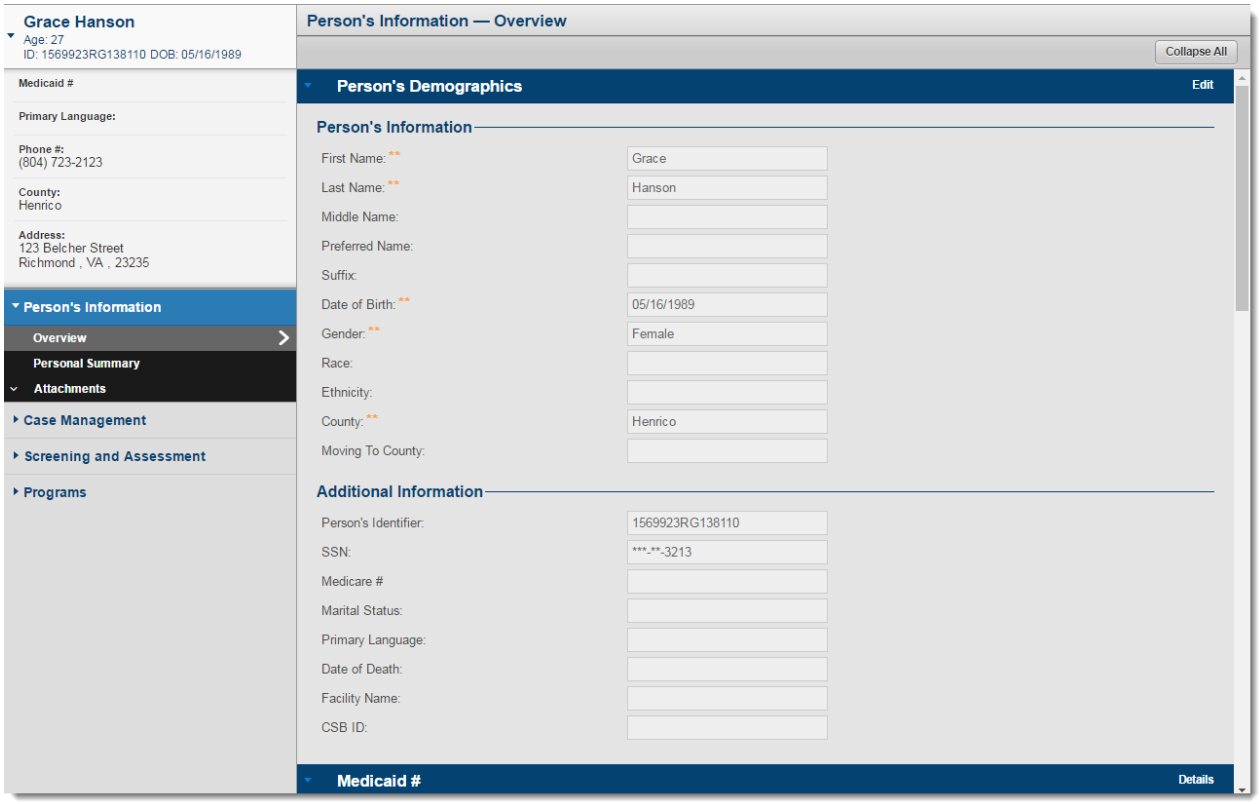
1. Click the drop down arrows to select the Diagnoses (select as many as needed).
2. Click **Save & Finish**.

   The individual has now been added to WaMS.

> **Important**: The diagnosis is required for an individual to be added to the Waitlist or receive a waiver.



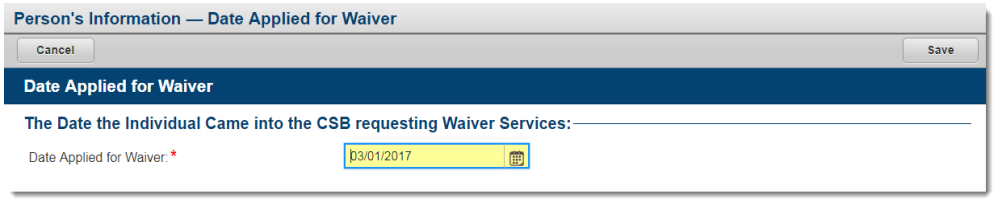
*The **Overview** page appears:*



2.2.7 Date Applied for Waiver

Add the date the individual came to the CSB to request Waiver services.

1. Scroll to the bottom of the *Overview Page*.
2. Click on **Edit**. *The Person's Information – Date Applied for Waiver window appears.*
3. Click in the *Date Applied for Waiver* field to select the appropriate date (or type it in the field).
4. Click on **Save**.

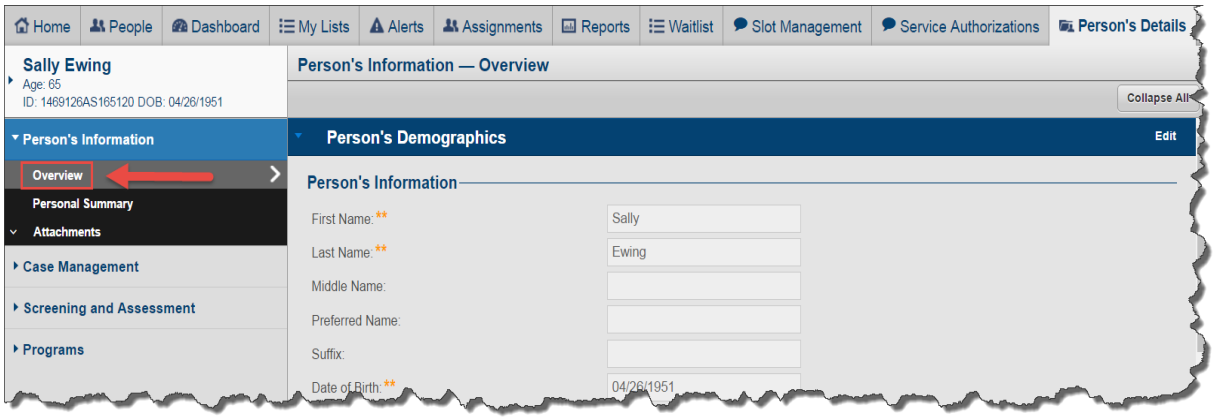


2.2.8 The Overview Page

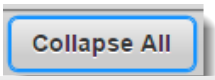
Once an individual has been added to WaMS their *Overview* page will be displayed. The *Overview* page can also be accessed by searching for an individual and clicking the *Summary* link (*Follow steps in Section 2.1: Locate an Existing Individual's Profile above*).

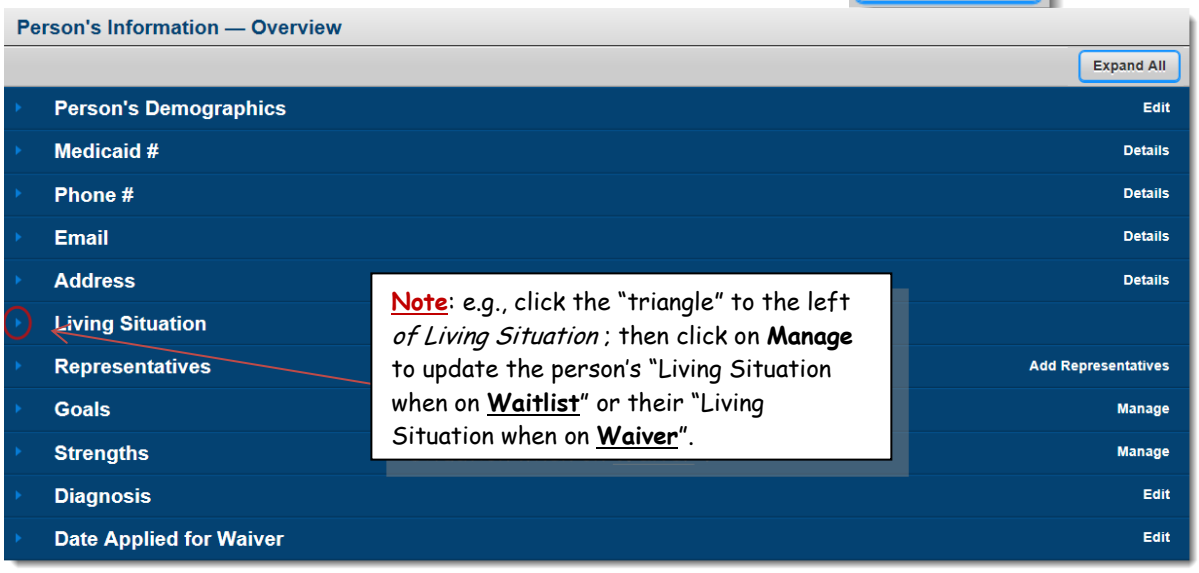
2.2.9 Update Person's Information/Overview Page

1. From the **Person's Details** tab, click on **Person's Information**, **Overview** on the *left navigation bar. The Person's Information – Overview displays.*



2. Click the Collapse **All** button to display *all* sections.





   a. Click **Edit, Details, Manage** and/or **Add Representatives** to update the *Person's information* as necessary.

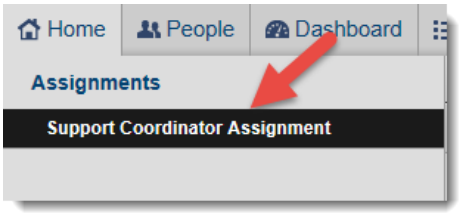
3 Support Coordinator Assignment

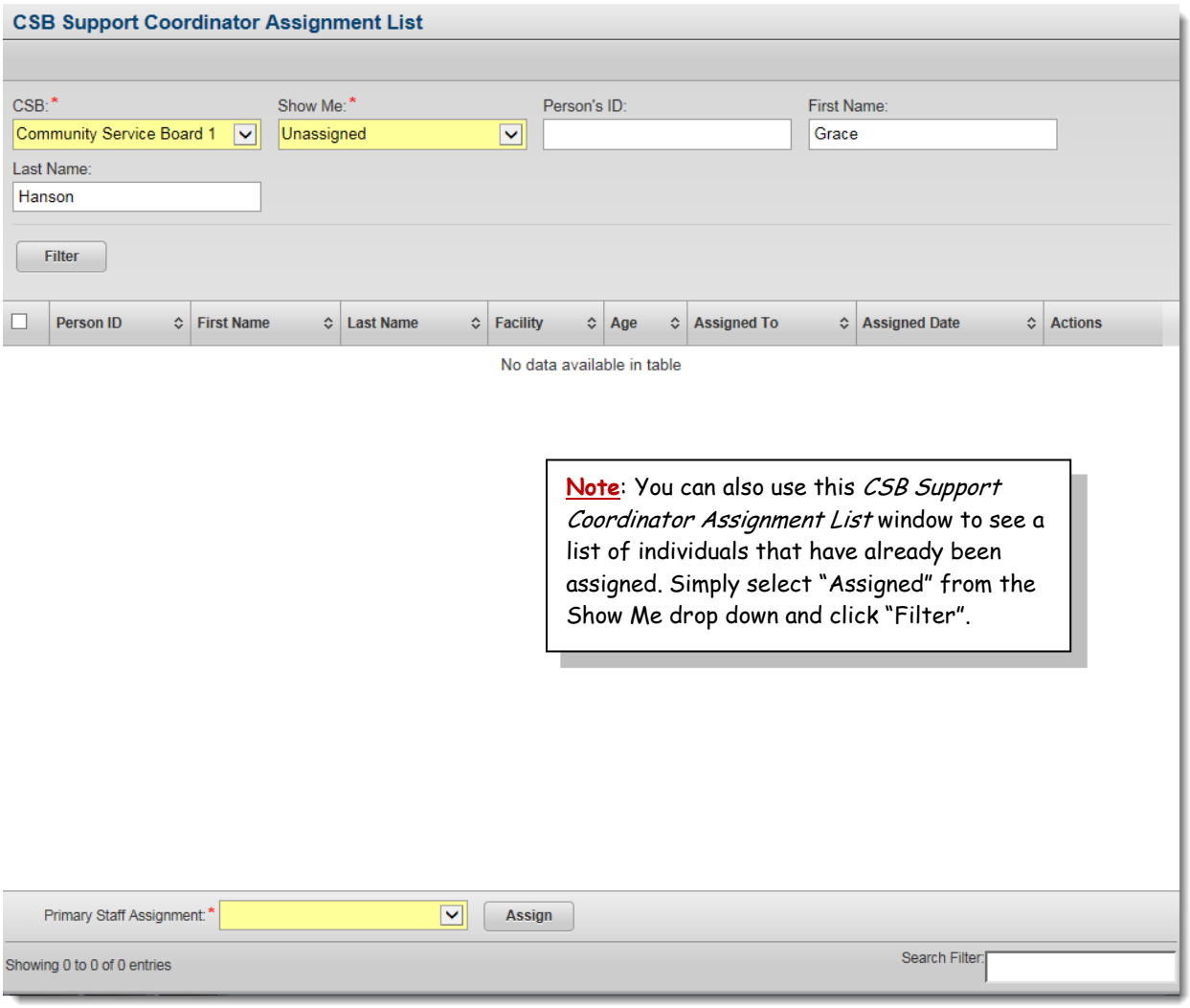
When an individual's profile is created, the individual added to WaMS is automatically assigned to the creating CSB Organization Unit. The **Assignments** tab allows authorized users to assign or reassign staff in their agency to an individual.

3.1 Assign Support Coordinator to an Individual

1. Click the **Assignments** tab.
2. Click on **Support Coordinator Assignment** (located on the left navigation bar).

   The CSB Support Coordinator Assignment List window appears.



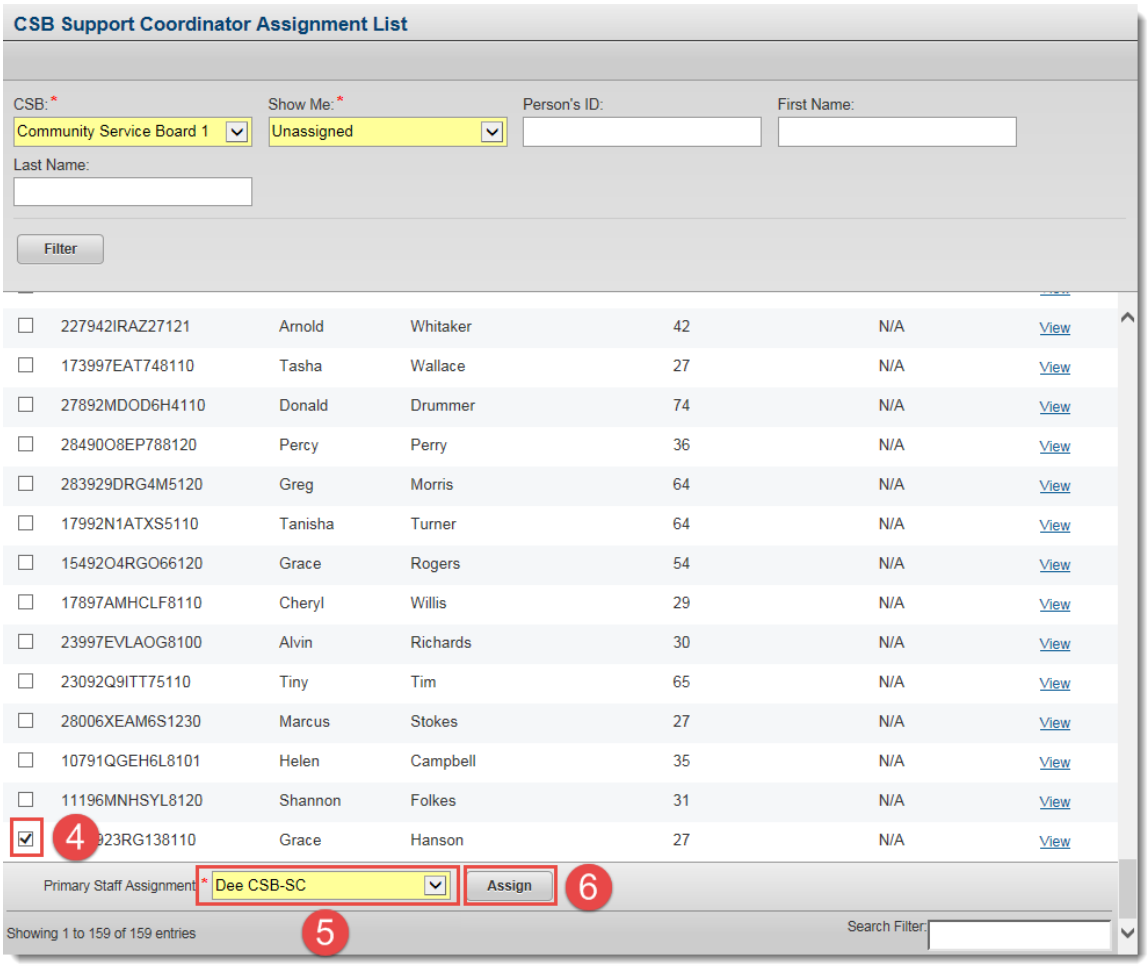


Note: You can also use this *CSB Support Coordinator Assignment List* window to see a list of individuals that have already been assigned. Simply select "Assigned" from the Show Me drop down and click "Filter".

3. Click the **Show Me** drop down list and select **Unassigned**.
4. Click on **Filter**.

A list of all individuals in your Organization Unit (OU) without an assigned Support Coordinator will appear.

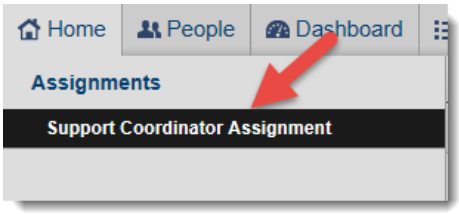
Note: If you are looking for a specific individual, type their ID in the *Person's ID* field, and/or their name in the *First Name* and *Last Name* fields.



5. Click the **check box(es)** next to the individuals' name(s) you wish to assign to a Support Coordinator.
6. Click the **drop down arrow** for the **Primary Staff Assignment** field to select the appropriate Support Coordinator.
7. Click **Assign**. *The newly assigned Support Coordinator will receive an Alert* (shown below).

3.2 Reassign Individual to Different Support Coordinator (Same CSB)

1. Click the **Assignments** tab.
2. Click **Support Coordinator Assignment** (located on the left navigation bar). *The CSB Support Coordinator Assignment List window appears.*
3. Click the **Show Me** drop down list and select **Assigned**.
4. Click on **Filter**. *A list of all individuals Assigned to Organization Unit will appear.*
    a. To filter the list for certain Support Coordinator(s) click the **Staff** drop down list and select the name of the Support Coordinator that the individual(s) is currently assigned to and click on **Filter**.
5. Click the **check box(es)** next to the individuals' name(s) you wish to reassign to a different Support Coordinator.
6. Click the **drop down arrow** for the **Primary Staff Assignment** field to select the *new* Support Coordinator to be assigned.
7. Click **Assign**.

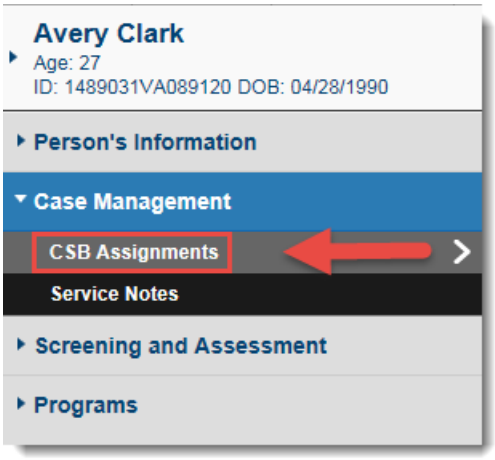


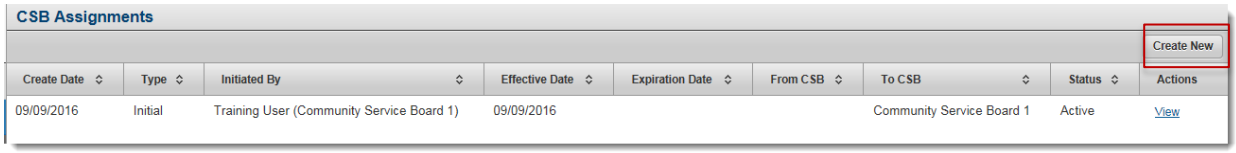
Note: If you are looking for a specific individual, type their ID in the *Person's ID* field, and/or their name in the *First Name* and *Last Name* fields.

3.3 Transfer Individual to a Different CSB

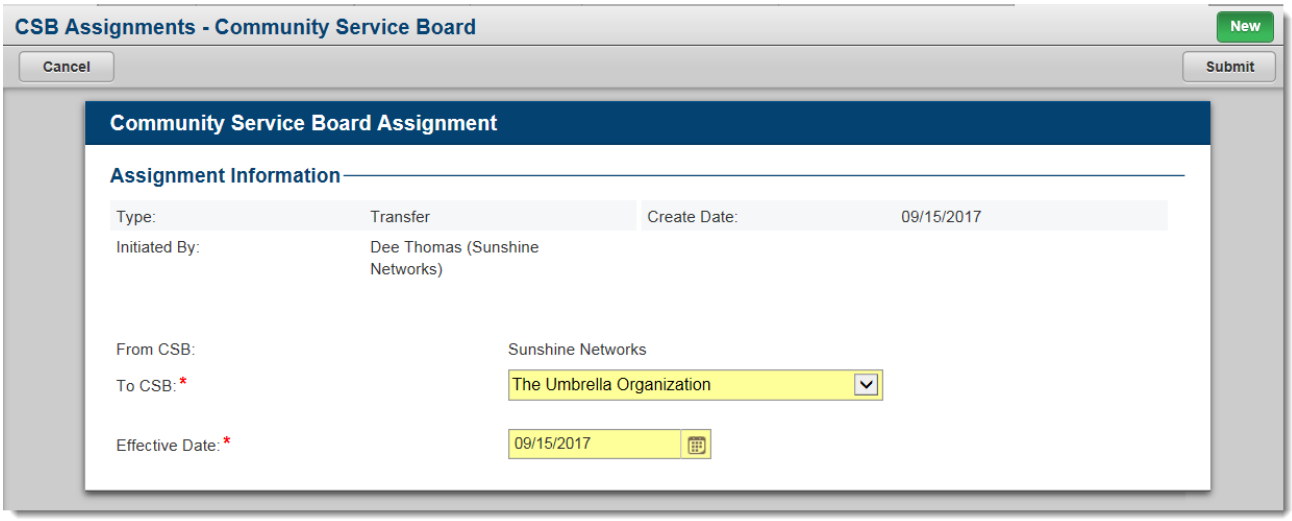
When an individual transfers to another area, the transferring CSB should transfer the individual in WaMS to the newly assigned CSB. This should be completed once the transfer date has been established and the new CSB is ready to accept the case. The transferring CSB's Support Coordinator is responsible for transferring the individual in WaMS.

1. Open the profile for the individual to be transferred to a new CSB. (See steps in ***Section 2.1: Locate an Existing Individual's Profile*** *above*).
2. Click on **Case Management**, **CSB Assignments**. *The CSB Assignment window opens.*





3. Click on **Create New**. *The Community Service Board Assignment dialog box appears.*



4. Click the **To CSB** dropdown arrow to select the CSB the individual should be transferred to.
5. Select the **Effective Date** calendar button to select the appropriate date for the transfer.
6. Click on **Submit**.

Note: The assigned Support Coordinator is automatically "unassigned" by the system when a CSB transfer occurs. A new Support Coordinator will have to be reassigned. Follow steps in Section 3.2 above.

Note: The Transfer will be in "Pending Status" if a future effective date is selected and will be unavailable to the receiving CSB until the effect date occurs.

4 The VIDES Survey

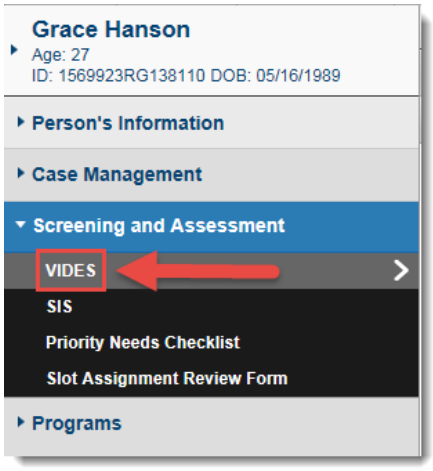
The *Virginia Individual Developmental Disability Eligibility Survey* (**VIDES)** details the process for determining the eligibility and *Level of Care* for infants under age of 3, children aged from 3 to 18, and adults over the age of 18. The **VIDES** must be created and submitted in order to add an individual to the *Waitlist*. The **VIDES** is located under the *Screening and Assessments* section.

> **Note**: The ***Waiver Application Date*** must be added in the *Overview* section before the VIDES can be completed.

4.1 Create a New VIDES

1. **Search** for the individual. (See steps in ***Section 2.1: Locate an Existing Individual's Profile*** *above*).

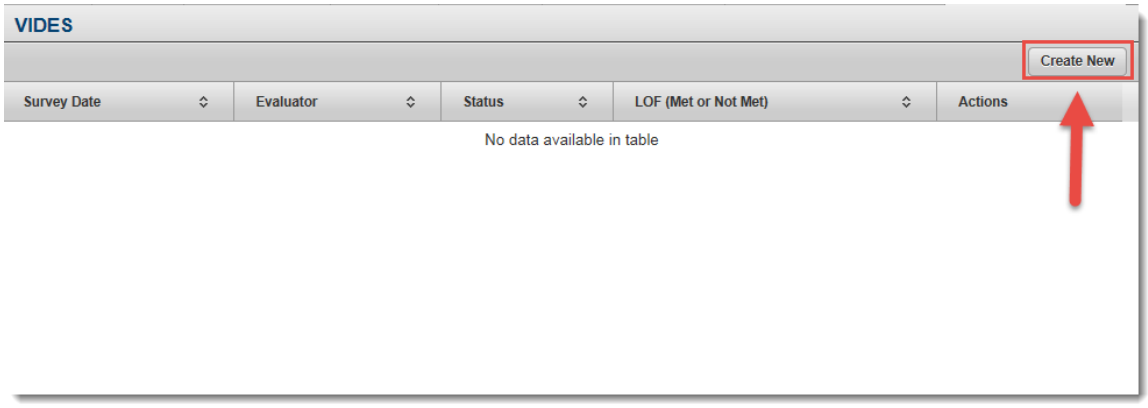
   From the **Screening and Assessments** section on the left navigation bar, click on **VIDES**.



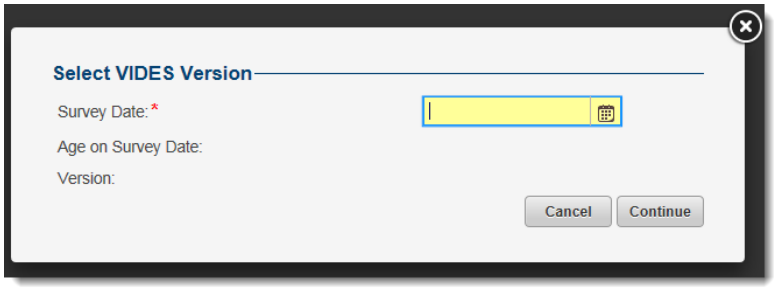
   The VIDES window appears on the right.

4.1.1 Start VIDES Questionnaire

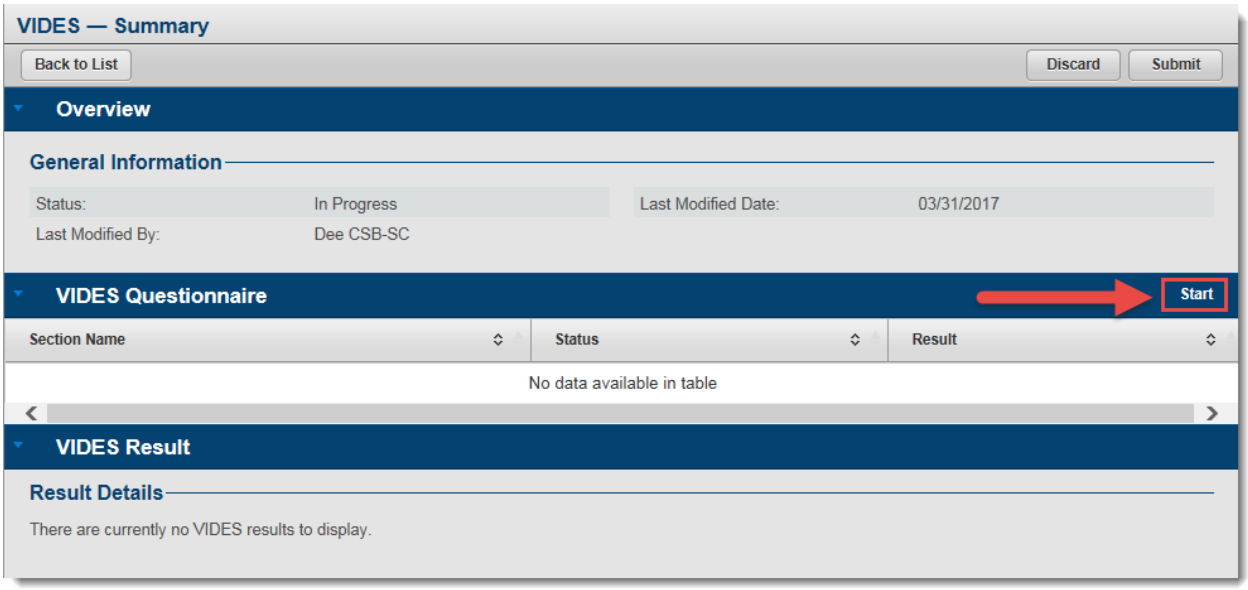
1. Click **Create New**.



The Select VIDES Version dialog box appears.



2. Click the **Calendar** button to select the date for the *Survey Date,* then click **Continue**. *The VIDES Summary window appears.*



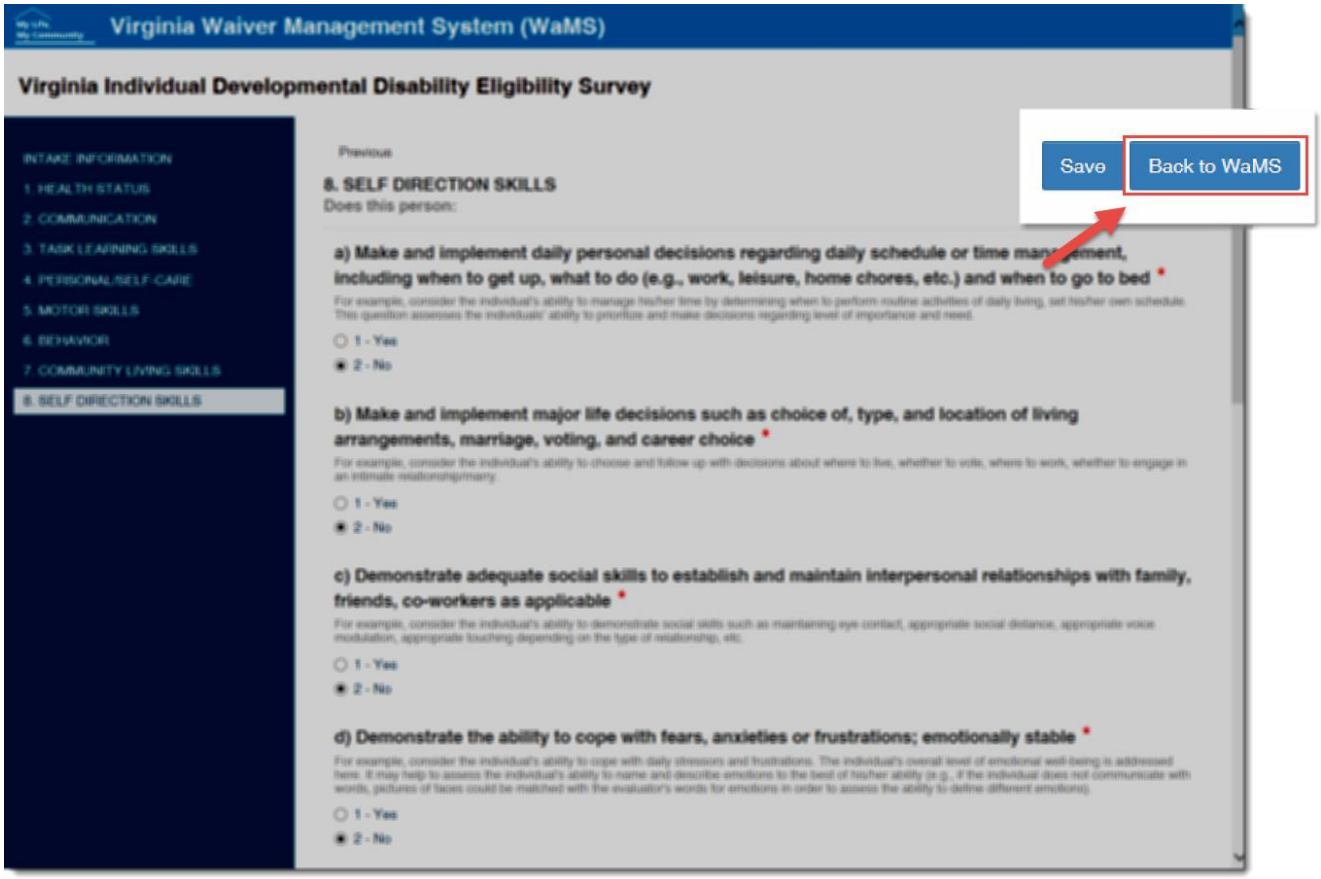
3. Click on **Start** in the *VIDES Questionnaire* section. The *Virginia Individual Developmental Disability Eligibility Survey* form opens in a new browser window outside of WaMS in Dynamic Forms.

4.1.2 Complete VIDES Questionnaire

The correct version of the VIDES (*Adult, Child* or *Infant*) is automatically selected and includes the individual's First and Last Name, Date of Birth, Age on Assessment Date, Survey Date and Evaluator.

1. Click on **Next**.
2. Complete all sections of the VIDES, selecting **Next** to go to each section of the form and adding notes as appropriate.
3. Click **Save** at the end of the last section.

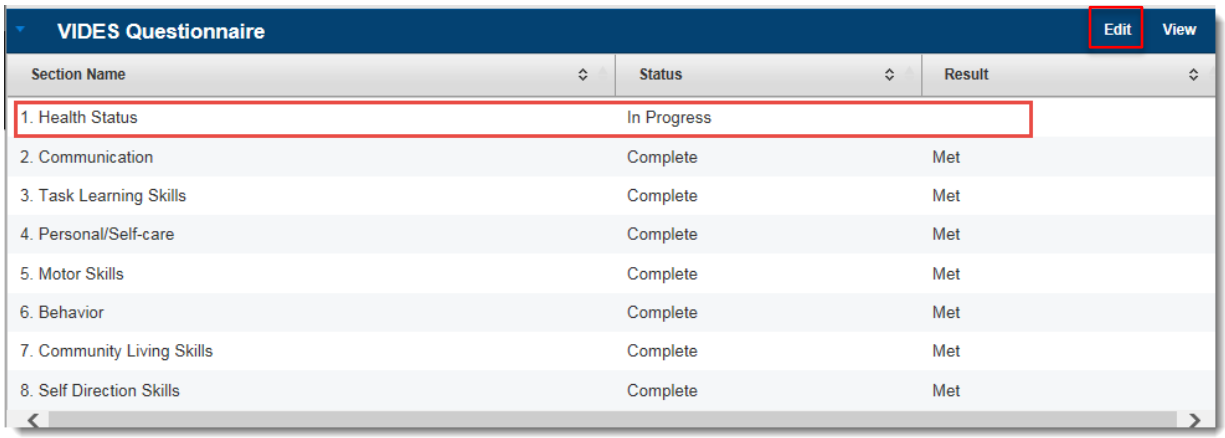
4. Click **Back to WaMS** to return to the WaMS environment.



> **Note**: Any unanswered question(s) will result in an incomplete survey.

4.2 Edit or View VIDES

If any of the questions in the VIDES remain unanswered the status will show as *In Progress* and you must *Edit* to continue.



Section Name	Status	Result
1. Health Status	In Progress	
2. Communication	Complete	Met
3. Task Learning Skills	Complete	Met
4. Personal/Self-care	Complete	Met
5. Motor Skills	Complete	Met
6. Behavior	Complete	Met
7. Community Living Skills	Complete	Met
8. Self Direction Skills	Complete	Met

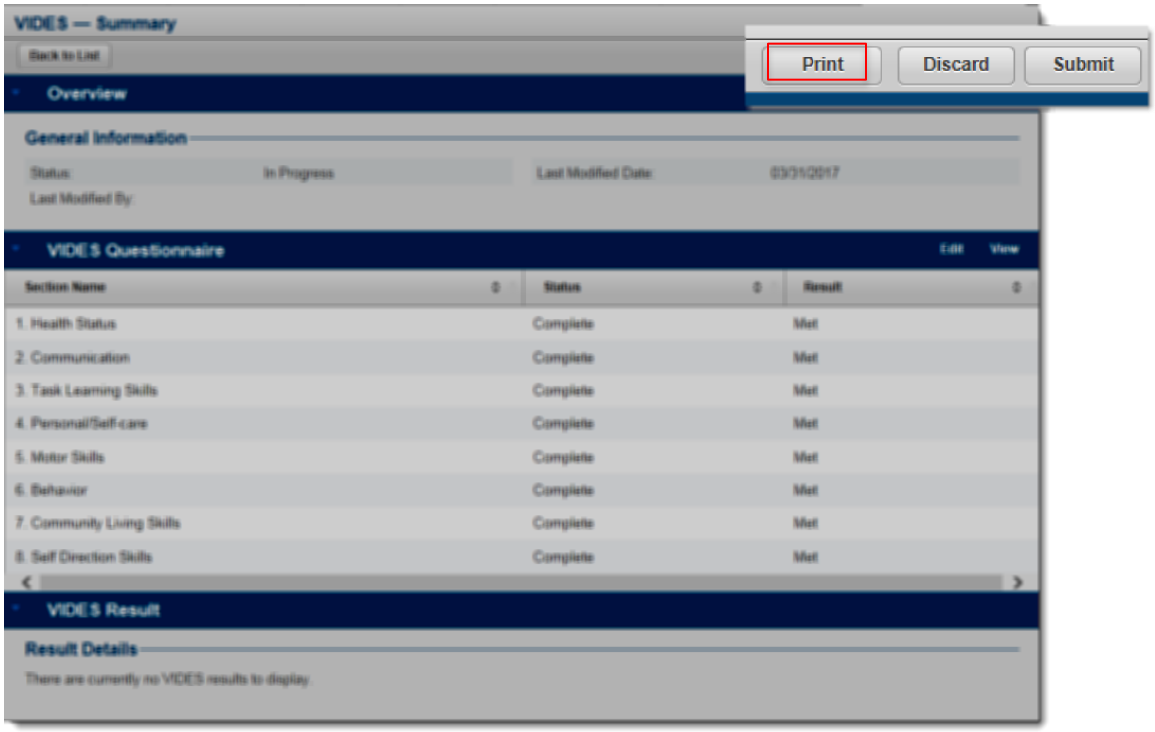
1. If necessary, access **VIDES** under *Screening and Assessment* and click **Summary** to open the **VIDES Questionnaire** page.
2. Click **Edit** in the **VIDES Questionnaire** to make changes or click **View** to review the **VIDES** without making changes.
3. Make updates as necessary.
4. Click **Save**.
5. Click **Back to WaMS**.

4.3 Print VIDES

The **Print** button becomes available for the VIDES once the form is *Complete*.

4.3.1 Print Completed VIDES Questionnaire

1. From the **VIDES Summary** window, click the **Print** button.



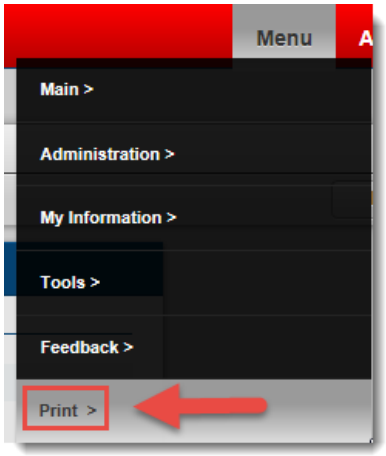
A PDF version of the VIDES Survey form opens in a new window.

2. **Print** (*Control +P, right-click and click Print, or click on the printer icon*) or **download** to *save* the PDF document.

4.3.2 Print VIDES Summary

To print a paper copy of the *VIDES Summary*, use the **Print** option under the **Menu**.

1. From the **VIDES Summary** window, click on **Menu, Print**.



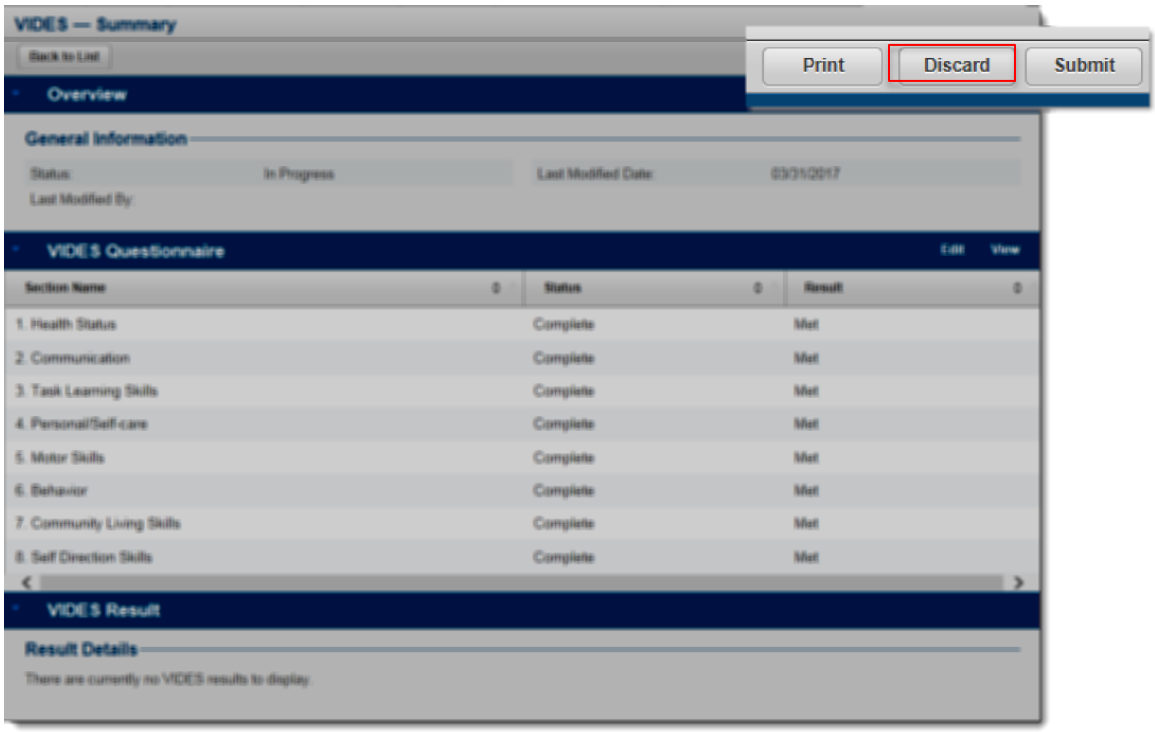
A PDF version of the VIDES Summary page opens in a new window.

2. **Print** (*Control +P, right-click and click Print,* or *click on the printer icon*) or **download** to *save* the PDF document.

4.4 Discard VIDES

If it is necessary, the VIDES can be discarded *before* it is submitted. To discard the VIDES:

1. From the **VIDES Summary** window, click the **Discard** button.



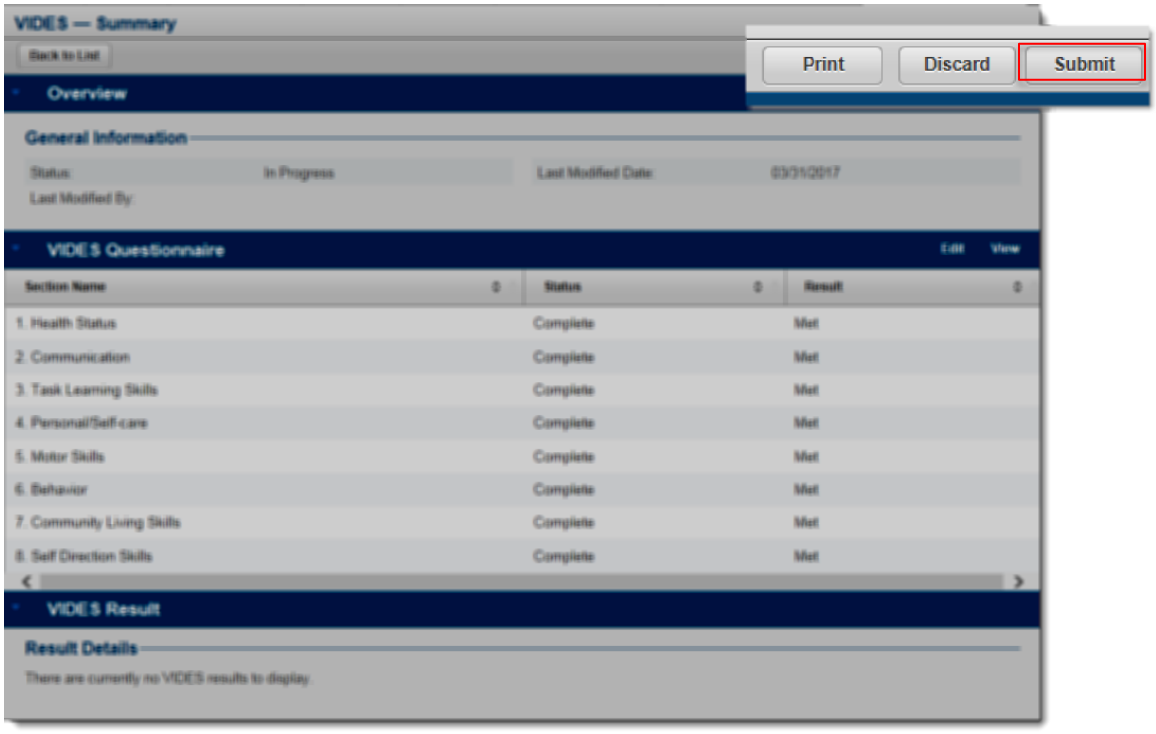
A **discarded** VIDES Questionnaire responses may be viewed or printed by selecting *Screening and Assessments*, *VIDES*.

1. Click the **Summary** link. *The VIDES Summary window opens.*
2. Click **View** *The discarded VIDES opens in a new browser window.*

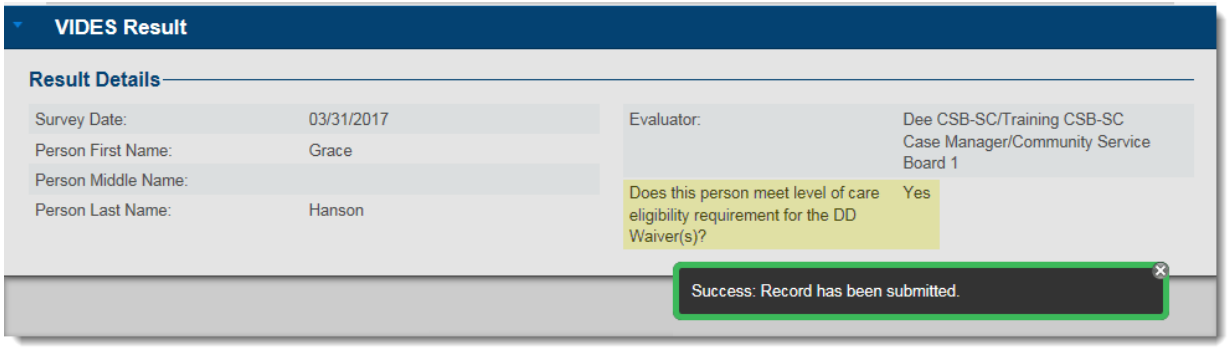
4.5 Submit VIDES

> **Note**: The VIDES is NOT complete until it is submitted!

1. From the **VIDES Summary** window, click the **Submit** button.



The "Success Record has been submitted" message appear and the VIDES results displays.



Points to Remember
• Children of different ages have different question requirements. Their questions will not go in alphabetical order. There may be missing alphabet designations. This is normal.
• VIDES results for each category are visible prior to submission; the results of each section (Met or Not Met) will be displayed once the status of the section is changed to complete.
• The VIDES Questionnaire will reflect the met/not met result for each category in the questionnaire, VIDES Results are not available until the VIDES is submitted in WaMS.
• If an individual has a completed VIDES it will display in the Personal Summary, Eligibility Information, section
• CSBs can create and edit the VIDES; however Providers can only view the VIDES

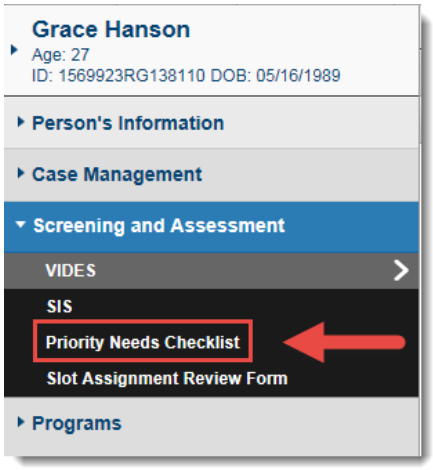
5 The Priority Needs Checklist

The **Priority Needs Checklist** must be completed and submitted in order to add an individual to the *Waitlist*. The checklist identifies the reason an individual falls into priority category (one, two or three) and is completed after the VIDES has been submitted. The **Priority Needs Checklist** is located under the *Screening and Assessments* section.

5.1 Create Priority Needs Checklist

1. **Search** for the individual. (See steps in ***Section 2.1: Locate an Existing Individual's Profile*** *above*).

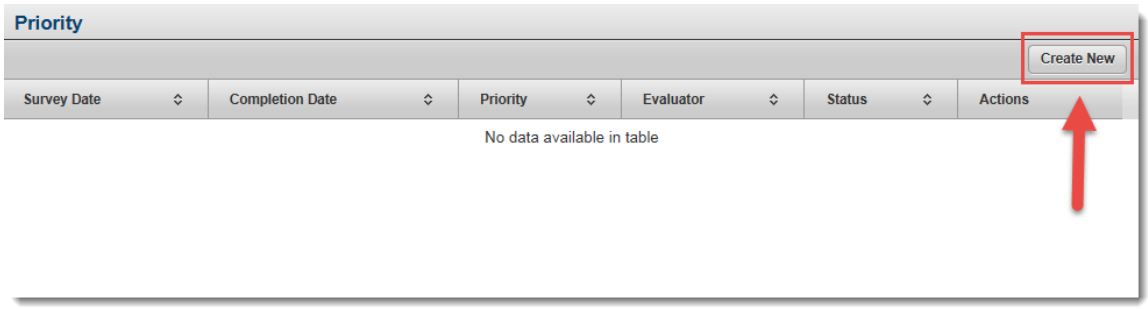
   From the **Screening and Assessments** section on the left navigation bar, click on **Priority Needs Checklist**



   The Priority window appears on the right.

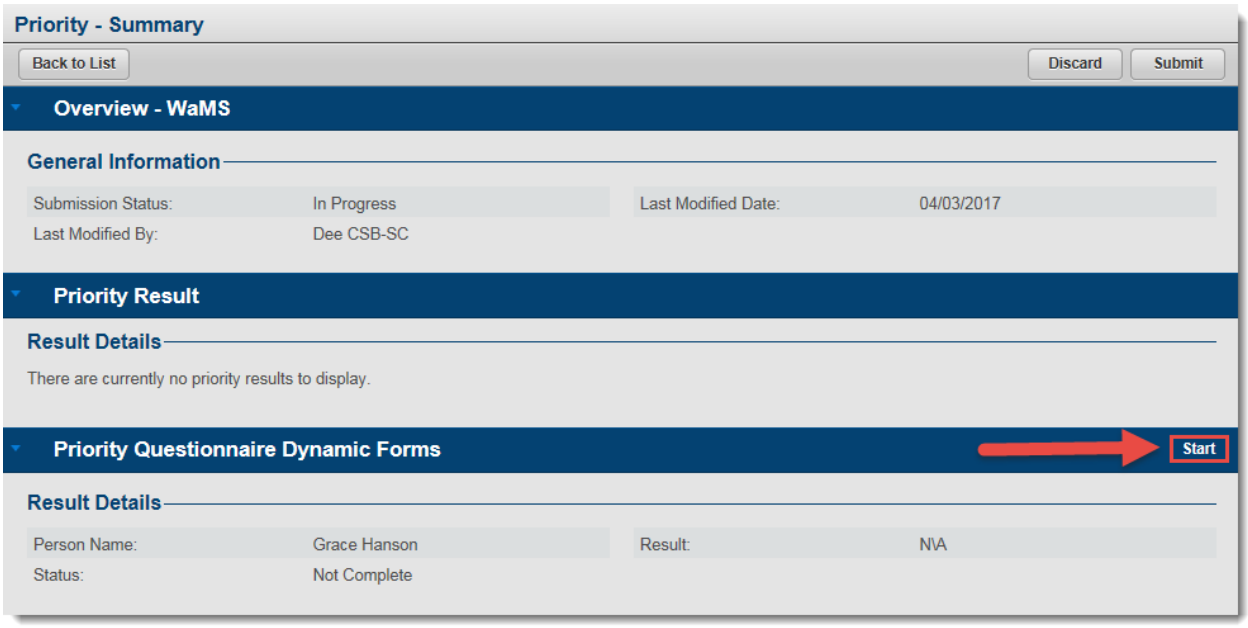
5.1.1 Start Priority Needs Checklist

1. Click **Create New**.



The Priority Survey Date dialog box appears. The survey defaults to the current date and may not be changed.

2. Click **Continue**. *The Priority - Summary window appears.*

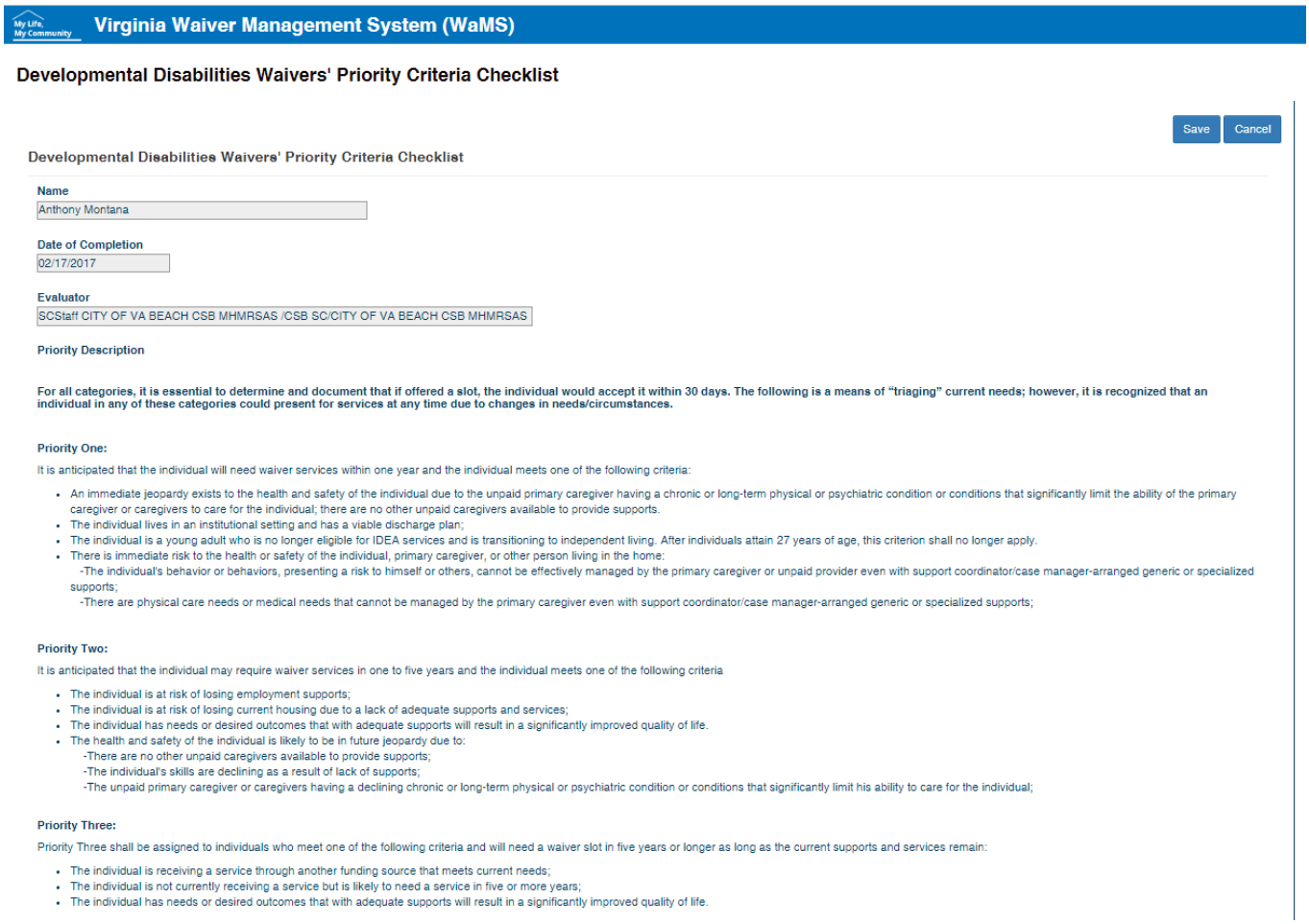


3. Click on **Start** in the *Priority Questionnaire Dynamic Forms* section. The *Developmental Disabilities Waivers' Priority Criteria Checklist* form opens in a new browser window outside of WaMS in Dynamic Forms.

5.2 Complete the Developmental Disabilities Waivers' Priority Criteria Checklist

The top portion (individual's name, completion date and the name of the Evaluator) is automatically filled-in.

> **Note**: For all priorities, it is essential to determine and document that if an individual is offered a slot, the individual will accept it within 30 days.



Virginia Waiver Management System (WaMS)

Developmental Disabilities Waivers' Priority Criteria Checklist

Save Cancel

Developmental Disabilities Waivers' Priority Criteria Checklist

Name
Anthony Montana

Date of Completion
02/17/2017

Evaluator
SCStaff CITY OF VA BEACH CSB MHMRSAS /CSB SC/CITY OF VA BEACH CSB MHMRSAS

Priority Description

For all categories, it is essential to determine and document that if offered a slot, the individual would accept it within 30 days. The following is a means of "triaging" current needs; however, it is recognized that an individual in any of these categories could present for services at any time due to changes in needs/circumstances.

Priority One:

It is anticipated that the individual will need waiver services within one year and the individual meets one of the following criteria:

- An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.
- The individual lives in an institutional setting and has a viable discharge plan;
- The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.
- There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home:
  -The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports;
  -There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports;

Priority Two:

It is anticipated that the individual may require waiver services in one to five years and the individual meets one of the following criteria

- The individual is at risk of losing employment supports;
- The individual is at risk of losing current housing due to a lack of adequate supports and services;
- The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.
- The health and safety of the individual is likely to be in future jeopardy due to:
  -There are no other unpaid caregivers available to provide supports;
  -The individual's skills are declining as a result of lack of supports;
  -The unpaid primary caregiver or caregivers having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limit his ability to care for the individual;

Priority Three:

Priority Three shall be assigned to individuals who meet one of the following criteria and will need a waiver slot in five years or longer as long as the current supports and services remain:

- The individual is receiving a service through another funding source that meets current needs;
- The individual is not currently receiving a service but is likely to need a service in five or more years;
- The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

4. Scroll down the questionnaire form and choose the appropriate **Priority Status** (*One, Two or Three)*:

PRIORITY ONE

It is anticipated that the individual will need waiver services within one year and the individual meets <u>one</u> of the following criteria:

☐ An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.

☐ The individual lives in an institutional setting and has a viable discharge plan;

☐ The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.

☐ There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home

Note: When selecting the last option "*There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home"*, there are additional conditions (select all that are appropriate)

☐ The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports;

☐ There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports

PRIORITY TWO

It is anticipated that the individual may require waiver services in one to five years and the individual meets one of the following criteria

☐ The individual is at risk of losing employment supports;

☐ The individual is at risk of losing current housing due to a lack of adequate supports and services;

☐ The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

☐ The health and safety of the individual is likely to be in future jeopardy

Note: When selecting the last option "*The health and safety of the individual is*, there are additional conditions. (select all that are appropriate)

☐ There are no other unpaid caregivers available to provide supports;

☐ The individual's skills are declining as a result of lack of supports;

☐ The unpaid primary caregiver or caregivers having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limit his ability to care for the individual;

PRIORITY THREE

Priority Three shall be assigned to individuals who meet one of the following criteria and will need a waiver slot in five years or longer as long as the current supports and services remain:

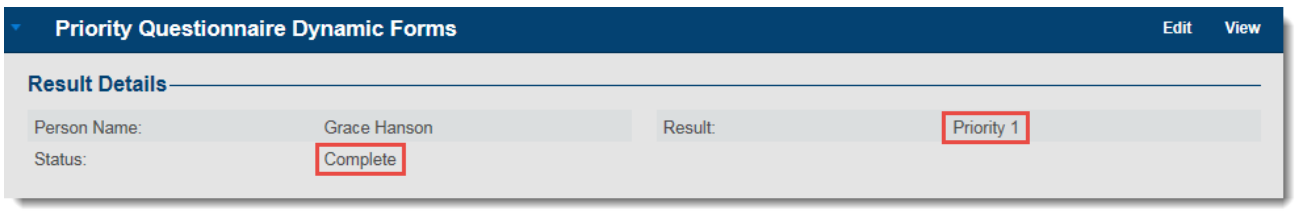
☐ The individual is receiving a service through another funding source that meets current needs;

☐ The individual is not currently receiving a service but is likely to need a service in five or more years;

☐ The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

5. Click on Save.
6. Click on **Back to WaMS**.

   *The Status for the form shows as **Complete** with the **Priority** selected as the Result.*

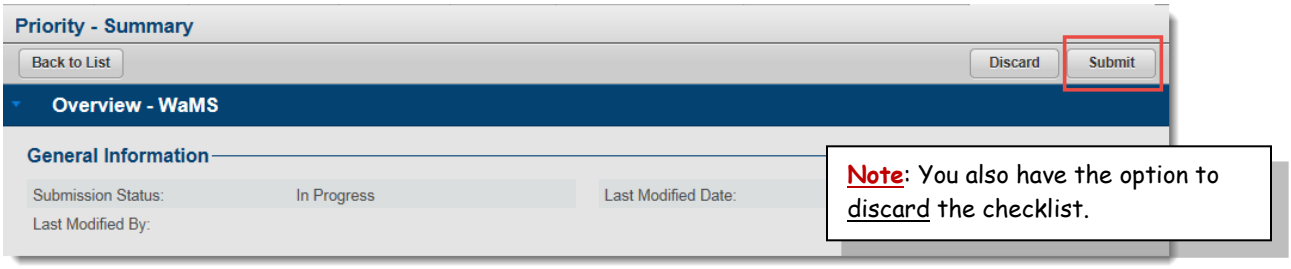


7. Select **Edit** to modify or **View** to see/review the checklist. A new checklist should be completed if the individual's priority level changes.

5.3 Submit Priority Needs Checklist

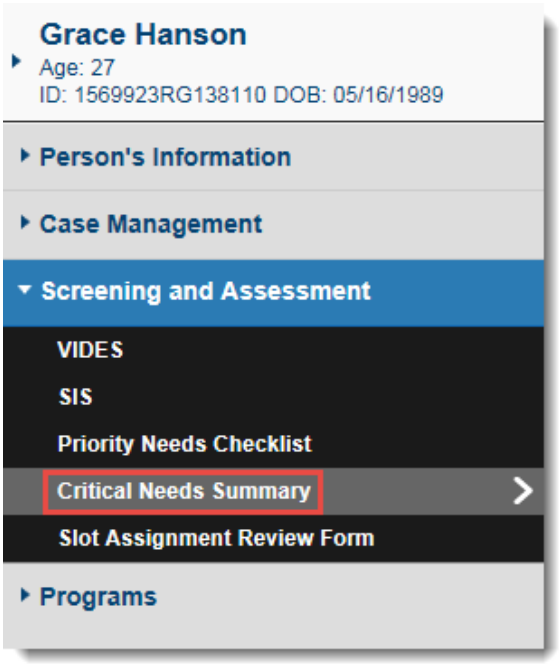
Note: The Priority Needs Checklist is NOT complete until it is submitted!

1. Click **Submit** in the *Priority – Summary* window.



*When Priority One is selected, the **Critical Needs Summary** option appears in the Screening and Assessment section.*

*The **Critical Needs Summary** (CNS) must be completed for anyone with **Priority One** status.*



5.4 Update Priority Needs Checklist

In order to change the priority of an individual must submit a new *Priority Needs Checklist* and *Critical Needs Summary* forms. See steps in **Section 7.2.3** (*Update information for Individual on the Waitlist*).

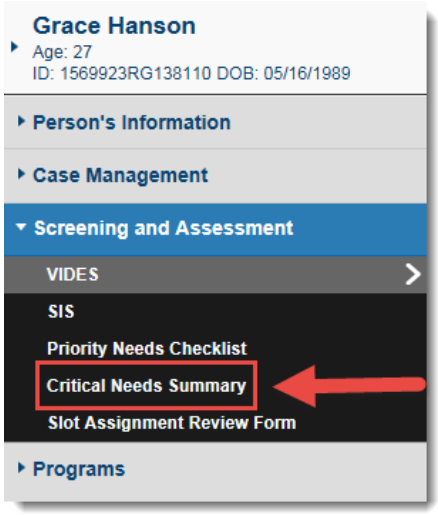
6 Critical Needs Summary

Individuals who are designated with a *Priority One* status must also have a **Critical Needs Summary** (CNS) completed. This is a required step in placing an individual on the Waitlist. The **Critical Needs Summary** option will appear under the *Screening and Assessments* section *after* the **Priority Needs Checklist** has been completed and submitted.

6.1 Create Critical Needs Summary

1. **Search** for the individual. (See steps in ***Section 2.1: Locate an Existing Individual's Profile*** *above*).

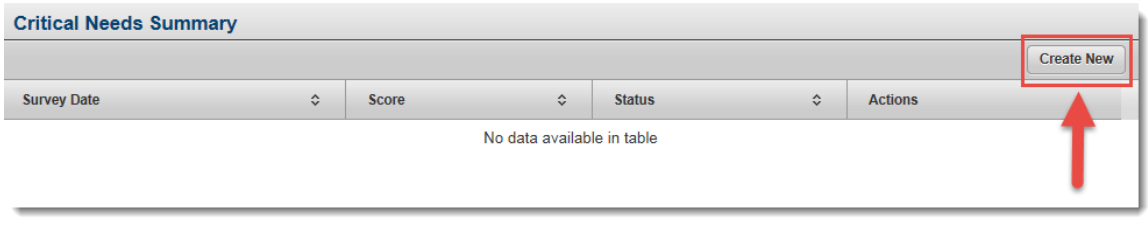
   From the **Screening and Assessments** section on the left navigation bar, click on **Critical Needs Summary**



   The Critical Needs Summary window appears on the right.

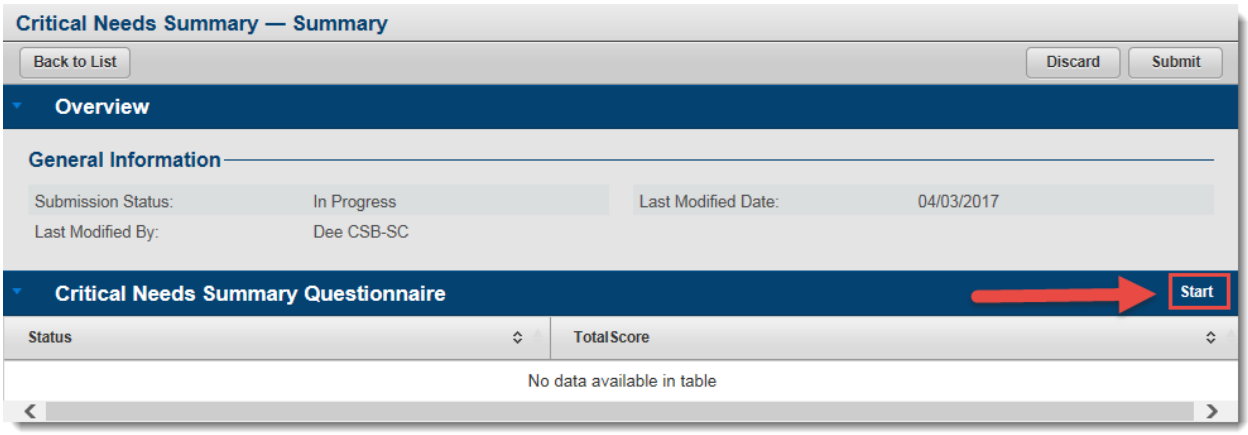
6.1.1 Start Critical Needs Summary

1. Click **Create New**.



   The Critical Need Summary Survey Date dialog box appears. The survey defaults to the current date and may not be changed.

2. Click **Continue**. *The Critical Needs Summary - Summary window appears.*



3. Click on **Start** in the *Critical Needs Summary Questionnaire* section. The *Critical Needs Summary* form opens in a new browser window outside of WaMS in Dynamics Forms.

6.2 Complete Critical Needs Summary

The top portion (*CSB name, Individual's name* and *Medicaid Number* and *if the individual is an adult*) is automatically filled-in.

Points to Remember
• The numbers next to each radio button are a score. Zero (0) indicates the statement does not apply to the individual.
• The Medicaid field is blank if not yet added to the *Person's Information Overview*.
• If the Medicaid number is added to the *Person's Information Overview* after the Critical Needs Summary has been started, the summary may be discarded and a new Critical Needs Summary created. NOTE: The discard function is only available while the Critical Needs Summary submission status is "in progress." If "completed," create a new Critical Needs Summary.
• When the WSAC meeting is convened and a slot is available for assignment, the waitlist is sorted by Critical Needs Summary score (highest to lowest). The appropriate number of individuals (based on number of slots available) is pulled to the "review pool" list to be considered for a slot.
• An individual being considered for a slot assignment (i. e., in the review pool) must have a Slot Assignment Review Form completed by the CSB for the WSAC to review.

1. Scroll down the questionnaire form and choose the appropriate scores for the individual.

2. Click on **Save** then click on **Back to WaMs** (top right).

6.3 Submit Critical Needs Summary

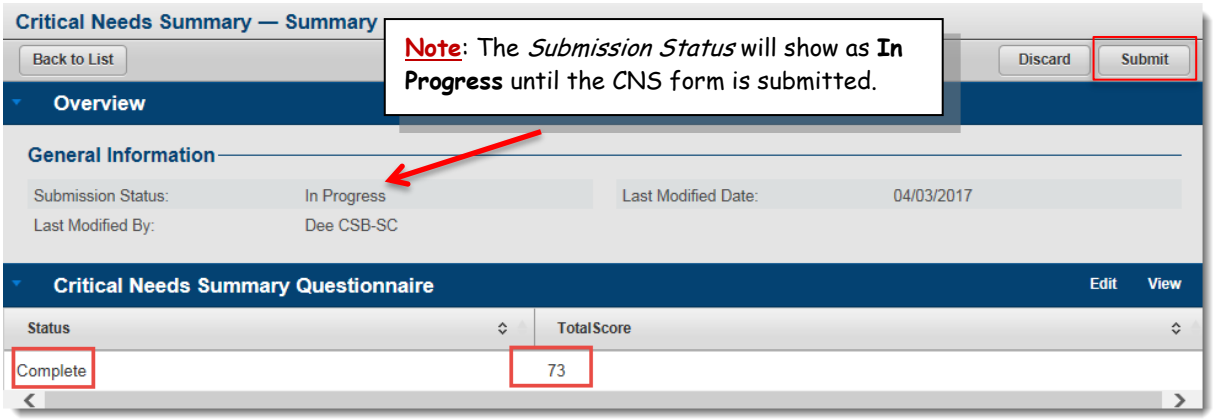
6.3.1 Edit Critical Needs Summary

If necessary, the Critical Needs Summary can be edited if the submission status is *In Progress*. Select **Edit** to modify or **View** to see/review the Critical Needs Summary.

6.3.2 Submit Critical Needs Summary

Note: The Critical Needs Summary is not complete until it is submitted!

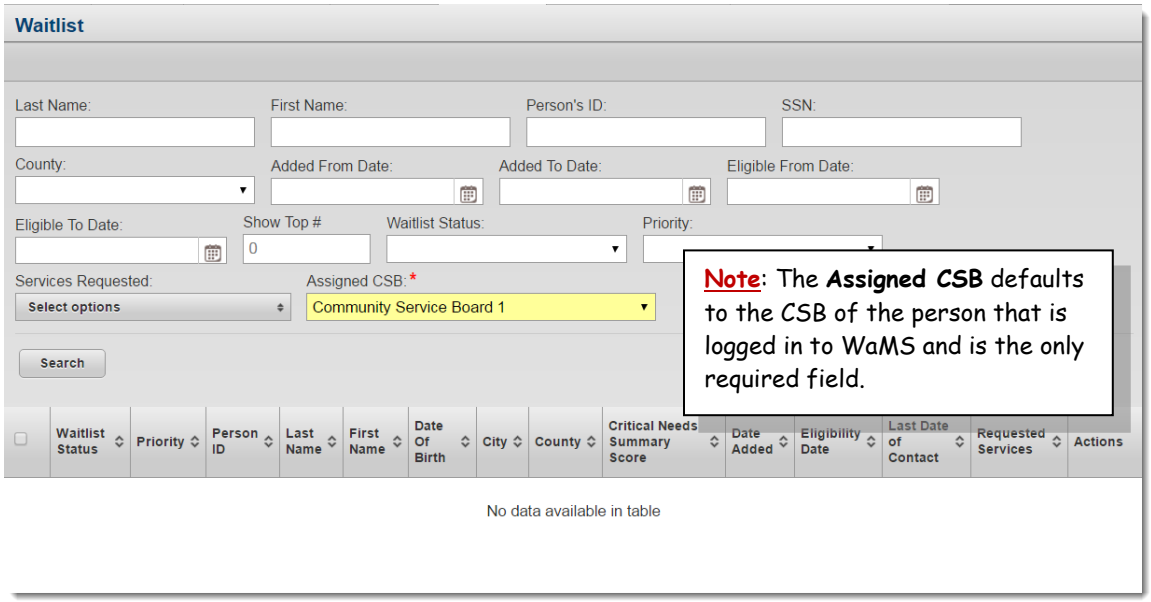
1. The *Status* shows as **Complete** with the **Total Score** displayed. Click **Submit** in the *Priority – Summary* window.
2. Click **Submit**. *The Submission status changes to "Submitted" and the form can no longer be edited.*



7 The Waitlist

7.1 The Waitlist Tab

The **Waitlist** tab displays individuals who meet criteria for the Developmental Disabilities (DD) Waiver but have not yet been assigned a slot. CSBs are only able to view persons assigned to their CSB.



7.1.1 Search for Individuals on the Waitlist

To find all individuals on the Waitlist in the organization or a specific individual do the following:

1. Click on the **Waitlist** tab from the top navigation bar.
2. Input as much or as little search criteria as needed (*the more search criteria input, the narrower the results*).
3. Click **Search**. *The search results appear.*

7.1.2 Search for Individuals by Waitlist Status

To find all individuals in the organization based on their waitlist status:

1. Click on the **Waitlist** tab from the top navigation bar.
2. Click the **Waitlist Status** down arrow to select one of the following statuses:
   - Active
   - Inactive
   - On Wave
   - Slot Assigned
3. Click **Search**. *The search results appear.*

7.2 Add Individual to Waitlist

An individual can be added to the **Waitlist** only after the following items are completed:

- ✓ VIDES
- ✓ A diagnosis has been entered (*Follow steps in Section 2.2.6: Person's Information Overview above*)
- ✓ Priority Needs Checklist
- ✓ Critical Needs Summary (for Priority One only)

An individual may be added to the Waitlist one of two ways:

1. In the *People* tab search results; or
2. From the *Person's Information* page

7.2.1 Add to Waitlist from the People Tab Search Results

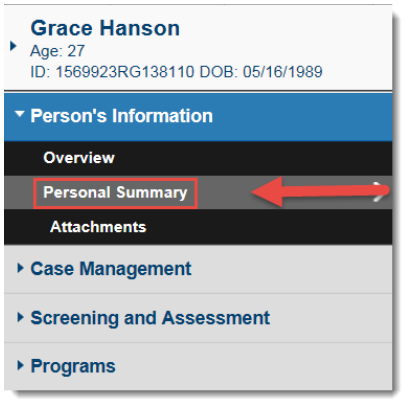
To add an individual to the Waitlist from the *People* tab search results:

1. Search for the individual. (*Follow steps in Section 2.1: Locate an Existing Individual's Profile above*).
2. From the results list, under *Actions*, click **Add to Waitlist.**

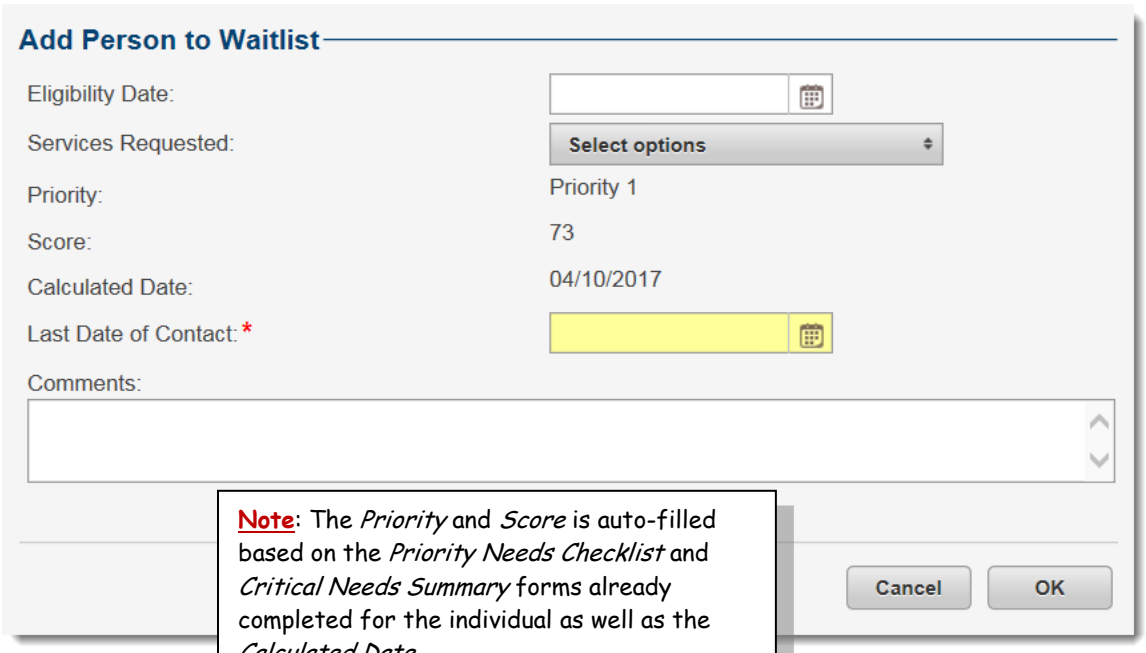
7.2.2 Add to Waitlist from the Person's Information Page

To add an individual to the Waitlist from the *Person's Information* page:

1. While in an individual's record, click **Person's Information**, **Personal Summary** from the left navigation menu. *The Personal Summary window appears.*
2. Scroll down to the *Waitlist/Slot Information* section.
3. Click **Add to Program Waitlist**.



The Add Person to Waitlist dialog box appears.



Note: The *Priority* and *Score* is auto-filled based on the *Priority Needs Checklist* and *Critical Needs Summary* forms already completed for the individual as well as the *Calculated Date*.

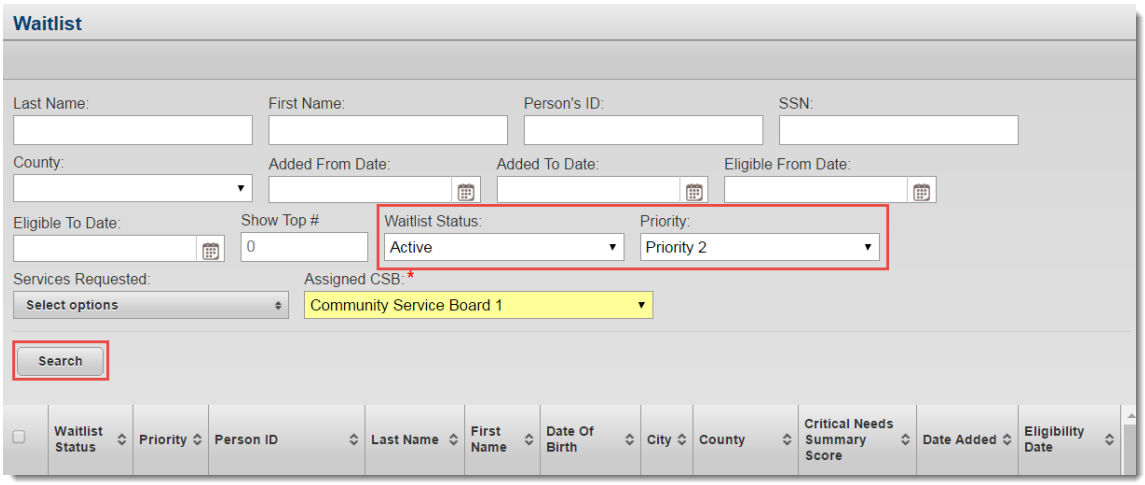
4. Add the **Eligibility Date** (if known).
5. Click the **Select options** arrows for the *Services Requested* to select each service required.
6. Click the Calendar to add **Last Date of Contact**.
7. Add any additional information in the **Comments** field.
8. Click **OK**. *The person is now added to the Waitlist.*

7.2.3 Update Information for Individual on the Waitlist

Update *requested services*, *priority status*, *critical needs score* and *date of last contact* using the **Waitlist** tab.

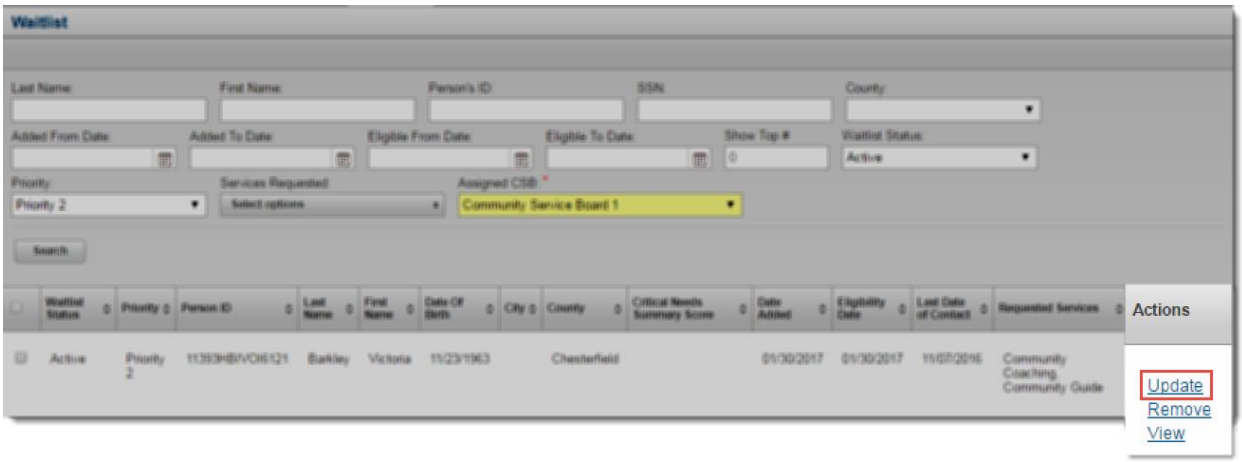
Note: The individual must be **Active** in order to update their information.

1. Click on the **Waitlist** tab from the top navigation bar.
2. Add the search criteria for the indivual to be updated from the Waitlist (i.e., Last Name, First Name, Person's ID, SSN, etc.) in the appropriate fields.
3. Click the Waitlist Status down arrow to select Active.
4. Click the Priority drop down arrow to select Priority 1, Priority 2, or Priority 3 if necessary.
5. Click **Search**.

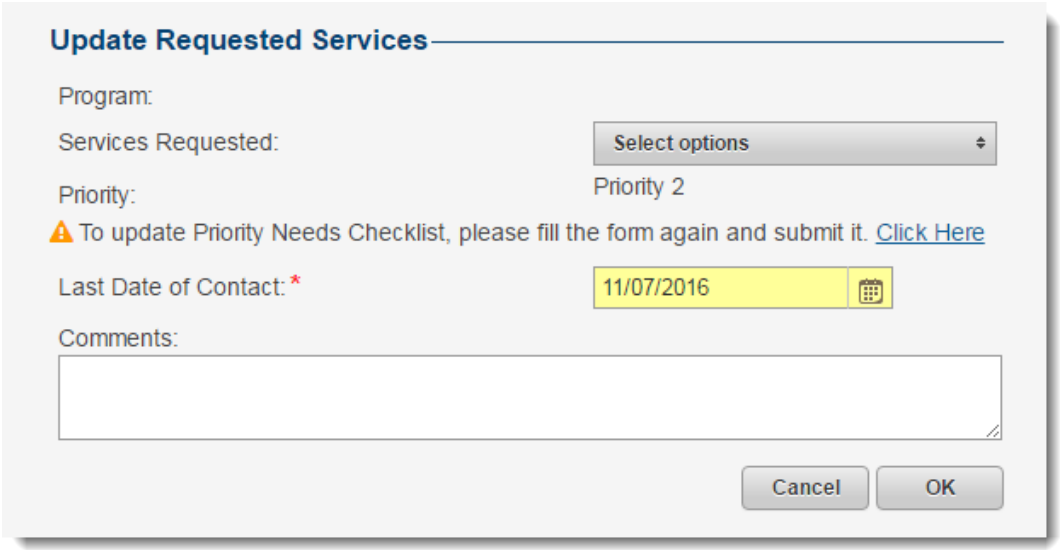


The search results appear.

6. Click **Update** link under *Actions* for the appropriate individual.



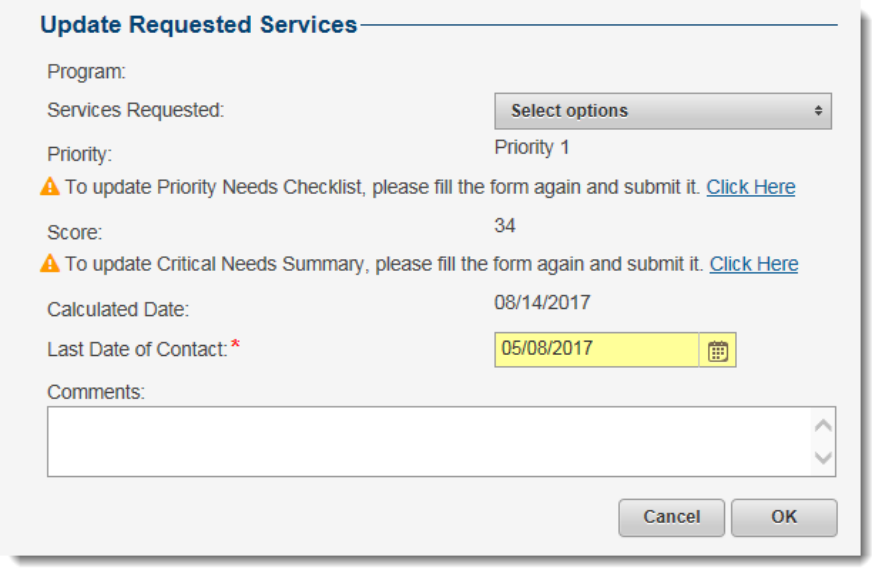
The Update Requested Services dialog box appears.



7. Click the **Select options** arrows to change the Services Requested.
    a. Disregard this field if no changes need to be made to the services requested
    b. Previously selected services are not identified in the dropdown
    c. Any new selection over writes all previous selections
8. To update the *Priority*, the **Priority Needs Checklist** form must be created and submitted. Click the **Click Here** link to go to the **Priority Needs Checklist**.
    a. Follow steps in *Section 5.1.1: Create Priority Needs Checklist above*.
    b. If the person is being assigned a *Priority One* Status, a *Critical Needs Summary* form must be submitted *before* the person's record will reflect *Priority One* status.

> **Note**: You can also select the **Critical Needs Summary** under the *Screening and Assessments* on the left navigation bar.

The Waitlist is updated once the new **Priority Needs Checklist** is submitted



Follow steps in Section 6.1.1: Create Critical Needs Summary above.

9. To update the **Last Date of Contact** click the **Calendar** and select the appropriate date.
10. Add any additional information in the **Comments** field.

    Click **OK**.

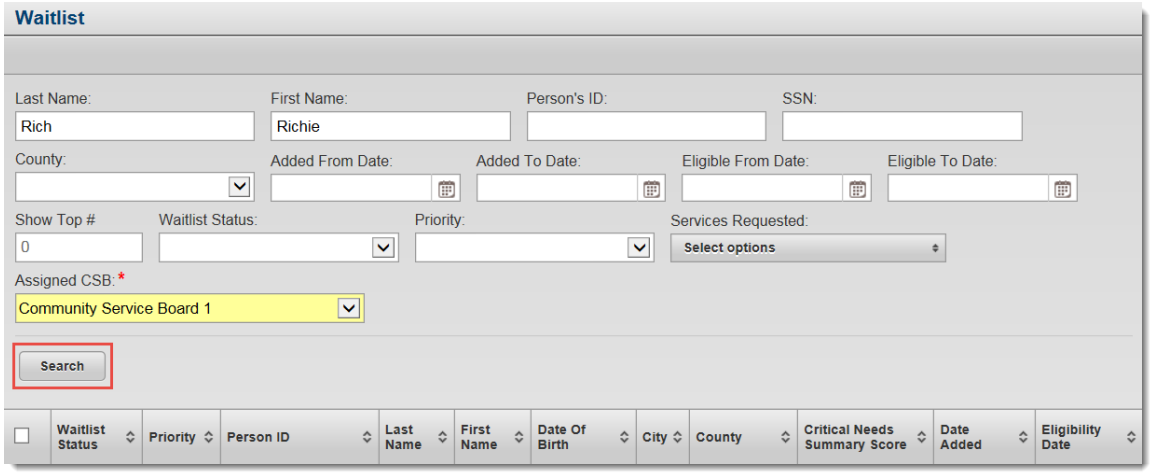
    The Waitlist information is automatically updated anytime a new Priority Needs Checklist and / or Critical Needs Summary is created and submitted.

7.2.4 Remove Individuals from the Waitlist

The Waitlist status must be *Active* for a person to be removed from the Waitlist.

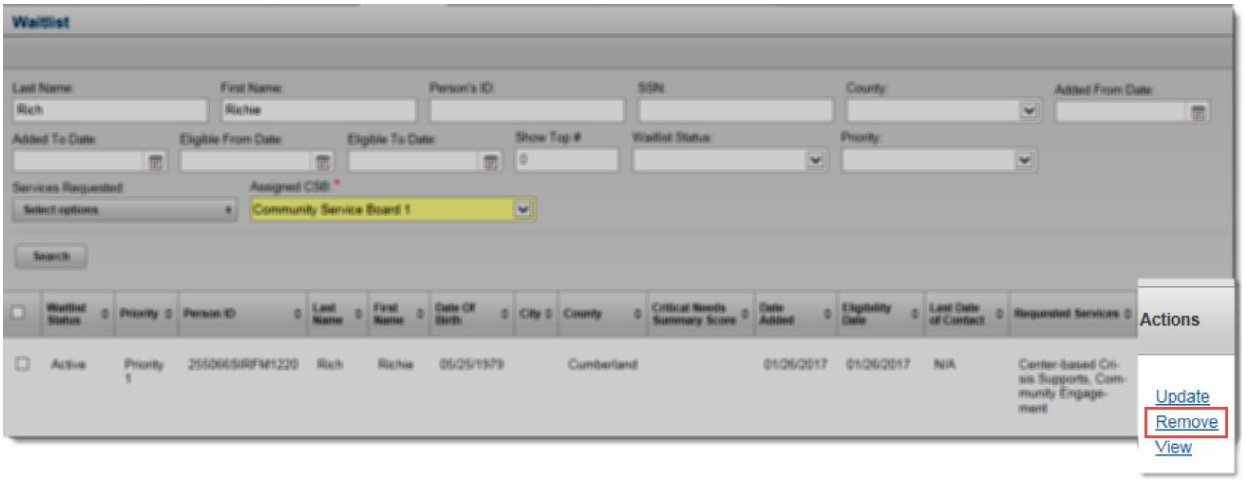
1. Click on the **Waitlist** tab from the top navigation bar.

2. Add the search criteria for the indivual to be removed from the Waitlist (i.e., *Last Name, First Name, Person's ID, SSN*, etc.) in the appropriate fields.
3. Click **Search**. *The search results appear.*

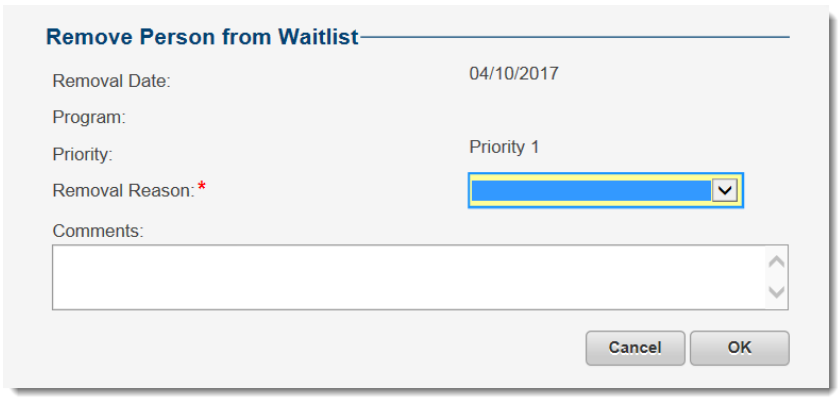


The search results list appears.

4. Click **Remove** link under *Actions* for the appropriate individual.



The Remove Person from Waitlist dialog box appears.



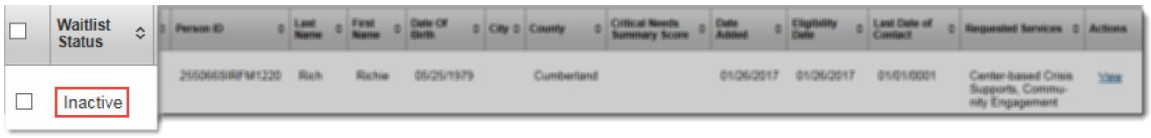
5. Click the **Removal Reason** drop down arrow to select the appropriate reason to remove the individual from the Waitlist.

   Reasons for Removal

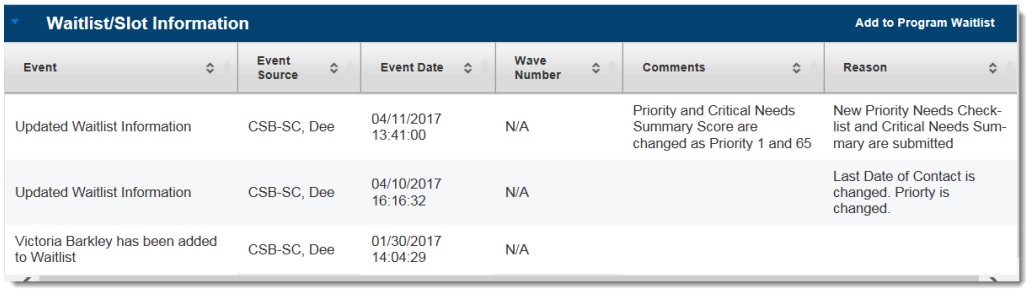
   - Declined
   - Not Eligible
   - Death
   - Moved
   - Did not Respond
   - Unable To Contact
   - Admitted to NF
   - Admitted to ICF/IID
   - Admitted to Other Waiver
   - Other

6. Add additional information in the Comments field if needed.
7. Click **OK.**

   The individual is removed from the Waitlist and Waitlist Status displays as "Inactive".



Changes to the Waitlist are reflected in the individual's **Person's Information**, **Personal Summary**, **Waitlist/Slot Information** section:



8 Slot Assignment Review Form

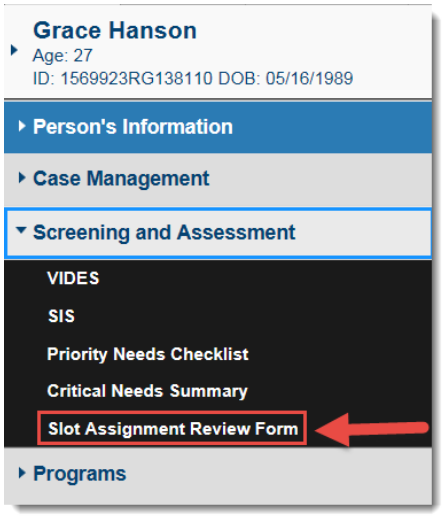
The CSB must complete a **Slot Assignment Review Form** (**SARF**) for an individual assigned with a *Priority One* status and included in the group of people being reviewed by the *Waiver Slot Assignment Committee* (WSAC). The form must be completed before the WSAC meeting. *See the WSAC Process Map (Attachment A).* The **Slot Assignment Review Form** is located under the *Screening and Assessments* section.

Note: **The SARF** is required for individuals who will be reviewed by the WSAC Committee.

8.1 Complete Slot Assignment Review Form

1. **Search** for the individual. (*Follow steps in Section 2.1: Locate an Existing Individual's Profile above*).
2. From the **Screening and Assessments** section on the left navigation bar, click on **Slot Assignment Review Form**.

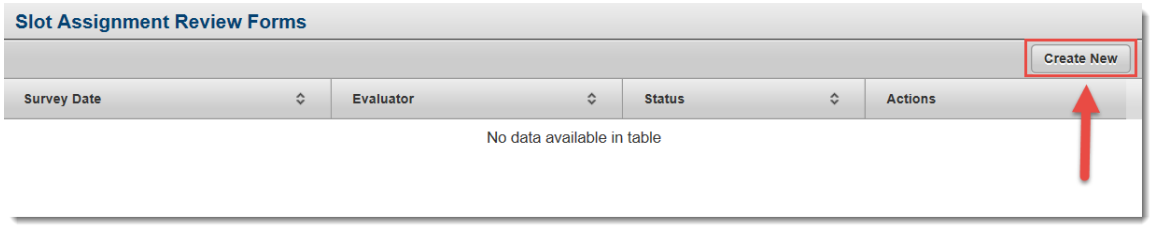
Note: Using the "WaMS version" of **SARF** is optional. A **Slot Assignment Review Form** template in MS Word or in an Electronic Health Records (EHR) system can be used in lieu of the form in WaMS. When using a form outside of WaMS it must be identical to the form in WaMS.



The Slot Assignment Review Forms window appears on the right.

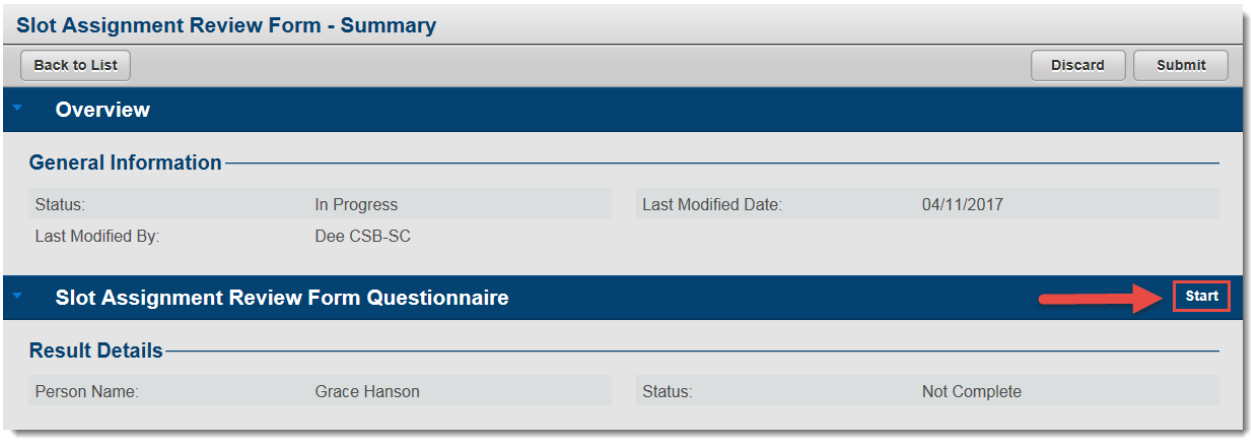
8.1.1 Start Slot Assignment Review Form

1. Click **Create New**.



The Slot Assignment Review Form Survey Date dialog box appears. The survey defaults to the current date and may not be changed.

2. Click **Continue**. *The Slot Assignment Review Form - Summary window appears.*



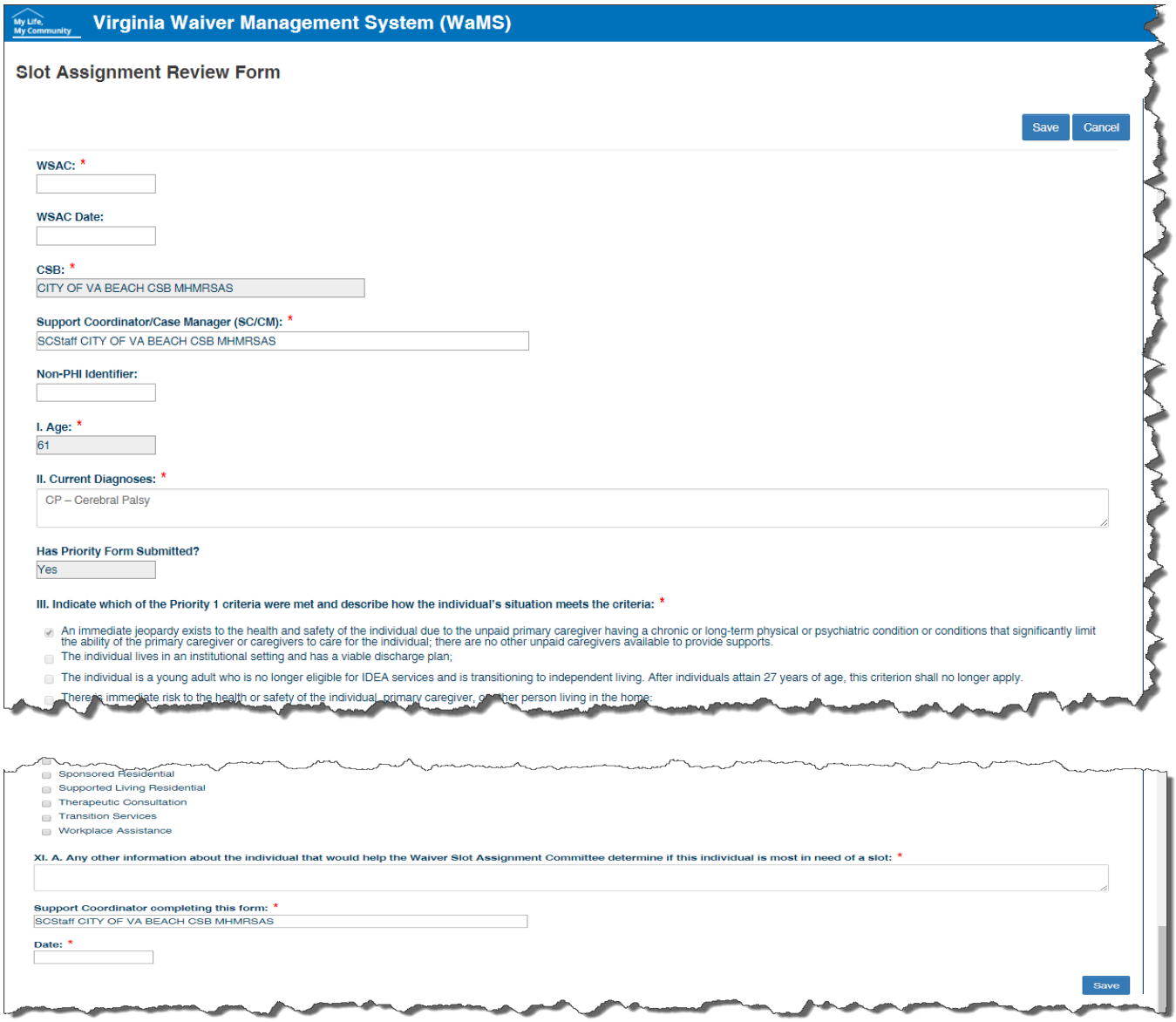
3. Click on **Start** in the *Slot Assignment Review Form Questionnaire* section. The *Slot Assignment Review Form* opens in a new browser window outside of WaMS in Dynamic Forms.

8.2 Slot Assignment Review Form (Dynamic Form)

1. In the top portion of the form, identify the **WSAC** committee/group name (e.g. City of VA Beach WSAC) or a combined WSAC covering more than one CSB (e.g. Arlington/Alexandria WSAC) and **WSAC Date**.

   The *CSB* name, *Support Coordinator/Case Manager* name, Individual's *age* and *current diagnosis*, and if *Priority* has been submitted, is automatically filled-in.

2. Scroll to complete the review form. *Be sure to add the Date at the bottom of the form.*



3. Click on **Save**.
4. Click on **Back to WaMS** (located at the top right portion of the window).

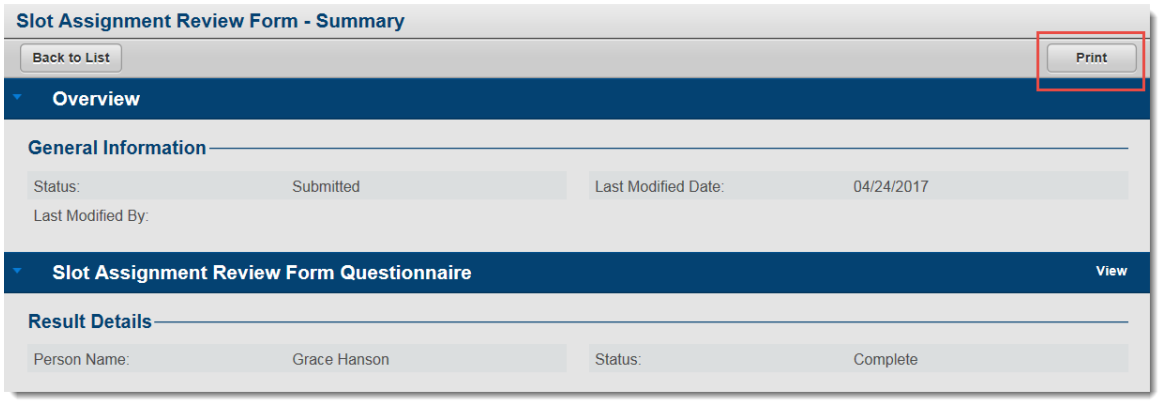
   *The Status shows as **Complete**. You will not be able to submit the form if the status shows as "Not Complete".*
5. Select **Edit** to modify or **View** to see/review the **Slot Assignment Review Form Questionnaire**.
6. Click **Submit**.

   The Slot Assignment Review Form is now ready to provide to the WSAC for their review during their session. Slots will be assigned based on the results of the WSAC session.

8.3 Print the Slot Assignment Review Form (Dynamic Form)

The **Print** button becomes available for the SARF once the form is *Complete* and has been *Submitted*.

1. From the *Slot Assignment Review - Summary* window, click on the **Print** button.



A PDF version of the Slot Assignment Review Form opens in a new window.

2. **Print** (*Control +P, right-click and click Print, or click on the printer icon*) or **download** to *save* the SARF as a PDF document.

9 Enrollment Status

When a slot has been assigned by DBHDS, the **Enrollment Status** for that an individual is **Projected Enrollment Status**. To initiate services, the individual's status must be changed to **Active**.

> **Note**: Prior to moving an individual from *Projected* to *Active* status the following must be completed:
>
> - Add a New Individual (See: 2.2)
> - Diagnosis(es) required to add to Waitlist
> - Medicaid Number added
> - VIDES submitted and Level of Functioning (LOF) for DD Waiver Met (See: 4.1)
> - Priority Needs Checklist submitted (See: 5.1)
> - Critical Needs Summary submitted (See: 6.1)
> - Individual added to Waitlist
> - (See:7.2)
> - Slot Assignment Review Form (See: 8.1)
> - Slot has been assigned by DBHDS.

9.1 Move from Projected to Active Status

There are several ways to locate an individual to move them from *Projected* to *Active* status.

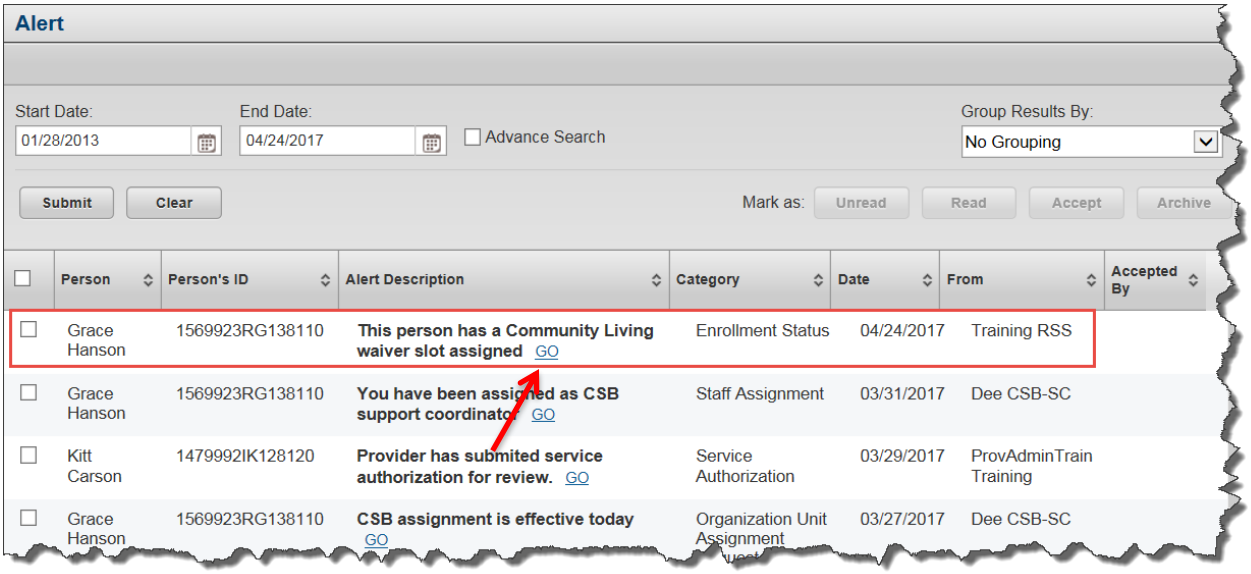
9.1.1 Locate the Individual

9.1.1.1 Via Search

1. **Search** for the individual. (*Follow steps in Section 2.1: Locate an Existing Individual's Profile above*).
2. Click on the **Summary** link. *The individual's Personal Summary page appears.*

9.1.1.2 Via Alerts

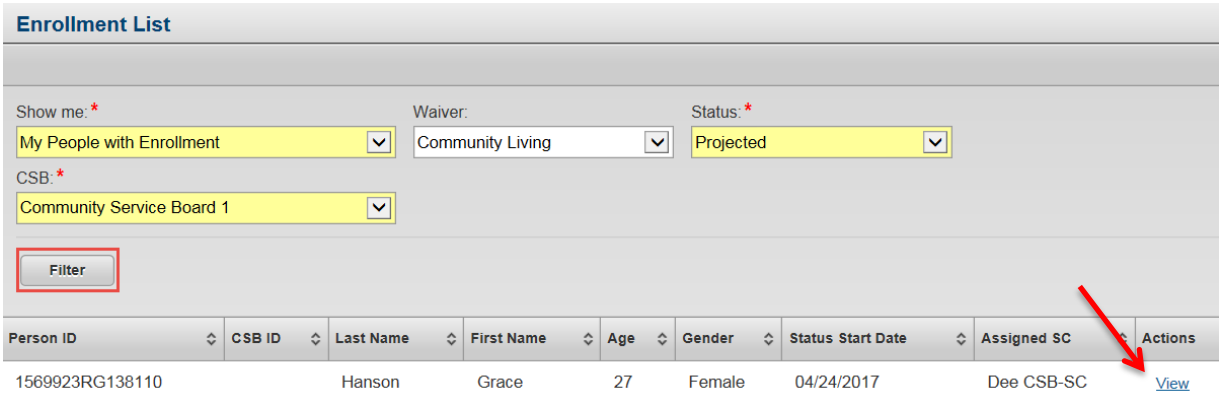
1. Click **Alerts** tab from the *top* navigation bar. *The list of alerts will appear.*



2. Click **GO**. *The individual's Personal Summary page appears.*

9.1.1.3 Via My List

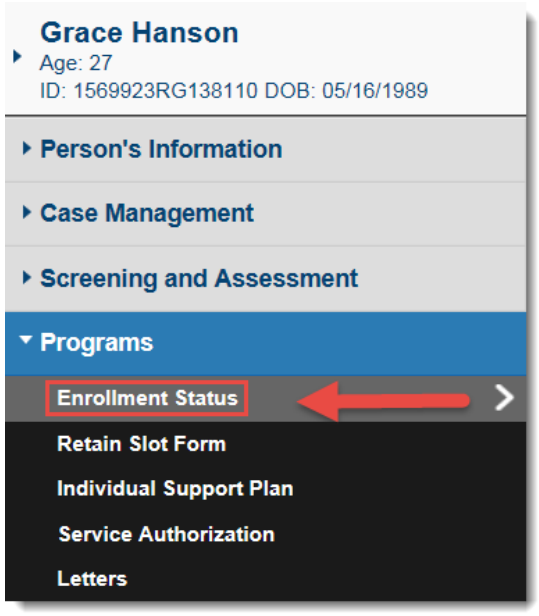
1. Click **My List** tab from the *top* navigation bar.
2. Click on **Enrollment Status** on the *left* navigation bar.
3. Ensure that:
    a. **My People with Enrollment** is selected for *Show me*
    b. **Projected** is selected for Status
    c. **Your CSB** is listed for CSB.
        i. The appropriate **Waiver** (*Community Living, Family and Individual Supports* or *Building Independence*) can also be selected if necessary.
4. Click **Filter**. *All individuals with Slots Assigned (Projected status) for the organization that have been assigned to you will appear.*

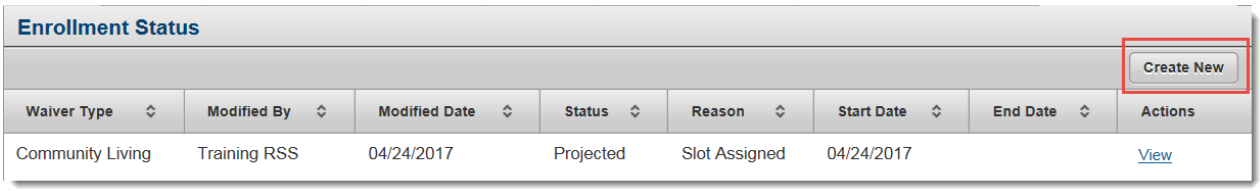


5. Click **View** for the appropriate individual in the list. *The individual's Personal Summary page appears.*

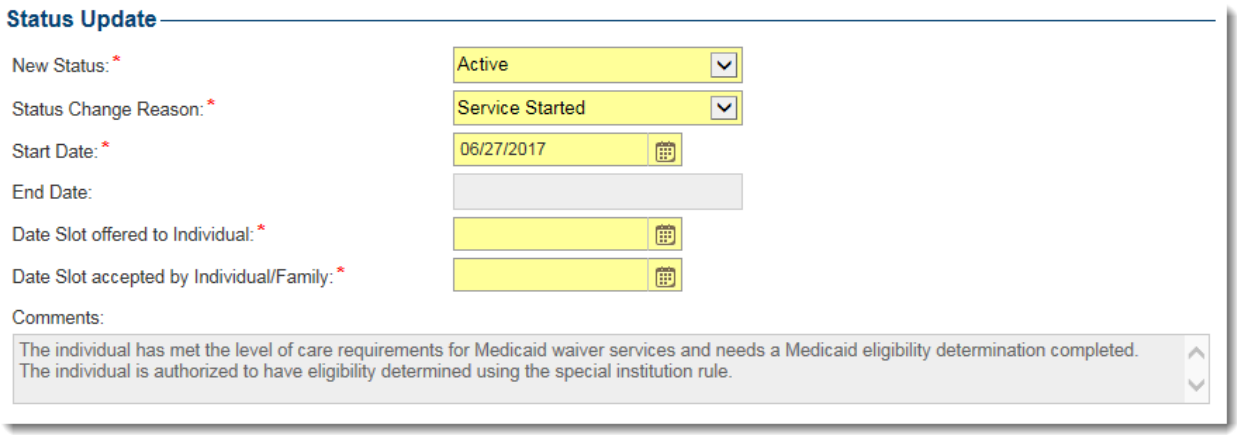
9.1.2 Create New Enrollment Status (Active)

1. Click on **Programs, Enrollment Status**. *The Enrollment Status window appears.*





2. Click on **Create New.** *The Select Waiver dialog box appears.*
3. Click on **Continue**. *The Enrollment Status dialog box appears.*

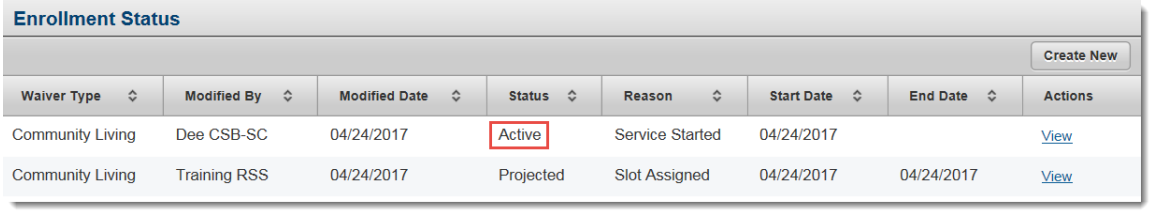


4. Ensure that:
   a. **Active** is selected for *New Status.*
   b. **Service Started** is selected for *Status Change Reason*.
5. Select the appropriate **Start Date**.
6. Select the **Date Slot offered to Individual**.
7. Select the **Date Slot Accepted by Individual/Family**.
   The **Level of Care** (LOC) statement is included in the **Comments** field.

Level of Care (LOC) Statement
The individual has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. The individual is authorized to have eligibility determined using the special institution rules.

Note: The *LOC statement* is automatically included in the *Comments* field by default. **The LOC statement cannot be amended in any way.**

8. Click **Save**. *The Enrollment Status window appears showing a new line with the status as "Active".*



- To print the Level of Care (LOC) statement which must accompany the *DMAS-225 form*, click **View** to open the *Enrollment Status* window and click on **Menu**, **Print** to print the screen (*see Section 15.6, Screen Print*).

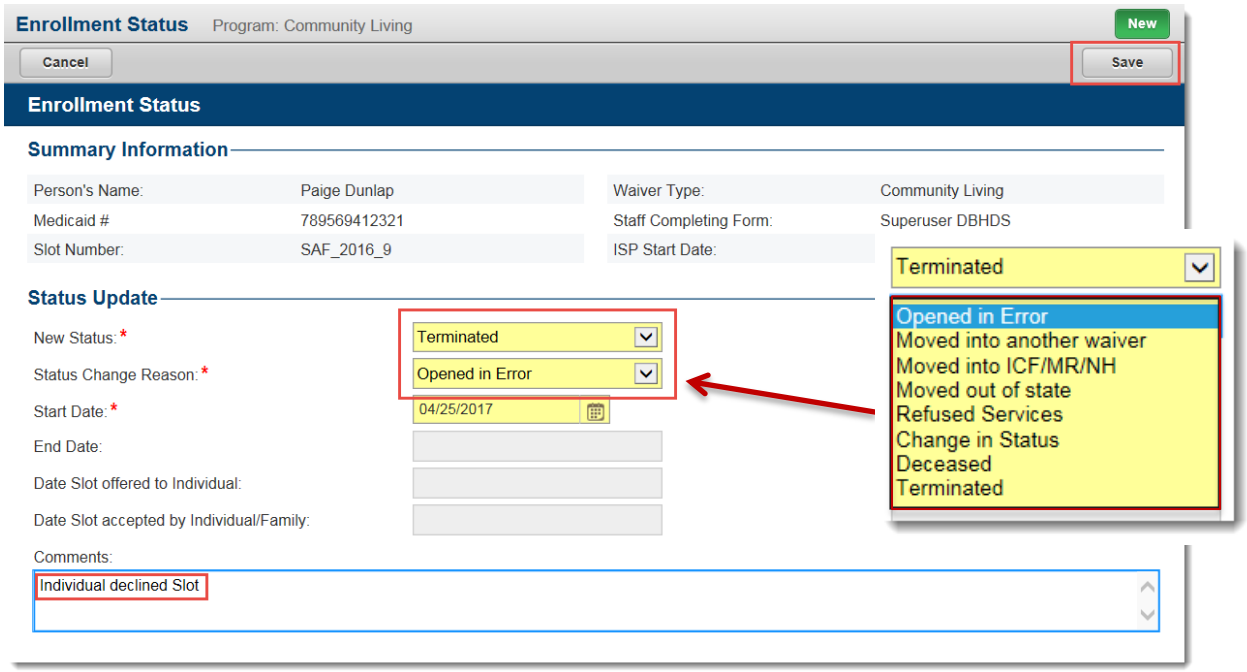
> **Note**: A Service Authorization must be submitted to DBHDS for approval within 30 days of Active Enrollment or a Retain Slot Form should be initiated.

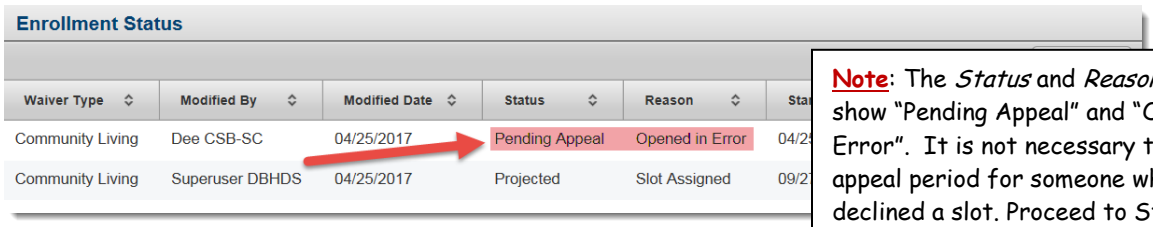
9.2 Release Slot

When an individual has been offered a slot but has decided to "decline" the slot, the assigned slot must be released. It is a two-step process to release a slot. Follow the steps below:

Step 1

1. Locate the individual using one of the steps above in sections **9.1.1.1** (*Search*), **9.1.1.2** (*Alerts*); or **9.1.1.3** (*My List*) above.
2. Click on **Create New**. *The Select Waiver dialog box appears and the waiver type is pre-populated.*
3. Click on **Continue**. *The Enrollment Status dialog box appears.*
4. Select **Terminated** for *New Status*.
5. Select the **Status Change Reason**:
6. Add information in the Comments field (i.e., "**Individual declined Slot**").
7. Click on **Save**.

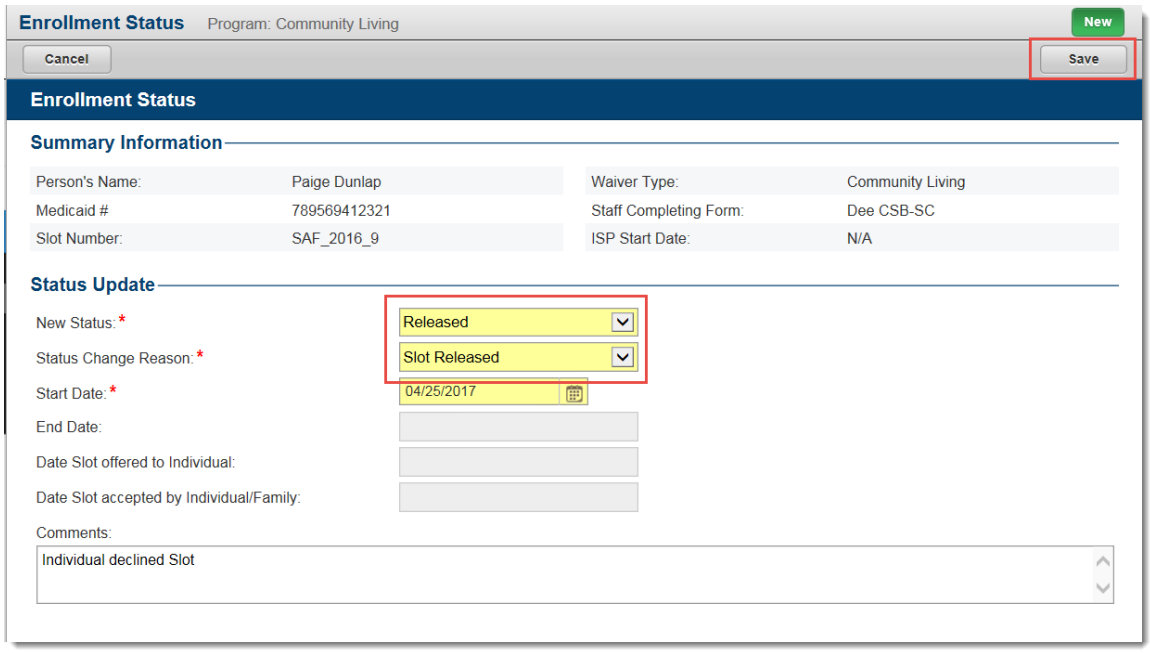




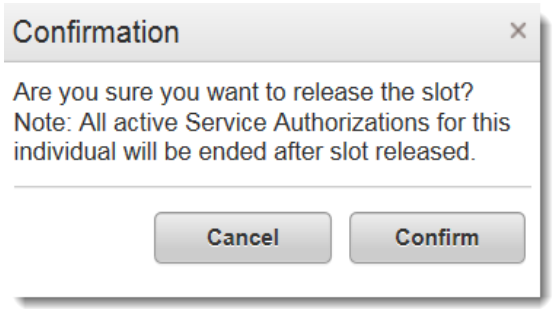
Note: The *Status* and *Reason* lines show "Pending Appeal" and "Opened in Error". It is not necessary to wait an appeal period for someone who has declined a slot. Proceed to Step 2 below to release the slot:

Step 2

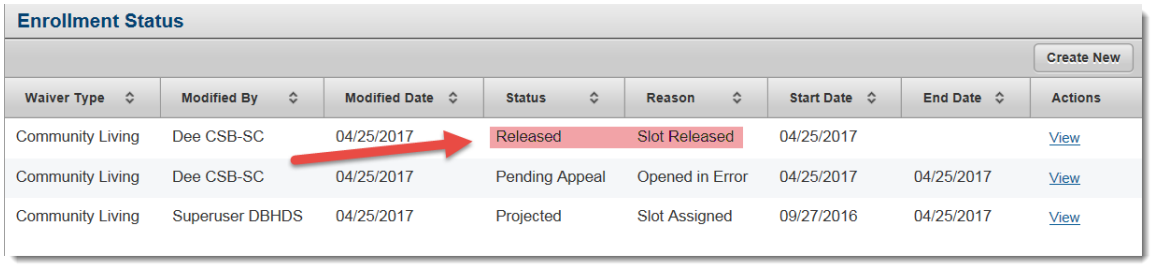
1. Click on **Create New**. *The Select Waiver dialog box appears and the waiver type is pre-populated.*
2. Click on **Continue**. *The Enrollment Status dialog box appears.*
3. Ensure that:
   a. **Released** is selected for *New Status*.
   b. **Slot Released** is selected for Status Change Reason



4. Click on **Save**. *The save Confirmation dialog box appears.*



5. Click on **Confirm**.



The Slot is now released.

9.3 Hold Status

There are several reasons to place an individual in *Hold* Status including:

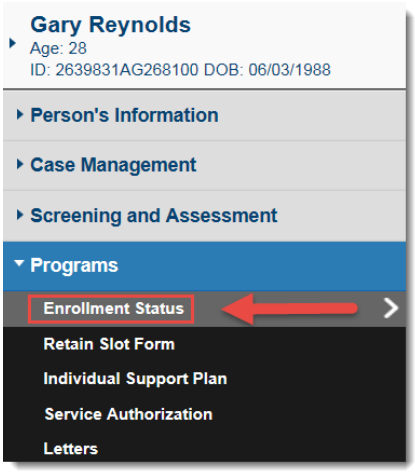
- ICF/IID Admission
- Incarceration
- Rehab hospital
- Loss of Medicaid Eligibility
- No waiver services for 30 uninterrupted days

9.3.1.1 Via My List

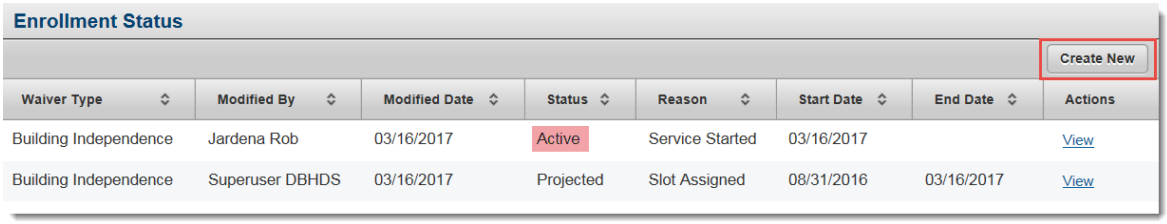
1. Click **My List** tab from the *top navigation bar*.
2. Click on **Enrollment Status** on *the left navigation bar*.
3. Ensure that:
    a. **My People with Enrollment** is selected for *Show me*
    b. Select **Active** for the *Status.*
    c. Your CSB is listed for CSB.
        i. The appropriate Waiver (Community Living, Family and Individual Supports or Building Independence) can also be selected if necessary.
4. Click **Filter**. All individuals with Slots Assigned (Active status) for the organization that have been assigned to you will appear.
5. Click on **View** for the appropriate individual to place in *Hold* status. *The individual's Personal Summary page appears.*

9.3.2 Create New Enrollment Status (Hold)

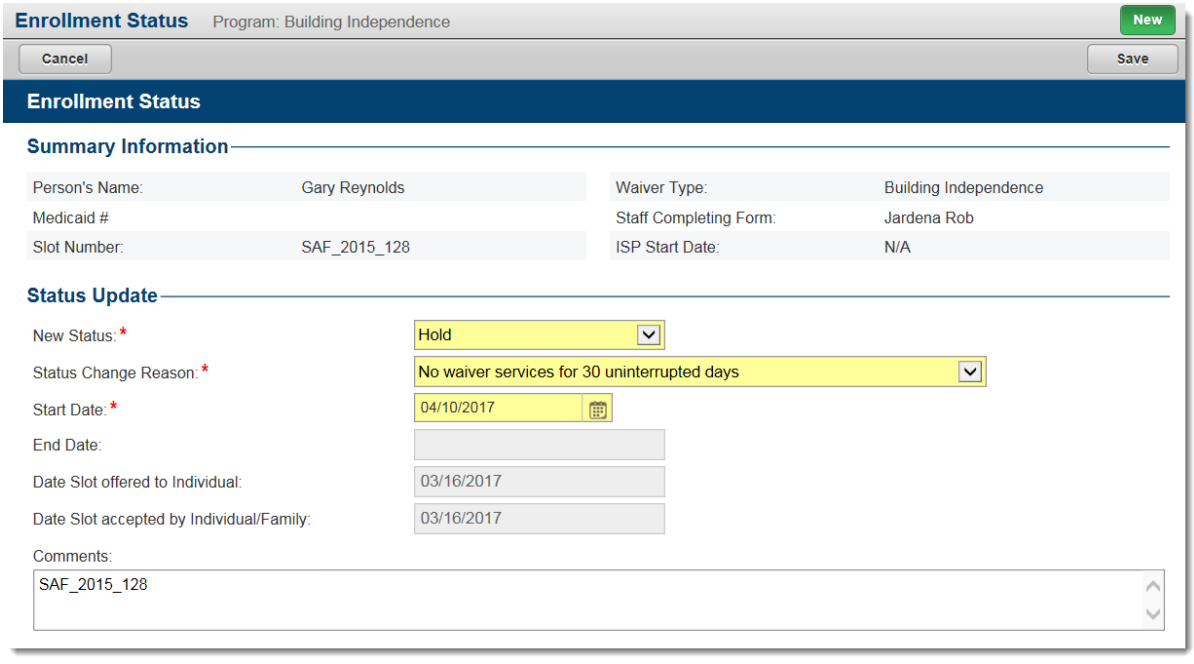
1. Click on **Programs, Enrollment Status**. *The Enrollment Status window appears displaying the "Active" individuals.*



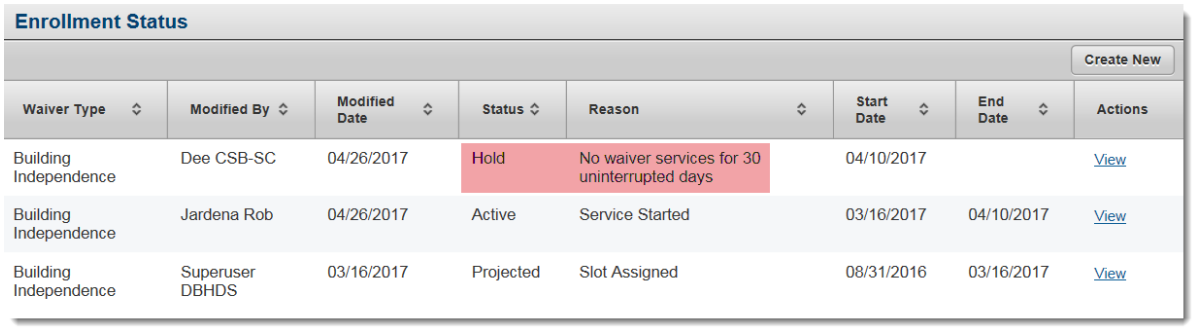
2. Click on **Create New.** *The Select Waiver dialog box appears.*



3. Click on **Continue**. *The Enrollment Status dialog box appears.*
4. Click the **New Status** drop down arrow and select **Hold**.
5. Click the **Status Change Reason** drop down arrow and select the appropriate *hold* reason.
6. Type information in the *Comments* field, if necessary.
7. Click on **Save**.



The individual status is now on hold. The **Retain Slot Form** must be completed after 30 days of interrupted services (see section **10.1: Complete Retain Slot Form**).



Enrollment Status

Create New

Waiver Type	Modified By	Modified Date	Status	Reason	Start Date	End Date	Actions
Building Independence	Dee CSB-SC	04/26/2017	Hold	No waiver services for 30 uninterrupted days	04/10/2017		View
Building Independence	Jardena Rob	04/26/2017	Active	Service Started	03/16/2017	04/10/2017	View
Building Independence	Superuser DBHDS	03/16/2017	Projected	Slot Assigned	08/31/2016	03/16/2017	View

9.4 Additional Enrollment Status Results

The table below identifies the available new status selections that can be made based on the *Enrollment Status* of the individual.

Enrollment Status - List	**Enrollment Status – Status Update**		**Enrollment Status - List**
Status Field	**New Status Field**	**Status Change Reason Field**	**Status Field**
Status of Enrollment at beginning of process	*What the status can be changed to based on current status*	*Reason for the new status*	*Updated Current Status of Enrollment*
Projected Projected	Active	Service Started	Active
	Terminated Terminated	Opened in Error	Pending Appeal
		Moved into another waiver	Pending Appeal
		Moved into ICF/MR/NH	Pending Appeal
		Moved out of state	Pending Appeal
		Refused Services	Pending Appeal
		Change in Status	Pending Appeal
		Deceased	Released
		Terminated	Pending Appeal
Active	Hold	ICF/IID Admission	Hold
		Incarceration	Hold
		Rehab hospital	Hold
		Loss of Medicaid Eligibility	Hold
		No waiver services for 30 uninterrupted days	Hold

Enrollment Status - List	Enrollment Status – Status Update		Enrollment Status - List
Status Field	**New Status Field**	**Status Change Reason Field**	**Status Field**
Status of Enrollment at beginning of process	*What the status can be changed to based on current status*	*Reason for the new status*	*Updated Current Status of Enrollment*
	Terminated	Opened in Error	Pending Appeal
		Moved into another waiver	Pending Appeal
		Moved into ICF/MR/NH	Pending Appeal
		Moved out of state	Pending Appeal
		Refused Services	Pending Appeal
		Change in Status	Pending Appeal
		Deceased	Released
		Terminated	Pending Appeal
Hold	Active	Service Resumed	Active
Terminated (Note: Does not apply to "Deceased" Status Change Reason)	Active	Appeal Approved	Active
	Released	Slot Released	Released

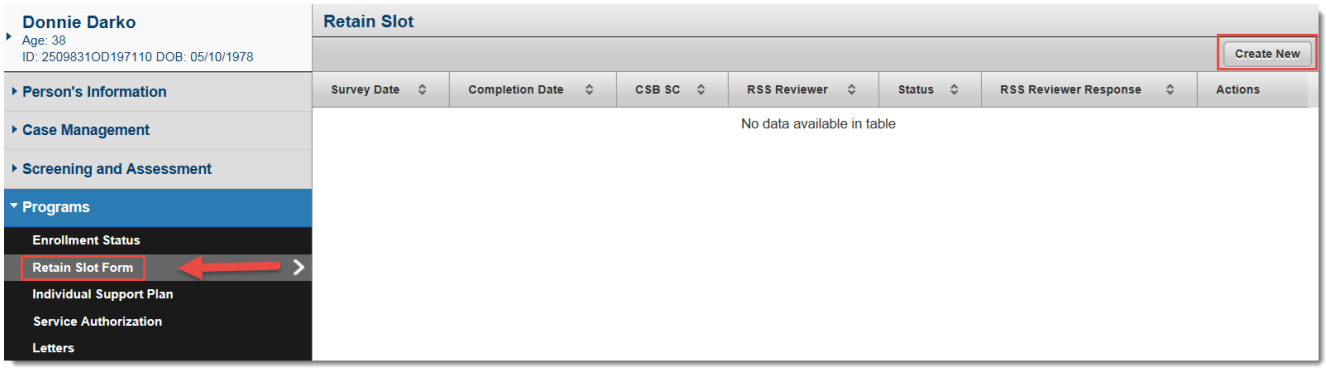
10 Retain Slot Form

When services for an individual are delayed in starting, or if services are interrupted for any reason, the CSB must request that the slot be held for that individual. The Support Coordinator should complete the **Retain Slot Form**.

10.1 Complete Retain Slot Form

10.1.1 Locate the Individual

1. Locate the individual using one of the steps above in sections 9.1.1.1(Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.
2. From the **Programs** section on the *left navigation bar*, click on **Retain Slot Form**. *The Retain Slot appears on the right.*
3. Click on **Create New** and click **Continue** to select the current date for the *Survey Date.*

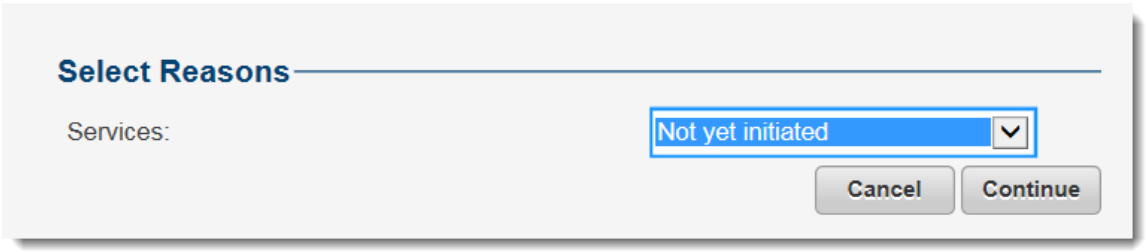


The Retain Slot Form – Summary window appears.

10.1.2 Start the Retain Slot Form

1. Click on **Start** to open the **Retain Slot Form**.

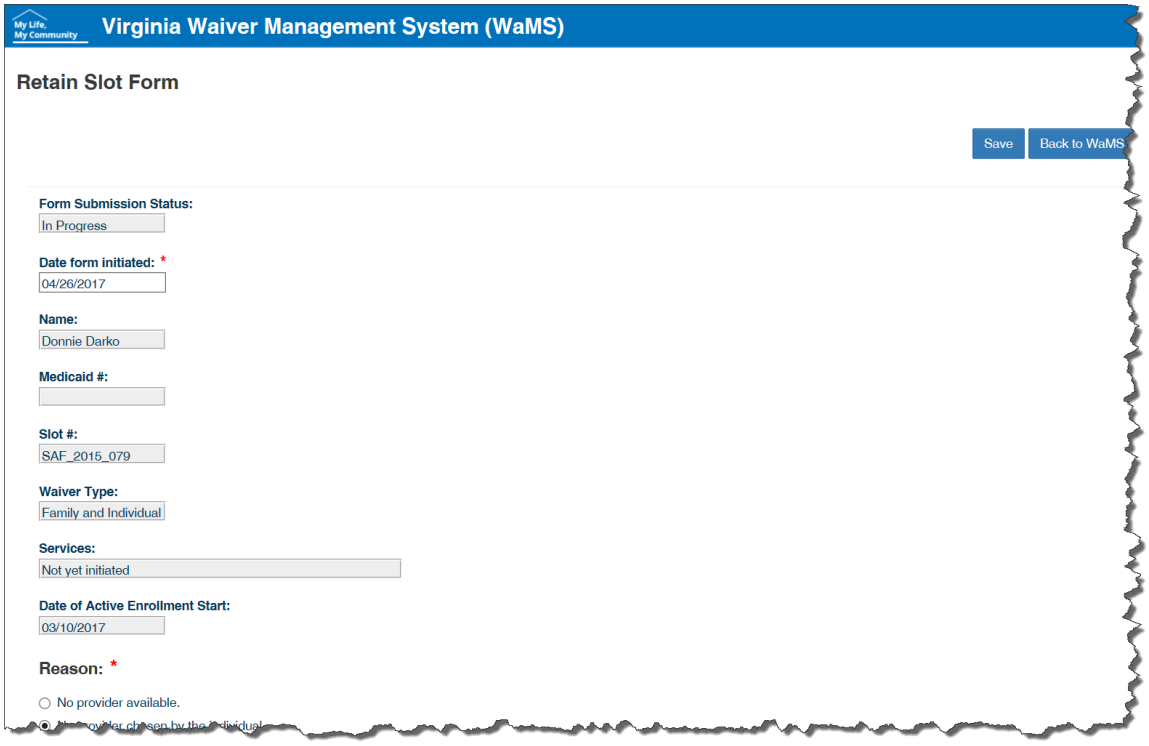
*The **Select Reasons** box appears.*



2. Click the **Services** down arrow to select the appropriate reason to hold the slot (**Not yet initiated** or **Services Interrupted**).
3. Click **Continue**. *The Retain Slot dynamic form opens in a new window outside of WaMS.*

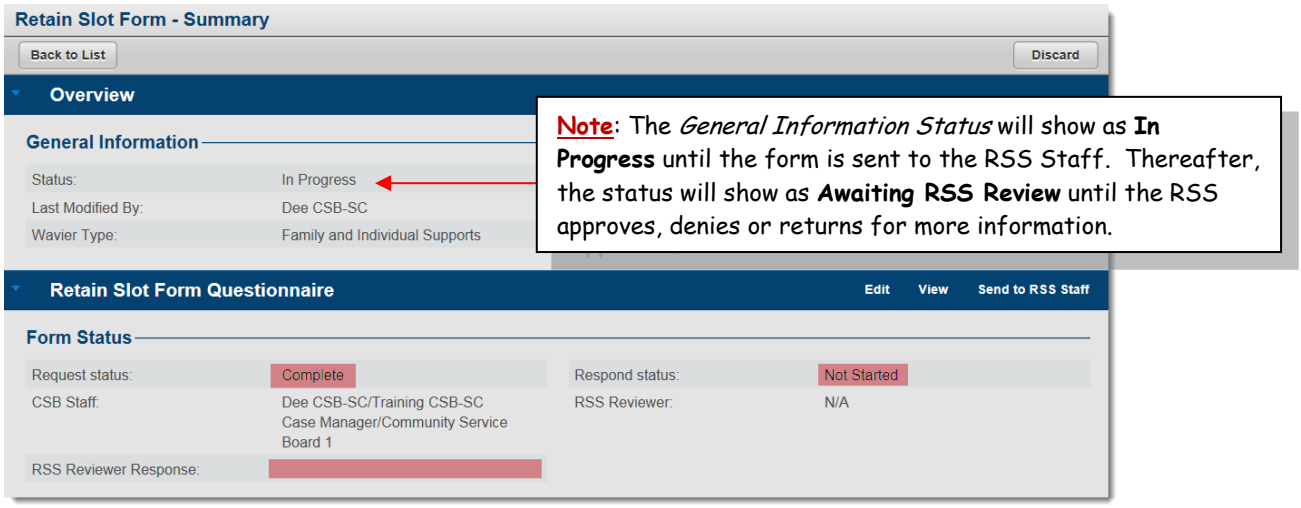
10.1.3 Create the Retain Slot Form

Required fields are denoted by a red asterisk (*).



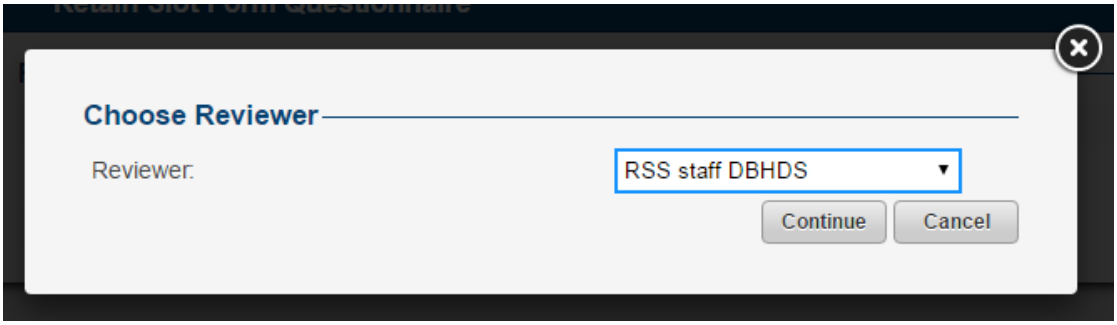
1. Select the **Reason**.
2. **Explain the situation and actions taken**.
3. Add the **Date of Anticipated Service Start**
4. Add the **Telephone Number**.
5. Add the **Date of Submission By Support Coordinator**
6. Click on **Save** then click on **Back to WaMs** (top right).

*The Retain Slot Summary form appears. The **Request Status** shows as **Complete**; the **Respond Status** shows as **Not Started** and the **RSS Reviewer Response** is blank.*



10.1.4 Send Retain Slot to RSS Staff for Review

1. Click **Send to RSS Staff**. *The Choose Review box appears*



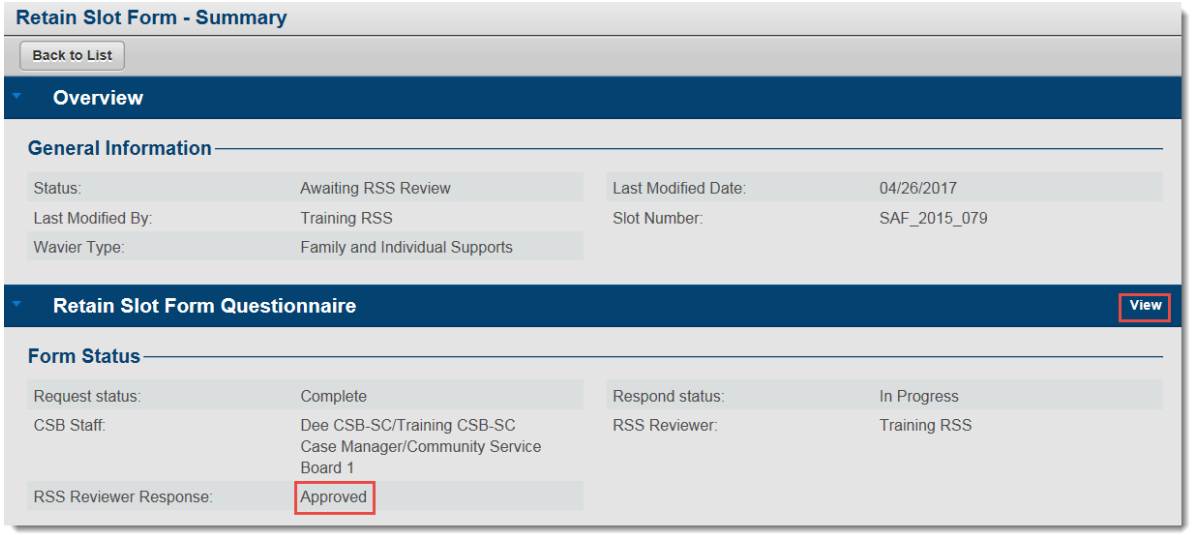
2. Click the **Reviewer** down arrow to select the appropriate *RSS staff* member to send the *Retain Slot Form* to.
3. Click **Continue**. *The General Information status changes to Awaiting RSS Review*.

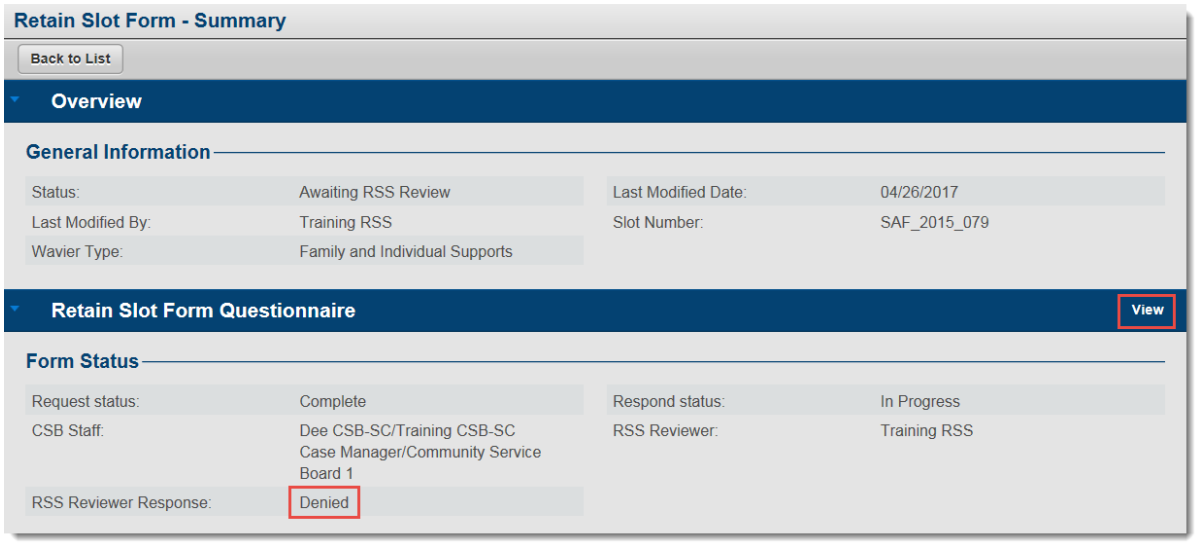
   The RSS can approve, deny or request additional information.

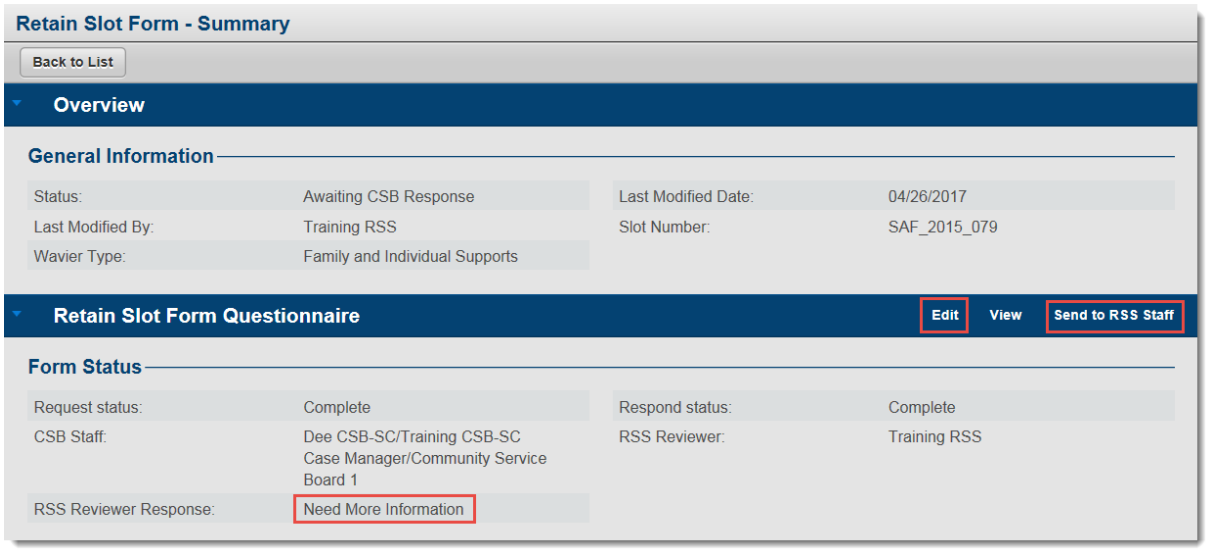
   - **APPROVED**: The slot may remain with the current individual for another 30 days.
   - **DENIED**: The request to retain the slot for an individual is denied. Send appeal rights notification and take steps to release the slot.
   - **MORE INFORMATION IS NEEDED**: The RSS may request additional information in order to approve the request to retain the slot.

Once the RSS Staff reviews and submits *the Retain Slot Form*, their response will appear in the *Form Status: RSS Reviewer Response* field.

- If the RSS Staff **Approves** or **Denies** the **Retain Slot Form** the CSB will be able to **View** the form to see any comments added by the RSS Staff.







If the RSS Staff **Needs More information**, the **Edit** option will be available.

- Click **Edit**, make appropriate changes, then Save the form and **Return to WaMS**.
- Choose **Send to RSS Staff** for approval.

11 Individual Support Plan

The Individual Support Plan (ISP) section in WaMS is used to enter information and attach documents necessary to determine services needed for an individual as well as the providers involved in providing services to the individual. To create an ISP in WaMS an individual must have an assigned slot. Additionally, the **Diagnosis** and **Living Situation** (***When On Waiver)*** in the Person's Information / Overview section must be completed.

The *Support Coordinator* is responsible for *Parts I through IV* of the ISP. The *Provider* is responsible for adding *Part V* and must have the *ISP Approver* role assigned in WaMS.

> **IMPORTANT: The following methods for both the CSB and the Provider(s) should be used for working with the ISP PRIOR to the CSB implementing the data exchange process with their electronic health records (EHR) system.**

CSB:

- Create new ISPs and Add Providers in the ISP section in WaMS
- Upload plan documents (Parts I-IV) in the ISP Attachments section:
  - Naming convention recommendation:

    [first initial][last name] Part I-IV [effective date] (e.g., GSmithPartI-IV100117.pdf)
- Use Form Notes to communicate with Providers

PROVIDER:

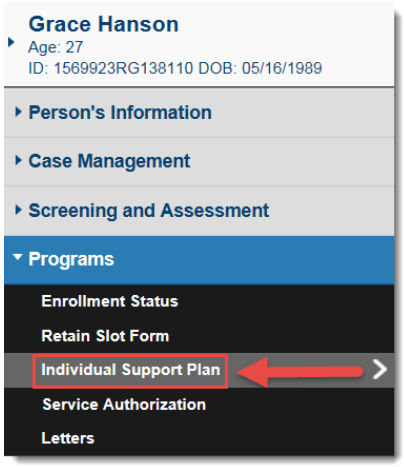
- Upload Plan for Supports (Part V) in the ISP Attachments section:
  - Naming convention recommendation:

    [first initial][last name] Part V [effective date (e.g., GSmithPartV100117.pdf)
- Use Form Notes to communicate with CSBs

11.1 Create New ISP

1. Locate the individual using one of the steps above in sections 9.1.1.1 (Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.

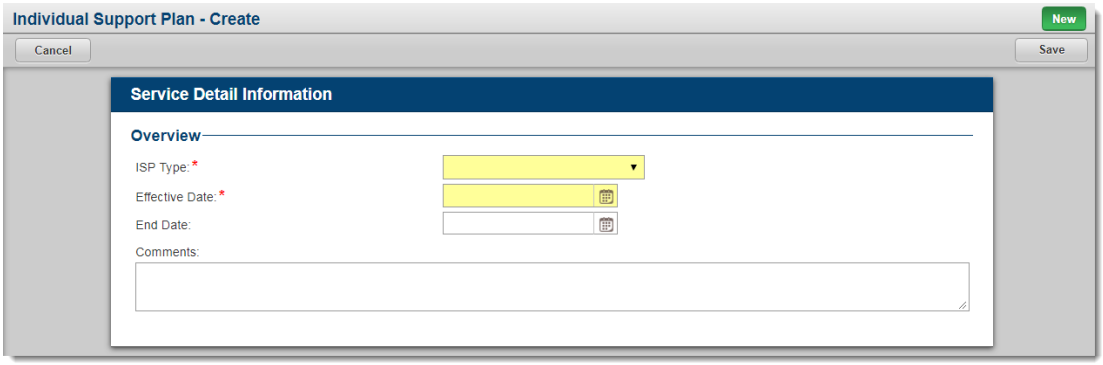
2. From the **Programs** section on the *left navigation bar*, click on **Individual Support Plan**.



The Individual Support Plan –List appears on the right.

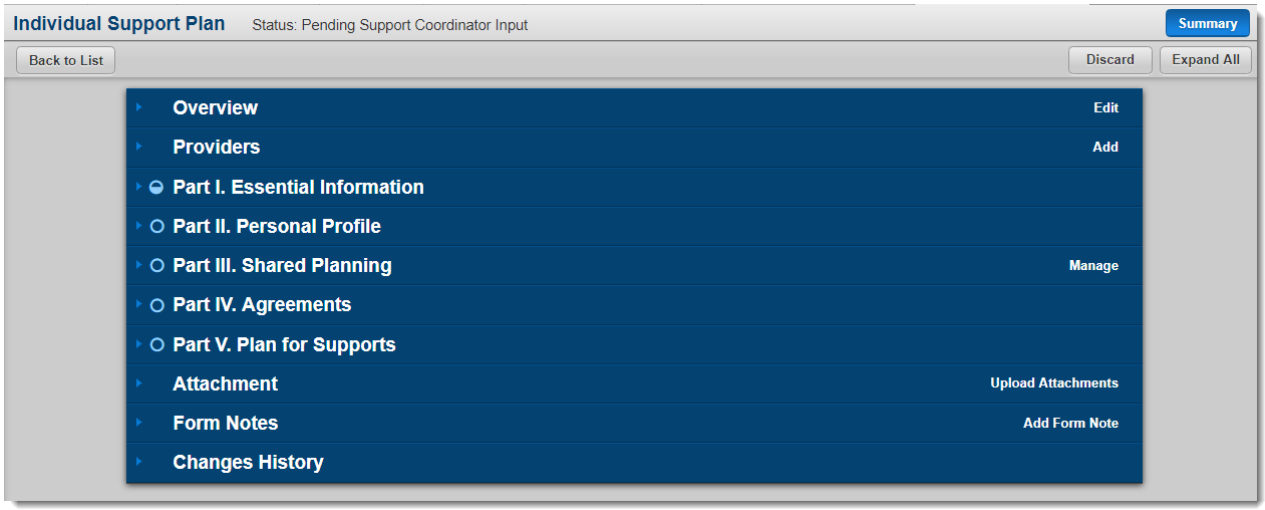
3. Click on **Create New**.
4. Confirm *Waiver* type from the *Select Waiver* drop down list.

5. Click on **Continue**. *The ISP Service Detail Information dialog box appears.*



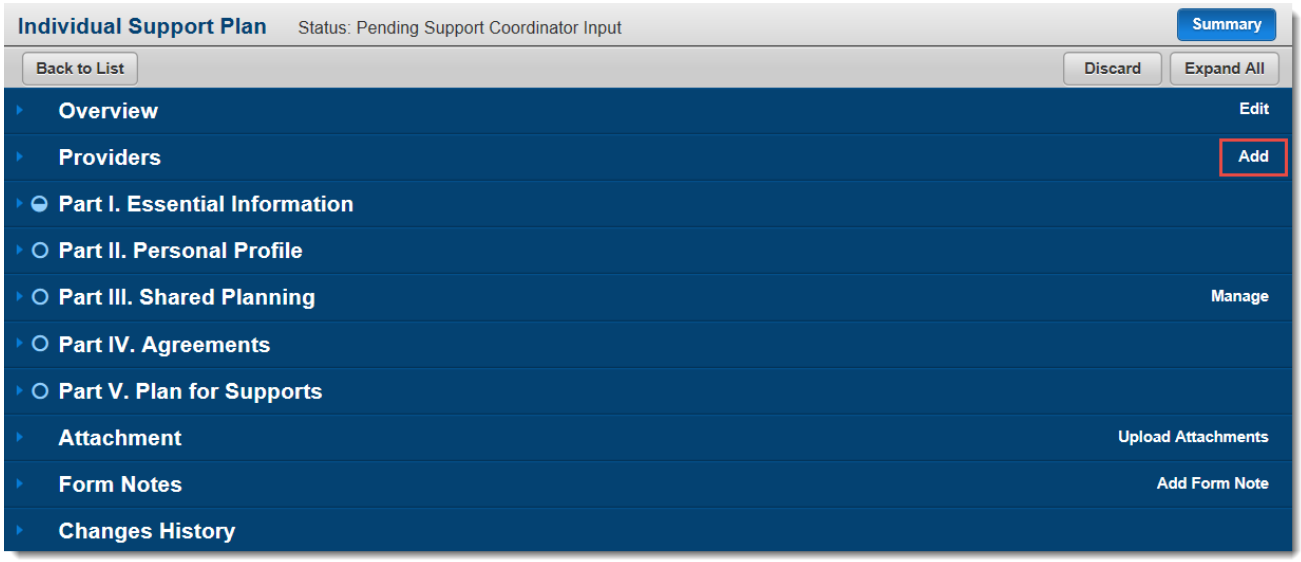
6. Click the *ISP Type* drop down arrow to select **Enrollment - new – ISP or initial**; or **Annual ISP – recertification** (use this option for every year following the initial ISP).
7. Click the **Effective Date** drop down arrow to select the ISP start date.
8. Add additional information as necessary in the **Comments** field.
9. Click on **Save**. The *Individual Support Plan – Summary* window appears and the ISP status is ***Pending Support Coordinator Input***.

Note: The default *End Date* is automatically calculated and inserted as one year from the Plan start date. This date can be changed at any time (for instance, if the Plan Year needs to end sooner, the end date can be changed to an earlier date). **End dates cannot be extended beyond one year**.

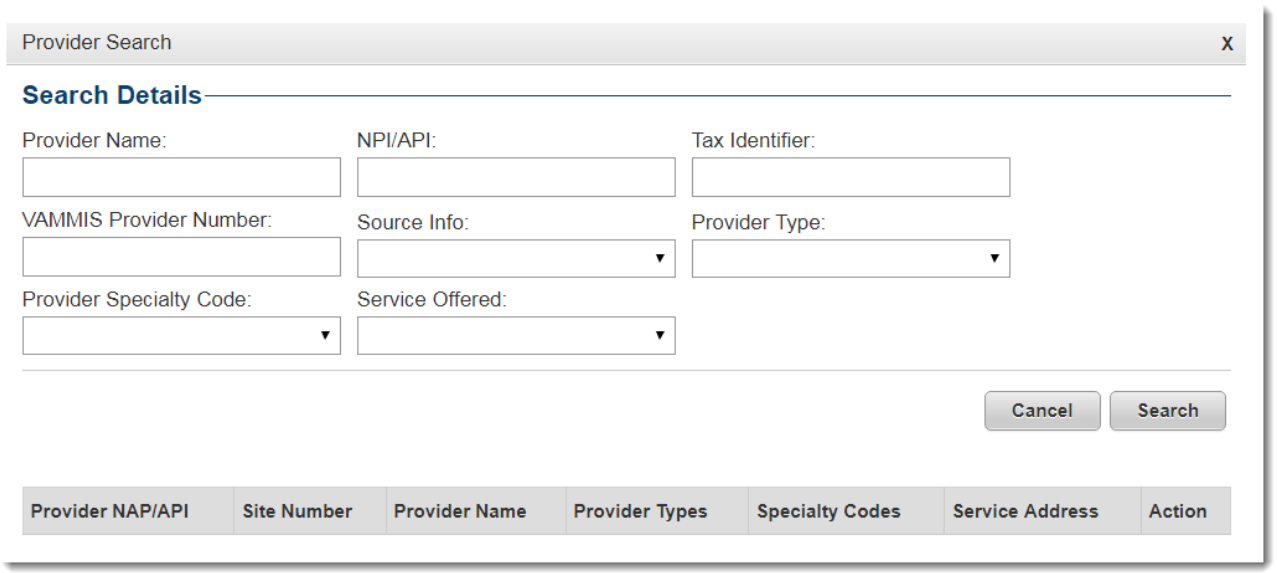


11.2 Add Provider

In order for Providers to have access to the ISP, upload attachments (*i.e., Part V, Plan for Supports*) and add Form Notes, the CSB must **Add** the Provider(s) who will be providing DD Waiver services to the individual.

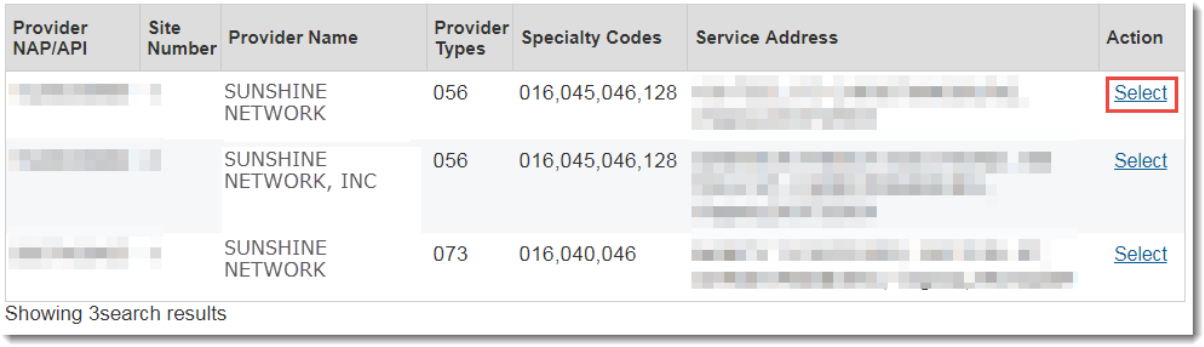


1. Click on **Add** from the *Providers* section. *The Provider Search dialog box appears.*



2. Input as much or as little search criteria as needed (*the more search criteria input, the narrower the results*).
3. Click **Search**. *The search results appear.*

4. Click **Select** to choose the appropriate Provider to be added to the ISP.

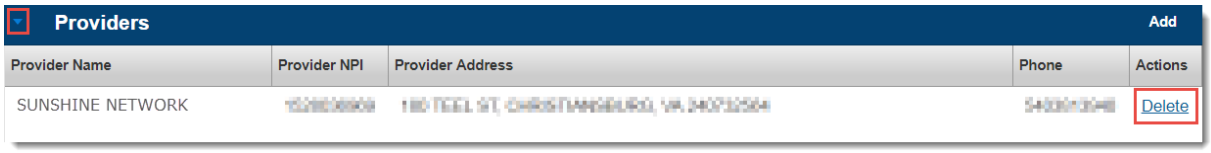


Provider NAP/API	Site Number	Provider Name	Provider Types	Specialty Codes	Service Address	Action
		SUNSHINE NETWORK	056	016,045,046,128		Select
		SUNSHINE NETWORK, INC	056	016,045,046,128		Select
		SUNSHINE NETWORK	073	016,040,046		Select

Showing 3search results

The ISP Main page reappears.

5. Click the **triangle** in the top left corner (next to Providers) to see all added providers.



Providers — Add

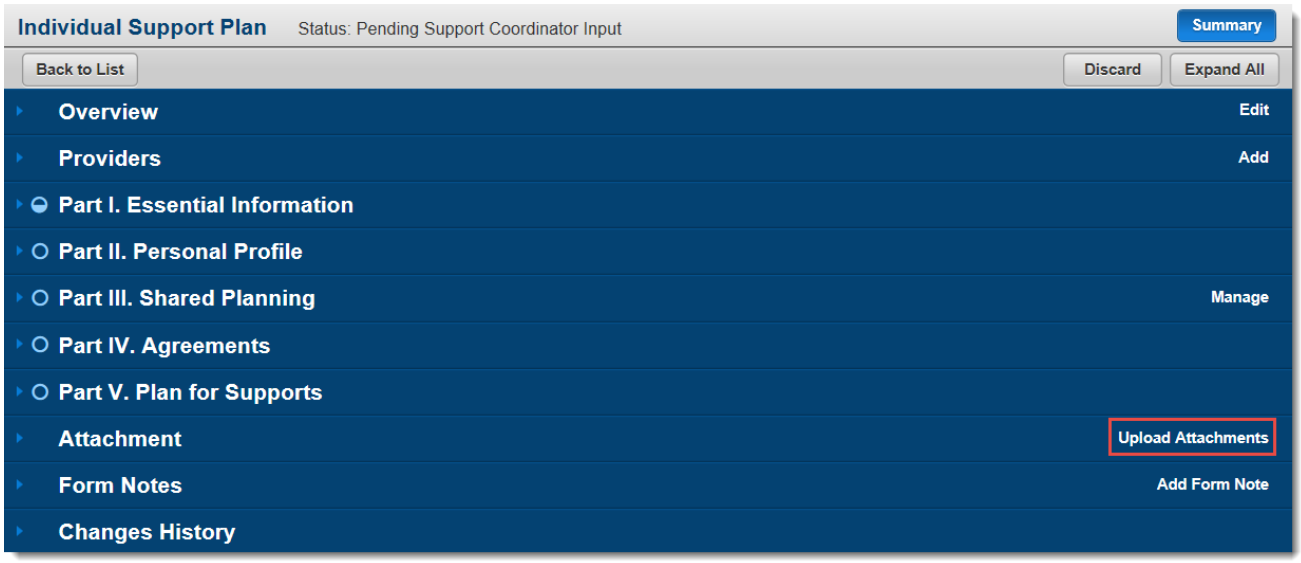
Provider Name	Provider NPI	Provider Address	Phone	Actions
SUNSHINE NETWORK				Delete

6. Click on **Delete** under *Actions* to remove an added provider.
7. Repeat steps 1 through 4 above to add additional providers.

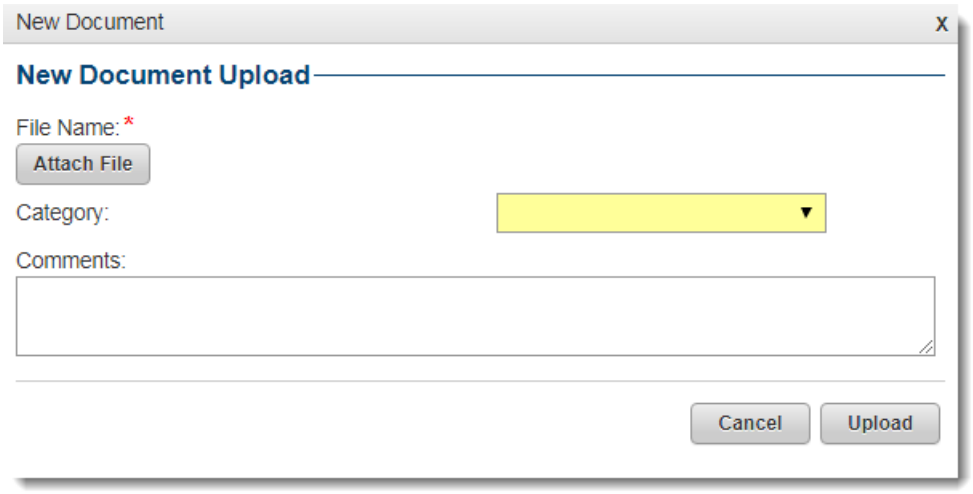
Note: Providers will lose access to an individual's details once the ISP end date has passed. They will also lose access if they are deleted from the ISP.

11.3 Upload Attachments to ISP

Attachments should be uploaded to an ISP in progress for the categories related to the plan such as, *Assisted Technology Plan, Environmental Modification, Nurse Plan, Therapeutic Consultation* and *Other*:



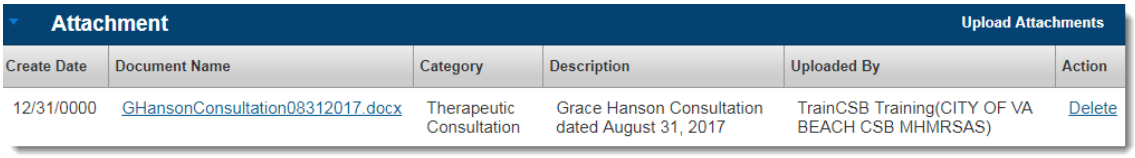
1. Click on **Upload Attachments** from the ISP *Attachment* section. *The New Document Upload dialog box appears.*



2. Click **Attach File** and browse to locate the attachment to upload.
3. Select the file to upload and click Open. *The file is attached and the file name appears above the Attach File button.*
4. Click the **Category** down arrow to select the appropriate category for the attachment.
5. Type a description for the attachment in the **Comments** field.
6. Click on **Upload**. *The file is attached and available in the Attachment section.*
7. Repeat steps 1 through 6 above to add additional attachments.
    a. Click the triangle next to *Attachments* to expand the category and click on the *Document Name* to download ad ded attachment(s).
    b. Click the triangle next to *Attachments* to expand the category to <u>delete</u> attachment(s).

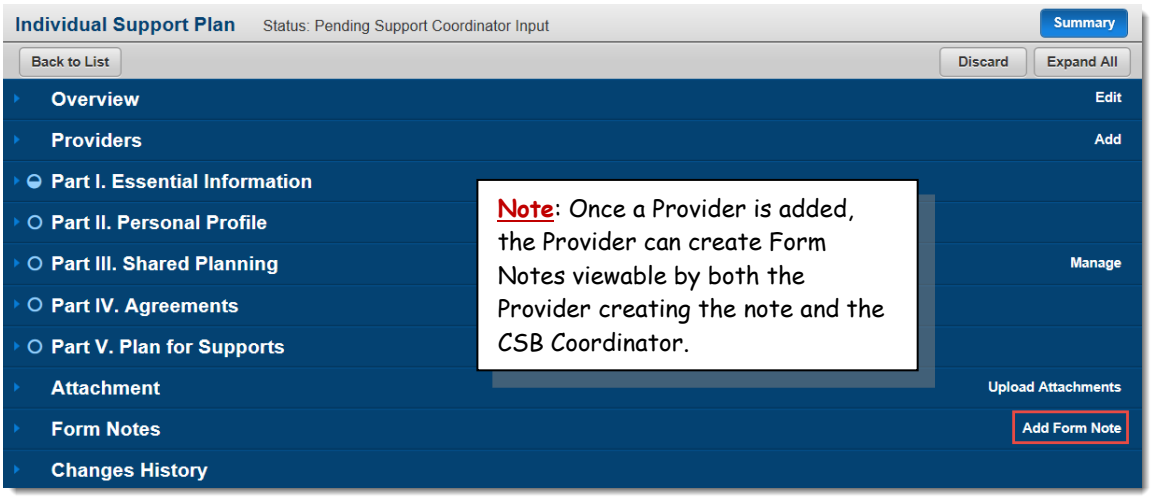
Assisted Technology Plan
Environmental Modification
Nurse Plan
Therapeutic Consultation
Other

Note: Attachments can only be deleted by the person who uploaded it.

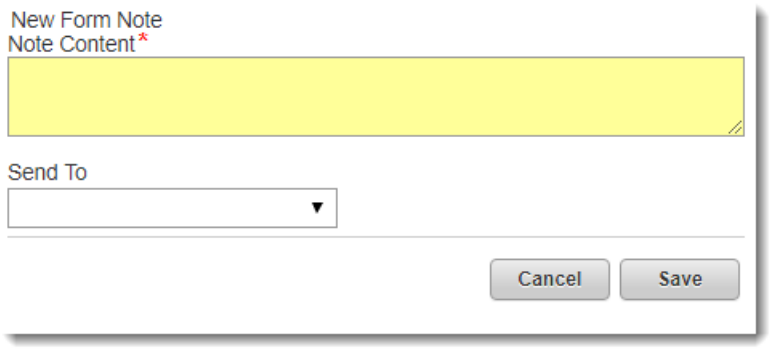


11.4 Add Form Note to ISP In Progress

Use *Form Notes* to communicate with Providers about the ISP.



1. Click on **Add Form Note** from the *Form Notes* section. *The Individual Support Plan New Form Note dialog box appears.*



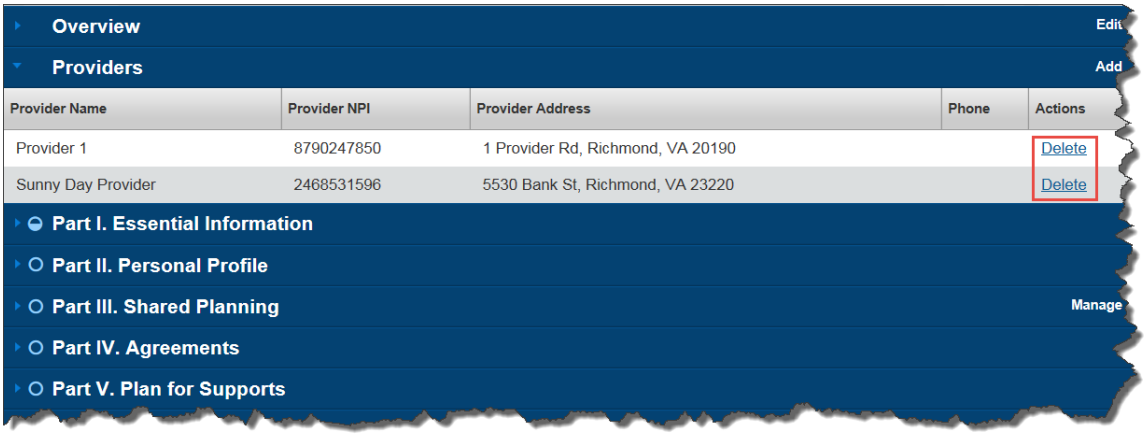
2. Enter the communication in the **Note Content** field.
3. To send the *Form Note* to a specific Provider, click the **Send to** down arrow to select the Provider who should see the note.
4. Click on **Save**. *The provider selected in the "Send To" list will receive an Alert that there is a note attached to the ISP.*

Note: To send the note to ALL Providers added for the individual, leave the "Send To" drop down box empty. As long as no specific provider is selected, ALL added Providers will be notified via an alert and will be able to view the Form Note.

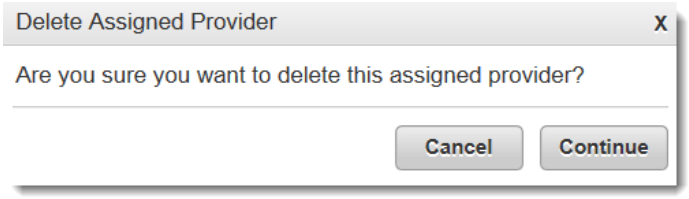
11.5 Remove Provider

Providers can be removed from the current year's ISP. Once a provider is removed, they will not have access to the ISP.

1. Click on the **Providers** heading. *The section will expand to display all added providers.*



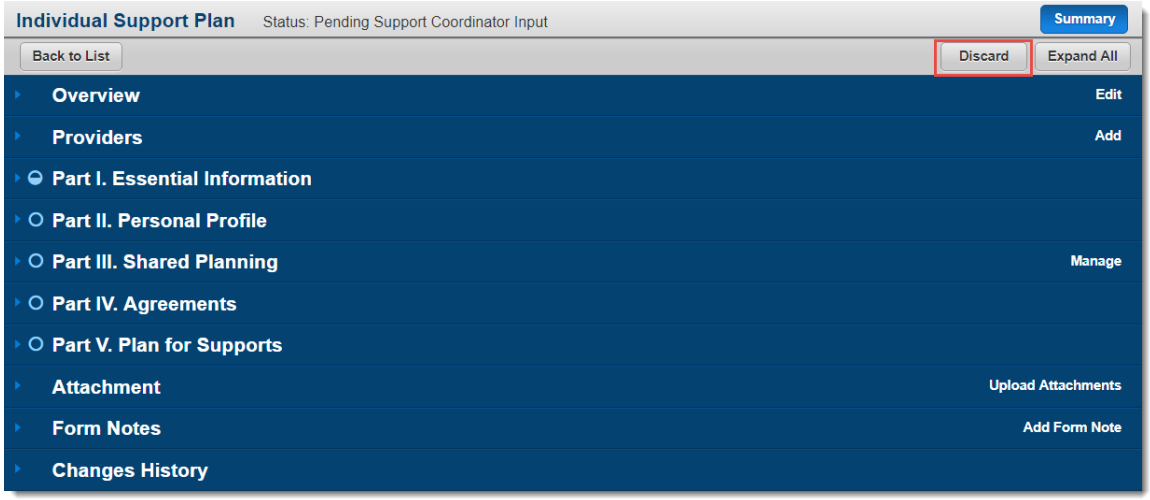
2. Under *Actions*, click on the **Delete** for the provider that should be removed from the ISP. *The Delete Assigned Provider box appears.*



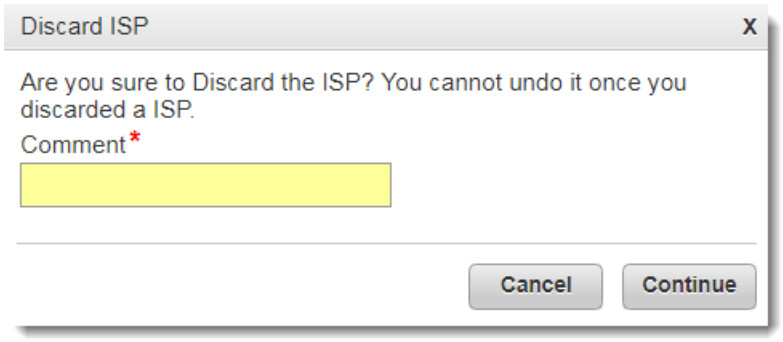
3. Click on **Continue**. The selected provider will be removed from the ISP.

11.6 Discard ISP

1. If necessary, select **Programs**, **Individual Support Plan** on the *left navigation bar* and click on **Summary** to open the ISP.



2. Click on **Discard**. *The Discard ISP box appears.*



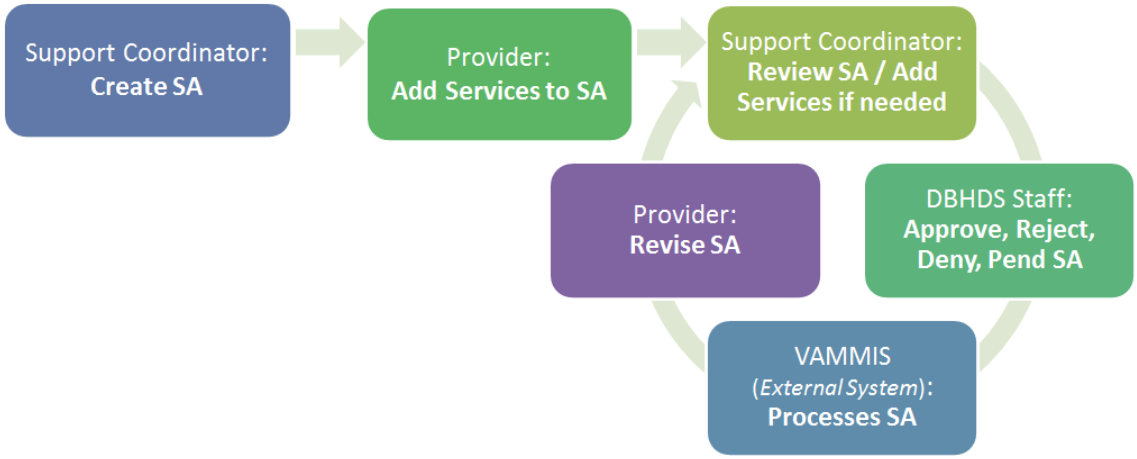
Note: Discard an ISP if it is opened in error. When an ISP is discarded, it will remain in the ISP list; however, it can no longer be edited!

3. Add a comment to the **Comment** field.
4. Click on **Continue**. *The ISP status will update to show as "Discarded".*

ISP Points to Remember
• An ISP can only be created when a person has an assigned slot
• During the time period that attachments for *Parts I-V* are being uploaded (i.e., Pre-EHR), the status for the ISP will remain in *Pending Support Coordinator Input* and will remain *Open* (in not complete status)
• The ISP process in this User Guide only applies until the CSB transitions to an automated data transfer of information from their EHR into WaMS OR a decision by the CSB to complete Parts I-IV directly into WaMS.

12 Service Authorizations

The overall process for requesting a Service Authorization (SA) is shown in the graphic below. The *Support Coordinator* begins the process by creating the SA.

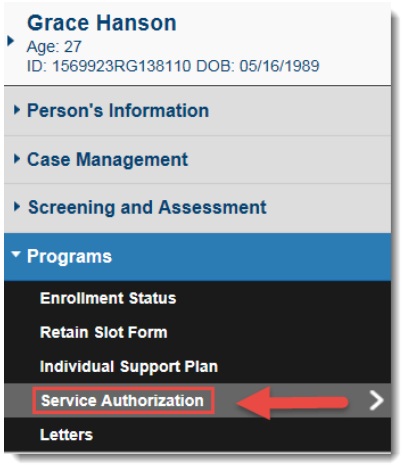


To create an SA the following must occur:

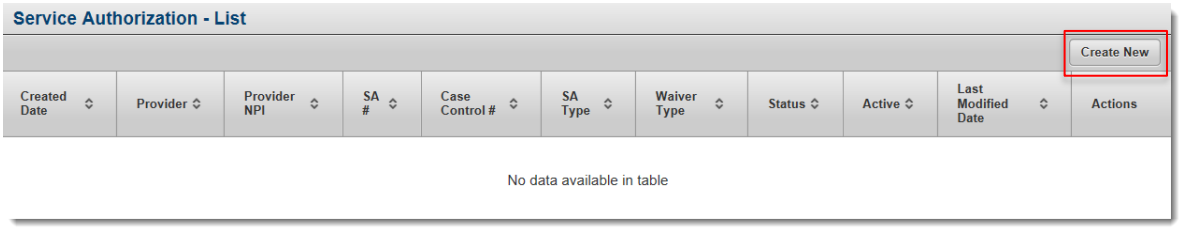
- Profile created (*See section 2.2 Add New Individual to WaMS*)
- VIDES submitted and LOF for DD Waiver Met (*See section 4.1: Create New VIDES*)
- Add Individual to the Waitlist (*See section 7.2: Add Individual to Waitlist)*
- Slot has been assigned by DBHDS
- Individual has an Active Enrollment Status (current or future) (*See section 9.1: Move from Projected to Active Status)*

12.1 Create Service Authorization

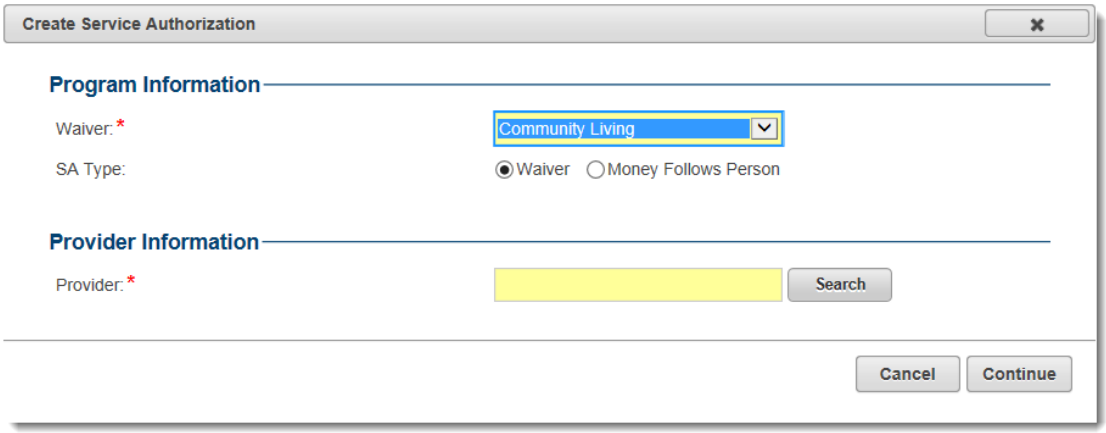
1. Locate the individual using one of the steps above in sections 9.1.1.1(Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.
2. From the **Programs** section on the *left navigation bar*, click on **Service Authorization**.



3. *The Service Authorization – List appears on the right.*

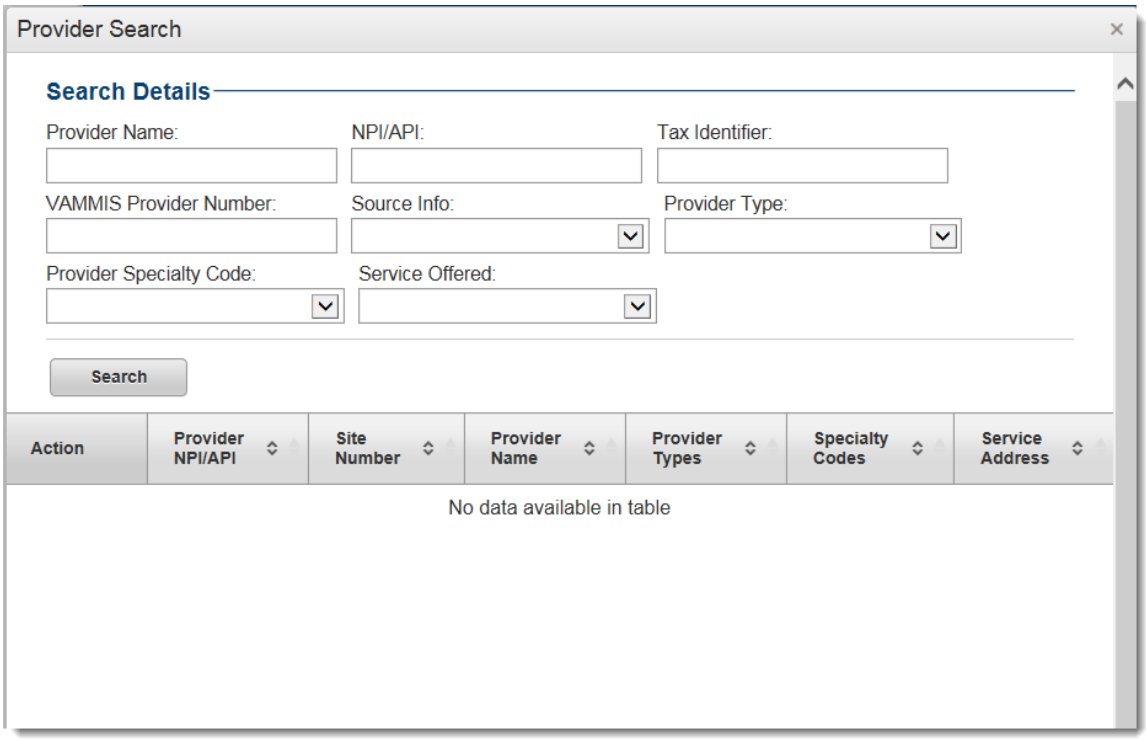


4. Click on **Create New**.
5. Confirm *Waiver* type from the *Select Waiver* drop down list.



12.1.1 Add Provider to Service Authorization

1. Click on **Search** to add the *Provider*. *The Provider Search dialog box appears.*



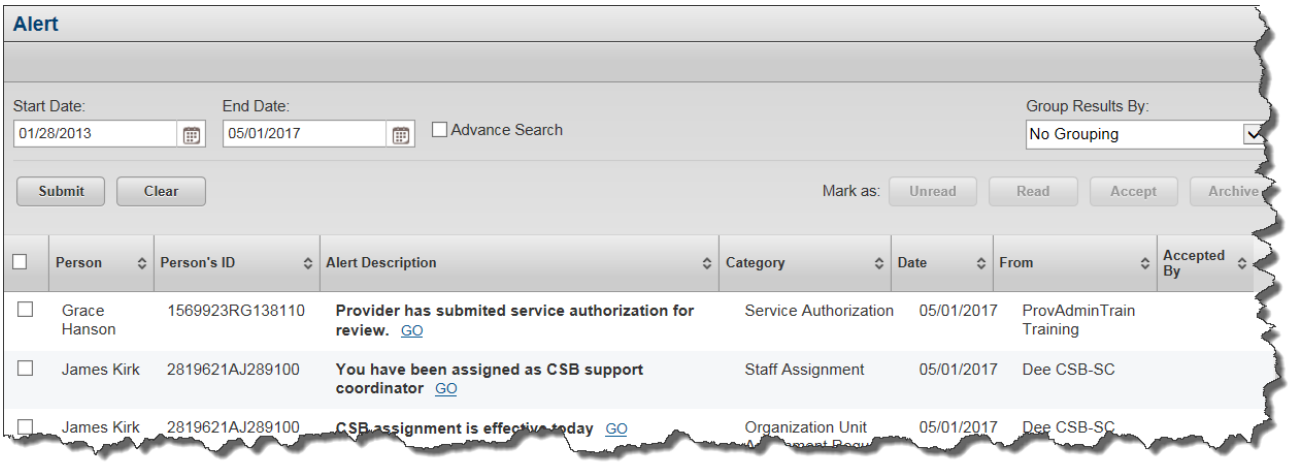
2. Input as much or as little search criteria as needed (*the more search criteria input, the narrower the results*).
3. Click **Search**. *The search results appear.*
4. Click **Select** to choose the appropriate Provider to be added to the SA.
5. Click on **Continue**. *The status shows as "Pending Provider Input". The Provider selected can now add services to the SA.*

12.2 Review Services

After the Provider has added service lines and submitted the SA back to the Support Coordinator, the Support Coordinator must review the SA. All service lines must be reviewed by the Support Coordinator before it can be submitted to DBHDS for review by the Service Authorization Consultants (a.k.a. PA Staff).

Note: Support Coordinators cannot add service lines before the provider has done so; however, service lines can be added, if necessary, during the review process.

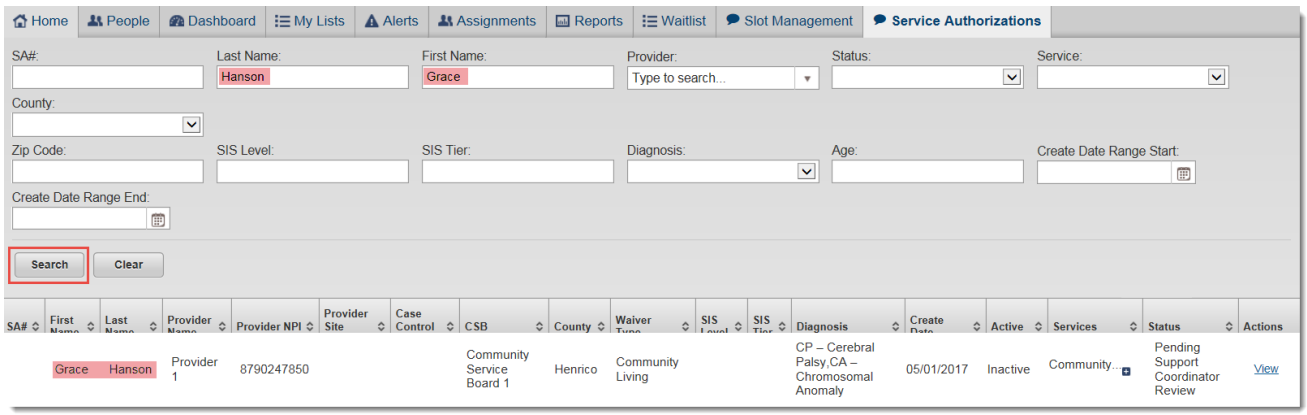
1. Locate the individual's SA using one of the steps above in sections 9.1.1.1(Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.



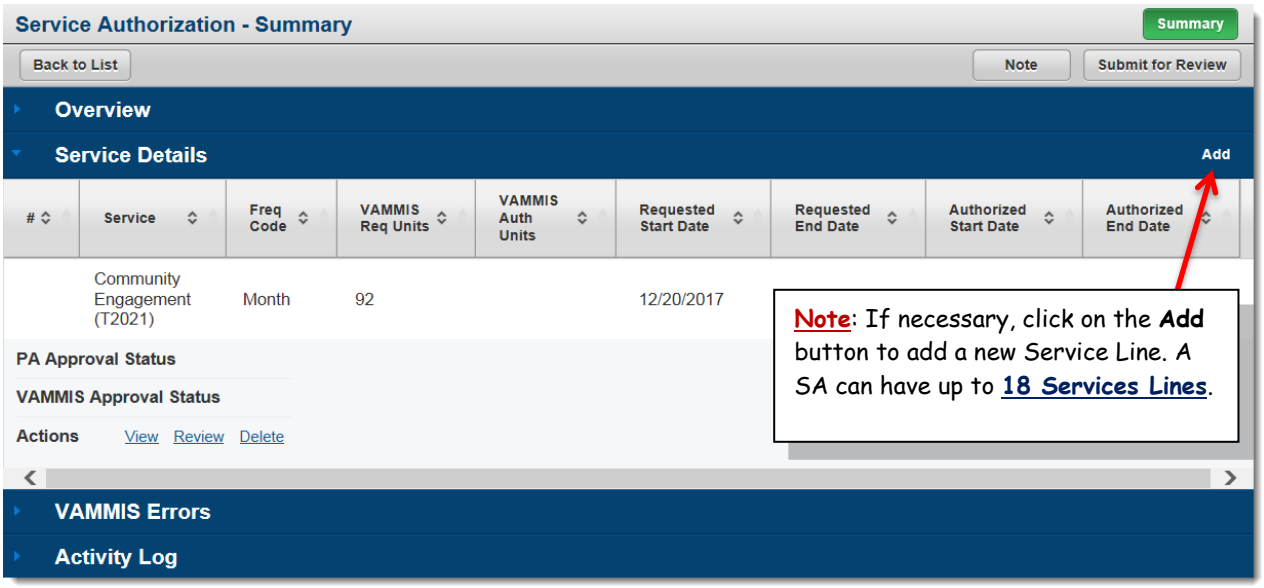
OR

2. Click on the **Service Authorization** tab.
7. Type in the criteria for the individual you are looking for (i.e., **Last Name**, and **First Name)**.
8. Click **Search**. *The search results will display a list of individuals which meet the search criteria.*

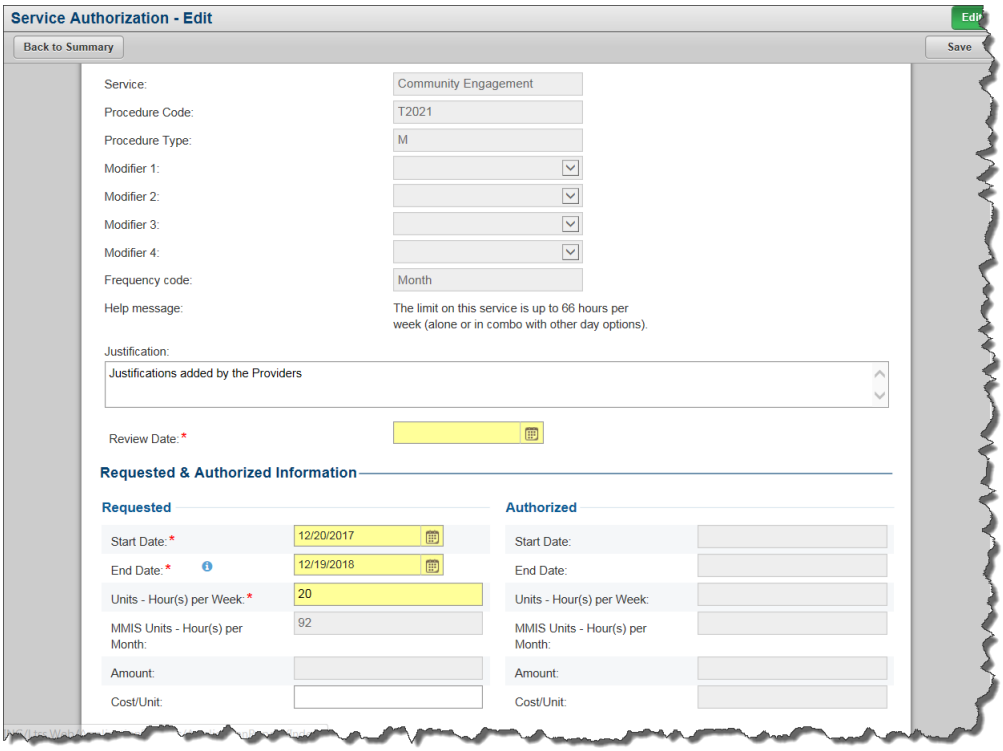
Note: Input as much information as you know in each field to retrieve the most accurate search.



9. Click on **View** link under *Actions* to open the SA. *The Service Authorization – Summary appears.*



10. Under the *Service Details* section, click on **Review**. *The Service Authorization - Edit window opens.*



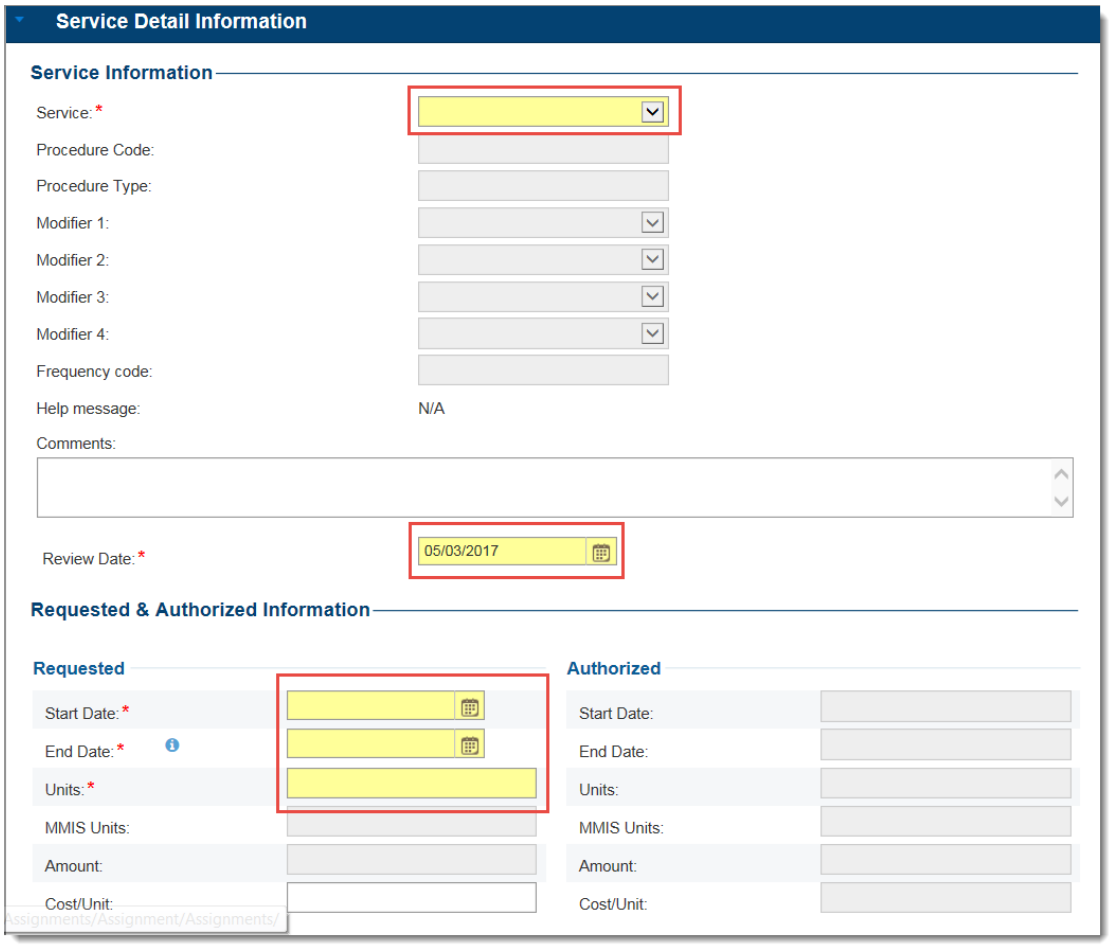
11. The *Justification* information for the service is added in the **Justification** field by the Provider. Make edits/adjustments to the justification area as necessary.
12. Modify the **Start Date**, **End Date**, **Units – Hour(s) per Week** fields if necessary, in the *Requested* section.
13. Click the **Calendar** icon for the *Review Date* to select the SA is being reviewed.
14. Click on **Save**.

12.3 Add Service Line

Support Coordinators can add service lines to an SA *after* the provider has added service lines and submitted the SA to the Support Coordinator. All service lines must be reviewed by the Support Coordinator before it can be submitted for review to the Service Authorization Consultants (a.k.a. PA Staff).

Note: Support Coordinators cannot add service lines before the provider has done so; however, they can be added, if necessary, during the review process.

1. Under the *Service Authorization – Summary* window, click on **Add**.



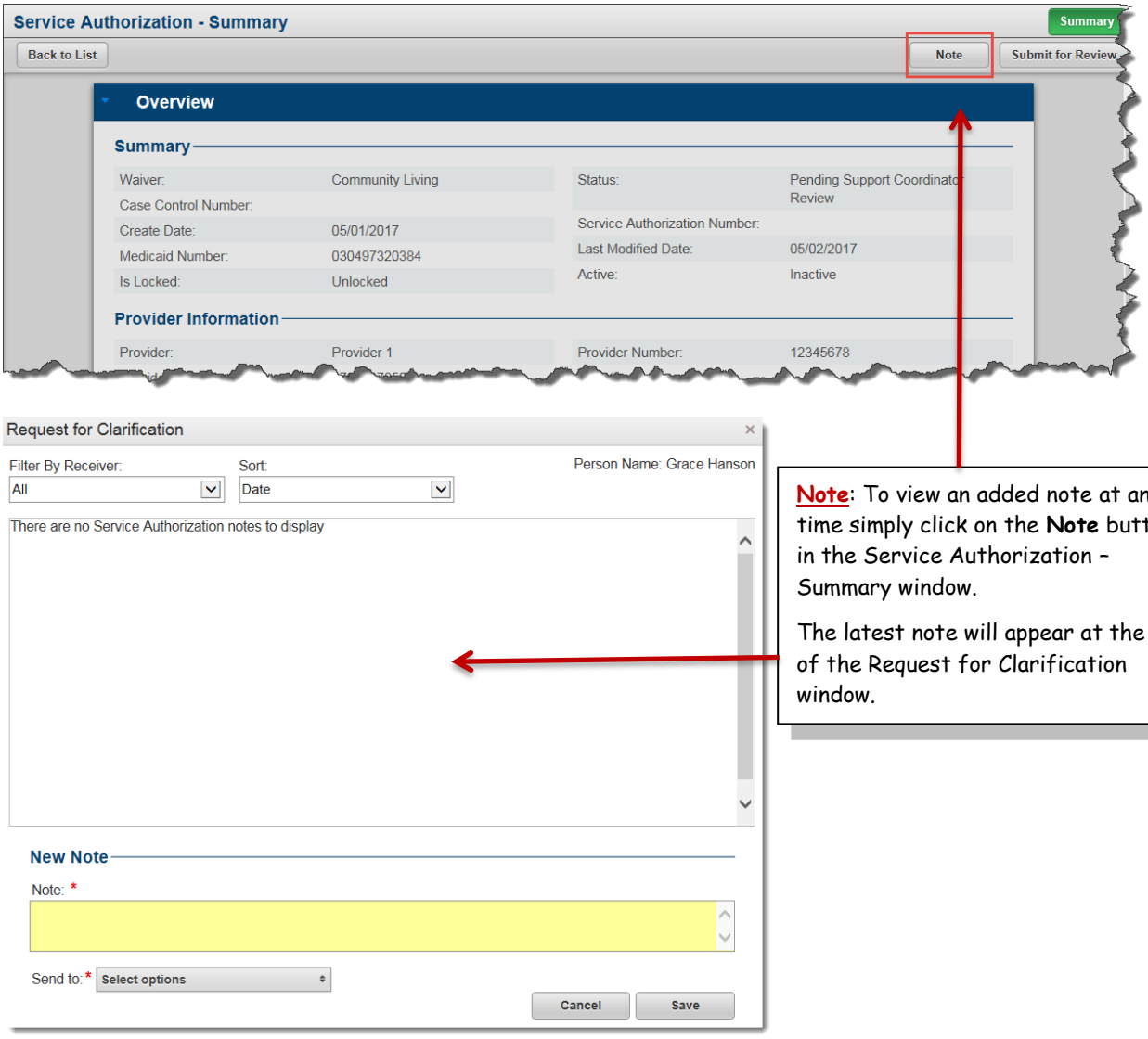
2. Under the *Service Information* and *Requested & Authorized Information* sections:
    a. Add *Comments* to provide information regarding the specific service for the PA Staff (*Service Authorization Consultants)*.
    b. The *Review Date* defaults to the current date.
    c. Select the *Service* drop down to choose the specific service,
    d. Click the *Calendar* icons to add the *Start* and *End Dates*.
    e. Add the number of *Units/Hours* for the service.
    f. Click on *Save*.

An SA can have a total of 18 service lines. After 18 lines have been added to a single, the system will automatically create a new SA with a new SA number.

12.4 Add Notes

Use *Notes* to communicate information regarding the SA to the Providers and DBHDS staff. The notes can be entered or viewed at any time. An *alert* will be sent to the selected organization(s) that a note has been added to the SA.

1. Click on **Note**. *The Request for Clarification note box appears.*



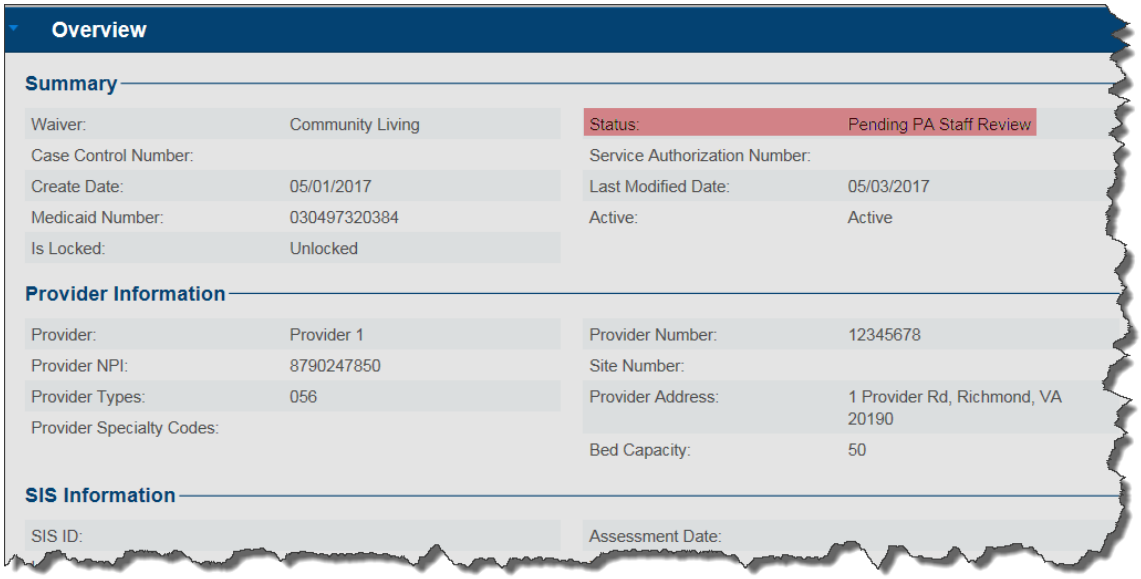
2. Click in the **Note** field to add the note.
3. Click the **Send to**: select arrows and select the appropriate organization(s) to send the note to (DBHDS or Provider).
4. Click on **Save**. *The Note is added to the Request for Clarification note box.*

12.5 Submit to PA Staff (Service Authorization Consultants)

Once all services have been added and reviewed, the *Support Coordinator* submits the SA to the *Service Authorization Consultants* for their review.

1. From the *Service Authorization – Summary* window, click on **Submit**. *The "Are you sure you want to submit for review?" dialog box appears.*

2. Click on **Continue**. *The SA is now in Pending PA Staff review status.*



Note: Once the SA is submitted for review, the SA can only be viewed. New service lines cannot be added and it cannot be deleted by the Provider or CSB; however, Notes can be viewed/entered at any time by clicking the "Note" button.

12.6 Revise SA

The SA can be revised by the Support Coordinator *or* the proposed Provider when the following conditions have been met:

- SA has the status of VAMMIS Approval Complete
- SA has at least one active service
- User has the Provider Admin user role

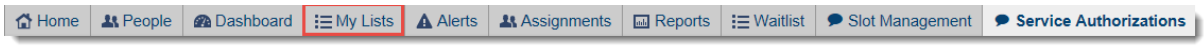
The Support Coordinator will need to create a *new* SA when:

- It is the first SA for the provider for an individual
- All services have ended/expired on all existing SAs for that provider
- A particular service (or group of services) is provided under a different provider number/NPI for the same provider

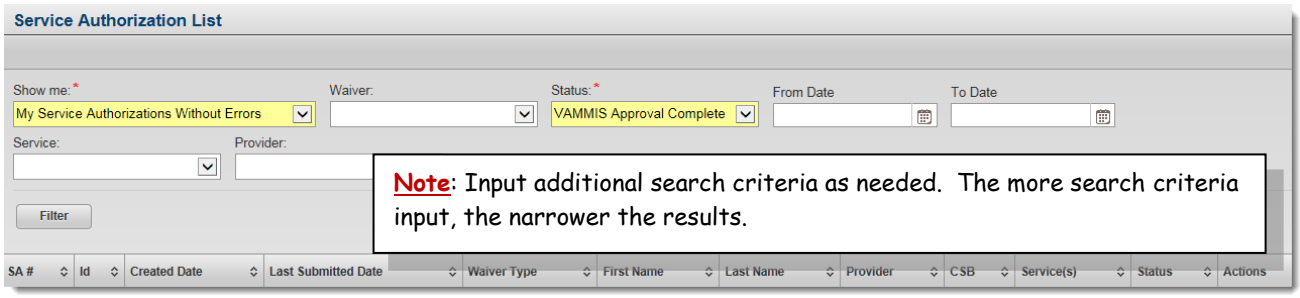
12.6.1 Locate the SA to be Revised

12.6.1.1 Using My Lists Tab

1. Click on the **My Lists** tab. *The My Lists window appears (displaying the Individual Support Plan and Service Authorization options on the left).*



2. Click on **Service Authorizations**. *The Service Authorizations List window appears.*
3. Click the **Status** down arrow to change to **VAMMIS Approval Complete**.



4. Click on **Filter**. *The search results appear. Select the specific Service Authorization that needs to be revised.*

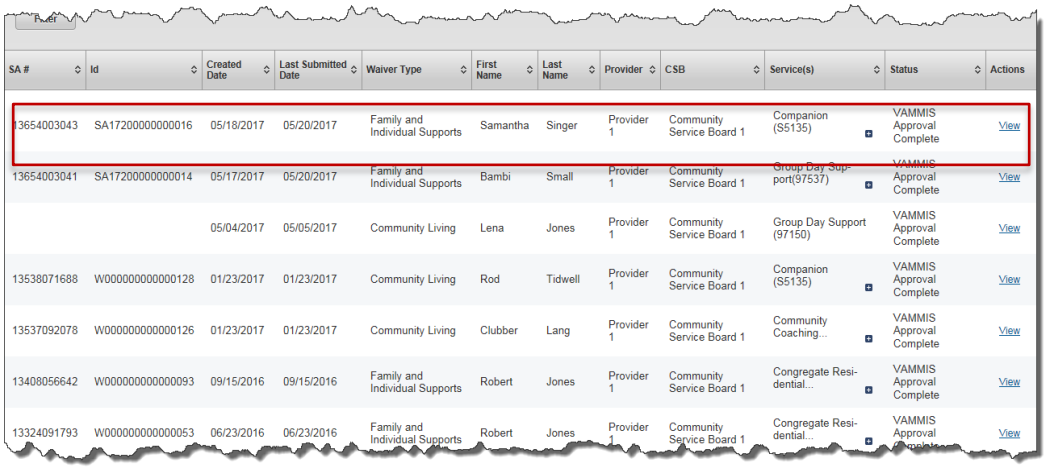
Note: You may need to scroll to find the appropriate SA.

OR

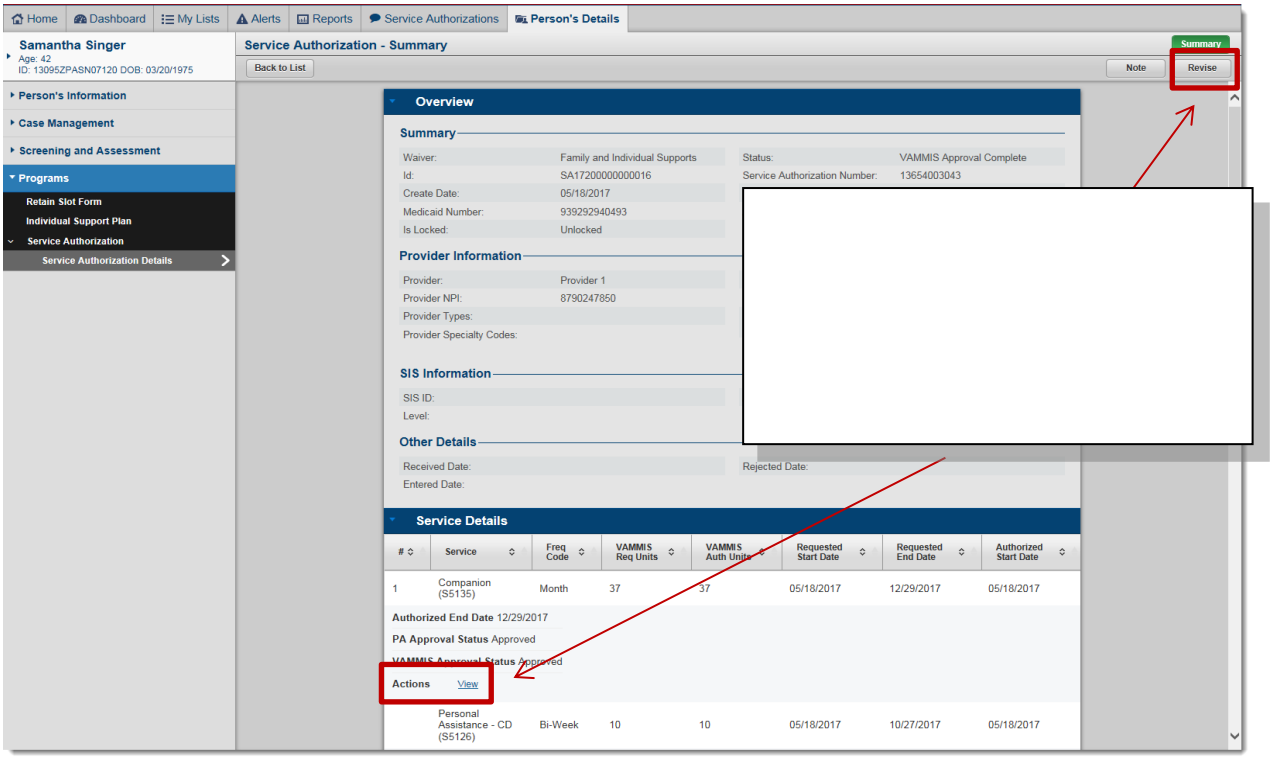
12.6.1.2 Using Service Authorizations Tab

The *Service Authorizations* tab can also be used to locate the SA. By using the SA tab, the individual's name is used to search without needing to know the status.

Follow the steps 2 through 5 in Section 12.2 above to search using the SA tab. The results will show all SAs associated with that individual.



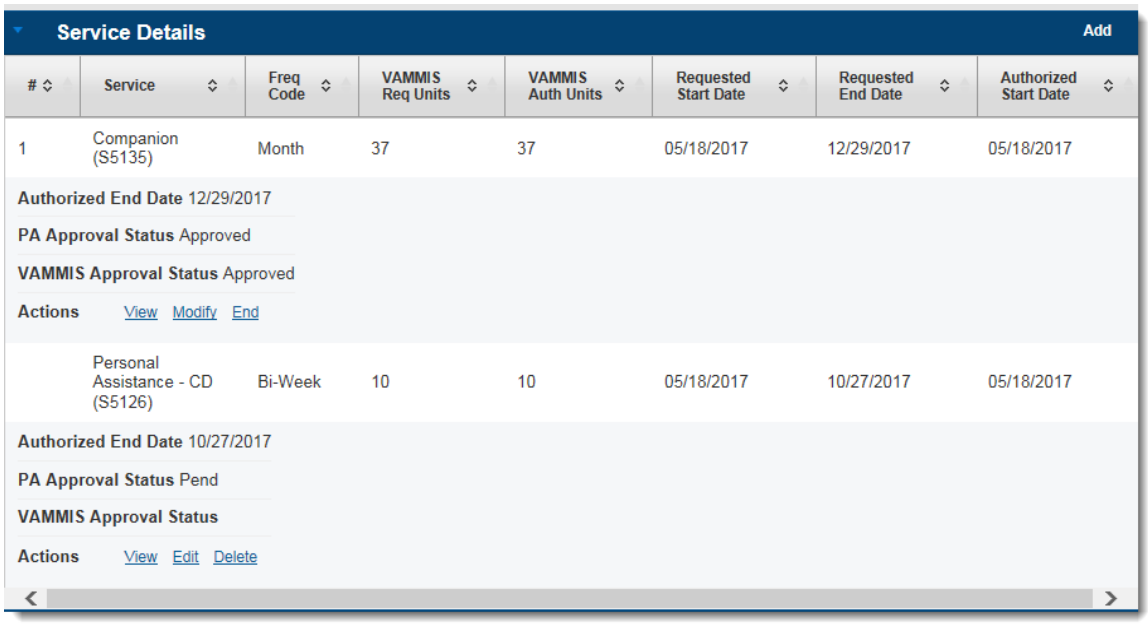
1. Click on **View** (*under Actions*) for the individual's SA that needs to be revised. *The Service Authorization – Summary window appears.*



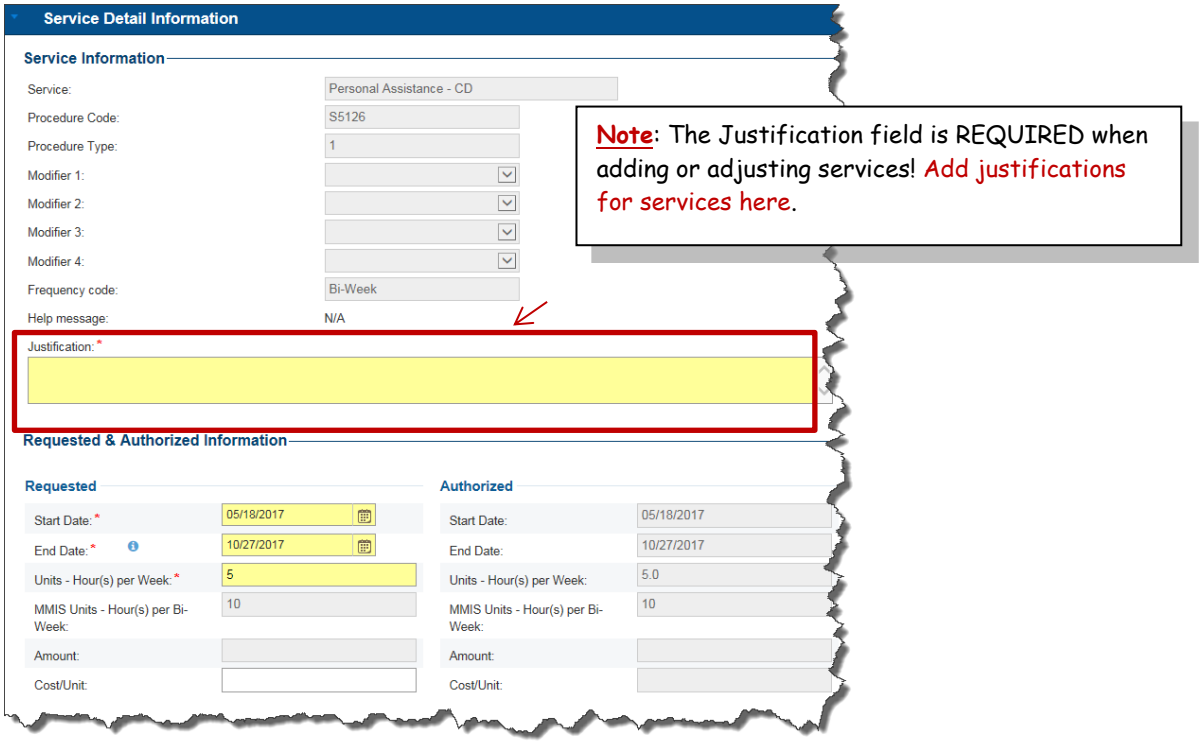
12.6.2 Revise the SA

1. Click on the **Revise** button. *The **Are you sure you want to revise?** prompt appears.*

2. Click on **Continue**. *The SA status changes to **Pending Provider Input** and can now be revised.*



- If the SA has been approved the *Modify* and *End* options are available for the service.
- If the SA has been pended, the *Edit* and *Delete* option are available for the service.
- If a New service is needed, the *Add* option is available.



The revised SA should be re-submitted to PA Staff for approval

13 Letters

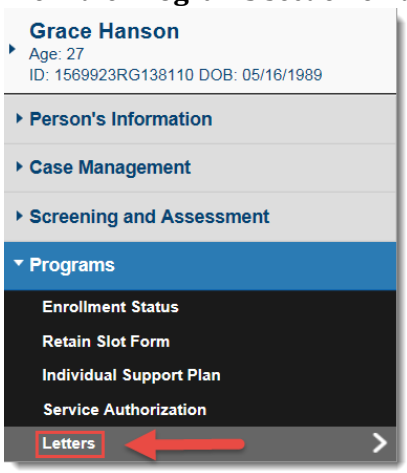
CSBs have the ability to create and print waiver letters for individuals directly from WaMS. Letters are located under **Programs**. There are two types of letters (*Slot Assignment* and *Notification of Right to Appeal*) that can be created for each Waiver type (Community Living, Family and Individual Supports and Building Independence).

The Slot Assignment Letter

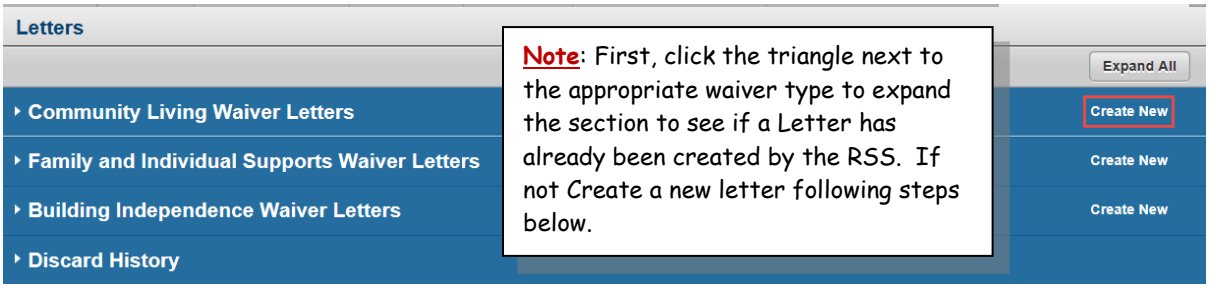
The Regional Support Specialists (RSS) at DBHDS usually create the Slot Assignment letter for Support Coordinator to print and provide to the individual; however, the CSB also has the ability to create the Slot Assignment Letter.

13.1 Create New Letters

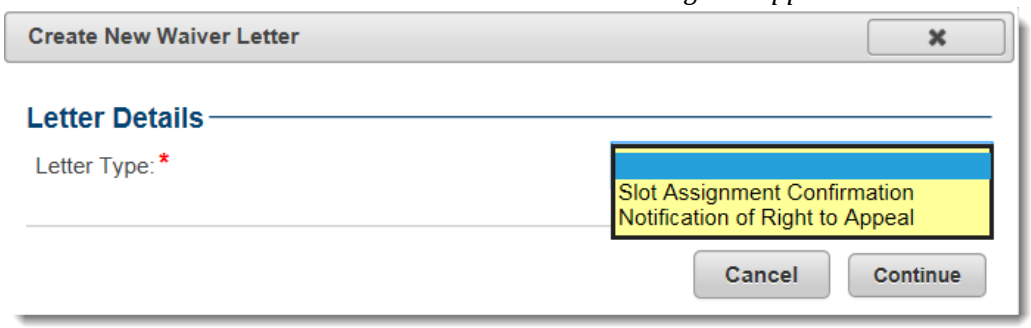
1. Locate the individual using one of the steps above in sections 9.1.1.1(Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.
2. From the **Programs** section on the *left navigation bar*, click on **Letters**.



The Letters window appears on the right.

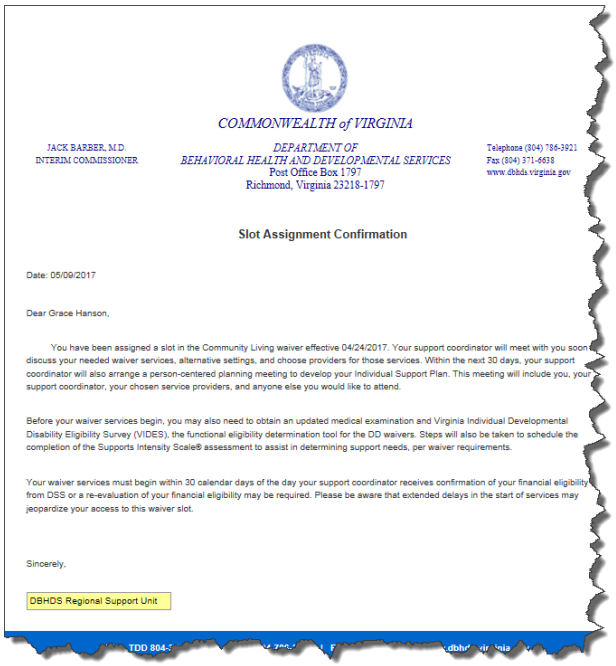


3. Click **Create New**. *The Create New Waiver Letters dialog box appears.*



4. Select the appropriate **Letter Type**.
   - *Slot Assignment Confirmation* Letter
     i. Informs the individual that they have been assigned a slot, and what to expect within the first 30 days, beginning with a call from their support coordinator.
     ii. Prints on DBHDS letterhead and signed by an RSS.
   - *Notification of Right to Appeal* Letter
     i. Titled *Notice of Action* once created
     ii. Used when there is a change to the individual's status for receipt of benefits.
     iii. Has four selections for the reason for the letter. More than one may be selected.
     iv. Signed by the CSB.
5. Click on **Continue**. *The Waiver Letter – Slot Confirmation window appears.*

Slot Assignment Confirmation Letter



COMMONWEALTH of VIRGINIA

JACK BARBER, M.D.
INTERIM COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

Slot Assignment Confirmation

Date: 05/09/2017

Dear Grace Hanson,

You have been assigned a slot in the Community Living waiver effective 04/24/2017. Your support coordinator will meet with you soon to discuss your needed waiver services, alternative settings, and choose providers for those services. Within the next 30 days, your support coordinator will also arrange a person-centered planning meeting to develop your Individual Support Plan. This meeting will include you, your support coordinator, your chosen service providers, and anyone else you would like to attend.

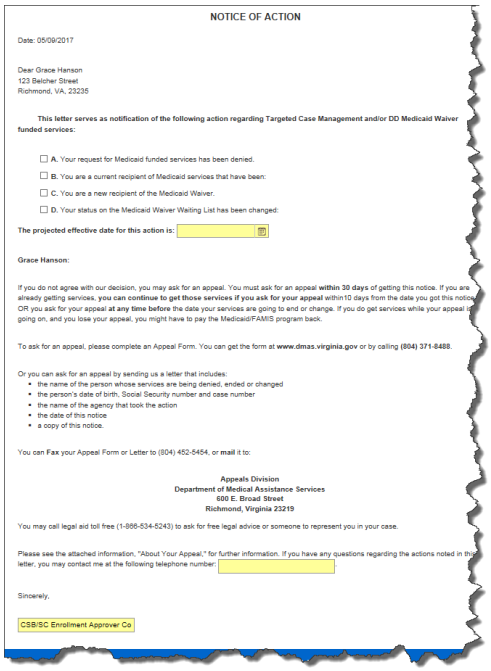
Before your waiver services begin, you may also need to obtain an updated medical examination and Virginia Individual Developmental Disability Eligibility Survey (VIDES), the functional eligibility determination tool for the DD waivers. Steps will also be taken to schedule the completion of the Supports Intensity Scale® assessment to assist in determining support needs, per waiver requirements.

Your waiver services must begin within 30 calendar days of the day your support coordinator receives confirmation of your financial eligibility from DSS or a re-evaluation of your financial eligibility may be required. Please be aware that extended delays in the start of services may jeopardize your access to this waiver slot.

Sincerely,

DBHDS Regional Support Unit

Notification of Action Letter



NOTICE OF ACTION

Date: 05/09/2017

Dear Grace Hanson
123 Belcher Street
Richmond, VA, 23235

This letter serves as notification of the following action regarding Targeted Case Management and/or DD Medicaid Waiver funded services:

☐ A. Your request for Medicaid funded services has been denied.
☐ B. You are a current recipient of Medicaid services that have been:
☐ C. You are a new recipient of the Medicaid Waiver.
☐ D. Your status on the Medicaid Waiver Waiting List has been changed:

The projected effective date for this action is:

Grace Hanson:

If you do not agree with our decision, you may ask for an appeal. You must ask for an appeal **within 30 days** of getting this notice. If you are already getting services, **you can continue to get those services if you ask for your appeal** within10 days from the date you got this notice OR you ask for your appeal **at any time before** the date your services are going to end or change. If you do get services while your appeal is going on, and you lose your appeal, you might have to pay the Medicaid/FAMIS program back.

To ask for an appeal, please complete an Appeal Form. You can get the form at **www.dmas.virginia.gov** or by calling **(804) 371-8488**.

Or you can ask for an appeal by sending us a letter that includes:
- the name of the person whose services are being denied, ended or changed
- the person's date of birth, Social Security number and case number
- the name of the agency that took the action
- the date of this notice
- a copy of this notice.

You can **Fax** your Appeal Form or Letter to (804) 452-5454, or **mail** it to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219

You may call legal aid toll free (1-866-534-5243) to ask for free legal advice or someone to represent you in your case.

Please see the attached information, "About Your Appeal," for further information. If you have any questions regarding the actions noted in this letter, you may contact me at the following telephone number:

Sincerely,

CSB/SC Enrollment Approver Co

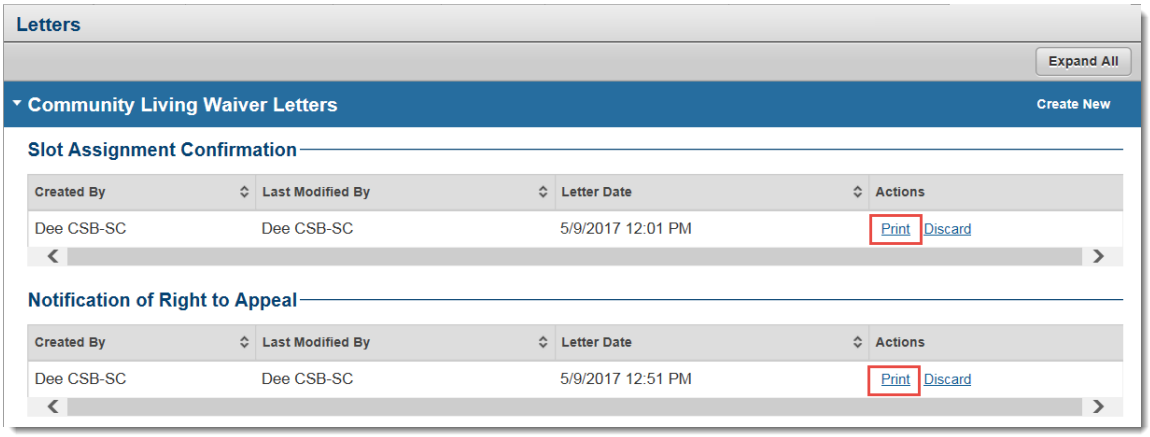
- For *Notice of Action* letter: Identify the purpose of the letter by clicking on the A, B, C and/or D check box(es), projected effective date and contact phone number.
    i. Square radio buttons – one or more selections may be selected
    ii. Circular radio buttons – only one selection may be chosen
- If desired, scroll to the bottom of the letter, below "Sincerely," click in the yellow field to type in name/title other than the default.

6. Click on **Submit**. The letter is saved in the appropriate waiver type section.

13.2 Print Letters

Once a letter is submitted, it is stored in WaMS and can be printed.

1. Access the appropriate letter(s) *(see number 2above*).
2. Click the down arrow next to the letter waiver type to be printed. *The Waiver type section expands.*
3. Click **Print** under *Actions*.

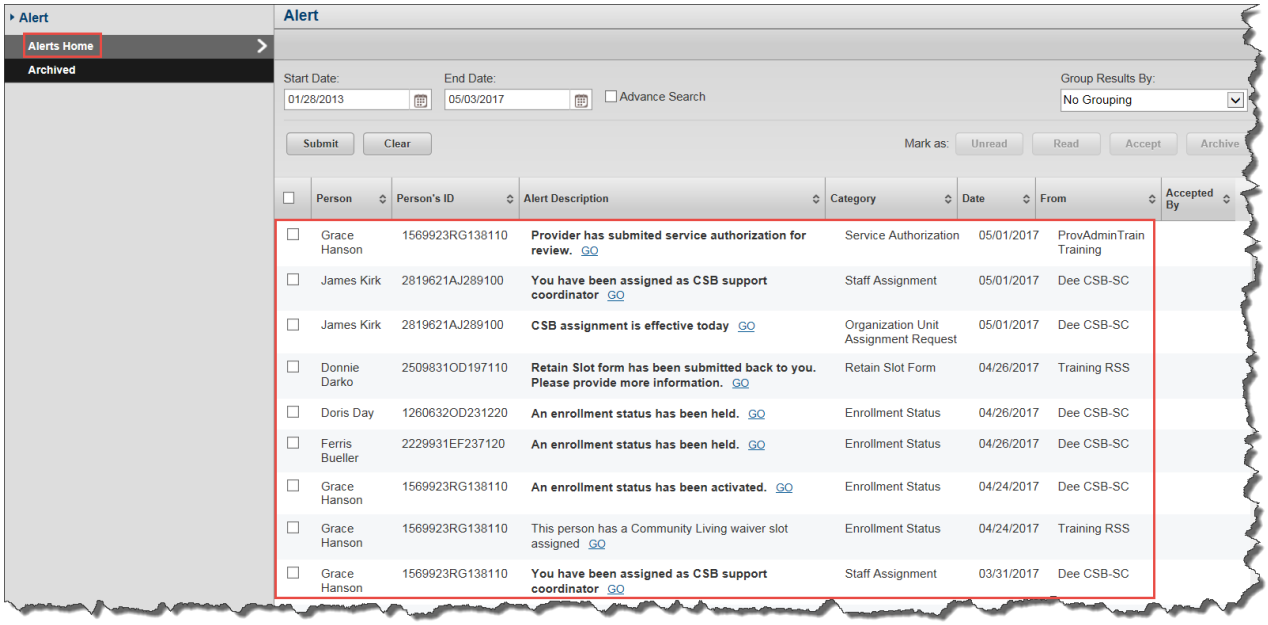


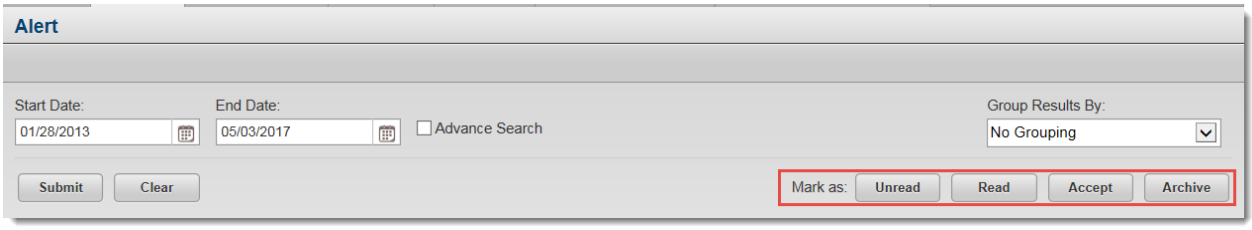
14 Miscellaneous

14.1 Alerts

Alerts inform the recipient that some type of action is required or has been completed. Alerts are specific to the user's role and assignments to specific tasks. Use Alerts to view and accept notifications from others. The list displays at most 500 records.

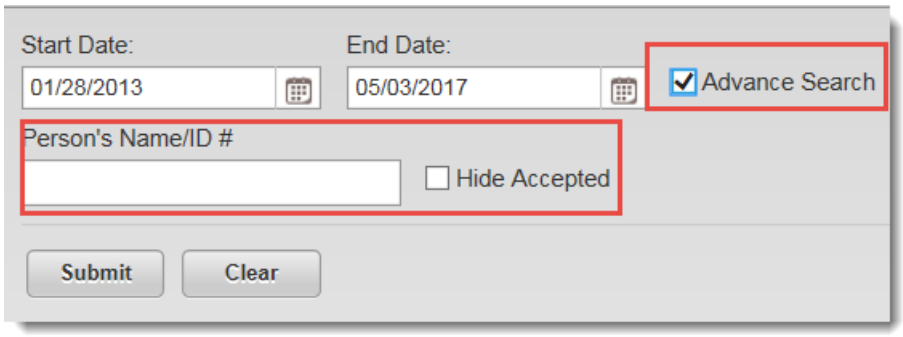
1. Click on the **Alerts** tab to display all current alerts.





2. Select the **Start** and **End** dates to narrow or broaden the search results.
3. Click the **check box** to the left of an individual's name to enable the *Mark as:* actions, then click on one of the actions:
    a. Unread – mark read items as *unread* to identify them as follow-up items. *Note*: *Unread and Read buttons will not be enabled at the same time*
    b. Read – mark unread items as read to identify completed actions or. *Note*: *Unread and Read buttons will not be enabled at the same time*
    c. Accept –Login name shows in the *Accepted By* column. This is a useful tool to easily identify what actions have been completed on the alert
    d. Archive – Move the selected alert to *Archived* (left menu item) to mark the alert as:

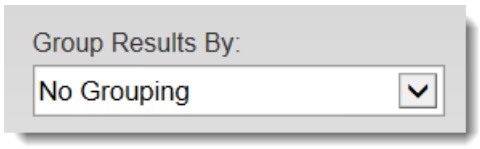
4. Click on **Archived** on the left nave bar to display all alerts that were marked as *Archive*.
5. Click on **Advance Search** check box to input the **Person's name or ID #.**



14.1.1 Grouping Alerts

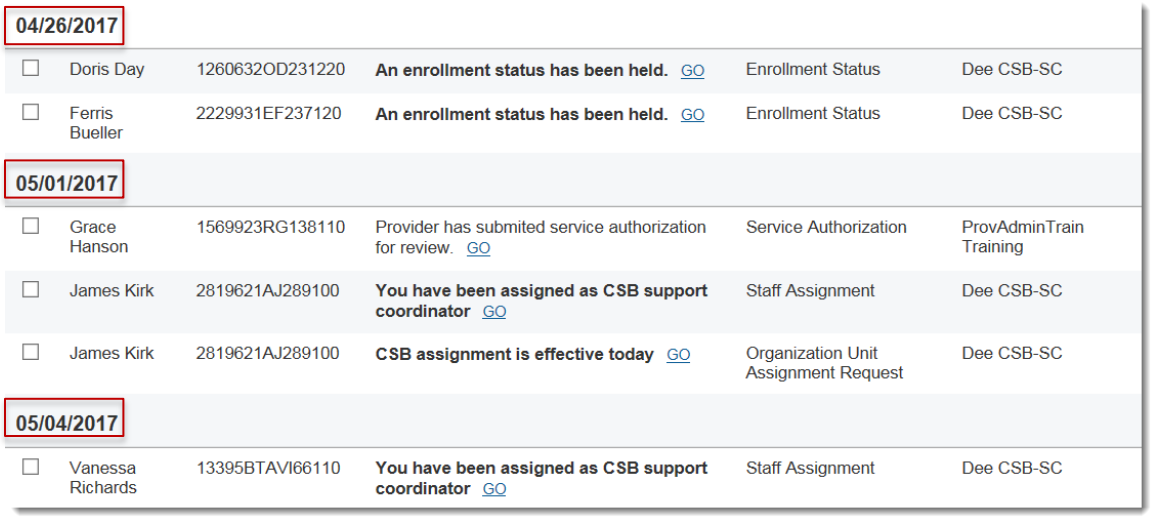
To easily sort and locate alerts, group them by a *Person's Name*, *Date* or *Category*.

1. Click on the **Group Results By:** down arrow.



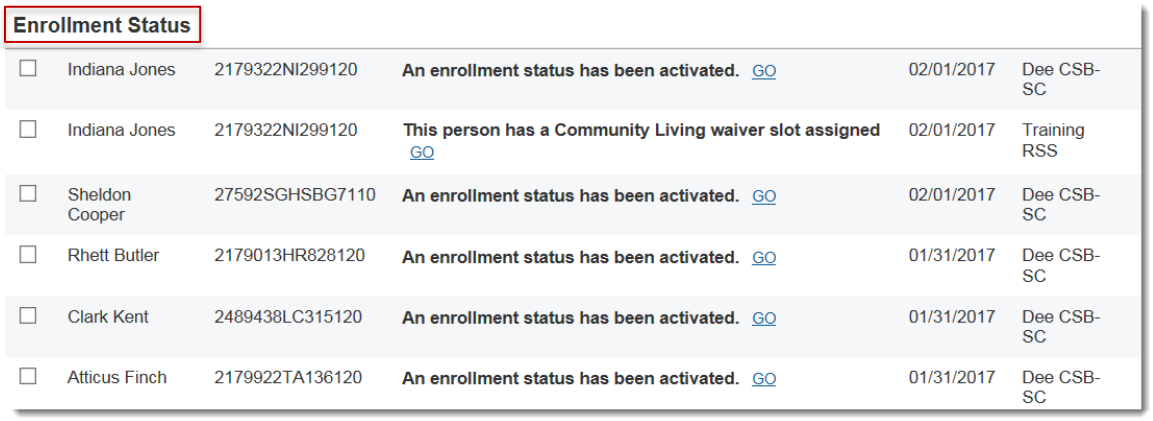
   a. Select **Person's Name** to group all alerts received for an individual together.

b. Select **Date** to group alerts by all individuals based on date the alert is received.



04/26/2017						
☐	Doris Day	1260632OD231220	**An enrollment status has been held.** GO	Enrollment Status		Dee CSB-SC
☐	Ferris Bueller	2229931EF237120	**An enrollment status has been held.** GO	Enrollment Status		Dee CSB-SC
05/01/2017						
☐	Grace Hanson	1569923RG138110	Provider has submited service authorization for review. GO	Service Authorization		ProvAdminTrain Training
☐	James Kirk	2819621AJ289100	**You have been assigned as CSB support coordinator** GO	Staff Assignment		Dee CSB-SC
☐	James Kirk	2819621AJ289100	**CSB assignment is effective today** GO	Organization Unit Assignment Request		Dee CSB-SC
05/04/2017						
☐	Vanessa Richards	13395BTAVI66110	**You have been assigned as CSB support coordinator** GO	Staff Assignment		Dee CSB-SC

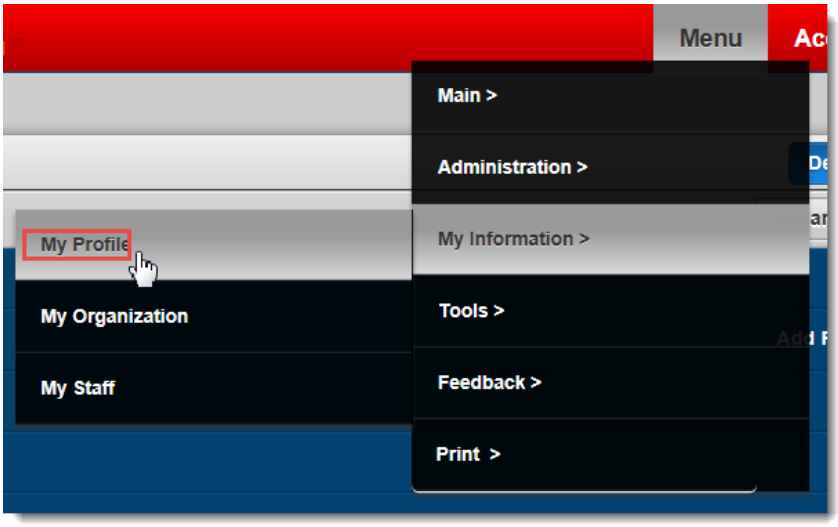
c. Select **Category** to group alerts by a category (i.e., *Staff Assignment, Enrollment Status, Service Authorization, Individual Support Plan, Organization Unit Assignment Request*).



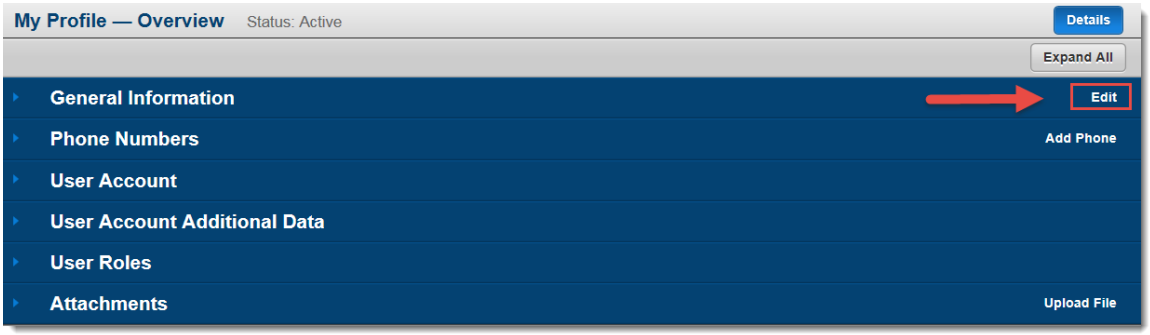
Enrollment Status					
☐	Indiana Jones	2179322NI299120	**An enrollment status has been activated.** GO	02/01/2017	Dee CSB-SC
☐	Indiana Jones	2179322NI299120	**This person has a Community Living waiver slot assigned** GO	02/01/2017	Training RSS
☐	Sheldon Cooper	27592SGHSBG7110	**An enrollment status has been activated.** GO	02/01/2017	Dee CSB-SC
☐	Rhett Butler	2179013HR828120	**An enrollment status has been activated.** GO	01/31/2017	Dee CSB-SC
☐	Clark Kent	2489438LC315120	**An enrollment status has been activated.** GO	01/31/2017	Dee CSB-SC
☐	Atticus Finch	2179922TA136120	**An enrollment status has been activated.** GO	01/31/2017	Dee CSB-SC

14.1.2 Alert Email Settings

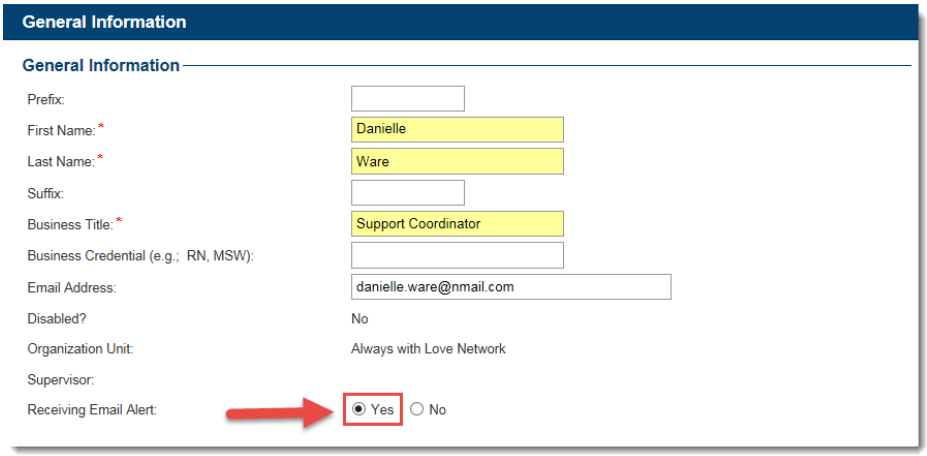
Update your user profile to be notified via email when an alert is sent in WaMS.



1. Click on **Menu**, **My Information**, **My Profile**. *The My Profile — Overview window appears*
2. Click on **Edit** for the *General Information* section.



3. Click on **Yes** radio button for the *Receiving Email Alert* section.



4. Click on **Save**.
5. Click on **Menu**, **Main**, **Home** to return to the WaMs main *Home* page.

14.1.3 Alert Categories (and text received)

Category	Alert Text
Enrollment Status	An enrollment status has been held.
	An enrollment status has been terminated.
	An enrollment status has been activated.
	This person has a {*program Name*} waiver slot assigned
	An enrollment status has been held.
	No additional extension to Retain the Slot are available. Please contact RSS.
	A Retain Slot Request must be submitted and the person placed on Hold status if the individual wishes to retain this slot.
	It has been 150 days since assignment to active enrollment status. Slot should be reassigned.
	It has been 120 days since assignment to active enrollment status and no SA has been submitted.
Individual Support Plan	The Individual Support Plan has been assigned to you
	A form note has been created
	A Form Note has been created
	The Individual Support Plan has been completed
	Individual Support Plan for this person is due on {*Due Date*}
	Attachment has been added to Individual Support Plan

Category	Alert Text
	Attachment has been removed from Individual Support Plan
	Attachment has been added to Individual Support Plan
	Attachment has been removed from Individual Support Plan
	The Individual Support Plan has been assigned to you
	Access to ISP has been revoked
Organization Unit Assignment Request	CSB assignment is effective today
	CSB assignment has been deactivated
	CSB assignment has been created effective {*Effective Date*}
	CSB transfer has been initiated. The current assignment will expire on {E*ffective Date*}
Retain Slot Form	Retain Slot Form has been submitted to you. Please review the form.
	Retain Slot form has been submitted back to you. Please provide more information.
Service Authorization	There is an error related to a Service Authorization.
	The Status Code for Service Authorization has been updated.
	The Status Code for Service Authorization has been updated.
	A new service authorization has been created.
	A service authorization has been deleted.

Category	Alert Text
	A person's slot has been released.
	Provider has submitted service authorization for review.
	A service authorization has been submitted to PA staff for review.
	A new service authorization has been submitted for review.
	A new note has been added to the Service Authorization record
	A new note has been added to the Service Authorization record
	A new note has been added to the Service Authorization record
	A service authorization has been sent back to provider.
	A service line has been removed from service authorization
	A service line has been removed from service authorization
	A service authorization has been sent back to Pending Support Coordinator Review.
SIS	Tier has changed from {*Previous Tier*} to {*Tier*} effective {*Assessment Date*}.
	Tier has changed from {*Previous Tier*} to {*Tier*} effective {*Assessment Date*}.
	Tier has added as {*Tier*} effective {*Assessment Date*}.
	Tier has added as {*Tier*} effective {*Assessment Date*}.

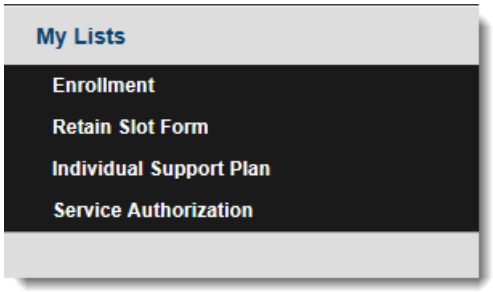
Category	Alert Text
Slot Assignment	Slot "{*Slot Number*}" has been released. This slot must be reassigned to another individual within 90 days of release.
Slot Deletion	Slot "{*Slot Number*}" has been deleted.
Staff Assignment	You have been assigned as CSB support coordinator
	You're no longer the assigned CSB support coordinator for this person

14.2 My Lists Tab

The *My Lists* tab allows for easy access to lists of individuals by of *Enrollment, Retain Slot*, *Individual Support Plan* and *Service Authorization*.

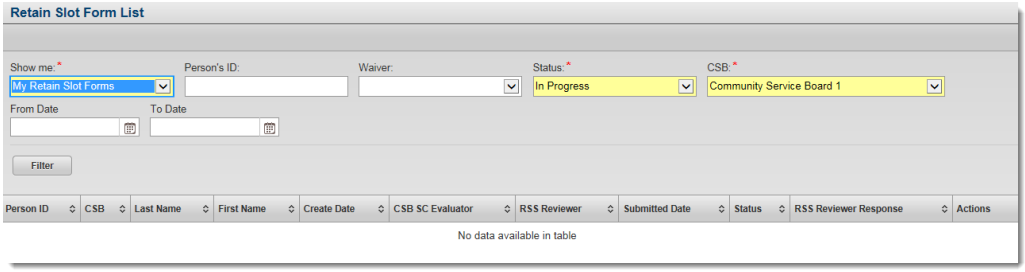
Note: CSBs are only able to view their own Organizational Unit ("OU").

1. Click on the **My Lists** tab. *The **My List** options appear on the left.*



14.2.1 Enrollment

1. Click on Enrollment.



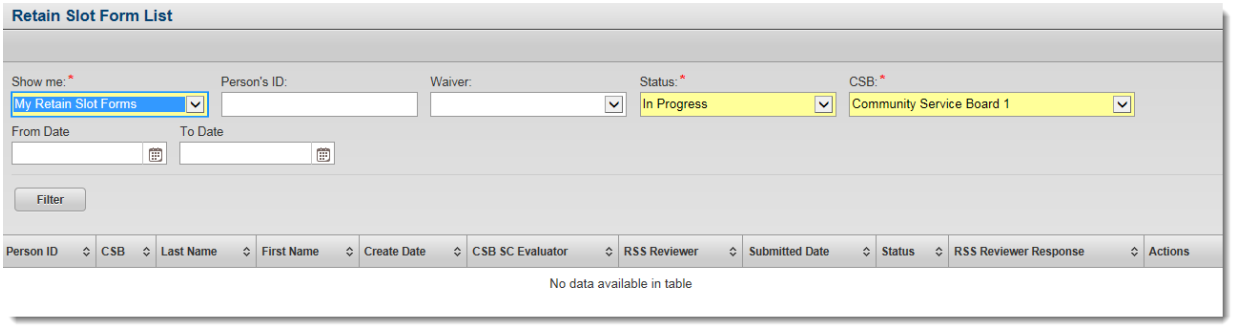
2. Complete required fields:
    a. **Show Me**
        i. My people with enrollment (those assigned to who is logged in)
        ii. People with Enrollment (everyone in the CSB)

b. **Status**
    i. Projected
    ii. Active
    iii. Hold
    iv. Released
    v. Pending Appeal
c. **CSB** (will default to the CSB of the person logged in)

14.2.2 Retain Slot

Access a list of assigned individuals with Retained Slots.

1. Click on **Retain Slot**.

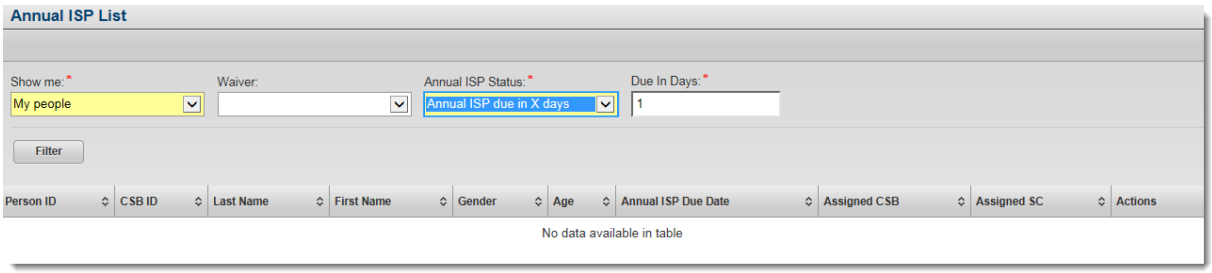


2. Complete required fields:
    a. **Show Me**
        i. My Retain Slot Forms (those assigned to who is logged in)
        ii. All Retain Slot Forms (everyone in the CSB)
    b. **Status**
        i. In Progress
        ii. Awaiting RSS Review
        iii. Awaiting CSB Response
        iv. Complete
        v. Discarded
    c. **CSB** (will default to the CSB of the person logged in)

14.2.3 Individual Support Plan

Access a list of assigned individuals with an Annual ISP status of Overdue or due in a given number of days

1. Click on **Individual Support Plan**.



2. Complete required fields:
    a. **Show Me**
        i. My people (those assigned to who is logged in)
        ii. All People (everyone in the CSB)
    b. **Annual ISP Status**
        i. Annual ISP overdue
        ii. Annual ISP due in X days
        iii. A required *Due in Days* field displays if Annual ISP due in X days is selected for you to add the specific number of days due

14.2.4 Service Authorizations

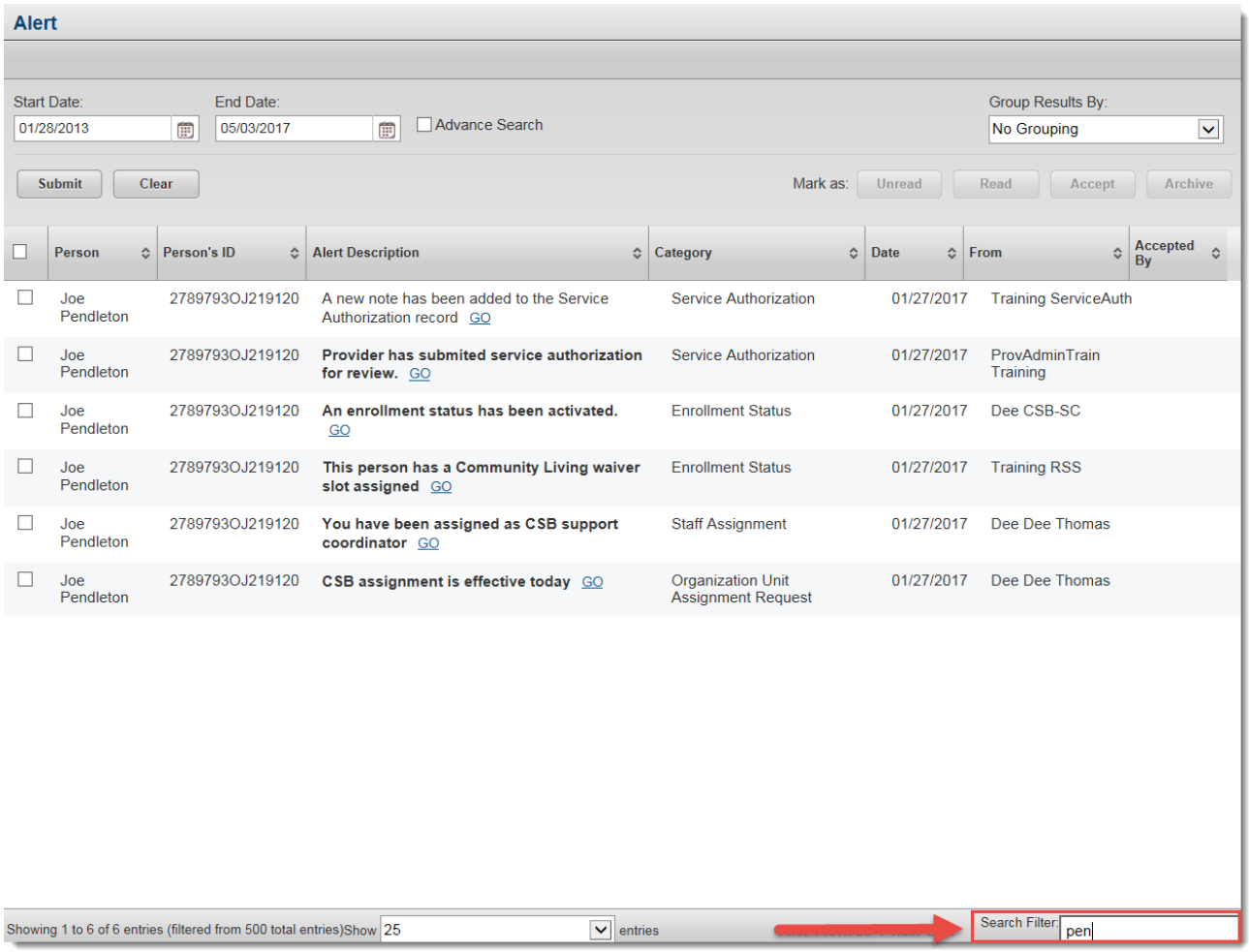
Access a list of assigned individuals with a Service Authorization based on status.

1. Complete required fields:
    a. **Show Me**
        i. My Service Authorizations without Errors (those assigned to the Support Coordinator)
        ii. My Service Authorizations with Errors (those assigned to the Support Coordinator)
        iii. All Service Authorizations without Errors (everyone in the CSB)
        iv. All Service Authorizations with Errors (everyone in the CSB)
    b. **Status**
        i. Pending Provider Input
        ii. Pending Support Coordinator Review
        iii. Pending PA Staff Review
        iv. Pending VAMMIS Approval
        v. VAMMIS Approval Complete
        vi. Waiver Slot Released
        vii. SA Terminated

14.3 Search Filter

When looking for a specific individual in the *My List* or *Alerts* or other tabs simply start typing their *first* or *last* name (or other column information known) in the *Search Filter* field (located in bottom right-hand corner) of each tab. The list will be filtered to display information that matches the criteria typed.

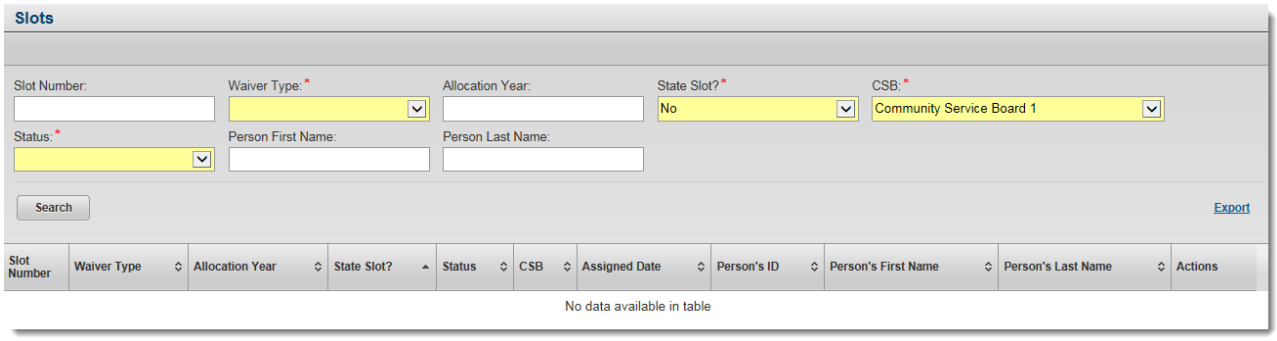
Begin typing the search criteria (i.e., first or last name) in the **Search Filter** field. *The list is filtered to display only the information that matches the criteria you type.*



14.4 Slot Management Tab

Use the **Slot Management** tab to view assigned slots by Waiver. The slot for a specific individual can be viewed by inputting their *first* and/or *last* name into the search criteria.

1. Click on the **Slot Management** tab. *The Slots window appears.*



2. Complete required fields using the drop-downs
    a. Waiver Type
        i. Community Living
        ii. Family and Individual Supports
        iii. Building Independence
    b. State Slot
        i. Defaults to No
    c. CSB
        i. Defaults to the CSB
    d. Status
        i. Available
        ii. Assigned
        iii. Assigned to Wave
3. Add known optional information to narrow the search
4. Click on **Search**.

> **Note**: The search will not yield results if there is a conflict in search criteria. Example: Person is not in the identified Waiver Type.

14.5 Search by Slot Number

1. Click on the **Slot Management** tab. *The Slots window appears*.
2. Add the Slot Number in the Slot Number field. *The required fields (Waiver Type, State Slot? and Status) are no longer required fields.*
3. Click **Search**.

14.6 Export Slot Information

1. Click on the **Slot Management** tab. *The Slots window appears*.
2. Complete required fields using the drop-downs
    a. Waiver Type
        i. Community Living
        ii. Family and Individual Supports
        iii. Building Independence
    b. State Slot
        i. Defaults to No
    c. CSB
        i. Defaults to the CSB
    d. Status
        i. Available
        ii. Assigned
        iii. Assigned to Wave

3. Add known optional information to narrow the search
4. Click on **Search**.
5. Click the **Export** link (above the *Actions* column).

6. Click to **Open** or **Save** the .xls file (or **Cancel** the export).
    a. Click on the Excel file at bottom of desktop; or
    b. Open from the *Save* location

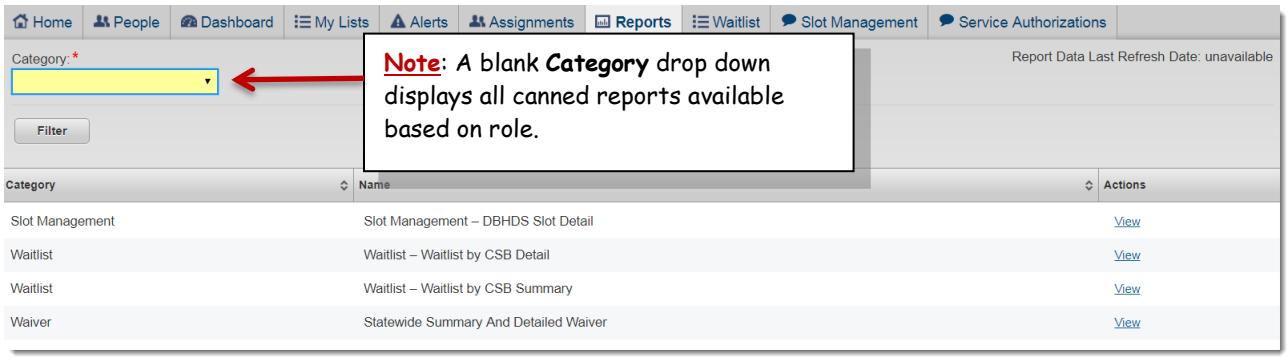
14.7 Reports Tab (Canned Reports)

There are several canned **Reports** available by default under the Reports tab. These reports are based on a predefined Business Intelligence model ~ WaMSBIModel.

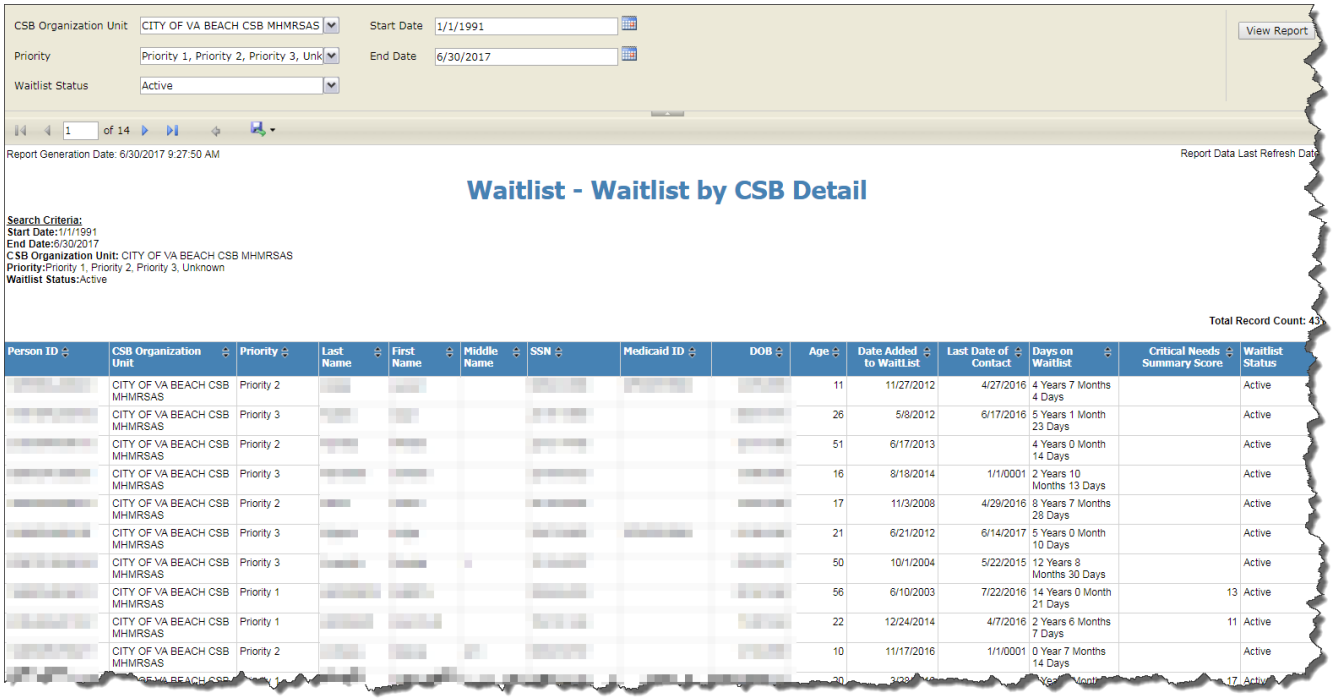
The reports available are based on the role of the person logged in to WaMS. CSB Administrators have access to generate reports for their OU.

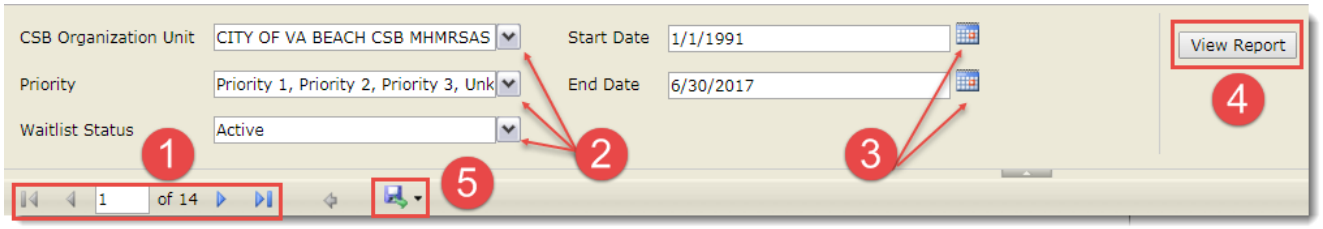
14.7.1 Generate Reports

1. Click on the **Reports** tab. The reports categories available appear by default (for instance:
    a. Slot Management
    b. Waitlist (detail or summary)
    c. Waiver



2. Click on **View** to open the appropriate report. *The report opens in a separate tab in the browser.*





1. Click **Next Page**, **Last Page** or **Previous Page**, **First Page** buttons to go to additional pages in the report (these buttons are available when there is more than one page in the report).
2. Click the drop down arrows to narrow search parameters.
3. Click the **Calendar** icons to select the Start and End dates for the report.
4. Click **View Report** when parameters of numbers 2 or 3 above are selected or modified to refresh the report.
5. Click the **Export drop down menu** to save the report as:
    c. Word
    d. Excel
    e. PowerPoint
    f. PDF
    g. TIFF file
    h. MHTML (web archive)
    i. CSV (comma delimited)

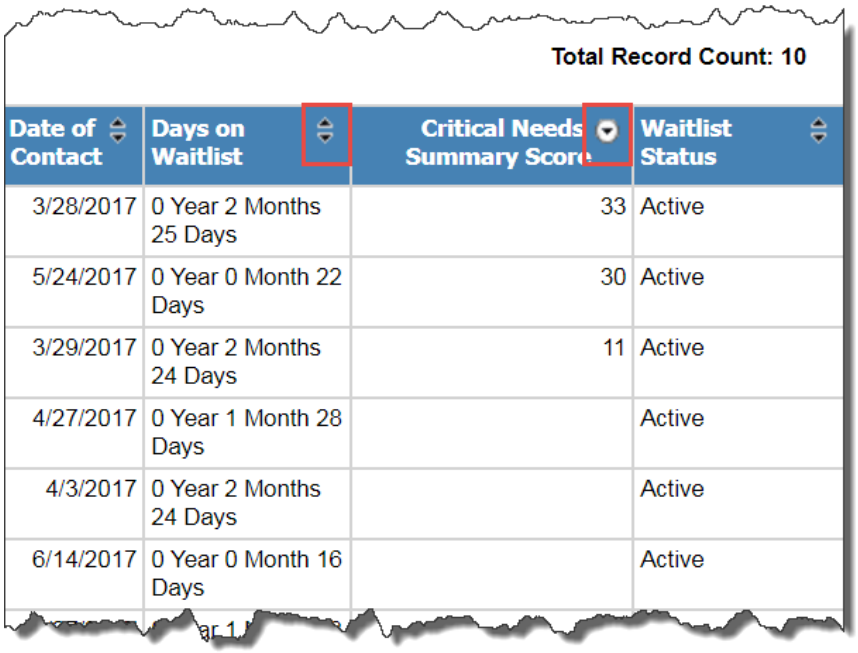
j. XML file with report data

k. Data Feed

14.7.2 Filter Reports

1. Click the **Up** and **Down** arrows  next to the column name to filter the data on that column.

   *The **Up** and **Down** arrows will change to a single white up or down arrow  once the filter is selected.*



Total Record Count: 10

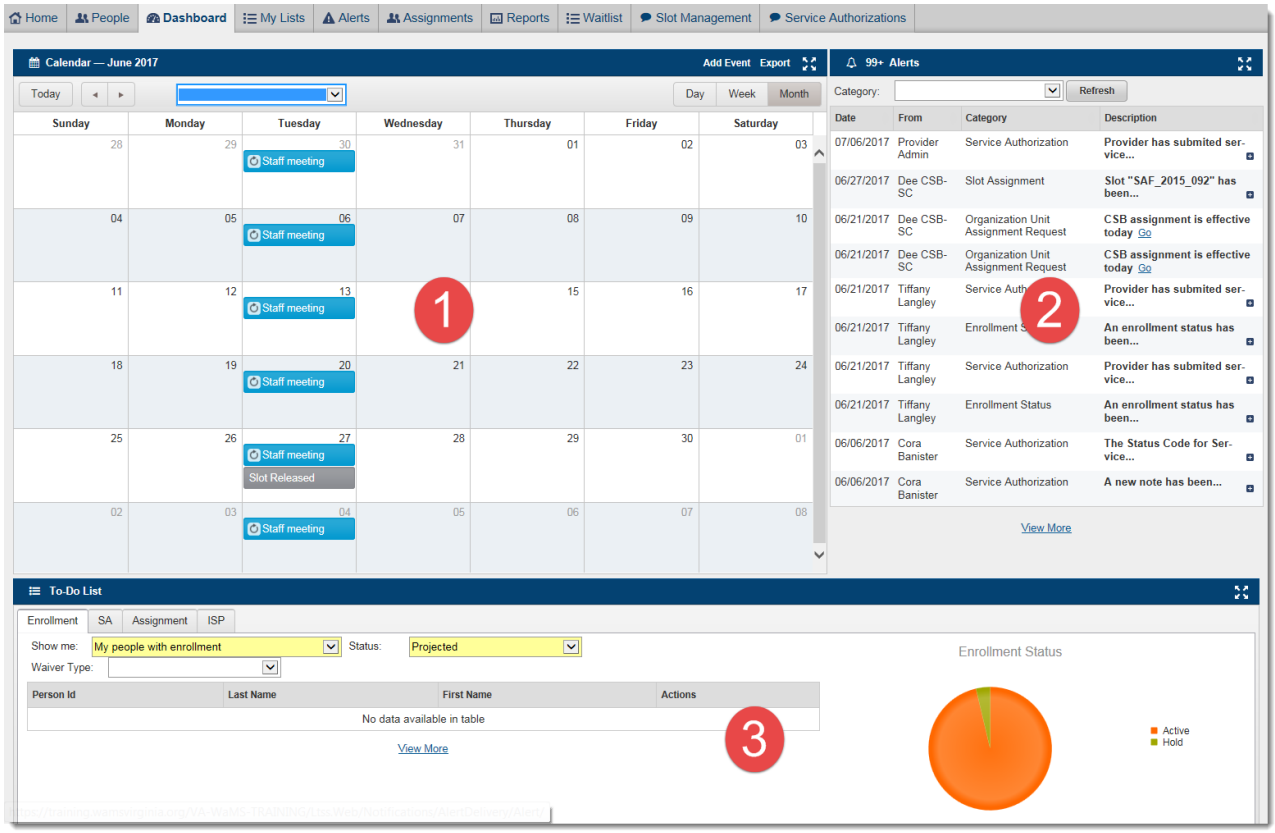
Date of Contact	Days on Waitlist	Critical Needs Summary Score	Waitlist Status
3/28/2017	0 Year 2 Months 25 Days	33	Active
5/24/2017	0 Year 0 Month 22 Days	30	Active
3/29/2017	0 Year 2 Months 24 Days	11	Active
4/27/2017	0 Year 1 Month 28 Days		Active
4/3/2017	0 Year 2 Months 24 Days		Active
6/14/2017	0 Year 0 Month 16 Days		Active

14.8 Dashboard

The Dashboard represents a snapshot of activities required and is based on the login role.

1. Click on the **Dashboard** tab. *The three sections of the Dashboard appear (1) Calendar, (2) Alerts, and (3) To Do List).*

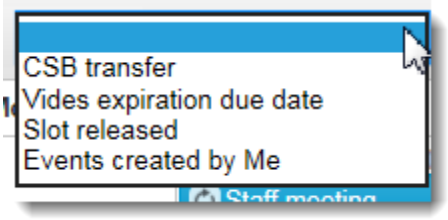
2. Click the **Expand** buttons to open each section in its own window.



14.8.1 Dashboard Calendar

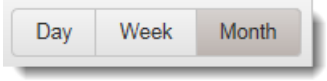
The dashboard calendar provides system generated reminders and manually added events

a. Click the calendar drop down arrow to filter view by specific events



b. Click the **Previous** and **Next** arrows next to "*Today*" to change the calendar month.

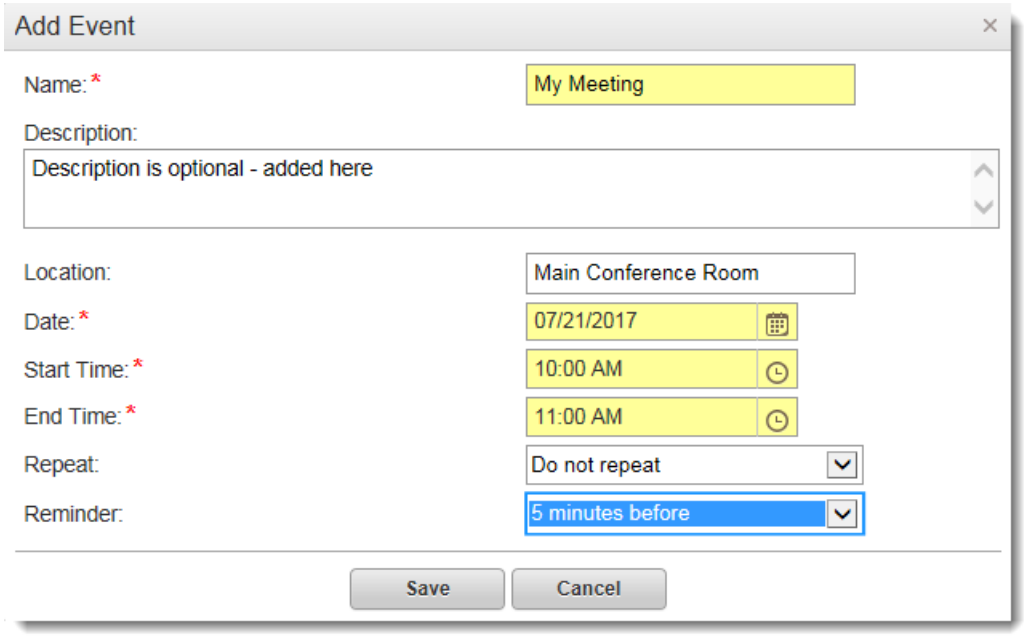
c. Click on the **Day**, **Week** or **Month** for the desired view.



14.8.1.1 Add Event

Meetings or reminders are added to the calendar manually as a one-time or recurring (repeating) event. Click **Add Event** in the Calendar title bar 

1. Input required information into the *Add Event* window
    a. Name of the event/reminder
    b. Date
    c. Start and End Times
2. Input optional information.
    a. Description or details about the event
    b. Repeat – Identify if or how often the event reoccurs. Recurring options are daily, weekly, monthly or yearly basis if applicable
    c. Reminder – Identify if or when a reminder should be generated
3. Click on **Save.** *The meeting appears in the calendar. Manually added events display in a different color from the system generated events.*

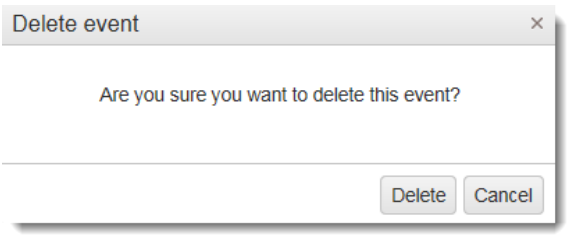


14.8.1.2 Edit a Manually Added Event

1. Double-click on the added event. *The Edit/View Event window appears.*
2. Make appropriate changes.
3. Click on **Save.**

14.8.1.3 Delete a Manually Added Event

1. Place the Mouse Pointer over event. *An X appears to the right of the Event Name.*
2. Click the **X**. *The Delete Event dialog box appears asking "Are you sure you want to*



delete this event".

3. Click on the **Delete** button**.** *The Event is removed from the calendar.*

14.8.2 Dashboard Alerts

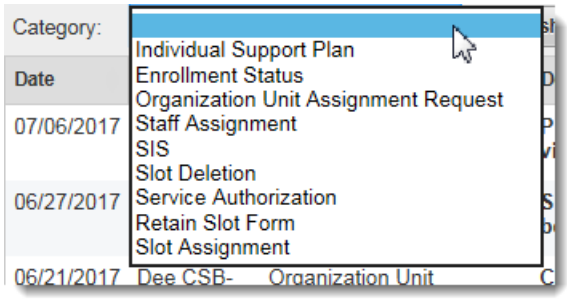
The Dashboard **Alerts** display the last 10 unread alerts in the dashboard sorted by date.

d. The dashboard reflects the number of alerts in the **Alerts** tab is in the upper left corner of the Dashboard Alerts title bar

e. If the number of alerts is below 99 the number displayed will decrease as each alert is clicked on

f. Alerts over 99 will display as **+99** and will remain at that number until there are 99 or less Alerts.

1. Click on the **Category** drop-down arrow to display a specific category *(i.e., alerts related only to Enrollment Status*)



2. Click on the category to be viewed.
3. Click the **+** in the description column to expand the alert and display the **Go** link.
4. Click on **Go** to go directly to the Individual's record. *The record will be opened in a new browser window.*

14.8.2.1 Refresh Alerts

Easily remove viewed and acted upon Alerts from the Dashboard and see newly added Alerts

1. Click on the **Refresh** button*. Acted on and viewed alerts will be removed from the list. Any new alerts will be added*.

14.8.3 Dashboard To Do List

The **To Do List** provides a snapshot of *Enrollment Status*, *SA (Service Authorization)*, *Assignments* and *ISP (Individual Support Plan).* Each has a graphic that provides a visual of pending and completed actions.

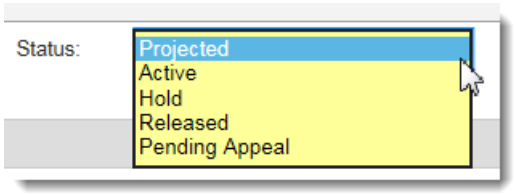
14.8.3.1 Enrollment Status

View the most recent *Enrollment Status* for assigned individual or those in the CSB by status.

1. Click on the **Enrollment** tab so it is the active tab (displays in white).
2. Click the **Show Me** down arrow to select:

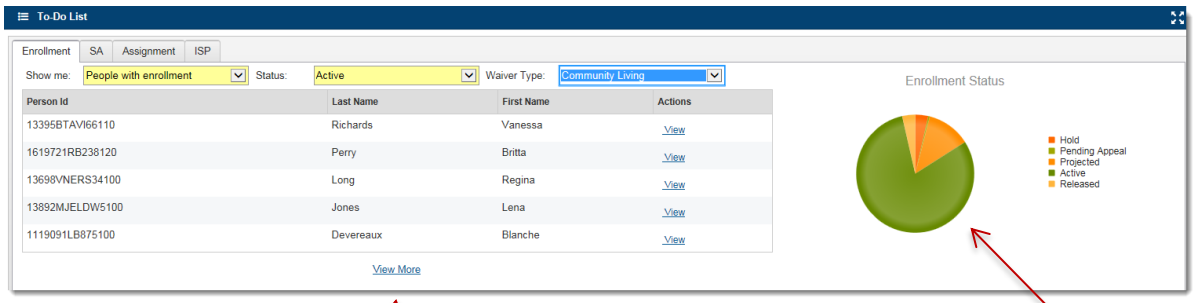
a. My people with enrollment: individuals assigned to the support coordinator
b. People **with Enrollment:** individuals in the CSB

3. Click the **Status** down arrow to select the appropriate status to display
   a. Projected
   b. Active
   c. Hold
   d. Released
   e. Pending Appeal



4. If necessary, click the **Waiver Type** down arrow to select the appropriate waiver to display
   a. Community Living
   b. Family and Individual Supports
   c. Building Independence

   Results automatically display as each selection is made.



5. Click on **View** to access the specific record in the Person's Details tab.

Note: To view the full *Enrollment Status* list for individuals click on the **View More** link. The **My List** tab opens in a new window.

Note: The pie chart is a visual representation of data based on the filter selections made. The pie chart changes based on the *Show Me*, *Status* and *Waiver type* selections. Hovering over pie chart displays the status and percentage representation of related data.

14.8.3.2 SA (Service Authorization)

View the most recent Service Authorizations by status.

1. Click on the **SA** tab so it is the active tab (displays in white).
2. Click the **Show Me** down arrow to select
   a. My Service Authorizations with error
   b. My Service Authorizations without error

c. All Service Authorizations with error
d. All Service Authorizations without error

3. Click the **Status** down arrow to select the appropriate status to display:
   a. Pending provider input
   b. Pending support coordinator review
   c. Pending PA staff review
   d. Pending VAMMIS approval
   e. VAMMIS approval complete
   f. Waiver slot released
   g. SA terminated
4. If necessary, click the **Waiver Type** down arrow to select the appropriate waiver to display
   a. Community Living
   b. Family and Individual Supports
   c. Building Independence

   Results automatically display as each selection is made.
5. Click on **View** to access the specific record in the Person's Details tab.

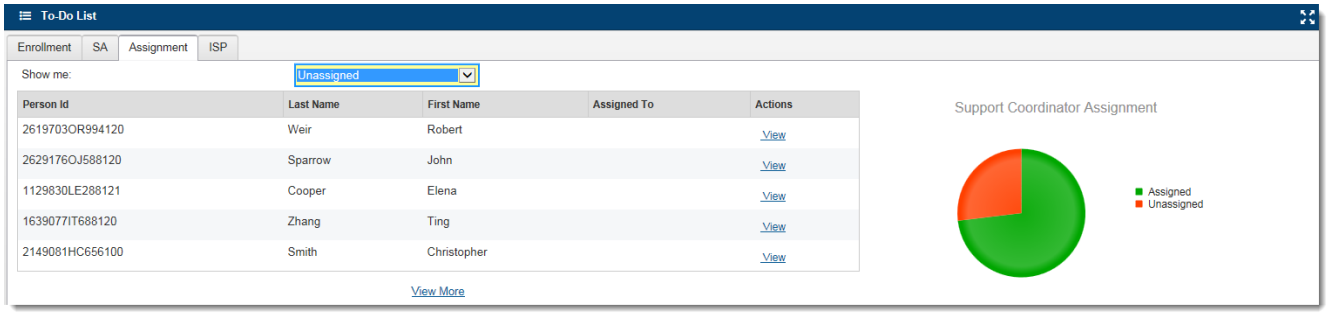
To view the full *SA* list for individuals click on the **View More** link. The *My List* tab opens in a new window.

14.8.3.3 Assignment

View recent assignments of individuals to the Support Coordinator or individuals in the CSB who have not yet been assigned to a Support Coordinator.

1. Click on the **Assignment** tab so it is the active tab (displays in white).
2. Click the **Show Me** down arrow to select
   a. Unassigned
   b. Assigned

   Results automatically display as each selection is made.
3. Click on **View** to access the specific record in the Person's Details tab.

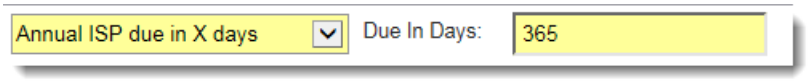


To view the full *Assignment* list for individuals click on the **View More** link. The *Assignments* tab opens in a new window.

14.8.3.4 ISP (Individual Support Plan)

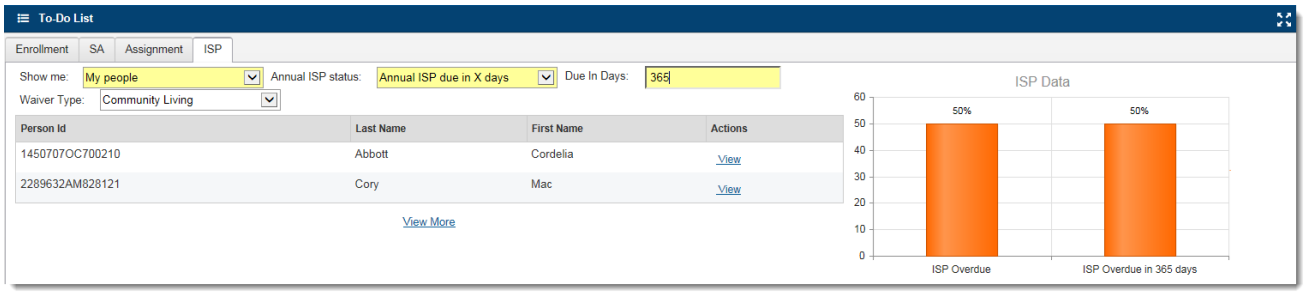
View the most recent ISP status based on selections in the *Show Me* and *Annual ISP* Status fields.

1. Click on the **ISP** tab so it is the active tab (displays in white).
2. Click the **Show Me** down arrow to select
   a. My people
   b. All people (in the CSB)
3. Click the **Status** down arrow to select the appropriate status to display:
   a. Annual ISP overdue
   b. Annual ISP due in X days
      - Add a number in the **Due in Days** field (i.e., 365 to see due in 1 year)



4. If necessary, click the **Waiver Type** down arrow to select the appropriate waiver to display
   a. Community Living
   b. Family and Individual Supports
   c. Building Independence

   Results automatically display as each selection is made.
5. Click on **View** to access the specific record in the Person's Details tab.



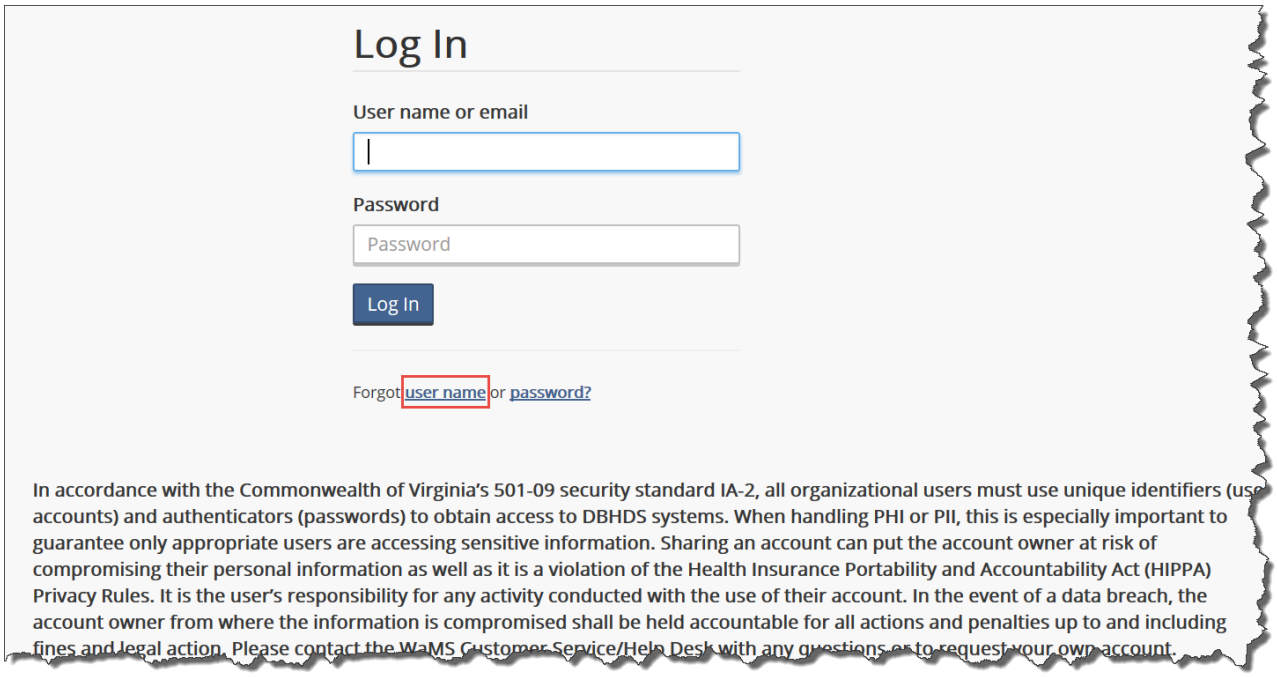
To view the full *ISP* list for individuals click on the **View More** link. The *My List* tab opens in a new window.

14.9 Forgot User Name or Password

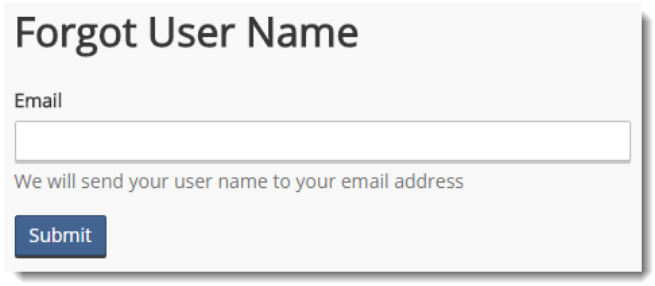
If the *User Name* has been forgotten, the system can send it to the email address that is associated with WaMS. If the *Password* has been forgotten, it can easily be reset by email.

14.9.1 Receive Forgotten User Name

1. At the WaMS **Log In** screen, click **user name**.



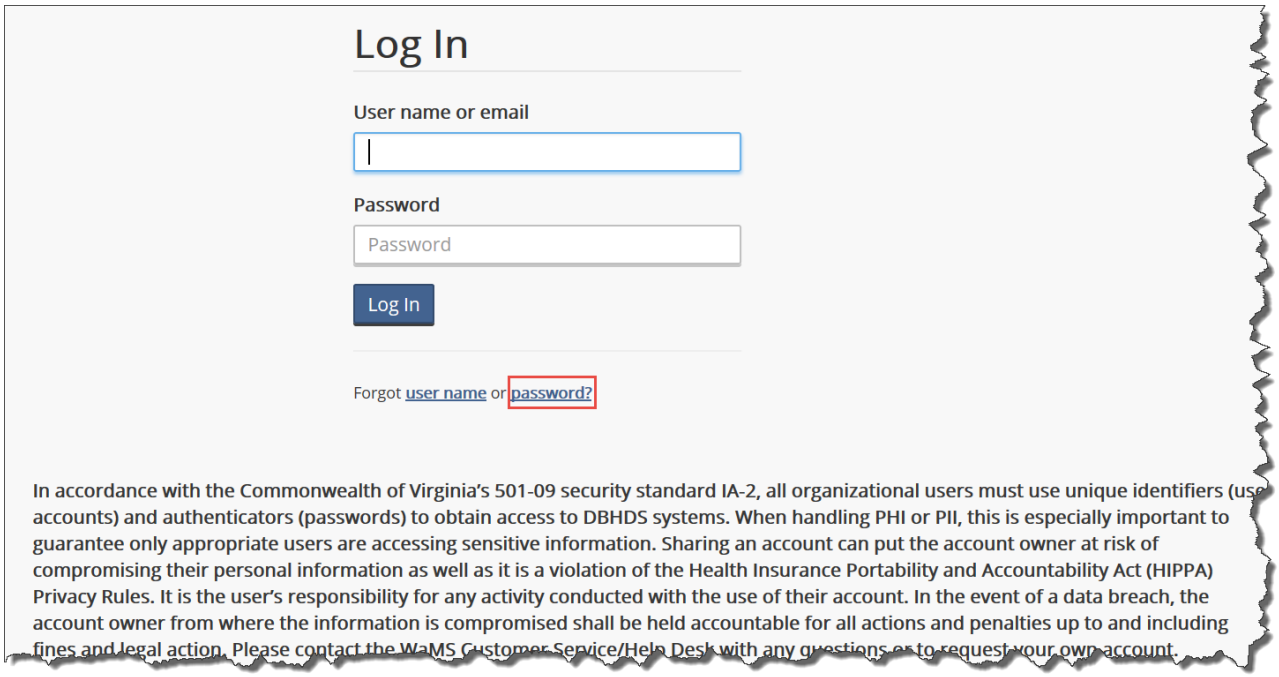
The Forgot User Name window opens.



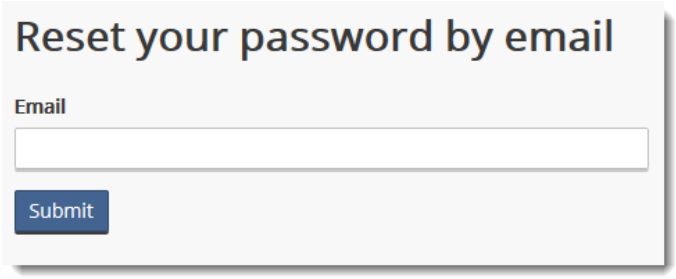
2. Enter the email address associated with the WaMS login.
3. Click on **Submit**.

14.9.2 Reset Password

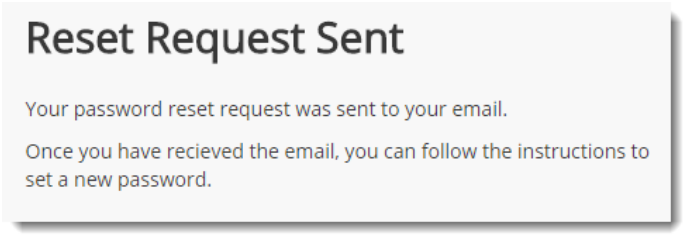
1. At the WaMS **Log In** screen, click **password?**.



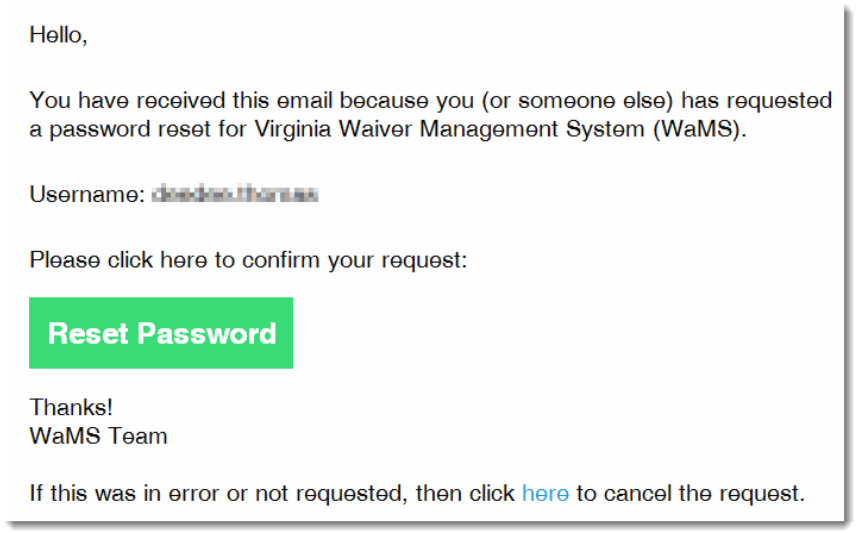
The Reset your password by email window opens.



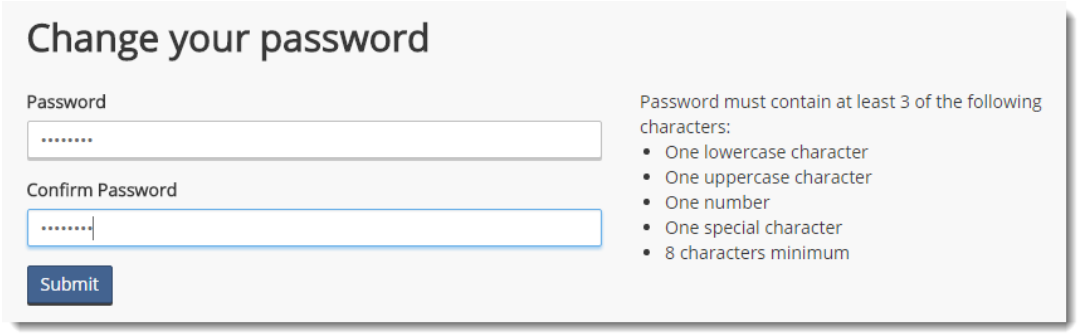
2. Enter the **email address** associated with the WaMS login.
3. Click on **Submit**. *The Reset Request Sent box appears.*



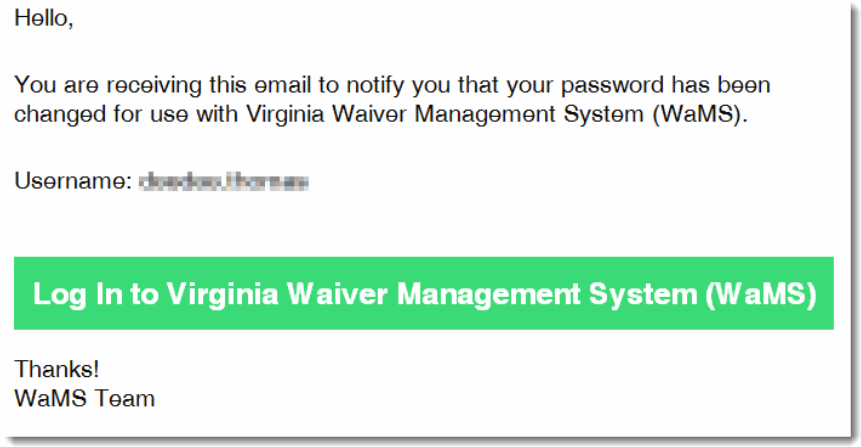
4. Click on the **Reset Password** link in the email to return to WaMS and create a new password.



5. In the *Change your password* window, type in a new **Password**, retype the new password in the **Confirm Password** field, and then click on **Submit**. (*note password parameters below*).

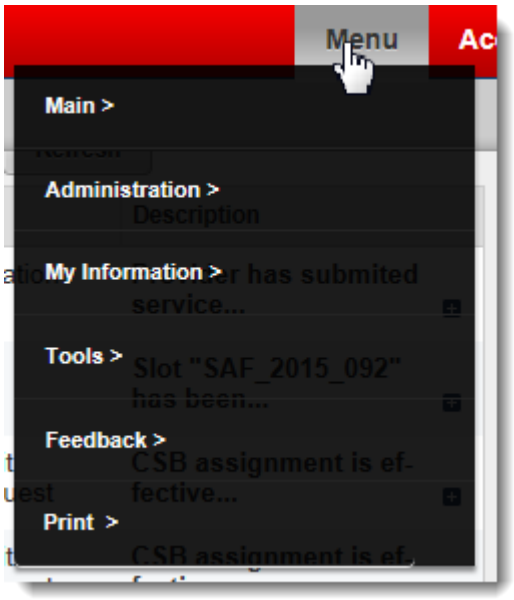


A confirmation email will be sent confirming that your password has been changed.



15 WaMS Menu Options

Menu options are available based on the organization and role of the user logged in.



15.1 Main

The **Main** submenu provides an alternative way to access the top-level navigation tabs.

To return to the WaMS *Home* page, click on **Main / Home**.

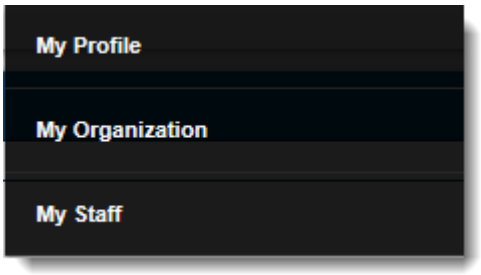
15.2 Administration / User Directory

Search for and obtain email and telephone information for other users of WaMS.

1. Click on **Menu**, **Administration**, **User Directory**. *The User Directory tab opens.*
2. Enter information into the **Organization Unit** and/or **Staff Name** fields.
3. Click on **Search**.

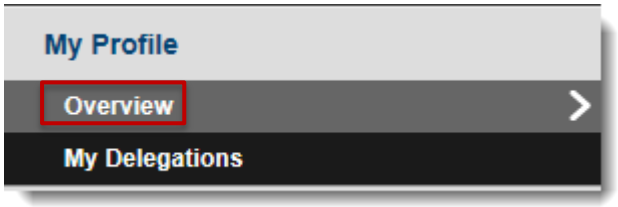
15.3 My Information

The **My Information** submenu includes *My Profile*, *My Organization* and *My Staff* options.



15.3.1 My Profile, Overview

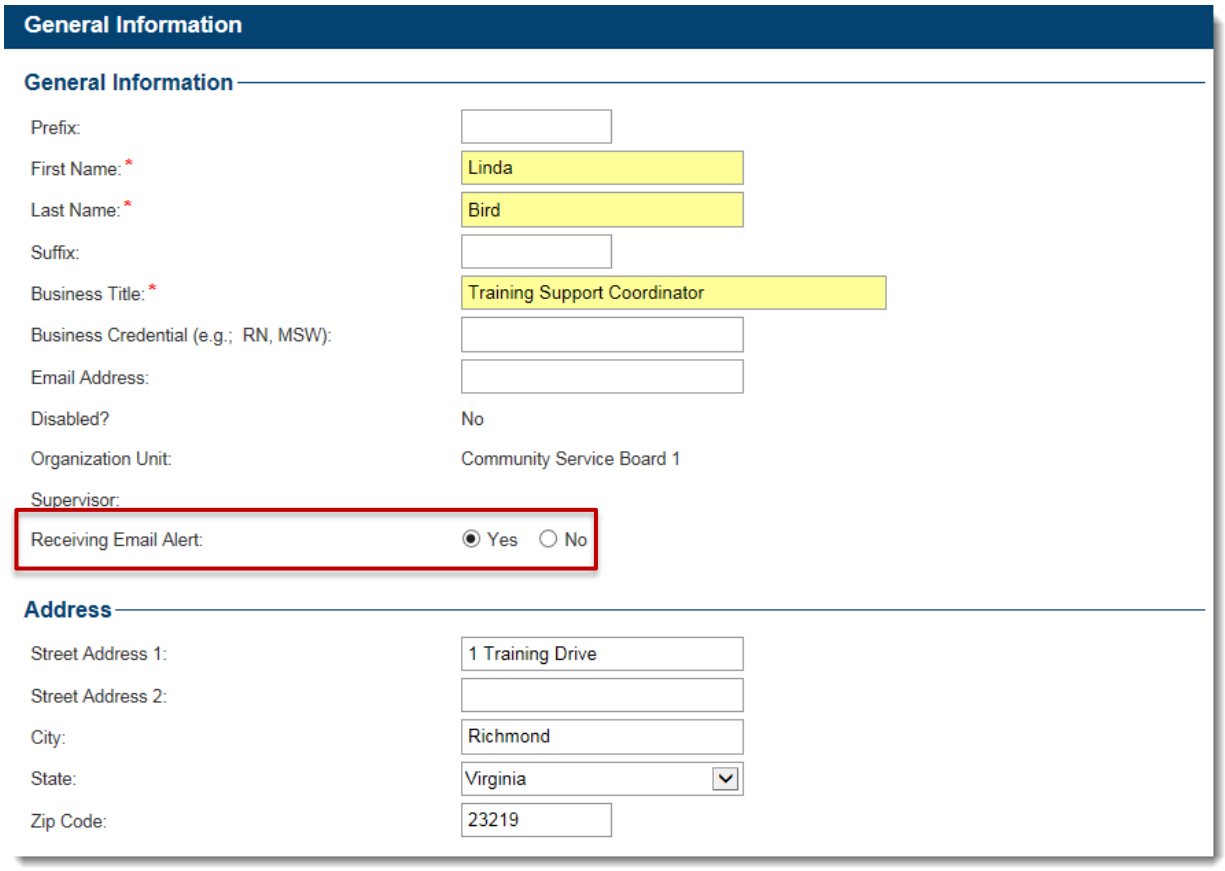
Use the **My Profile, Overview** submenu view and edit certain user and login information such as name, title, email address, phone number and address assigned to the account. This is also where to view the specific *Role (s)* assigned to the user account.



15.3.1.1 Receive Email Alerts

To receive emails when *Alerts* are received in addition to being notified in WaMS, edit the *General Information* under *My Profile*:

1. Click on **Menu**, **My Information, My Profile**. *The My Profile - Overview tab opens.*
2. Click on the *General Information* **Edit** button. *The My Profile — General Information window opens.*



3. Click on the **Yes** radio button for *Receiving Email Alert* to select it.
4. Click on **Save**.

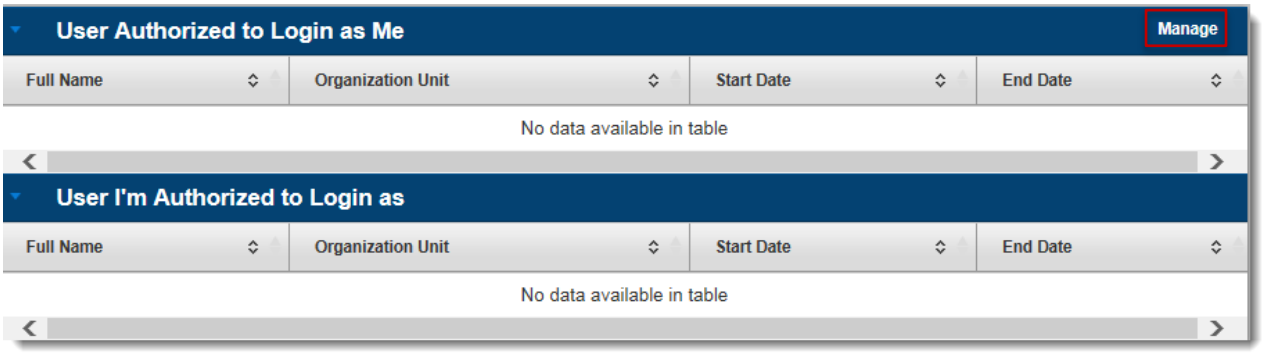
Each time an Alert is received, an email will also be sent to the email address listed in the My Profile section.

15.3.2 My Profile, My Delegations

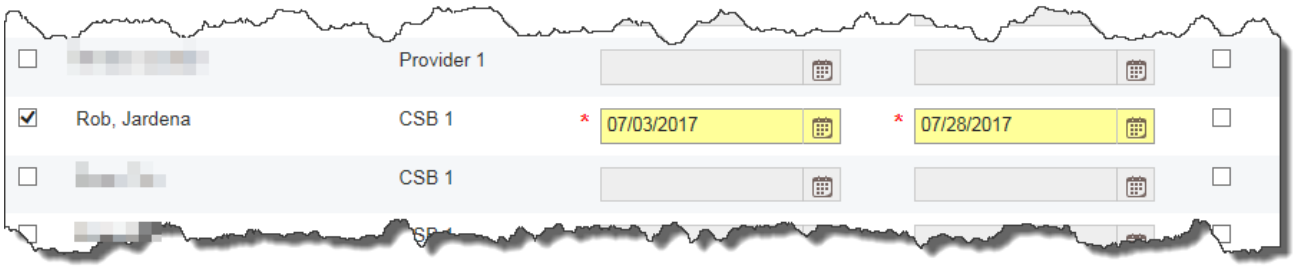
Use **My Profile, My Delegations** to set up delegate access to WaMS. This allows a person you designate to work in WaMS on your behalf. The delegate logs on as the user they are completing the authorization for.

15.3.2.1 Assign Delegate

1. Click on **Menu**, **My Information, My Profile**. *The My Profile - Overview tab opens.*
2. Click on **My Delegations.** *The My Profile — My Delegation window opens.*

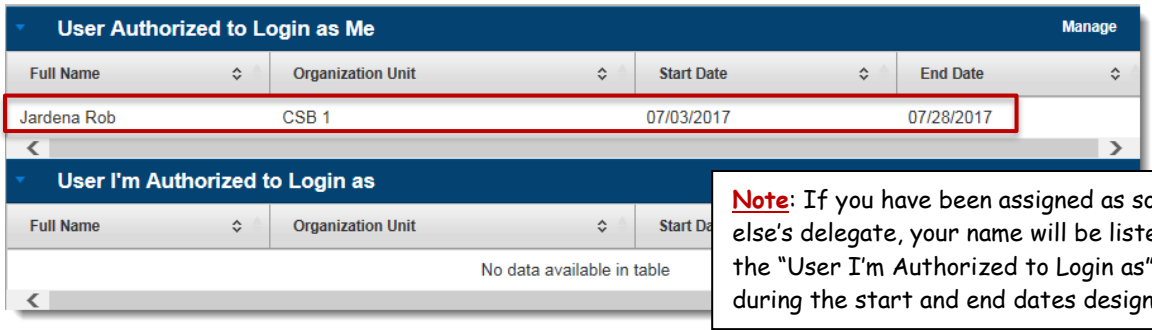


3. Click on **Manage**. *The My Delegation — User(s) Authorized to Login as Me window opens displaying all users in the Organization Unit.*
4. Click the **checkbox** next to each desired user(s) to be set as a delegate. *The start and end date fields become required.*
5. Enter the **Start Date** and **End Date** of the delegation.



6. Click on **Save**. *The delegate(s) name appears in the "User Authorized to Login as Me" section along with the start and end dates.*

Note: The delegate will no longer be able to login as that user after the end date. The End Date should be the day after the last day permission is needed.

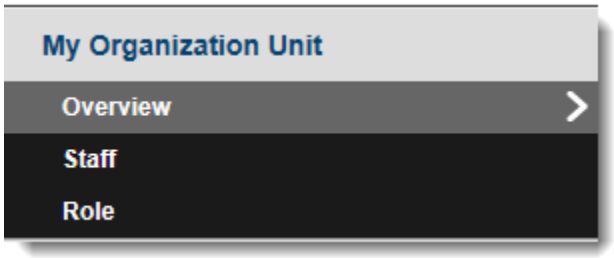


Note: If you have been assigned as someone else's delegate, your name will be listed under the "User I'm Authorized to Login as" section during the start and end dates designated..

15.3.2.2 Remove Delegate (Deactivate)

1. Click on **Manage** in the *My Delegation — User(s) Authorized to Login as Me* window.
2. Locate your delegate's name, then click the **checkbox** next to delegates name to remove the check. *The start date and end date will also be removed.*
3. Click on **Save**. *The delegate(s) name is removed from the "User Authorized to Login as Me" section along with the start and end dates and will no longer be able to login as your delegate.*

15.3.3 My Organization Unit



15.3.3.1 Overview

Use to see and edit certain attributes of the organization, including organization name, point of contact, address, Service Areas and Telephone numbers.

15.3.3.2 Staff

Use to search for existing staff and create new staff members. (See **Section 16 – Add New Staff Members**) for step-by-step instructions for adding new staff members.

15.3.3.3 Role

Use to view roles available to the organization and to see view and edit permissions allowed for a role.

15.3.4 My Staff

Opens the *Staff Search — Overview* window to allow for locating existing staff and creating new staff in the organization. (See **Section 16 – Add New Staff Members**) for step-by-step instructions for adding new staff members

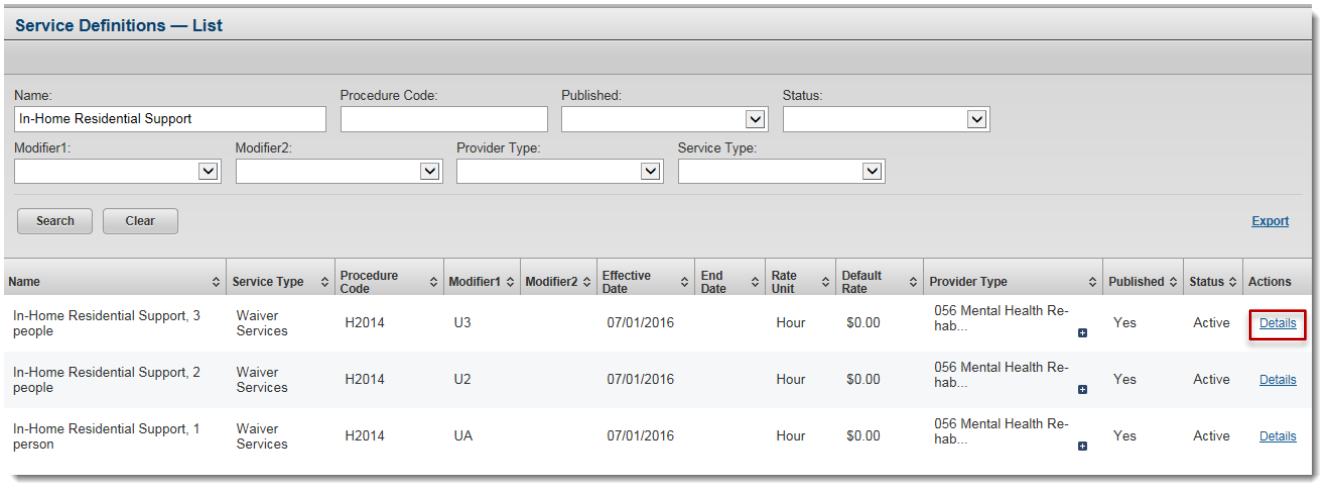
15.4 Tools

Use **Tools** to access **Service Definitions**. Service Definitions describe the parameters of all services.

15.4.1 Service Definitions

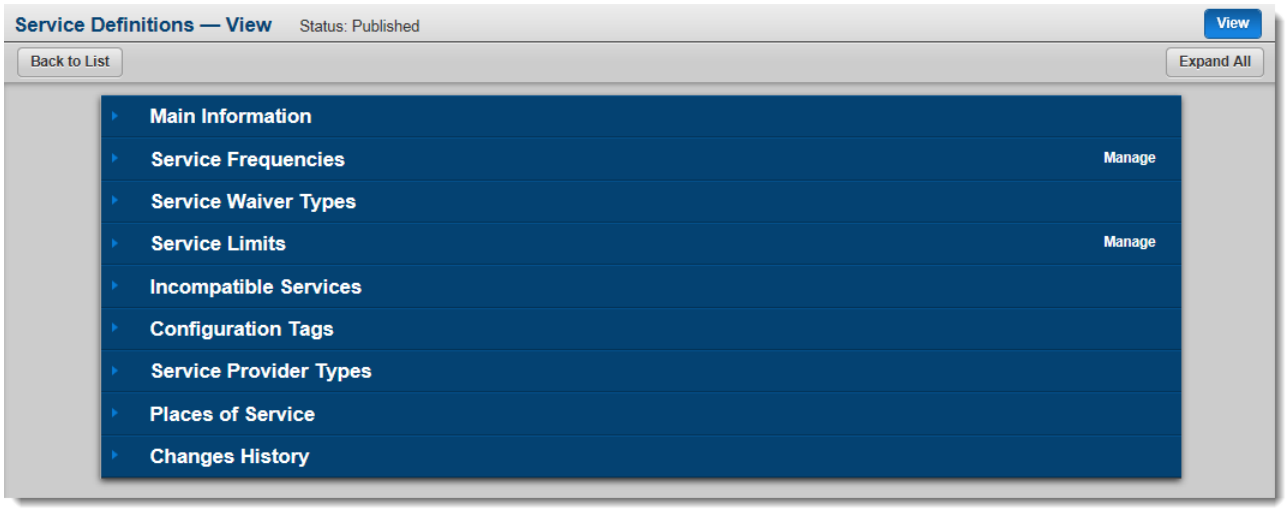
1. Click on **Menu, Tools, Service Definitions.** *The Service Definitions — List window appears.*
2. Type in the search criteria:
    - Name
    - Procedure Code
    - Published
    - Status
    - Modifier 1
    - Modifier 2
    - Provider Type
    - Service Type
3. Click on **Search**.

> Note: Click the **Clear** button to clear search fields and begin a new search.

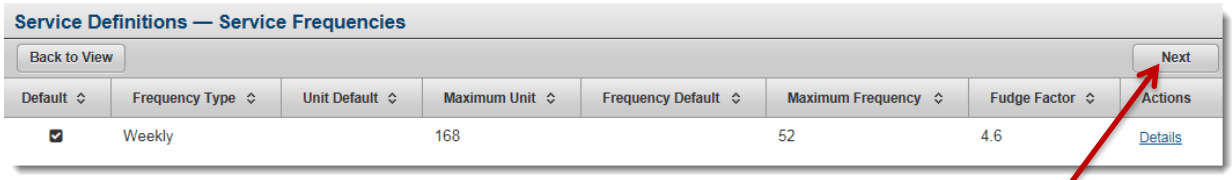


15.4.1.1 View Service Definition Details

1. Click **Details** under the *Actions* column. *The Service Definition – View window opens.*

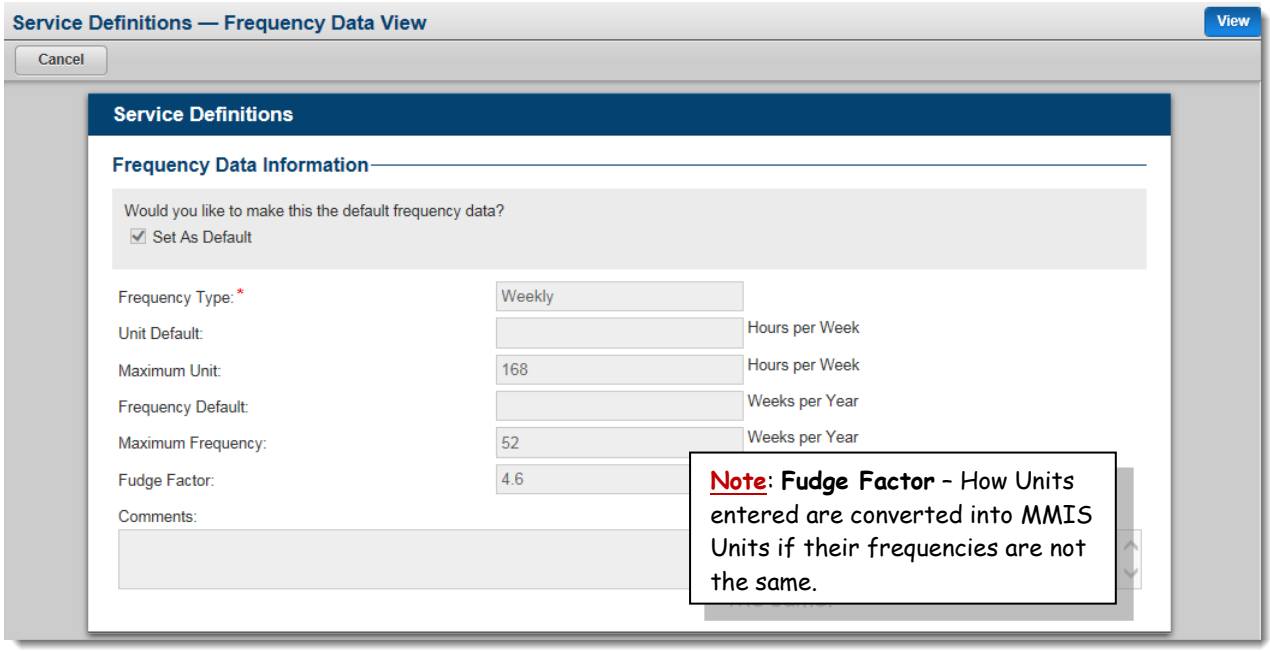


2. Click **Manage** for the category name to view additional details.



3. Click **Details** under the *Actions. The Service Definitions — Frequency Data View window opens with additional information.*

Note: The **Next** button is not active. The following message is received when the **Next** button is clicked: "**Error: Access denied. Reason: No permission. You're not authorized to access.**"

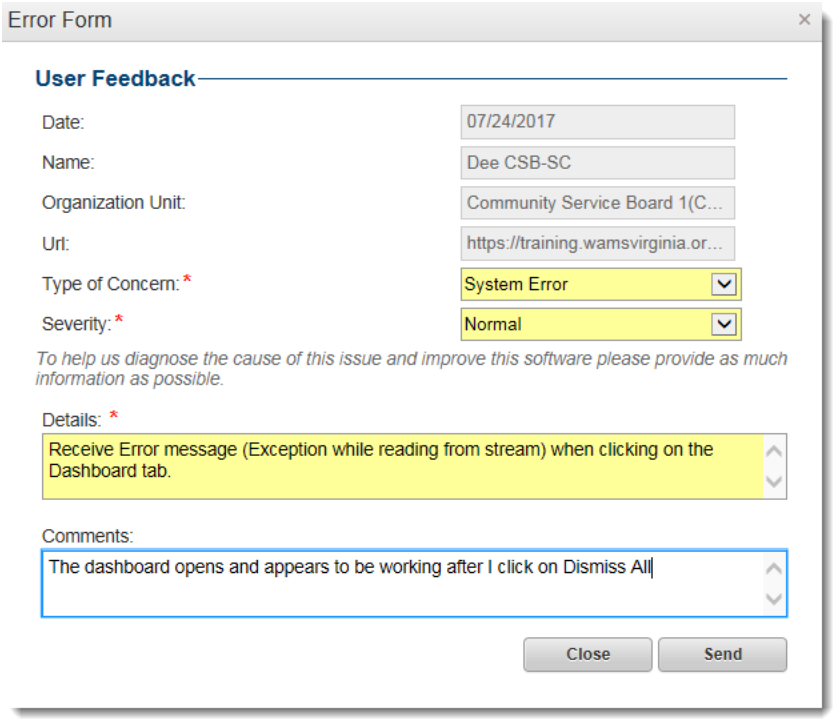


15.5 Feedback

Use the **Feedback** option to send feedback to the WaMS Help Desk. Create new feedback and send to the WaMS Help Desk or view a list previously submitted.

15.5.1 Submit Feedback to WaMS Helpdesk

1. Click on **Menu**, **Feedback**, **Create**. *The Error Form appears.*



2. Complete the required fields:
   - **Type of Concern**: System Error, Question/Comment, Unknown
   - **Severity**: Normal, Urgent
   - **Details**: Free form comments field to address the concern
3. Add additional comments if necessary in the **Comments** field.
4. Click on **Send**.

15.5.2 View List of Previously Submitted Feedback

1. Click on **Menu**, **Feedback**, **List**.

2. Click the **Status** drop down arrow to select submissions that are *Pending*, *In Progress* or *Resolved*.
3. If necessary, select the **Severity** (*Normal* or *Urgent*) and/or **Waiver Type** (*Community Living, Family and Individual Supports or Building Independence*) to narrow the search.
4. Click on **Search**. *The submitted List appears.*

   *To perform another search, click on **Clear** to remove the search results and repeat steps 2 – 4 above.*

15.5.2.1 Add a Note to the Submitted Feedback Form

1. From the *List* search results (*by performing Steps 1-4 in **Section 15.5.2** above*), click on **View** under *Actions*. *The Status window opens.*

2. Scroll to the bottom of the *Status* window to display the **Notes** section.

3. Click on **Add**. *The Error Note field appears.*
4. Add additional information for the error in the *Error Note* field.
5. Click on **Save**. Added information appears in the *Notes* field.

Note: Use the Notes field to add notes to the feedback or review notes added by the WaMS Help Desk.

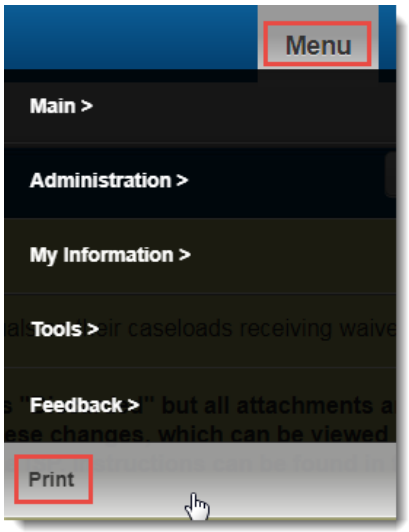
15.5.2.2 Export Submitted Feedback Form

1. Click **Export To CSV** to create an Excel file of the feedback list.

15.6 Print (Print the Screen)

When the **Print** option is selected, a PDF version of any page in WaMS is created for printing or saving (downloading).

1. From any WaMS page, click on **Menu**, **Print**. *A PDF version of the page opens in a new window.*
2. **Print** (*Control +P* or *click on the printer icon*) or **download** to save the PDF document.

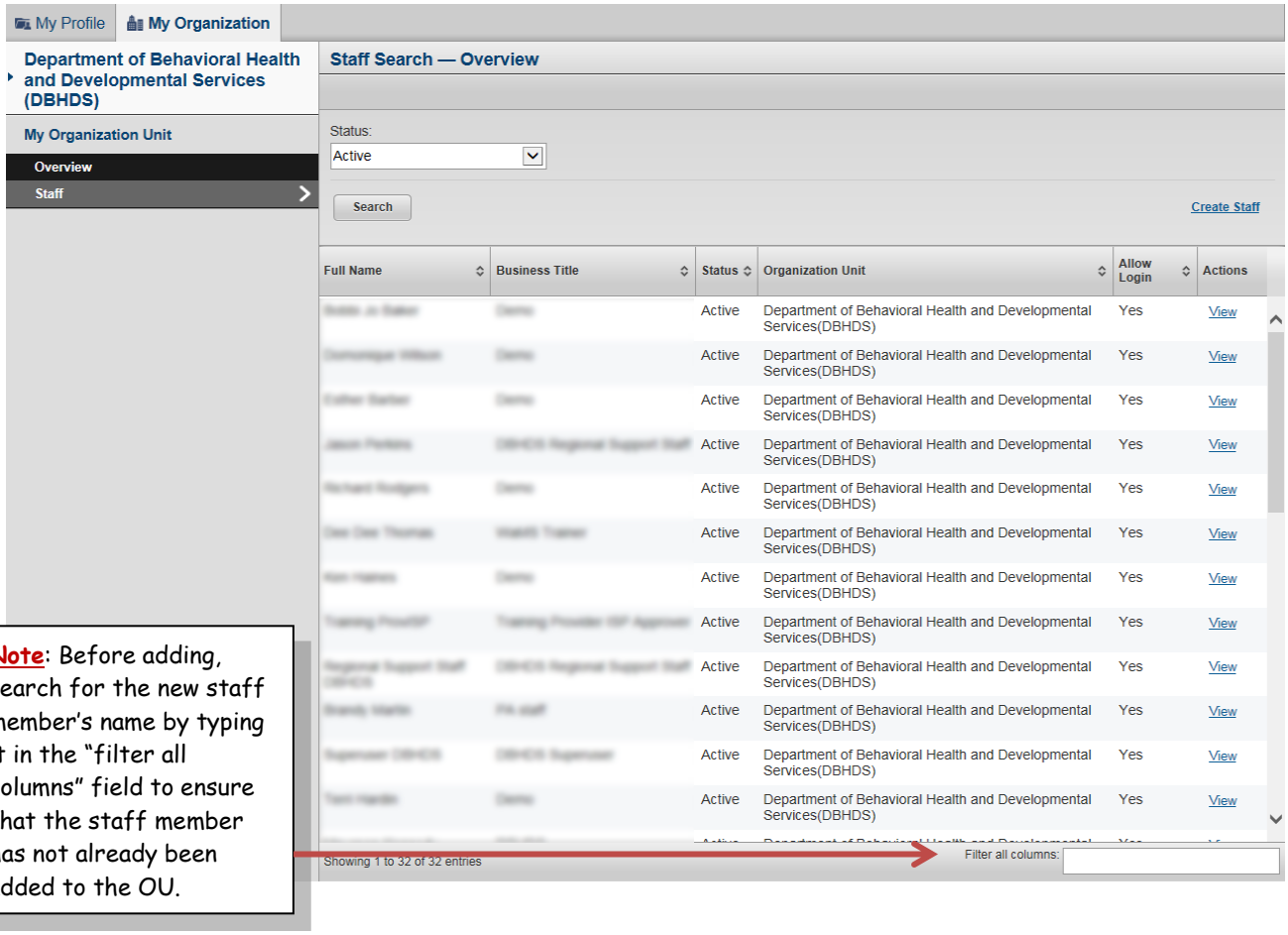


16 Add New Staff Members

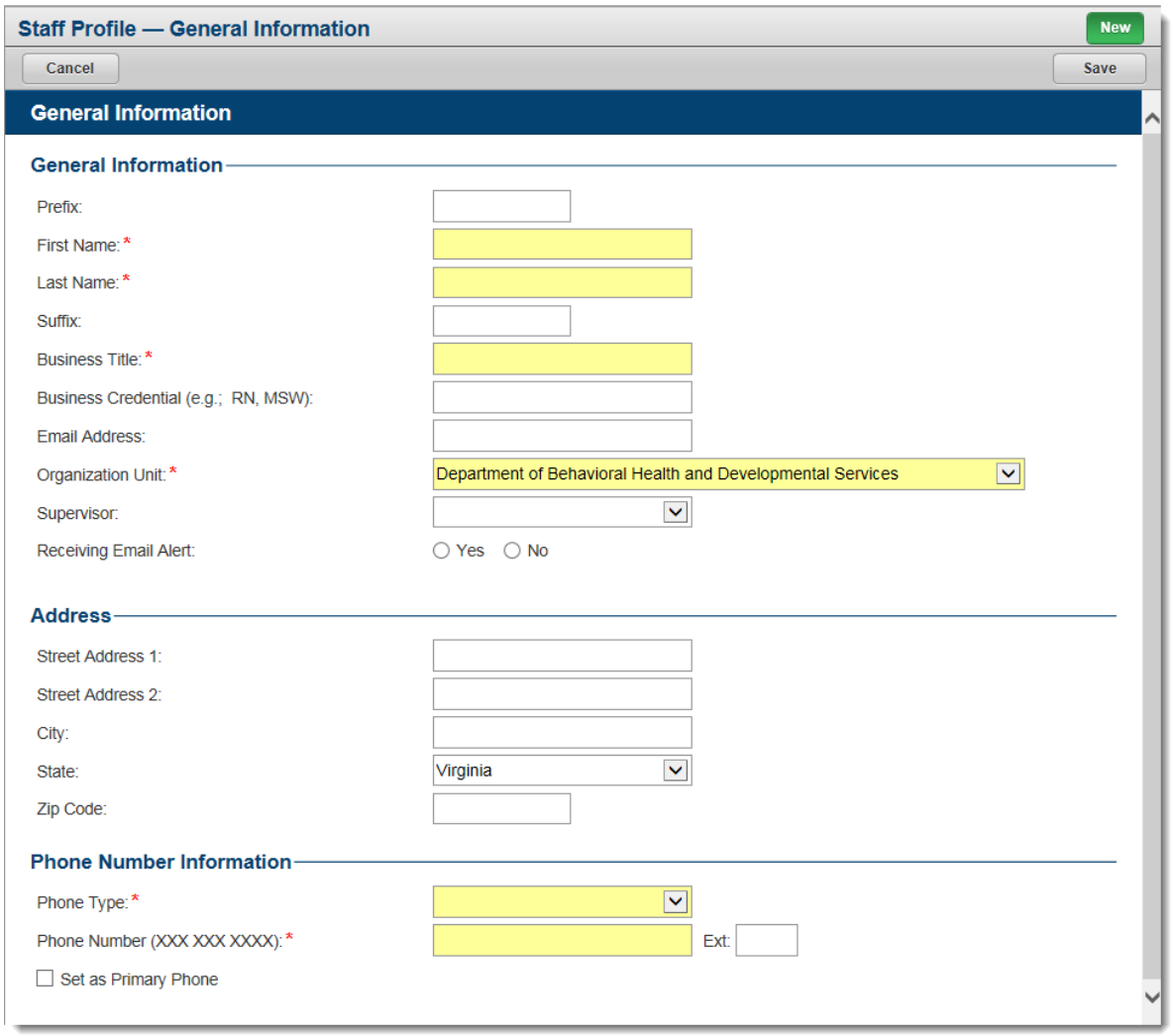
A new Staff Member profile should be created for each person who should access to WaMS. 1) Add the New Staff Member to WaMS; and 2) add the member's Role. Once the new member has been added, they will need to confirm and create a password in order to log in to WaMS.

16.1 Complete Staff Profile – General Information

1. Click on **Menu**, **My Information**, **My Staff**. *The Staff Search — Overview window appears on the My Organization tab:*



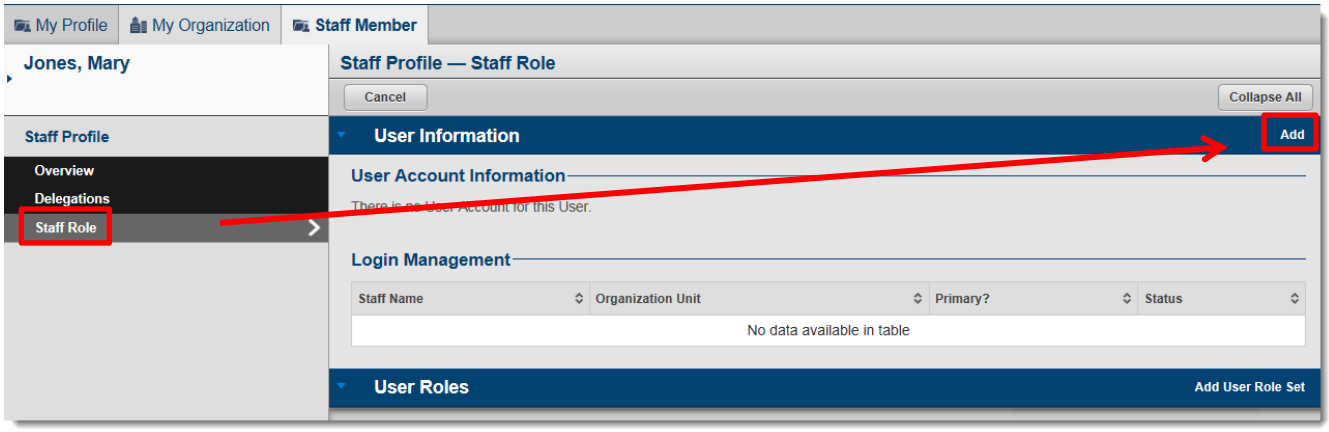
2. Click **Create Staff**. *The Staff Profile — General Information window appears.*
3. Complete the fields for the new staff member's *General Information*.
    a. **Required Fields**: (denoted by yellow field with red asterisk): First Name, Last Name, Business Title, Organization Unit, Phone Type and Phone Number.
    b. **Optional Fields**: Prefix, Suffix, Business Credential (e.g., RN, MSW), Email Address, Supervisor, Address, Phone Ext.



4. Click **Save**. *The New Staff Member has been added to the OU. You will receive a Success: Record has been created message.*

16.1.1 Add User Information

1. From the left navigation, click **Staff Role**. *The Staff Profile — Staff Role window appears.*

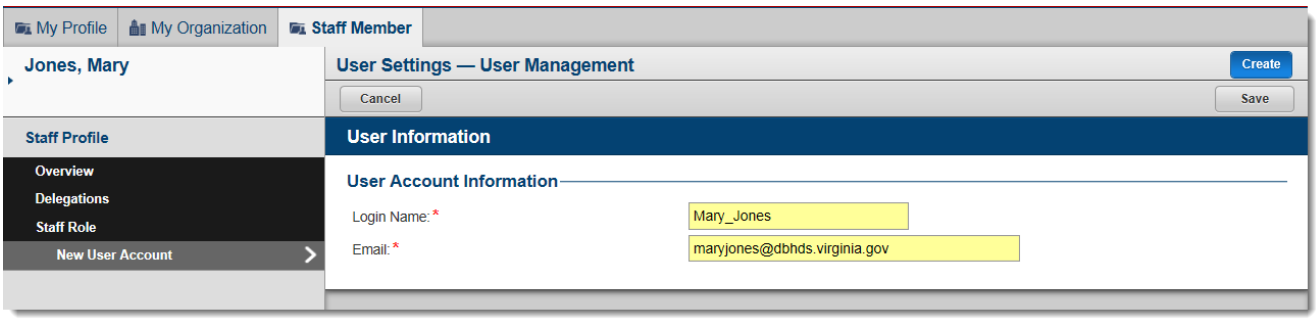


2. Click **Add**. *The User Settings — User Management window appears.*
3. Type in login information for the new staff member (login name and email address) in the appropriate fields.

*An email is sent to the new staff member at the email address provided letting them know that their account has been created. The new user must confirm their email address by clicking on **Confirm Account Creation**. They will then be provided with an opportunity to set their WaMS login password. Once the password has been set, the new user can log into WaMS.*

Note: The *New User Account* email address must be an accurate work email in order to receive the New Staff Log-on email.

Forwarding the link to a new staff member will not provide WaMS access.

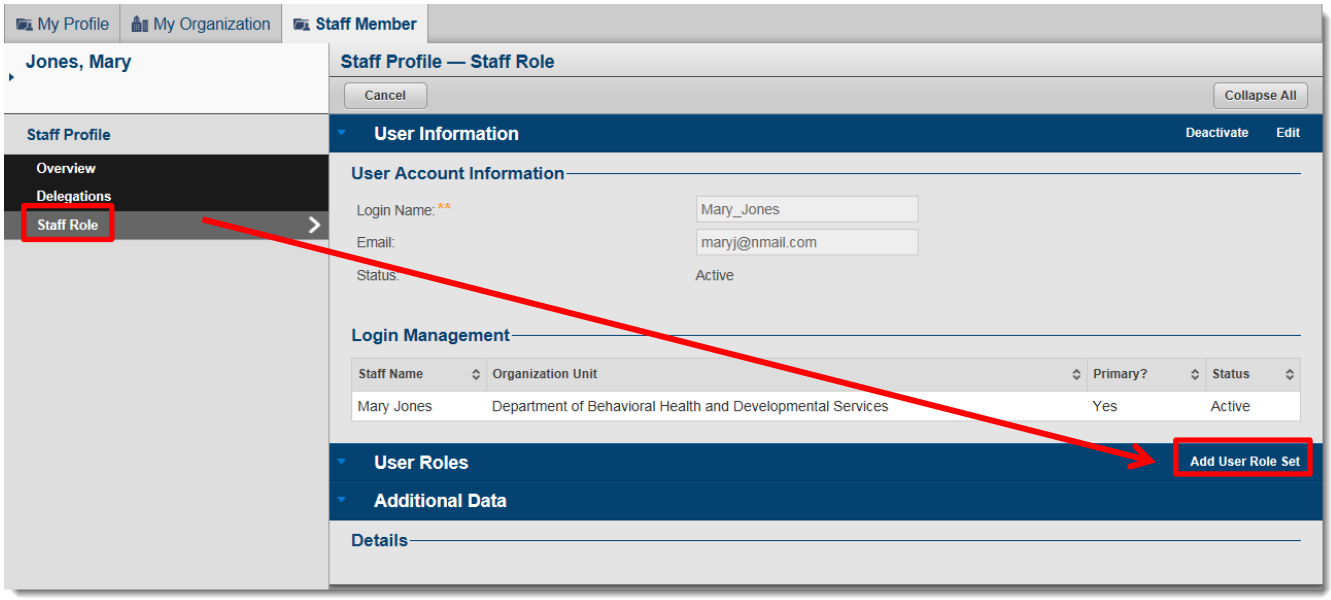


4. Click **Save**.

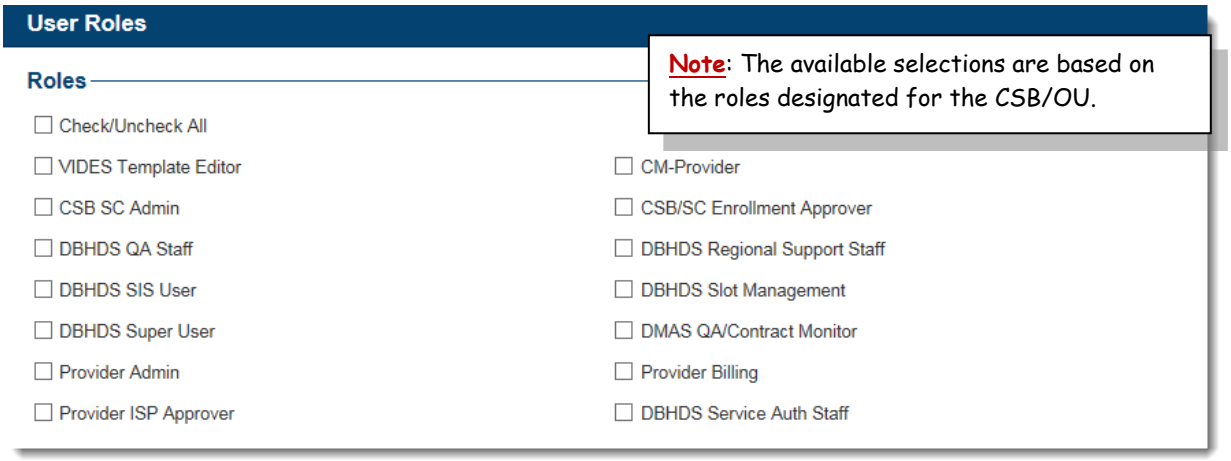
16.2 Add Role for New Staff Member

1. Make sure **Staff Role** is selected from the left navigation.

2. Click **Add User Role Set**. *The User Settings — User Roles window appears.*



3. Select the appropriate role(s) for the new staff member.



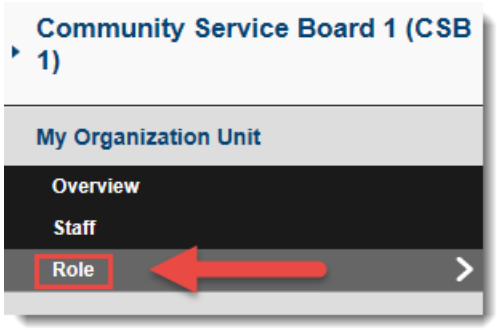
4. Click **Save**. *The New Staff Member's role has been added to the OU. You will receive a Success: Record has been created message.*

After a new staff member's account has been created, the new user must confirm their email address from their email account by clicking on *Confirm Account Creation*. They will receive an email to set their WaMS login password. After the password has been set, the new staff member will be able to log into WaMS.

Note: WaMS will send two emails: 1) the account has been verified; and 2) the password has been changed.

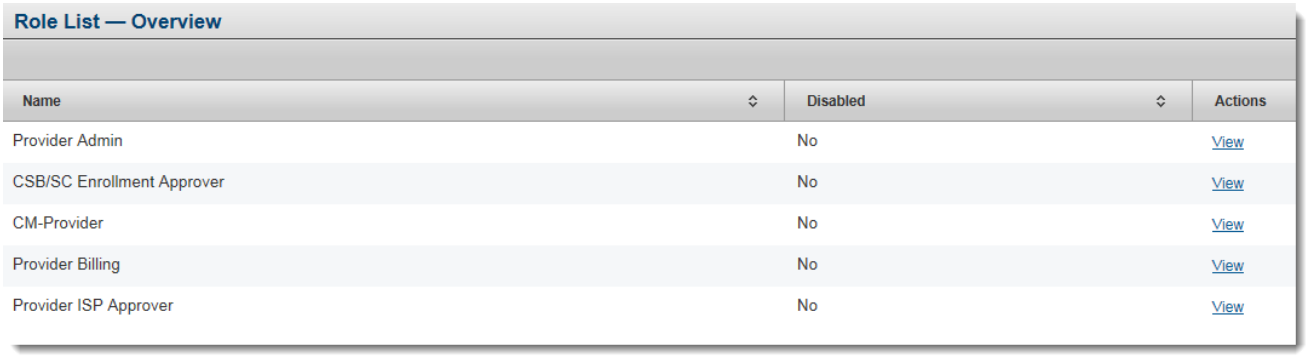
17 CSB Role Permissions

To see the list of roles and permissions available in WaMS for the organization:

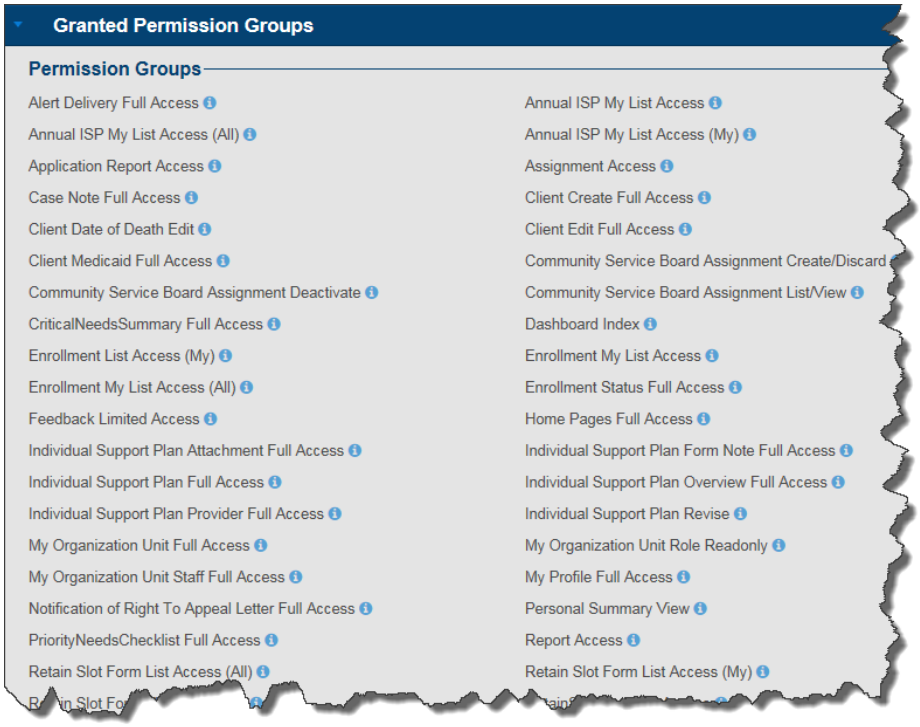


1. Click on **Menu**, **My Information**, **My Organization**.
2. Click on **Role.**

   The Role List — Overview window for the organization opens.

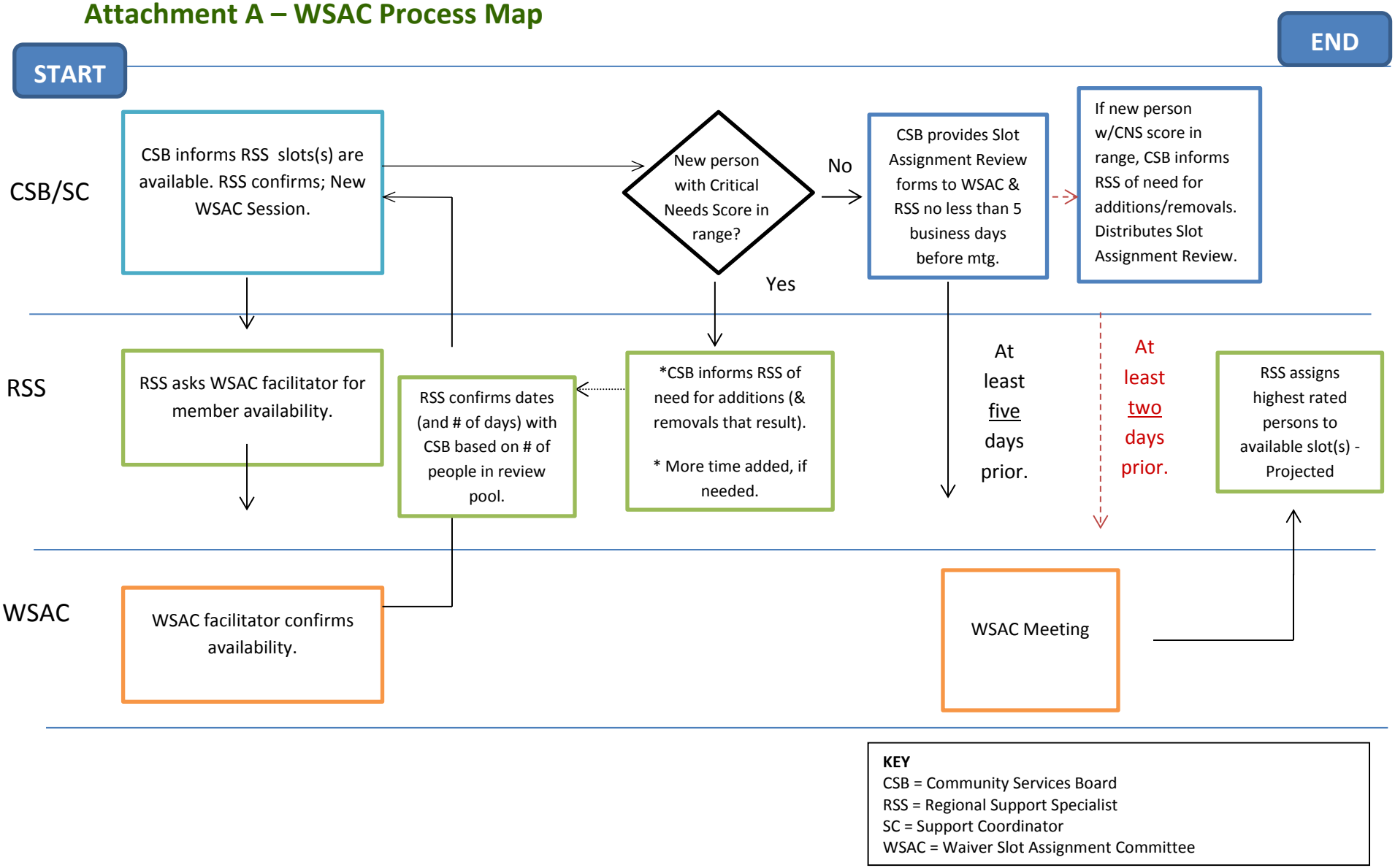


3. Click on **View** for a specific role. *The Role details appear displaying permissions available for that role.*



18 Index

Attachment A – WSAC Process Map



Support Coordination Manual
Developmental Disabilities
Chapter 3
Who Does the Support Coordinator Serve?

- Introduction
- Diagnostic & Statistical Manual (DSM-5)
- Developmental Disability
    - Intellectual Disability
    - Cerebral Palsy
    - Autism Spectrum Disorder
- Co-Occurring Disorders
- Communication
    - Types of Communication
    - Role of Behavior in Communication
    - Support Coordinator Role
    - Assistive Devices
- Role of Family, Legal Guardians, Authorized Representatives, Power of Attorneys
    - Family and Friends
    - Legal Guardianship and Conservatorship
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Support Coordination Manual
Developmental Disabilities
Chapter 3
Who Does the Support Coordinator Serve?

Introduction

A Support Coordinator (SC) supports ***people***. Each person served will have a unique story. This is one of the exciting things about the job of a Support Coordinator. SCs experience the privilege of meeting and interacting with people from all walks of life who honor the SC with their presence and stories. Each person supported will have some form of developmental disability A diagnosis can inform the SC in general about a person but keep in mind that each person's disability affects them in unique ways. A disability does not define who a person is. It describes what condition(s) they have and is just one aspect of who they are. It is the SC's job to get to know the whole person along with gaining an understanding of how their disability affects them. Person centered values and practices described in Chapter 1 assist in getting to know a person.

Diagnostic & Statistical Manual (DSM-5)

Diagnostic labels are used for medical billing but most settings are moving away from using them in practice, instead focusing on the person, without labels. It is important to keep this in mind in reading the information about the prominent diagnoses of people who use Support Coordination services.

A major diagnostic and classification system used in the U.S. is the Diagnostic and Statistical Manual on Mental Disorders (DSM-5). The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a classification of disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. (DSM-5 p. xii) The current DSM-5 is a revision that was published in 2013.

It is highly recommended that SCs have ready access to a DSM-5 for reference.

A Support Coordinator is not responsible for determining a diagnosis; however, it is important to know about them since they may:

- Determine eligibility for certain resources and services,
- Inform decisions about the kind of services and supports a person might need, and
- Help gain understanding of other diagnoses someone has in addition to a developmental disability, referred to as a 'dual diagnosis' or 'co-occurring disorder'.

Section II of the DSM-5 includes twenty two Mental Disorder categories. A major category under this section is entitled Neurodevelopmental Disorders. Many of the people who use Support Coordination services will have a diagnosis from this section. ***However, when determining eligibility for a DD Waiver, a person must meet the criteria of a developmental***

disability as outlined below, regardless of a diagnostic label. More about determining eligibility may be found in chapter 5 (link to chapt 5 diagnostic elig)

Neurodevelopmental Disorders at a glance (link)

Developmental Disability

Virginia uses the definition set forth by the Developmental Disabilities Act and adopted by the Virginia General Assembly.

BOX

Definition

A developmental disability means a severe, chronic disability of an individual that:

(i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness;
(ii) is manifested before the individual reaches 22 years of age;
(iii) is likely to continue indefinitely;
(iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and
(v) reflects a need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

A child from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

There are many conditions that qualify as a developmental disability including autism, cerebral palsy, other mental or neurological conditions (seizures) and intellectual disabilities which include Down syndrome, fetal alcohol spectrum disorder (FASD) (https://www.nofas.org/) and Fragile X syndrome (https://www.genome.gov/19518828/learning-about-fragile-x-syndrome/). Other developmental disabilities may be strictly physical, such as blindness or deafness that began from birth or childhood.

Descriptions of the most prevalent developmental disabilities follow.

Intellectual Disability

The term intellectual disability, as defined by the American Association of Intellectual and Developmental Disabilities (AAIDD) and utilized by the state of Virginia, means a person has significant limitations in **intellectual functioning** (reasoning, learning, problem solving) and in **adaptive behavior**, which covers a range of everyday social and practical skills. The disability originates before the age of 18.

BOX

Intellectual Functioning refers to general mental capacity, such as learning, reasoning, problem solving, and so on. Generally, an IQ test score of around 70 or as high as 75 indicates a limitation in intellectual functioning.

Adaptive Behavior is the collection of conceptual, social, and practical skills that are learned and performed by people in their everyday lives.

- **Conceptual skills** include language and literacy; money, time, and number concepts; and self-direction.
- **Social skills** include interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules/obey laws and to avoid being victimized.
- **Practical skills** include activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone.

Additional Considerations
The AAIDD emphasizes that when determining whether a person has an intellectual disability, many things need to be taken into account including, but not limited to, the person's linguistic diversity, cultural differences, and their community environment.

To read about the minor differences between the DSM-5 criteria vs AAIDDs definition of ID, go to:
https://www.apa.org/pi/disability/resources/publications/newsletter/2016/09/intellectual-disability.aspx

Down syndrome

Down syndrome is the leading cause of intellectual disability. Down syndrome is a common genetic variation that usually causes delay in physical, intellectual, and language development.

Some common physical traits that may or may not be present are:

- low muscle tone;
- small stature;

- an upward slant to the eyes; and
- a single deep crease across the center of the palm

People with Down syndrome possess a wide range of mental ability and have their own unique personalities, capabilities and talents, just as we all do.

More information about Down syndrome may be found at https://www.ndsccenter.org/ and http://www.ndss.org/

Cerebral Palsy

According to the National Institutes of Health (NIH) cerebral palsy refers to a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination. Cerebral palsy (CP) is caused by damage to or abnormalities inside the developing brain that disrupt the brain's ability to control movement and maintain posture and balance. The term cerebral refers to the brain; palsy refers to the loss or impairment of motor function.

Cerebral palsy affects the motor area of the brain's outer layer (called the cerebral cortex), the part of the brain that directs muscle movement.

In some cases, the cerebral motor cortex hasn't developed normally during fetal growth. In others, the damage is a result of injury to the brain either before, during, or after birth. In either case, the damage is not repairable and the disabilities that result are permanent.

In addition to effects on the body, about 30 to 50 percent of children with cerebral palsy have some level of cognitive impairment.

For more information about CP go to: http://www.cerebralpalsy.org/
https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Hope-Through-Research/Cerebral-Palsy-Hope-Through-Research

Autism Spectrum Disorder

According to the American Psychiatric Association, "autism spectrum disorder (ASD) is a complex developmental disorder that can cause problems with thinking, feeling, language and the ability to relate to others. It is a neurological disorder, which means it affects the functioning of the brain. The effects of autism and the severity of symptoms are different in each person."

People with autism spectrum disorder often have difficulty of varying degrees in social-interaction and communication and have a tendency to engage in repetitive behaviors.

Specific diagnostic criteria may be found in the DSM-5.

With a recent change in diagnostic criteria for autism spectrum disorder, there are a group of people who may have been diagnosed as having ASD but who would now be diagnosed with social (pragmatic) communication disorder (SCD). SCD encompasses problems with social interaction, social understanding and pragmatics. Pragmatics refers to using language in proper context.

The diagnostic criteria for SCD may be found in the DSM-5.

More information about autism spectrum disorder may be found at: https://www.psychiatry.org/patients-families/autism/what-is-autism-spectrum-disorder and https://www.autismspeaks.org

http://csesa.fpg.unc.edu/resources/autism-at-a-glance

Co-occurring Disorders

The term 'dual diagnosis' or 'co-occurring disorder' most often refers to someone who has both a substance- related/addictive disorder diagnosis along with a mental illness. However, it is also a term used when a person has a developmental disability along with a mental illness, behavioral difficulties or a substance related disorder. The types of psychiatric disorders persons with developmental disabilities experience are the same as those seen in the general population. However, the estimated prevalence of mental illness in the population of people with developmental disabilities is higher than in the general population.

Resource: http://thenadd.org/resources/information-on-dual-diagnosis-2/

A Support Coordinator will serve people with co-occurring disorders. Using the DSM-5 as a reference can help the SC gain an understanding of these disorders. It is essential that the SC understands how their organization supports those who present with co-occurring disorders. More than ever, collaboration across disability providers is crucial.

Communication

A Support Coordinator will meet people who may communicate in different ways. It may sometimes be assumed a person is not communicating because they do not use words to talk. The truth is that everyone communicates in some way. All people have the need to communicate to express choice, feelings, needs, likes and dislikes.

Communication is an exchange of ideas between people through a system of words, signs, or behaviors like gestures, body language and actions. Some people use words to communicate, however, we do not use words alone to get our ideas across. We also employ behaviors to

communicate, such as facial expressions (smiles, frowns, eye blinking), pointing or other physical gestures, vocal sounds, eye contact, and body movements. A number of studies have been conducted to understand what percent of human communication is non-verbal. While the studies disagree on an exact percentage, all agree that most communication is nonverbal. In fact, nonverbal behavior is the most crucial aspect of communication.

Although some people may not use words to communicate, it does not mean that they cannot understand what others are saying. Intellectual or physical challenges may be the reason some people lack the ability to talk, but it does not mean that they do not understand what is happening around them. Some people have trouble using words to communicate because of physical (e.g., a hearing or motor impairment) or genetic factors related to their developmental disability. Sometimes medications affect verbal communication, and when medications are changed, the ability to communicate may reappear. Sometimes a brain injury can affect someone's ability to communicate. A person's ability to speak language can appear at any age; therefore we should not assume language stops developing at a certain age.

Types of Communication

Communication works two ways: expressing information (expressive skills) or receiving information (receptive skills). Expressive communication means talking or communicating in any form and receptive communication means understanding what someone is trying to tell you. Expressive communication refers to how people "share or express" information. Receptive communication refers to how people "receive" information, or "what information they take in."

Some people cannot speak (expressive skills), but may understand what is being said to them (receptive skills). Some individuals can speak clearly and are easily understood (expressive skills), yet may not understand what is said to them (receptive skills).

Role of Behavior in Communication

A person's behaviors, even behaviors that we don't like, are attempts to communicate. If you cannot make yourself understood, or feel that no one is paying attention to your requests, you might become so frustrated that you use challenging behaviors to communicate. Knowing what you want and being unable to express it to others is an endless battle for people with limited or poor expressive skills. Think about how you might behave if others could not understand you.

Support Coordinator Role

A Support Coordinator needs to pay close attention to all forms of communication. People who communicate without using language usually develop a way to express their likes and dislikes, ask for things and show pleasure, displeasure, pain, or unhappiness through movements and behaviors. Sometimes, it can be hard to figure out what someone is trying to communicate. People who spend the most time around a person, such as family, friends and direct support

professionals, are excellent resources when it comes to understanding how that person communicates. A communication chart (The International Learning Community for Person Centered Practices, (http://sdaus.com/communication-chart) is useful in capturing and documenting unique ways someone communicates. This can be developed and shared among family, friends and the professionals in a person's life. This person centered thinking tool can save someone from having to continually "teach" a new professional in their lives how they communicate.

Assistive Devices in Communication

Some people use assistive devices to communicate. The terms assistive device or assistive technology can refer to any device that helps a person with hearing loss or a voice, speech, or language disorder to communicate. The following link provides information about assistive devices for people with hearing, voice, speech, or language disorders. https://www.nidcd.nih.gov/health/assistive-devices-people-hearing-voice-speech-or-language-disorders

BOX

COMMUNICATION TIPS

1. Be an active listener and be patient when talking with a person with a disability. Wait a little longer for a response.

2. Do not insist on eye contact. Although someone may not be looking at you, they may be listening and understanding every word that you are saying. Do not assume that because someone is not looking at you, they do not know what's happening.

3. When you are in a group that includes the person you support, it is important that you not hold a conversation that ignores them, or speak about them as if they are not there.

4. Pay close attention to gestures, facial expressions, vocal sounds and movements used by the people you support. Be observant, watch for patterns and share what you have learned with your co-workers.

5. Talk to the person's parents, family members, friends, providers. Chances are someone understands their communication efforts quite well.

6. Use a positive, age-appropriate, and respectful tone of voice.

7. Ask questions. This helps you gather information and shows you are interested in what the person is saying.

8. Do not say you understand the person if you do not. Apologize and remind them that you are trying to understand them and do not give up. If need be, ask a co-worker or someone who knows the person well for assistance.

9. Check for understanding of concepts you have shared. If you are not being understood, find other ways to explain the content of your message.

Role of family, Legal Guardians, Authorized Representatives, Powers of Attorney

When working with someone it should be presumed that they can tell all about themselves, handle of their own affairs and make informed decisions about their goals and support needs to the same degree as someone who does not have a disability. In many instances, however, a person may want/need the input from others who know them well. This can come from family or friends on an informal basis and/or from a legal guardian, conservator or authorized representative on a formal basis. No matter who is included in the process of getting to know someone, it is important to always remember that the person who uses services is at the center of all information gathering and planning. Each of these roles is discussed below.

BOX

"Person-centered planning celebrates, relies on, and finds its sober hope in people's interdependence. At its core, it is a vehicle for people to make worthwhile, and sometimes life changing, promises to one another." John O'Brien

Family & Friends

A Support Coordinator will encounter a wide variety of family. It is important to gain an understanding of what "family" means to the person being supported and who they consider a part of their family. An SC should ask for loved ones' names and what they are called by the person. With permission from the focus person, SCs should treat family members and friends as partners in getting to know and planning with them. Including and getting to know family members will go a long way to build trust with someone and their family.

Tips for including Families:

- Start with the assumption that families want to make a positive contribution and have the best interests of their family member at heart.
- Resist the temptation to characterize families as 'over-protective', 'not interested,' or 'barriers to. . .'
- Engage families by asking for their side of the story. It may end up providing important information about history and ways to support their loved one.

- Recognize that often family members know the person best. They care about the person in a way that is different from everyone else and they will probably be involved in supporting their loved one for the rest of their lives.
- Appreciate the huge commitment, energy, and knowledge a family brings to the table.
- Make it a priority, as long as a person agrees, to sustain, value, and strengthen family/friends connections.

Source: Person Centered Planning: Key Features and Approaches, Helen Sanderson http://familiesleadingplanning.co.uk/Documents/PCP%20Key%20Features%20and%20Styles.pdf

At times the goals of a person being supported are at odds with the goals a family member has for them. This can present a challenge for everyone involved. A person centered thinking tool that may be helpful in these instances is Working/Not Working. (http://sdaus.com/whats-working-not-working). This negotiation tool takes into account several perspectives and helps find common ground among the parties involved, while identifying what isn't going well in someone's life.

Legal Guardianship (LG) and Conservatorship

BOX

"Guardian" means a person appointed by the court who is responsible for the personal affairs of an incapacitated person, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, therapeutic treatment, and, if not inconsistent with an order of involuntary admission, residence. (22VAC30-70-10)

"Conservator" means a person appointed by the court who is responsible for managing the estate and financial affairs of an incapacitated person (22VAC30-70-10)

"Incapacitated person" means an adult who has been found by a court to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements for his health, care, safety, or therapeutic needs without the assistance or protection of a guardian or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator. (22VAC30-70-10)

In Virginia, one's parent is considered to be a child's legal guardian (LG) until the child reaches the age of 18. Once a child reaches 18, a parent may petition the Circuit Court of Virginia to become a LG for their child with a developmental disability if they feel their loved one is incapable of making life decisions. A person's LG may also be someone unrelated to them. No matter who the court appointed LG is, it is important as the SC to remember that

- A legal guardian has to be appointed by the court
- The LG ultimately makes all decisions that are made regarding the care of the "incapacitated person." *(This is a legal term and is only used here because it is such. It is not recommended that anyone should be referred by this term in everyday language*.) This does not mean that the voice of the person themselves should not be heard. In fact, it is incumbent on the LG as part of their responsibilities to encourage participation in all decision making.
- It is also the guardian's responsibility to file annual reports with the local Department of Social Services.

A conservator, also appointed by the Circuit Court of Virginia, handles the financial affairs for someone. The LG and conservator may or may not be the same person.

The responsibilities of the conservator are to take care of and preserve the assets and income of the "incapacitated person" and to file annual reports with the Commissioner of Accounts regarding money and property received and disbursed.

Source: VALegalAid.org https://www.valegalaid.org/resource/adult-guardianship-and-conservatorship

Authorized Representative (AR)

Box

"Authorized representative" means a person permitted by law or the human rights regulations to authorize the disclosure of information or to consent to treatment and services or participation in human research. The decision-making authority of an authorized representative recognized or designated under this chapter is limited to decisions pertaining to the designating provider. Legal guardians, attorneys-in-fact, or health care agents appointed pursuant to § 54.1-2983 of the Code of Virginia may have decision-making authority beyond such provider.

It is important to note that an AR acts on behalf of someone who *lacks the capacity* to make decisions about informed consent and participation in research. Lack of capacity is not something that can be decided by a Support Coordinator, a family member or even the person using Support Coordination services.

Determining Capacity

If the person who uses services is suspected of lacking the capacity to consent to treatment, services, or research or to authorize the disclosure of information, the Support Coordinator, must, according to the Human Rights Regulations (12VAC35-115-145. Determination of

Capacity to Give Consent or Authorization), obtain an evaluation conducted by or under the supervision of a licensed professional who is not directly involved with the individual to determine whether they have capacity to consent or to authorize the disclosure of information.

See the specific requirements at:
https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section145/

Therefore, before an AR or LG is selected, it must be determined by the above means that the person served is not capable of making informed decisions about care or consent to participate in research. This is true even if the person supported requests an AR or LG to be designated.

Power of Attorney (POA)

BOX "Power of Attorney" is defined as a writing or other record that grants authority to an agent to act in the place of the principal, whether or not the term power of attorney is used. "Principal" means an individual who grants authority to an agent in a power of attorney. (§ 64.2-1600)

There are three types of Power of Attorney: General Power of Attorney, Limited Power of Attorney and Durable Power of Attorney. More about each of these is discussed in the document referenced below.

BOX

RESOURCE DOCUMENTs

The codes governing consent and substitute decision making are numerous and complex. Below is a document that gives additional information about the roles of legal guardians and authorized representatives in substitute decision making. Another document provided describes a study about Supported Decision Making.

Link Participation in Decision making (at a glance)

Link to Virginia Supported Decision making (at a glance)

Futures Planning

Families of those served all wonder about their family member's life after they are gone and what it will be like when they are no longer able to be there for their loved one. Whether they seek out guidance about this topic or not, as a Support Coordinator, it is important to broach the topic and at least offer information to the family. The Arc's Center for Future Planning is a great place to start.
Resources: https://futureplanning.thearc.org/ or
http://www.wrightslaw.com/info/future.plan.index.htm

BOX

Five Wishes

Five Wishes brings a holistic approach to a living will by including a person's care and comfort choices. It provides a means to legally document one's choices for medical treatment, comfort, and care wishes.

To get copies of Five Wishes, visit the website at https://fivewishes.org/ to order. If you buy 25 or more copies, they are only $1 each.

Neurodevelopmental Diagnostic Disorders At-a-Glance

Neurodevelopmental Disorders						
Intellectual Disabilities	**Communication Disorders**	**Autism Spectrum Disorder**	**Attention Deficit-Hyperactivity Disorder**	**Specific Learning Disorder**	**Motor Disorders**	**Other Neurodevelopmental Disorders**
317 Intellectual Disability, Mild **318.0** Intellectual Disability, Moderate **318.1** Intellectual Disability, Severe **318.2** Intellectual Disability, Profound	**315.32** Language Disorder	**299.00** Autism Spectrum Disorder	**314.00 or 314.01** depending on specifiers	**315.00, 315.2,315.1** depending on specifiers	**315.4** Developmental Coordination Disorder	**315.8** Other Specified Neurodevelopmental Disorder
315.8 Global Developmental Delay	**315.39** Speech Sound Disorder				**307.3** Stereotypic Movement Disorder	**315.9** Unspecified Neurodevelopmental Disorder
319 Unspecified Intellectual Disability	**315.35** Childhood Onset Fluency Disorder (Stuttering) **315.39** Social (Pragmatic) Communication Disorder				TIC Disorders **307.23** Tourette's Disorder **307.22** Persistent (chronic) motor or vocal tic disorder (specify motor or vocal) **307.21** Provisional tic disorder **307.20** Other Specified Tic Disorder, Unspecified Tic Disorder	
	307.9 Unspecified Communication Disorder					

Participation in Decision-making and Consent

Karen A. Taylor,
Office of the Attorney General

March 2017

How Consent Obtained

- Human Rights Regulations (12 VAC 35-115)
- Health Care Decisions Act (§ 54.1-2981 et seq.)
- Judicial Authorization (§§ 37.2-1100 through -1109)
- Guardianship (§§ 64.2-2000 through -2029)
- Two Physician/Dentist Rule (§ 54.1-2970)

Participation in Decision-Making 12 VAC 35-115-70

- Rights & Duties
- Consent
- Informed Consent
- Capacity
- Surrogate Decision-Making

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Each individual has a right to participate meaningfully in decisions regarding all aspects of services affecting him. This includes the right to:

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Consent or not consent to receive or participate in services.
  - ISP and discharge plan shall incorporate the individual's preferences consistent with his condition and need for service and the provider's ability to address them;
  - Services record shall include evidence that the individual has participated in the development of his ISP and discharge plan, in changes to these plans, and in all other significant aspects of his treatment and services; and
  - Services record shall include the signature or other indication of the individual's or his authorized representative's consent.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Give or not give **informed consent** to receive or participate in treatment or services that pose a risk of harm greater than ordinarily encountered in daily life and to participate in human research except research that is exempt under § 37.2-162.17 of the Code of Virginia.
- Informed consent is always required for surgical procedures, electroconvulsive treatment, or use of psychotropic medications.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- To be informed, consent for any treatment or service must be based on disclosure of and understanding by the individual or his authorized representative of the following information:

1. An explanation of the treatment, service, or research and its purpose;
2. When proposing human research, the provider shall describe the research and its purpose, explain how the results of the research will be disseminated and how the identity of the individual will be protected, and explain any compensation or medical care that is available if an injury occurs;

Participation in Decision-making and Consent. 12 VAC 35-115-70

3. Description of adverse consequences and risks associated with the research, treatment, or service;
4. Description of benefits that may be expected from the research, treatment, or service;
5. Description of alternative procedures that might be considered, along with their side effects, risks, and benefits;
6. Notification that the individual is free to refuse or withdraw his consent and to discontinue participation in any treatment, service, or research requiring his consent at any time without fear or reprisal against or prejudice to him; and

Participation in Decision-making and Consent. 12 VAC 35-115-70

7. Description of the ways in which the individual or his authorized representative can raise concerns and ask questions about the research, treatment, or service to which consent is given.

- **Evidence of informed consent shall be documented** in an individual's services record and indicated by the signature of the individual or his authorized representative on a form or the ISP.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- **Informed consent for electroconvulsive treatment** requires the following additional components:

  (1) Informed consent shall be in writing, documented on a form that shall become part of the individual's services record. This form shall:

  (a) Specify the maximum number of treatments to be administered during the series;

  (b) Indicate that the individual has been given the opportunity to view an instructional video presentation about the treatment procedures and their potential side effects; and

  (c) Be witnessed in writing by a person not involved in the individual's treatment who attests that the individual has been counseled and informed about the treatment procedures and potential side effects of the procedures.

Participation in Decision-making and Consent. 12 VAC 35-115-70

(2) Separate consent, documented on a new consent form, shall be obtained for any treatments exceeding the maximum number of treatments indicated on the initial consent form.

(3) Providers shall inform the individual or his authorized representative that the individual may obtain a second opinion before receiving ECT and the individual is free to refuse or withdraw his consent and to discontinue participation at any time without fear of reprisal against or prejudice to him. The provider shall document such notification in the individual's services record.

Participation in Decision-making and Consent. 12 VAC 35-115-70

(4) Before initiating ECT for any individual under age 18 years, two qualified child psychiatrists must concur with the treatment. The psychiatrists must be trained or experienced in treating children or adolescents and not directly involved in treating the individual. Both must examine the individual, consult with the prescribing psychiatrist, and document their concurrence with the treatment in the individual's services record.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Have an authorized representative make decisions for him in cases where the individual has been determined to lack capacity to consent or authorize the disclosure of information.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- If an individual who has an authorized representative who is not his legal guardian objects to the disclosure of specific information or a specific proposed treatment or service, the director or his designee shall immediately notify the human rights advocate and authorized representative. A petition for LHRC review of the objection may be filed under 12 VAC 35-115-200.
- If the authorized representative objects or refuses to consent to a specific proposed treatment or service for which consent is necessary, the provider shall not institute the proposed treatment, except in an emergency in accordance with this section or as otherwise permitted by law.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Be accompanied, except during forensic evaluations, by a person or persons whom the individual trusts to support and represent him when he participates in services planning, assessments, evaluations, including discussions and evaluations of the individual's capacity to consent, and discharge planning.
- Request admission to or discharge from any service at any time.

Participation in Decision-making and Consent. 12 VAC 35-115-70

The provider's duties:

- Providers shall respect, protect, and help develop each individual's ability to participate meaningfully in decisions regarding all aspects of services affecting him. This shall be done by involving the individual, to the extent permitted by his capacity, in decision making regarding all aspects of services.
- Providers shall ask the individual to express his preferences about decisions regarding all aspects of services that affect him and shall honor these preferences to the extent possible.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers shall give each individual the opportunity, and any help he needs, to participate meaningfully in the preparation of his services plan, discharge plan, and changes to these plans, and all other aspects of services he receives. Providers shall document these opportunities in the individual's services record.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers shall obtain and document in the individual's services record the individual's or his authorized representative's consent for any treatment before it begins.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- For **minors** in the legal custody of a natural or adoptive parent:
  - Provider shall obtain this consent from at least one parent.
  - Consent of a parent not needed if a court has ordered or consented to treatment or services pursuant to § 16.1-241 D, 16.1-275, or 54.1-2969 B of the Code of Virginia, or a local department of social services with custody of the minor has provided consent.
  - Reasonable efforts must be made, however, to notify the parent or legal custodian promptly following the treatment or services.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Additionally, a competent minor may independently consent to treatment for sexually transmitted or contagious diseases, family planning or pregnancy, or outpatient services or treatment for mental illness, emotional disturbance, or substance use disorders pursuant to § 54.1-2969 E of the Code of Virginia.

Participation in Decision-making and Consent. 12 VAC 35-115-70

Emergencies:

- Providers may initiate, administer, or undertake a proposed treatment without the consent of the individual or the individual's authorized representative in an emergency. All emergency treatment or services and the facts and circumstances justifying the emergency shall be documented in the individual's services record within 24 hours of the treatment or services.

  a. Providers shall immediately notify the authorized representative of the provision of treatment without consent during an emergency.

Participation in Decision-making and Consent. 12 VAC 35-115-70

b. Providers shall continue emergency treatment without consent beyond 24 hours only following a review of the individual's condition and if a new order is issued by a professional who is authorized by law and the provider to order treatment.

c. Providers shall notify the human rights advocate if emergency treatment without consent continues beyond 24 hours.

d. Providers shall develop and integrate treatment strategies into the ISP to address and prevent future emergencies to the extent possible following provision of emergency treatment without consent.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers shall obtain and document in the individual's services record the consent of the individual or his authorized representative to continue any treatment initiated in an emergency that lasts longer than 24 hours after the emergency began.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers may provide treatment in accordance with a court order or in accordance with other provisions of law that authorize such treatment or services including the Health Care Decisions Act (§ 54.1-2981 et seq. of the Code of Virginia).
- Provisions of these regulations are not intended to be exclusive of other provisions of law but are cumulative.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers shall respond to an individual's **request for discharge** and shall make sure that the individual is not subject to punishment, reprisal, or reduction in services because he makes a request.
  - However, if an individual leaves a service against medical advice, any subsequent billing of the individual by his private third party payer shall not constitute punishment or reprisal on the part of the provider.

Participation in Decision-making and Consent. 12 VAC 35-115-70

Discharge of Voluntary admissions:

- Individuals admitted under § 37.2-805 of the Code of Virginia to state hospitals operated by the department who notify the director of their intent to leave shall be discharged when appropriate, but no later than eight hours after notification, unless another provision of law authorizes the director to retain the individual for a longer period.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Minors admitted under § 16.1-338 or 16.1-339 of the Code of Virginia shall be released to the parent's or legal guardian's custody within 48 hours of the consenting parent's or legal guardian's notification of withdrawal of consent, unless a petition for continued hospitalization pursuant to § 16.1-340 or 16.1-345 of the Code of Virginia is filed.

Participation in Decision-making and Consent. 12 VAC 35-115-70

Discharge of Involuntary admissions:

- When a minor involuntarily admitted under § 16.1-345 of the Code of Virginia no longer meets the commitment criteria, the director shall take appropriate steps to arrange the minor's discharge.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- When an individual involuntarily admitted under § 37.2-817 has been receiving services for more than 30 days and makes a written request for discharge, director shall determine whether the individual continues to meet the criteria for involuntary admission.
- If the director denies the request for discharge, he shall notify the individual in writing of the reasons for denial and of the individual's right to seek relief in the courts. The request and reasons for denial shall be included in the individual's services record.
- Anytime the individual meets any of the criteria for discharge set out in § 37.2-837 or 37.2-838 of the Code of Virginia, the director shall take all necessary steps to arrange the individual's discharge.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- If at any time it is determined that an individual involuntarily admitted under Chapter 11 (§ 19.2-167 et seq.) or Chapter 11.1 (§ 19.2-182.2 et seq.) of Title 19.2 of the Code of Virginia no longer meets the criteria under which the individual was admitted and retained, the director or commissioner, as appropriate, shall seek judicial authorization to discharge or transfer the individual. Further, pursuant to § 19.2-182.6 of the Code of Virginia, the commissioner shall petition the committing court for conditional or unconditional release at any time he believes the acquittee no longer needs hospitalization.

Participation in Decision-making and Consent. 12 VAC 35-115-70

Discharge of Certified admissions:

- If an individual certified for admission to a state training center or his authorized representative requests discharge, the director or his designee shall contact the individual's community services board to finalize and implement the discharge plan.

Substitute Decision Making

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

- If the capacity of an individual to consent to treatment, services, or research or authorize the disclosure of information is in doubt, the provider shall obtain an evaluation ~~from a professional who is qualified by expertise, training, education, or credentials and~~ **conducted by or under the supervision of a licensed professional** not directly involved with the individual to determine whether the individual has capacity to consent or to authorize the disclosure of information.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

1. Capacity evaluations shall be obtained for all individuals who may lack capacity, even if they request that an authorized representative be designated or agree to submit to a recommended course of treatment.
2. In conducting this evaluation, the professional may seek comments from representatives accompanying the individual pursuant to 12 VAC-35-115-70 A 4 about the individual's capacity to consent or to authorize disclosure.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

3. Providers shall determine the need for an evaluation of an individual's capacity to consent or authorize disclosure of information and the need for a substitute decision maker whenever the individual's condition warrants, the individual requests such a review, at least every six months, and at discharge, except for individuals receiving acute inpatient services.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

a. If the individual's record indicates that the individual is not expected to obtain or regain capacity, the provider shall document annually that it has reviewed the individual's capacity to make decisions and whether there has been any change in that capacity.

b. Providers of acute inpatient services shall determine the need for an evaluation of an individual's capacity to consent or authorize disclosure of information whenever the individual's condition warrants or at least at every treatment team meeting. Results of such reviews shall be documented in the treatment team notes and communicated to the individual and his authorized representative.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

- **Capacity evaluations** shall be conducted in accordance with accepted standards of professional practice and shall indicate the specific type of decision for which the individual's capacity is being evaluated (e.g., medical) and shall indicate what specific type of decision the individual has or does not have the capacity to make. Capacity evaluations shall address the type of supports that might be used to increase the individual's decision-making capabilities.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

- If the individual or his family objects to the results of the licensed professional's determination, the provider shall immediately inform the human rights advocate.

  a. If the individual or family member wishes to obtain an **independent evaluation** of the individual's capacity, he may do so at his own expense and within reasonable timeframes consistent with his circumstances. If the individual or family member cannot pay for an independent evaluation, the individual may request that the LHRC consider the need for an independent evaluation pursuant to 12 VAC 35-115-200 B.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

- The provider shall take no action for which consent or authorization is required, except in an emergency, pending the results of the independent evaluation. The provider shall take no steps to designate an authorized representative until the independent evaluation is complete.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

b. If the independent evaluation is consistent with the provider's evaluation, the provider's evaluation is binding, and the provider shall implement it accordingly.

c. If the independent evaluation is not consistent with the provider's evaluation, the matter shall be referred to the LHRC for review and decision under 12 VAC 35-115-200.

Authorized Representatives

Authorized Representatives. 12 VAC 35-115-146

- When it is determined in accordance with 12 VAC-35-115-145 that an individual lacks the capacity to consent or authorize the disclosure of information, the provider shall recognize and obtain consent or authorization for those decisions for which the individual lacks capacity from the following if available:
  1. An attorney-in-fact who is currently empowered to consent or authorize the disclosure under the terms of a durable power of attorney;
  2. A health care agent appointed by the individual under an advance directive or power of attorney in accordance with the laws of Virginia; or

Authorized Representatives. 12 VAC 35-115-146

3. A legal guardian of the individual, or if the individual is a minor, a parent with legal custody of the minor or other person authorized to consent to treatment pursuant to § 54.1-2969 A of the Code of Virginia.

- If an attorney-in-fact, health care agent or legal guardian is not available, the director shall designate a substitute decision maker as authorized representative in the following order of priority:

Authorized Representatives. 12 VAC 35-115-146

- The individual's **family member**. In designating a family member, the director shall honor the individual's preference unless doing so is clinically contraindicated.

  a. If the director does not appoint the family member chosen by the individual, the individual shall be told of the reasons for the decision and information about how to request LHRC review according to 12 VAC 35-115-200.

Authorized Representatives. 12 VAC 35-115-146

b. If the individual does not have a preference or if the director does not honor the individual's preference in accordance with these regulations, the director shall select the best qualified person, if available, according to the following order of priority unless, from all information available to the director, another person in a lower priority is clearly better qualified.

(1) A spouse;

(2) An adult child;

(3) A parent;

(4) An adult brother or sister; or

(5) Any other relative of the individual.

Authorized Representatives. 12 VAC 35-115-146

- **Next friend** of the individual. If no other person specified above is available and willing to serve as authorized representative, a provider may designate a next friend of the individual, after a review and finding by the LHRC that the proposed next friend has, for a period of six months within two years prior to the designation either:

  a. Shared a residence with the individual; or

  b. Had regular contact or communication with the individual and provided significant emotional, personal, financial, spiritual, psychological, or other support and assistance to the individual.

Authorized Representatives. 12 VAC 35-115-146

- In addition to the conditions set forth above, the individual must have no objection to the proposed next friend being designated as the authorized representative.
- The person designated as next friend also shall:

a. Personally appear before the LHRC, unless the LHRC has waived the personal appearance; and

b. Agree to accept these responsibilities and act in the individual's best interest and in accordance with the individual's preferences, if known.

Authorized Representatives. 12 VAC 35-115-146

- The LHRC shall have the discretion to waive a personal appearance by the proposed next friend and to allow that person to appear before it by telephone, video, or other electronic means of communication as the LHRC may deem appropriate under the circumstances. Waiving the personal appearance of the proposed next friend should be done in very limited circumstances.
- If, after designation of a next friend, an appropriate family member becomes available to serve as authorized representative, the director shall replace the next friend with the family member.

Authorized Representatives. 12 VAC 35-115-146

- No director, employee, or agent of a provider may serve as an authorized representative for any individual receiving services delivered by that provider unless the authorized representative is a relative or the legal guardian
- When a provider, or the director, an employee, or agent of the provider is also the individual's guardian, the provider shall assure that the individual's preferences are included in the services plan and that the individual can make complaints about any aspect of the services he receives.

Authorized Representatives. 12 VAC 35-115-146

- The provider shall document the recognition or designation of an authorized representative in the individual's services record, including evidence of consultation with the individual about his preference, copies of applicable legal documents such as the durable power of attorney, advance directive, or guardianship order, names and contact information for family members, and, when there is more than one potential family member available for designation as authorized representative, the rationale for the designation of the particular family member as the authorized representative.

Authorized Representatives. 12 VAC 35-115-146

- If a provider documents that the individual lacks capacity to consent and no person is available or willing to act as an authorized representative, the provider shall:
  1. Attempt to identify a suitable person who would be willing to serve as guardian and ask the court to appoint that person to provide consent or authorization; or
  2. Ask a court to authorize treatment (See § 37.2-1101 of the Code of Virginia).
- Court orders authorizing treatment shall not be viewed as substituting or eliminating the need for an authorized representative.

Authorized Representatives. 12 VAC 35-115-146

- Providers shall review the need for court-ordered treatment and determine the availability of and seek an authorized representative whenever the individual's condition warrants, the individual requests such a review, or at least every six months except for individuals receiving acute inpatient treatment.
- Providers of acute inpatient services shall review the need for court-ordered treatment and determine the availability of and seek an authorized representative whenever the individual's condition warrants or at least at every treatment team meeting. All such reviews shall be documented in the individual's services record and communicated to the individual.

Authorized Representatives. 12 VAC 35-115-146

- When the provider recognizes or designates an authorized representative, the provider shall notify the court that its order is no longer needed and shall immediately suspend its use of the court order.

Authorized Representatives. 12 VAC 35-115-146

- Conditions for **removal of an authorized representative**. Whenever an individual has regained capacity to consent as indicated by a capacity evaluation or clinical determination, the director shall immediately remove any authorized representative designated pursuant to the above, notify the individual and the authorized representative, and ensure that the services record reflects that the individual is capable of making his own decisions.

Authorized Representatives. 12 VAC 35-115-146

- Whenever an individual with an authorized representative who is his legal guardian has regained his capacity to give informed consent, the director may use the applicable statutory provisions to remove the authorized representative. (See § 37.2-1012 of the Code of Virginia.) If powers of attorney and health care agents' powers do not cease of their own accord when a clinician has determined that the individual is no longer incapacitated, the director shall seek the consent of the individual and remove the person as authorized representative.

Authorized Representatives. 12 VAC 35-115-146

- The director shall remove the family or next friend authorized representative if the authorized representative becomes unavailable, unwilling, or unqualified to serve.
- The individual or the advocate may request the LHRC to review the director's decision to remove an authorized representative under the procedures set out at 12 VAC-35-115-180, and the LHRC may reinstate the authorized representative if it determines that the director's action was unjustified.

Authorized Representatives. 12 VAC 35-115-146

- Prior to any removal under this authority, the director shall notify the individual of the decision to remove the authorized representative, of his right to request that the LHRC review the decision, and of the reasons for the removal decision. This information shall be placed in the individual's services record.
- If the individual requests, the director shall provide him with a written statement of the facts and circumstances upon which the director relied in deciding to remove the authorized representative.

Authorized Representatives. 12 VAC 35-115-146

- The director may otherwise seek to replace an authorized representative who is an attorney-in-fact currently authorized to consent under the terms of a durable power of attorney, a health care agent appointed by an individual under an advance directive, a legal guardian of the individual, or, if the individual is a minor, a parent with legal custody of the individual, only by a court order under applicable statutory authority.

Special procedures for LHRC reviews involving consent and authorization

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- The individual, his authorized representative, or anyone acting on the individual's behalf may request in writing that the LHRC review the following situations and issue a decision:

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

1. If an individual objects at any time to the appointment of a specific person as authorized representative or any decision for which consent or authorization is required and has been given by his authorized representative, other than a legal guardian, he may ask the LHRC to decide whether his capacity was properly evaluated, the authorized representative was properly appointed, or his authorized representative's decision was made based on the individual's basic values and any preferences previously expressed by the individual to the extent that they are known, and if unknown or unclear in the individual's best interests.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- The provider shall take no action for which consent or authorization is required if the individual objects, except in an emergency or as otherwise permitted by law, pending the LHRC review.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC determines that the individual's capacity was properly evaluated, the authorized representative is properly designated, or the authorized representative's decision was made based on the individual's basic values and any preferences previously expressed by the individual to the extent that they are known, or if unknown or unclear in the individual's best interests, then the provider may proceed according to the decision of the authorized representative.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC determines that the individual's capacity was not properly evaluated or the authorized representative was not properly designated, then the provider shall take no action for which consent is required except in an emergency or as otherwise required or permitted by law, until the capacity review and authorized representative designation is properly done.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC determines that the authorized representative's decision was not made based on the individual's basic values and any preference previously expressed by the individual to the extent known, and if unknown or unclear, in the individual's best interests, then the provider shall take steps to remove the authorized representative pursuant to 12 VAC 35-115-146.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If an individual or his family member has obtained an independent evaluation of the individual's capacity to consent to treatment or services or to participate in human research or authorize the disclosure of information under 12 VAC 35-115-80, and the opinion of that evaluator conflicts with the opinion of the provider's evaluator, the LHRC may be requested to decide which evaluation will control.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC agrees that the individual lacks the capacity to consent to treatment or services or authorize disclosure of information, the director may begin or continue treatment or research or disclose information, but only with the appropriate consent or authorization of the authorized representative. The LHRC shall advise the individual of his right to appeal this determination to the SHRC under 12 VAC 35-115-210.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC does not agree that the individual lacks the capacity to consent to treatment or services or authorize disclosure of information, the director shall not begin any treatment or research, or disclose information without the individual's consent or authorization, or shall take immediate steps to discontinue any actions begun without the consent or authorization of the individual. The director may appeal to the SHRC under 12 VAC 35-115-210 but may not take any further action until the SHRC issues its opinion.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If a director makes a decision that affects an individual and the individual believes that the decision requires his personal consent or authorization or that of his authorized representative, he may object and ask the LHRC to decide whether consent or authorization is required.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- Regardless of the individual's capacity to consent to treatment or services or authorize disclosure of information, if the LHRC determines that a decision made by a director requires consent or authorization that was not obtained, the director shall immediately stop such action unless and until such consent or authorization is obtained. The director may appeal to the SHRC under 12 VAC 35-115-210 but may not take any further action until the SHRC issues its opinion.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- Before making such a decision, the LHRC shall review the action proposed by the director, any determination of lack of capacity, the opinion of the independent evaluator if applicable, and the individual's or his authorized representative's reasons for objecting to that determination.
- To facilitate its review, the LHRC may ask that a physician or licensed clinical psychologist not employed by the provider evaluate the individual at the provider's expense and give an opinion about his capacity to consent to treatment or authorize disclosure of information.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- The LHRC shall notify all parties and the human rights advocate of the decision within 10 working days of the initial request.

For Further Information

- Check the Department web site
- http://www.dbhds.virginia.gov/professionals-and-service-providers/human-rights-for-service-providers
  - Frequently Asked Questions (FAQ)

REPORT OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES

Supportive Decision-Making Study (HJR 190, 2014)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 6

COMMONWEALTH OF VIRGINIA
RICHMOND
2015

Supportive Decision Making Study
House Joint Resolution 190

To the Governor and the General Assembly

Prepared by the
Secretary of Health and Human Resources

November 2014

Executive Summary

The attached report contains information about the background and context for the alternative to guardianship known as Supported Decision Making. Below is an executive summary that provides specific responses to the three elements of HJR 90 as written.

i) examine the use of supported decision-making for individuals with intellectual and developmental disabilities in the Commonwealth;

At the present time, the Commonwealth has no official position on Supported Decision Making. Its use as an alternative to guardianship and other forms of substitute decision making is not codified in code, policy, or documents detailing appropriate standards of care. It is not formally or widely used within the Commonwealth at this time. While it is true that the concept of using natural supports, such as family and friends, to aid in the decision making process is discussed as a strategy for implementing guardianship arrangements, this occurs more by happenstance than by any conscious orchestration.

ii) compare the Commonwealth's policies and practices related to supported decision-making and informed choice to the policies and practices used in other jurisdictions; and

The Commonwealth currently has no defined policies or practices related to Supported Decision Making. Other jurisdictions have no structured mechanism in place to implement the Supported Decision Making model; states are in the process of exploring the utility of the model for their communities. One state is presently conducting research on the application of Supported Decision Making within the disability community. Other countries are exploring the model as well.

iii) after consultation with The Arc of Virginia, Voices of Virginia, the Autism Society, the Down Syndrome Association, the Jenny Hatch Justice Project, and other stakeholders, recommend strategies to improve the use of supported decision-making in the Commonwealth and ensure that individuals with intellectual and developmental disabilities are consistently informed about and receive the opportunity to participate in their important life decisions.

Recommendations based upon consultation with the above referenced agencies may be found at the end of the full report.

Background

The State of Virginia has developed extensive plans to close all but one training center in the Commonwealth. While these efforts have been guided by the tenets of the settlement agreement with the Department of Justice, they also reflect a broader understanding within the disability community that persons with intellectual disabilities are entitled to live lives that are as independent and self-directed as possible. As a result, the entire array of services offered to those with cognitive deficits is under review, from employment practices, to housing options, to crisis response systems. In ensuring that changes to the system meet the needs, preferences, and values of the individuals served, those practices and legal codes related to decision making capacity are likely to move to a prominent position in the process.

The issue of decision making capacity and what should be done to support those who need assistance in exercising this capacity has taken a position of prominence in the state in recent years. The case of Ms. Jenny Hatch has challenged disability providers, the guardianship system, and, perhaps, the legal community to reconsider the notion that individuals with more than a very mild intellectual disability cannot make effective decisions on their own behalf. In the case of Ms. Hatch, a petition to codify a guardianship relationship between Ms. Hatch and her parents was denied by the Virginia Circuit Court in Newport News, with Judge Pugh opting instead for a limited, time-restricted guardianship relationship between Jenny and her long-time friends, Kelly Morris and James Talbert. During the course of that trial, the practice of Supported Decision Making was presented as the rational, ethical, and most healthy psychological approach for assisting individuals with disabilities, such as Ms. Hatch, to be as autonomous as possible.

In understanding the relationship between Supported Decision Making and legal decision making capacity, it is important to understand that plenary decision making capacity does not exist. Capacity is specific to the type of decision that needs to be made. Generally, decision-making capacity falls within certain areas of a person's life including medical care, housing, finances, support services, and personal decisions (i.e., whether to get married, vote, or live with a friend). A person may have capacity to make one type of decision, yet lack the capacity to make decisions within another life arena. Therefore, any evaluation of an individual's decision making capacity must be determined in the context of the issue at hand. Supported Decision Making assumes that the individual has some ability to participate in and communicate about decisions that will influence their own lives. It assumes capacity while buttressing this skill with input from trusted friends, relatives, or support providers. Supported Decision Making replicates what we all do naturally: talk to our support system when confronting an important life decision and, when needed, ask professionals to present information to us in "layman's terms".

The theory behind Supported Decision Making is consistent with the state's vision for a system of care that is person-centered, community-based, and rooted in respect for the rights of the individual. To be consistent with this vision, the Supported Decision Making model should be used in any case where the issue of decision making capacity has been legitimately raised. This process will allow the individual to continue to use and improve their ability to make good decisions, while ensuring that they understand the relevant elements that need to be considered.

Virginia's Position on Supported Decision Making

The Commonwealth appears to have no formal position on the use of Supported Decision Making. Virginia continues to adopt the approaches as defined in the Commonwealth's Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, and Operated by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (i.e., the *Blue Book*). But at least one court in Virginia has positively evaluated the utility of the model as an alternative to guardianship as evidenced by the Jenny Hatch case. Given the legal outcome in the case of Jenny Hatch, it appears that Virginia may be in a unique position to assume a leadership role in this area of human rights, translating the model of Supported Decision Making into a defined standard of care.

Other states are also exploring supported decision making. For example, Pennsylvania's Disability Rights Network has published a booklet entitled *Consent, Capacity, and Substitute Decision Making*. While helpful, this resource primarily offers definitions and explanations about types of decision making and types of substitute decision making. The concept of Supported Decision Making as a specific practice is not mentioned in the document. The State of Massachusetts has initiated a small pilot study to offer supported decision making to a group of 10 individuals currently under guardianship. North Carolina and Maryland are also exploring the value of Supported Decision Making within their communities.

Other countries such as Australia, Canada, Sweden and England are also examining Supported Decision Making as an alternative to guardianship or other court-sanctioned substitute decision making arrangements. Indeed, reviews of these efforts have been published in Australia and Canada.

Initial Recommendations

1. In an effort to begin to formalize Supported Decision Making as a legitimate alternative to Guardianship, add Supportive Decision Making to the less restrictive alternatives in guardianship and conservatorship statute as well as to DBHDS code concerning Authorized Representatives.
2. Individuals who are appointed to positions as guardians or authorized representatives should be required to receive training in Supported Decision Making and Person Centered Planning. They should espouse their commitment to incorporating such practices into their roles. Failure to participate in designated training would be grounds for removal of the individual from their decision making role.
3. Because a capacity evaluation should always be the first step in any discussion of programs or processes that seek to impact a person's right to make a decision freely and at will, it is recommended that the Commonwealth develop a standardized procedure for completing capacity evaluations. Additionally, it is recommended that a minimum standard relative to the written report summarizing the findings of the capacity evaluation be developed.
4. Capacity is a poorly understood concept among providers and some mental health professionals. It is recommended that a general training on capacity and Supported Decision Making be developed and offered. It is recommended that part of this training include a discussion of all types of decision making assistance commonly in use and what type of clinical presentation is appropriate for each.

These recommendations in whole or in part were endorsed by representatives of The Arc of Virginia, the Down Syndrome Association of Northern Virginia, Voices of Virginia, the Autism Society of America- Central Virginia Chapter and the Autism Society of America- Northern Virginia Chapter. Quality Trust (Jenny Hatch Justice Project) and Down Syndrome Association of Greater Richmond are also in agreement with the recommendations.

Conclusion:

The Commonwealth may be in a distinct position to build momentum for the development of a formal position on supported decision making due to the national news coverage of the Jenny Hatch case and the on-going involvement of the Quality Trust for Individuals with Disabilities. Supported Decision Making is consistent with current expectations from the Centers for Medicare and Medicaid Services in their final rule around Home and Community Based Waiver Services as it relates to person centered practices. Developing some standardized expectations around assessing and reporting on capacity as well as training both provider staff and potential legal guardians and authorized representatives regarding supported decision making will only serve to enhance

and improve the way Virginia supports and respects the rights of individuals with developmental disabilities.

Support Coordination Manual
Developmental Disabilities
Chapter 4
Support Coordination Process:
Preparation & Engagement

- Preparation
  - Enhancing Knowledge, Skills & Abilities
  - Self-Examination
  - Understand Those Served
- Engagement
  - Healthy Relationship Core Components
  - Positive Helping Relationship

Support Coordination Manual
Developmental Disabilities
Chapter 4
Support Coordination Process:
Preparation and Engagement

Preparation

Most people enter this field because they want to help others and Support Coordinators (SC) do just that. Like most career paths, preparation for this job began with a desire and was followed by education, a job search and landing a position. In order to become employed as a SC, there are knowledge, skills and abilities that are required by the Code of Virginia.

BOX

Qualifications of Case Management Employees or Contractors

http://dbhds.virginia.gov/assets/doc/QMD/OL/ch.105.full.wemergcompliance.9.01.18docx.pdf (emergency regulations)

Once hired, there are many things the Support Coordinator can do to continue preparing to carry out the day to day tasks of providing supports and services to people in need. Above all else, it is imperative that the Support Coordinator keeps this at the forefront of all they do:

Remember that YOU make a Difference!

The suggestions presented below are not things that can be accomplished all at once or before the SC begins their job, but are ways to continue the preparation process throughout their tenure as a Support Coordinator.

Enhancing Knowledge, Skills, Abilities

Get to know resources:

- Stay abreast of the supports and services that are in the region including within one's own CSB. This includes varied resources such as primary healthcare, behavioral healthcare, social services, employment services and various providers of DD Waiver services.
- Understand that people are resources. Get to know your co-workers. Find out the gifts each colleague has to offer. Develop relationships with professionals from other service provider agencies

Become a life-long learner:

- Be open to new concepts and stay up on best practices in, among other things, treatment modalities and intervention techniques, person centered practices,

independent living skills training, supportive counseling, family education, and crisis intervention.

- Attend ongoing training, webinars, and conferences
- Read articles and books
- Consider joining the Case Management Society of America (http://www.cmsa.org/)
- Use supervision to build skills and knowledge
- Learn one's organization's particular Support Coordination processes and protocols
- Memorizing all of the regulations, laws that affect the SC's job would be a daunting task. Know which laws regulate practice and know where to find them.
- Research conditions and disorders that people have that are unfamiliar
- And above all, do not be afraid to **ASK QUESTIONS!**

Self- examination

- Build awareness of your own attitudes and biases which may affect the helping relationship. All humans hold biases. This can include biases about a number of characteristics as outlined in chapter 1. These biases can include how one views a person with a disability.
- Identifying topics that are personally uncomfortable (i.e., sexuality and disability, death) and address them with a supervisor
- Be willing to have an open mind to the shared experiences with those served.

Understand those Served

- Treat persons with disabilities as human beings rather than as their disability.
- Understand that working with someone with a developmental disability often involves ***many*** conversations about a particular topic or issue in order for true understanding to take place.
- Know that people with disabilities, including those with an intellectual disability, can speak for themselves. Be open to other communication styles (sign language, use of devices, etc.)
- Be mindful that the expressed negative experiences related to disability are real.
- Consider the effects that labels may have on those served.
- Being aware of how people with disabilities describe themselves.
- Respect the fact that people with disabilities know their own bodies and experiences.
- Recognize the abilities and strengths of persons with disabilities and incorporate them into the helping relationship.
- Recognize that most persons with disabilities do not live their life "focusing" on their disability and limitations.

Reference: https://www.counseling.org/docs/default-source/vistas/article_09.pdf?sfvrsn=157ccf7c_12
Stuntner (2012)

BOX

"When you see, meet or think about a person with a disability, presume competence."

Kathie Snow **Disability is Natural**
https://www.disabilityisnatural.com/

Engagement

Engagement is a key component in providing effective Support Coordination services. It significantly increase the likelihood that someone will:

- Access needed services
- Remain connected to services
- Actively participate in services
- Achieve their outcomes

Engagement starts in the first meeting and continues until services are no longer needed. SCs start to build a relationship in the first meeting when they introduce themselves, explain their role in the relationship, build common ground and begin the assessment and planning process.

At times SCs have to reach out to those they serve, along with their family members to encourage them to participate in services. This is particularly important if someone has missed meetings or stopped participating in services. This might include making phone calls and/or visits to the home or places in the community to further develop the relationship and improve the person's engagement in services. People with developmental disabilities may need additional support to understand the consequences of missed meetings/appointments.

Engagement is enhanced by using the following strategies:

- Be respectful.
- Always address someone by the name they prefer.
- Be friendly and use eye contact when talking.
- Respect cultural norms.
- Be responsive to the person's requests.
- Be on time and follow-through with tasks you've agreed to.
- If someone does not want to talk and asks you to leave, remain polite, say goodbye, and let them know when you will return.
- Create an inviting environment.
- Make people feel comfortable and offer private spaces for talking.
- Be sure that meeting areas are clean, well lit, and not too noisy.
- Use reflective listening.
- Use person-centered outcomes.

- Make sure all services are helping those served reach their intended outcomes.
- Reinforce achievements along the way.
- When outcomes are not met in a realistic time frame, it should be viewed as a problem with the outcome or the steps toward it, not with the person.
- Be honest and knowledgeable; if you do not know the answer, then seek guidance first
- Support informed choices
    - Engage a person in making choices about their lives.
    - Encourage looking at all options involved when making decisions.
    - Discuss ways to cope with lack of choices in certain situations.

Healthy Relationship Core Components

The core conditions of a helping relationship include empathy, respect and authenticity.

Empathy in the helping relationship has long been recognized as the most powerful determinant in someone progressing toward meeting their outcomes. Empathy is the ability to perceive and communicate accurately and with sensitivity, the feelings and experiences of another person. It means not just listening, but actively responding, with compassion, an attempt at understanding the experience of another person's world. Empathy goes beyond the facts, circumstances, and events of someone's life and conveys an understanding of how those circumstances uniquely affect them.

Respect in the helping relationship means having unconditional positive regard for the person seeking services. It means not evaluating or judging their thoughts, feelings, or behaviors as good or bad. Each person is accepted and valued for who they are. This does not mean that a SC approves of thoughts or behaviors of which the society may disapprove. Rather it means that despite such thoughts and behaviors, SCs are able to communicate in words and actions that they value those they support as people.

Authenticity, or genuineness, in the helping relationship refers to a SC being themselves. It means that the inner experience and outward expression match. Being genuine shows people that the SC is trustworthy. This aids in building a positive relationship. It also serves as a model to encourage those seeking services to be their true selves.

This link gives additional information about the core components of a helping relationship.
https://www.essaytyping.com/core-conditions-helping-relationship-therapists-journal/)

Positive Helping Relationship

Other ways the SC can create and maintain a positive helping relationship are by:

- Providing support and encouragement
- Collaborating with the person seeking services and their supporters
- Offering reassurance to those seeking services and their supporters

- Identifying and refraining from expressing personal biases
- Monitoring and managing personal reactions to the behavior of others

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- Diagnostic Eligibility Form
- Annual Risk Assessment
- Annual Risk Assessment Instructions
- A Brief Overview of Psychotropic Medication Use
- DMAS 459 Recipient Choice
- Priority Needs Criteria Checklist
- Sample Right to Appeal Letter
- DD Waiver Services and Support Options
- Critical Needs Summary Guidance
- Needed Services Form
- Documentation of Individual Choice Form
- Cover Letter Choice
- Cover Letter Second Reminder
- WSAC committee intro letter
- WSAC volunteer application
- WSAC Membership Parameters
- WSAC session operations
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- Emergency Slot Request Form
- Reserve Slot Request Form
- SIS Standard Operating Procedure
- SIS SC User Guide
- SIS Review Form
- SIS Interview Information for Respondent
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- SIS FAQs Individuals & Families
- Support Levels and Tiers
- SIS Initial Request Form
- SIS Initial Request Instructions
- SIS Reassessment Request Instructions
- SIS Administration
- VA Informed Choice DMAS 460
- DMAS 225 SC Responsibilities
- DMAS 225

Support Coordination
Developmental Disabilities
Chapter 5
Support Coordination Process:
Assessment

How to Screen, Assess and Conduct an intake

The CSB/BHA is the single point of entry for a person seeking services.

The CSB/BHA will schedule an intake appointment with the individual. The individual should be asked to have required documentation available for the person doing the intake. Each CSB/BHA should have a process for intakes. Please ask your supervisor for more information.

Case Management and Wait List Eligibility Flow chart at a glance (link)

Eligibility for Support Coordination

Intellectual Disability Support Coordination (ID SC)

To be eligible for ID Support Coordination a person must have a diagnosis that confirms an intellectual disability (ID) (link to Chap 3) To be eligible for Developmental Disability Coordination a person must have a diagnosis that confirms a developmental disability. (Link to Chap 3)

Eligibility for Part C Support Coordination

The Infant & Toddler Connection of Virginia provides early intervention supports and services to infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. Early intervention supports and services focus on increasing a child's participation in family and community activities that are important to the family. In addition, supports and services focus on helping parents and other caregivers know how to find ways to help their child learn during everyday activities. These supports and services are available for all eligible children and their families regardless of the family's ability to pay.

Assessment and Eligibility for Developmental Disability (DD) Waivers

To be eligible for the Developmental Disability (DD) waiver a person must meet 3 criteria: diagnostic eligibility, functional eligibility and financial eligibility.

Diagnostic Eligibility

Diagnostic eligibility means that a person must have a disability that affects their ability to live and work independently. The Diagnostic Eligibility Review form can be used to ensure that collected documentation substantiates a diagnosis that confirms eligibility for SC services. For more information on the descriptions, symptoms and other criteria for diagnosing DD please see chapter 3.

At a Glance-Diagnostic Eligibility Review Form

Functional Eligibility-Virginia Individual Developmental Disability Eligibility Survey (VIDES)

In order to meet functional eligibility requirements a person must need the same support as someone who is living in an Intermediate Care Facility for people with an intellectual/developmental disability (ICF-ID/D). This is determined by the Virginia Individual DD Eligibility Survey (VIDES). There are different versions of this assessment depending on the age of the person seeking services.

- Infant VIDES -under the age of 3
- Children VIDES –between the ages of 3 through 17
- Adult VIDES - 18 and older

Functional eligibility is established when someone meets the following established dependency level for the age appropriate VIDES.

- Infant VIDES- must meet 2 out of the 5 categories
- Children VIDES - must meet 2 out of 8 categories
- Adult VIDES - must meet 3 out of 8 categories

The VIDES should be completed in the online Waiver Management System (WaMS) and/or in an electronic health record. Only an SC who has been trained may administer the VIDES. Ask your supervisor for training.

WaMS CSB User Guide at a glance (link to chapter 2 in at a glance section)

Financial Eligibility

Financial eligibility means that the person seeking services meets the financial criteria to receive Medicaid. This is determined by the local Department of Social Services following the Medicaid eligibility rules used for people who need long term care.

An SC might determine that a person only meets one or two of the three eligibility criteria for adults to receive a DD Waiver. For example, a person with an ID diagnosis may not meet the minimum functioning criteria on the VIDES, rendering them ineligible to be placed on the DD Waiver wait list. In this instance, the SC would provide that person with appeal rights and work with them to determine alternative options and resources that are available in the community. Community resources are listed in Chapter 11 (link).

Box

*Note: A person can be on the waitlist and not meet financial eligibility criteria

**Note: A person with a DD diagnosis not eligible for the waitlist is not eligible for TCM.

Information Gathered at Intake
(Check with your Supervisor for agency specific requirements)

- Documentation to support diagnosis of developmental disability (to include ID if applicable)
- Consent to Exchange Information
- VIDES
- Human Rights Notification
- Documentation of Choice between Institution and Community based services
- Appeal Rights if placing on the waitlist

- Guardianship/Court Documents (if applicable)
- Voter Registration

Person Centered Individual Service Plan (PC ISP)

The PC ISP is comprised of 5 parts. The Essential Information Part I, Personal Profile Part II, Shared Planning Part III, Agreements Part IV, and Plan for Supports Parts V

More detailed information can be found in Chapter 7. (link to Virginia's Individual Support Plan in WaMS.

Risk Assessment

The Annual Risk Assessment (ARA) is completed by the SC during the initial assessment and annually thereafter. Completion of the ARA is based on the same numeric scale used on Sections 3A-Exceptional Medical Supports and 3B-Exceptional Behavioral Supports of the Supports Intensity Scale (SIS®) which is described further along in this chapter. This means that the Annual Risk Assessment will reflect changes in the person's level of support needs from year to year. The Annual Risk Assessment is a review of a person's current level of support needs. The Annual Risk Assessment and Fall Risk Assessment is required to be updated annually for anyone on the DD Waiver wait list and for anyone who is utilizing DD Waiver services. If individuals are also served by a Care Coordinator (CC) under the Commonwealth Coordinated Care Plus (CCC Plus) waiver, the CC is required to complete an annual health risk assessment (HRA) and an Individualized Care Plan with the person using the CCC+ waiver. SCs should communicate and collaborate with the CC to obtain a copy of the HRA and the Individualized Care Plan to mitigate risks.

More detailed information about how an SC can assist in identifying health and safety risks can be found in Chapter 10. (link to chapter 10)

Box

Annual Risk Assessment at a glance

Annual Risk Assessment instructions at a glance

Overview of Psychotropic Medication use at a glance

Human Rights Notification

During the initial assessment and annually thereafter, the SC must ensure that the person is aware of and has reviewed their human rights as described in the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, funded, or operated by the Department of Behavioral Health and Developmental Services (Human Rights Regulations). Support Coordination organizations are required to notify each individual and his authorized representative about these rights and how to file a complaint. The notice shall be in writing and in any other form most easily understood by the person using services. The notice shall provide the name and phone number of the human rights advocate and give a short description of the human rights advocate's role. The provider shall give this notice to and discuss it with the individual at the time services begin and every year thereafter. This notice shall be signed and filed in the person's services record.

More information regarding the Human Rights Regulations is located at http://dbhds.virginia.gov/quality-management/human-rights

Consents to Exchange Information

The SC is responsible for ensuring there is documentation of Consent to Exchange Information. During the initial assessment and annually thereafter, the SC should ensure there are current consent forms for any collateral contacts or organizations to which the SC must communicate and/or release information pertaining to the person who uses SC services.

Choice of Waiver/Intermediate Care Facility

During the initial assessment and while screening for the DD Waiver wait list, the SC is responsible for ensuring documentation that indicates the person's desire for ID/DD community based care. This documentation ensures that the person has chosen community based care over institutional services. The required documentation is known as the Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services (DMAS 459). It is completed during the initial screening for the DD Waiver program, and annually until the individual receives a DD Waiver. It should be maintained in the person's electronic health record.

The Documentation of Recipient Choice Between Institutional Care or Home and Community Based Services (DMAS 459) at a glance (link)

Three Types of Developmental Disability Waivers

Virginia has three waivers for people with Developmental Disabilities. They are the Building Independence Waiver, the Family and Individual Supports Waiver and the Community Living Waiver. More detailed information about the three DD Waivers can be found in Chapter 6. (link to Chapter 6 Descriptions of Three DD waivers)

Wait List

In Virginia, the need for DD Waiver services is greater than the number of slots Virginia has to distribute. Therefore, everyone who requests DD Waiver services is added to a waitlist. Because DD waiver slots are distributed based on urgency of need and the number of waiver slots are made available based on Virginia's budget, there is no way to tell how long a person will remain on the waitlist. There is, however, a method for determining the urgency of need among those waiting for services.

Priority Needs Checklist

The Priority Needs Checklist must be completed and submitted in order to add a person to the wait list. The checklist identifies the reason a person falls into priority category (one, two or three) and is completed after the VIDES has been conducted. The Priority Needs Checklist is located and completed in WaMS under the Screening and Assessments section. Priority status is based on how much and how quickly someone is in need of help.

BOX

Key Points to Remember:

The priority screening should be reviewed anytime there is a change in circumstance to assure it accurately reflects the support needs of the person seeking services.

Only those who meet Priority One status can be assigned an available DD Waiver slot.

Those assigned with a Priority two and Priority three status cannot be awarded a CL Waiver or IS waiver, unless every person in the state, who is assigned a Priority One status, already has a Slot.

For the BI waiver, a person assigned to Priority Two or Three may receive a slot if no one in a lower priority category has requested independent living.

Priority Needs Criteria Checklist at a glance (link)

WaMS User guide at a glance (link)

Right to Appeal

Once a person has been placed on the DD Waiver waitlist, the Support Coordinator must send a letter notifying them of appeal rights. Additionally, if a person on the waitlist has a change in priority status, they must also be issued appeal rights if moving to a lower priority.

Box

Sample Right to Appeal Letter at a glance (link)

Critical Needs Summary

The SC must also complete a Critical Needs Summary (CNS) in WaMS for those designated as having a Priority One status. The purpose of the CNS is to determine a person's level of urgency. This is a required step in placing a person on the waitlist. In WaMS, the CNS option will appear under the Screening and Assessments section after the Priority Needs Checklist has been completed and submitted.

BOX

Key point to remember:
When placing someone on the Wait List, the Support Coordinator should ensure the family knows what services they would utilize if offered a waiver slot. The SC should regularly monitor the needs of people and discuss the services that are available under the DD Waiver. Remember that a person must be willing to use services within 30 days of being awarded a slot. The following guide is a helpful tool that can be given to the person requesting services and their family, when placed on the waiting list. Additionally, once a year the Virginia Department of Behavioral Health and Developmental Services will send a letter to everyone on the DD Waiver wait list. Included in the letter will be instructions to review and sign the Documentation of Individual Choice Between Institutional Care or Home and Community-Based Services form and the Needed Services form.

DD Waiver Services and Support Options at a glance
Critical Needs Summary Guidance at a glance
Needed Services form at a glance

WaMS user guide at a glance (link)

Documentation of Individual Choice Between Institutional Care or Home and Community-Based Services form at a glance

Cover letter choice packet at a glance

Cover letter Choice (Second reminder) at a glance

DD Waiver Slot Allocation General Information

DD Waiver slots become vacant when someone who was previously using DD Waiver services moves out of state, passes away, moves into a nursing facility or institution, no longer meets eligibility criteria, or chooses to no longer utilize the supports provided under the DD Waiver. Currently the number of slots is limited by the availability of funding for DD Waiver services. Funds are managed at the state level and the appropriation of additional funds to increase the number of slots is dependent upon General Assembly Action. Each CSB is allotted a designated number of slots. If an assigned slot becomes vacant, the CSB must use it in a timely manner to provide DD Waiver services to another eligible individual. Slots are reassigned to people on the DD Waiver Waiting list by the Waiver Slot Assignment Committee (WSAC).

When the General Assembly allocates more than 40 slots for a given waiver, allocations will be made by providing one slot per board then a standard calculation (considering priority numbers per board) will be used to disseminate the remaining slots.

When the General Assembly allocates less than 40 slots for a given waiver, allocations will be made by combining all WSACs within a region. Each WSAC will be represented by the assigned facilitator and two additional representatives per committee.

Waiver Slot Assignment Committee (WSAC)

Waiver Slot Assignment Committees (WSAC) were developed to establish a means for determining the assignment of DD Waiver slots. The DD Waiver separates the eligibility determining entity (CSB SCs) from the entity who determines slot assignment. There is a WSAC in each locality/region of Virginia. The committee is comprised of people with diverse personal and professional backgrounds, as well as varied knowledge and expertise and no identified conflict of interest. For more information on qualifications for committee members and the responsibilities of the WSAC members please see the links below.

BOX

WSAC Committee Introduction Letter at a glance

WSAC Volunteer Application at a glance

WSAC membership parameters at a glance

SCs play an important role in the assignment of a vacant DD Waiver slot. They must ensure that information in WaMS accurately reflects an individual's current needs. When a slot is available for assignment, the CSB contacts the WSAC facilitator and a WSAC meeting is convened. Please see the link below for more information on the SC's role in the operations of WSAC.

BOX

WSAC Sessions Operations at a glance

Slot Assignment Review Form at a glance

WSAC review schedule at a glance

WSACs name ID Key for email at a glance

At times, an SC may provide support to someone who needs immediate access to DD waiver services. There is a specific criteria that the person must meet in order for a SC to request access to an Emergency DD Waiver Slot. After exploring all possible alternative options a CSB can request access to an Emergency Waiver slot by submitting an Emergency Slot Request form.

BOX

Emergency Slot Request Form at a glance

At times, a SC may be providing support to someone who has experienced a change in their assessed needs requiring services available in a different waiver. The reserve slots enable a safety net with which someone can return to the original waiver, if needed. The SC must ensure that the person meets the criteria in order to request a Reserve DD Waiver slot. There is a chronological waitlist that DBHDS keeps for reserve slots funded by the General Assembly action.

BOX

Reserve Slot Request Form at a glance

Slot Assignment

Once a person is offered a DD Waiver slot, the SC is responsible for ensuring that the transition to Waiver services includes a thorough review of the assessment information and service options under the DD waiver. Those responsibilities are listed below.

Review/update Assessment and VIDES

Upon receipt of a DD Waiver slot, the SC will arrange a PC ISP development meeting to review and update all assessment information including the VIDES, Annual Risk Assessment, Essential Information (Part I) and the Personal Profile (Part II) to ensure accuracy.

Supports Intensity Scale (SIS®)

The Supports Intensity Scale (SIS®) is a standardized assessment tool, specifically designed to measure the pattern and intensity of supports needed by individuals to be successful in areas of life, similar to their non-disabled peers in the community.

Once awarded a DD Waiver slot, the SC will assist in scheduling and document the attempts to schedule the SIS® assessment and will serve as a respondent during the assessment. At this time in Virginia, the SIS® is conducted by Ascend. The SC can share a copy of the *SIS FAQS for Individuals and Families* in order to prepare them for the upcoming assessment.

Once the SIS® has been conducted, the SC will be sent a copy of the assessment which will be used to determine the extent of supports needed. The SC needs to ensure that a copy of the assessment is sent to all the providers that support the individual.

For adults, there are seven levels of support needs determined by the SIS® and Supplemental Questions. Additionally, there are four reimbursement tiers. A number of services (group home, sponsored residential, supported living, independent living supports, group day, community engagement, and group supported

employment) will be reimbursed according to these tiers. This process provides greater reimbursement for smaller settings and for supporting those with more intensive needs.

For more information on the SIS® and the SC's role in the assessment, see the links below.

BOX

Ascend Home Page https://www.ascendami.com/ami/

Virginia Standard Operating Procedures for the SIS at a glance

SIS User Guide

SIS® Review Form at a glance

SIS® Interview Information for respondent at a glance

Sample SIS® Assessment at a glance

SIS® FAQs for individuals and families at a glance

Support Levels and Tiers at a glance

SIS® Initial request form at a glance

SIS® Initial request instructions at a glance

SIS® reassessment request instructions at a glance

SIS® administration at a glance

Physical Exam

Upon receipt of a DD Waiver slot, the SC must obtain documentation of a recent physical examination, and documented in WaMS. The physical is required upon the initiation of a DD Waiver slot and updated when significant medical changes occur. The physical exam must have been completed no more than 12 months prior to the initiation of DD Waiver services.

DMAS 460 Virginia Informed Choice Form

When working with a person to determine their choice of providers, it is crucial for the SC to ensure the person is aware of all of their options. The person should be given information on all available DD Waiver services and SCs. A great tool that SCs can use is the *DD Waiver Service and Support Options guide*. Many CSBs keep an up to date list of local DD Waiver providers. Additionally, the SC could direct the person and their family to the DMAS provider search tool located here. (We will hyperlink with shorter address)

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/Provider%20Resources/Search%20For%20Providers/!ut/p/z1/jY8xC8IwFIR_i0NH-15sFXGLqENRcJHGt0gqMS20SUmjwX9v0UnQ6m13fHdwQCCAjLxVWvrKGln3_kizU7ZPOVsi2-F6w5AnfLrqzQS3KeRPAL-II9A__QGAhudzoF9IBqRrW7zecFMkcw3k1EU55eKr6-PS-7ZbRBhhCCHW1upaxWfbRPipUtrOg3gnoW0OAsdU3AMfPQAM03sk/dz/d5/L2dQX18tQSEhL29Ld3dBQUFRaENFSVFoQ0VJUWhDRUlRZy80TmxIWXgyY2RnblpKMktkbW5ZWjJXZGpuWjUyQmRrWFlsMlpkaFhaVjJOZG5YWU4yVFEhL1o2X0pQNEExQjAxTThFREEwQTNBUFIwRVMwMDAwL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzND

QxL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ1EwL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ1E3L1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQzYzL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ001L1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ0UxL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ1UxL1o2X0pQNEExQjAxTTgyQjUwQTcyVlM0QVAwMDAwL1o2X0pQNEExQjAxTTgyTjAwUUNCQVUyRUwwMDAwL1o2X0pQNEExQjAxTTgyQjUwQTcyVlM0QVAwMDAxL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzNFMwL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQzU3L1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ0wzL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ0Q1L1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ1Q1L1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQzMxL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ0o2L1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ0IyL1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQ1I0L1o2X0pQNEExQjAxTU9LOEEwQTNDOFBRVkQzQzcw/

More information about how a SC can support a person through their personal choices and decision making can be found in Chapter 1. (link to Chapter 1 Personal Choice and Decision making)

Once providers have been chosen, the SC is required to complete the Virginia Informed Choice Form (DMAS 460). A signed copy must be retained in the person's electronic medical record. The DMAS 460 should be reviewed and completed with the person and/or substitute decision-maker at enrollment into the DD Waiver, updated annually (and include choice of SC), when there is a request for a change in waiver providers, when new services are requested, when the person wants to move to a new location and/or is dissatisfied with the current provider.

Virginia Informed Choice Form DMAS 460 at a glance

DMAS 225 Medicaid Long Term Care (LTC) Communication Form

The Department of Medical Assistance Services (DMAS) 225 is a form that serves as a method of communication between the SC and the Local Department of Social Services (LDSS). Prompt submission of this form is necessary to insure that LDSS has correct and current information in order to determine patient pay responsibilities and ensure ongoing eligibility for Medicaid. For more detailed information about the SC's role as it pertains to patient pay see the link below. More information about patient pay can be found in chapter 6 (link to patient pay in chapter 6)

BOX

DMAS 225: SC Responsibilities at a glance

DMAS 225 Form at a glance

Waiver Slot Management

In addition to updating the assessments and obtaining documentation of informed choice, the SC is also responsible for enrolling the person into the newly assigned slot. When a slot has been assigned, the enrollment status of the person, in WaMS, is listed as *Projected Enrollment Status*. In order to initiate services, the person's status must be moved to *Active* status. This process is completed in WaMS. See the WaMS CSB User Guide Section 9 for more detailed instructions of how to move a person from *Projected* to *Active* status

WaMS CSB User guide at a glance (link)

Update Person Centered Individual Support Plan (PC ISP)

During the process of initiating DD Waiver services, the Person Centered Individual Support Plan (PC ISP) should be reviewed and updated to reflect the person's choice of Waiver services and providers. This will include developing a new PC ISP or updating all five parts of the PC ISP. More detailed information about the PC ISP process and plan development can be located in Chapter 7. (link to chapter 7)

Update WaMS Data

In order for DD Waiver services to be initiated the SC should ensure that any information in WaMS is accurate and up to date, including but not limited to:

- Individual's Profile (demographics, contact information, diagnosis etc.)
- Current/updated VIDES

Review, Add, Change Service Providers

Once a person with a new DD Waiver slot has chosen service providers, the SC is responsible for adding the chosen providers into WaMS prior to the authorization of services. Service providers cannot access an individual in WaMS until the CSB has added the provider(s). Attachments related to the PC ISP are then loaded into WaMS in preparation for the authorization process. More detailed instructions on how to add, remove and change service providers can be found in the WaMS CSB User Guide Section 11.

WaMS CSB User Guide at a glance

Service Authorization (SA)

Service Authorization (SA) of DD Waiver services is completed in WaMS. The overall process for requesting SA is as follows:

1. SC creates the SA in WaMS
2. Provider adds services to SA
3. SC Reviews/adds/changes as needed
4. DBHDS staff approve, reject, deny or pend SA
5. VAMMIS processes the SA

Note: SCs complete SAs for environmental mods, PERS and assistive technology as the provider.

More detailed instructions of how to create SAs can be located in section 12 of the WaMS user guide.

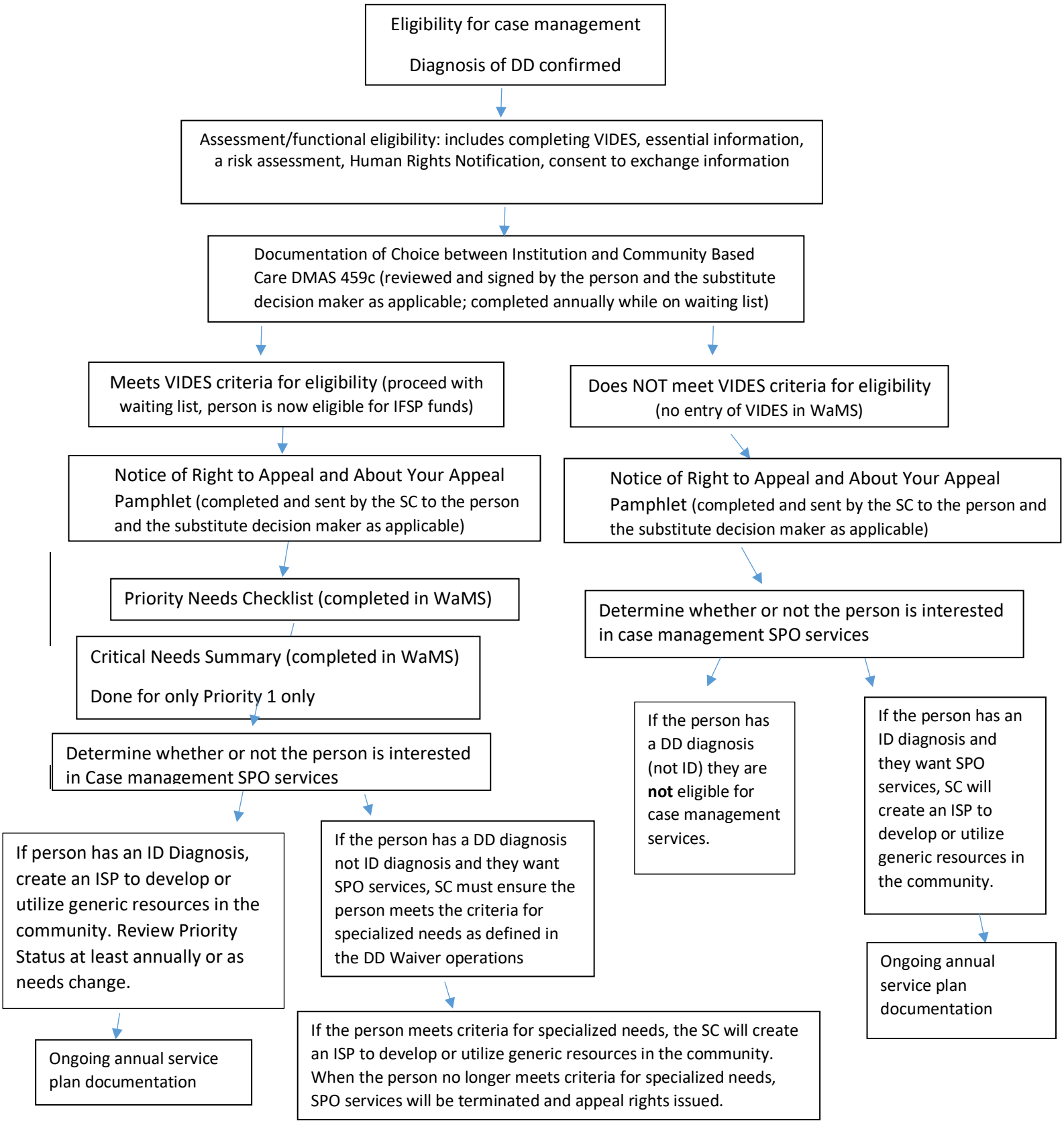
WaMS User Guide at a glance

Retain a Slot

At times, the services for a person are delayed in starting or may be interrupted for some reason such as a hospitalization or difficulty in locating a service provider. In this instance, if services are interrupted or delayed for 60 days, the CSB must request that the DD Waiver slot be held for that person. The SC will then complete the *Retain Slot Form* located in WaMS. More detailed instructions on how to complete a *Retain Slot Form* can be found in section 10 of the WaMS CSB user guide.

WaMS CSB User Guide at a glance

Case Management and Wait List Eligibility Flowchart



Diagnostic Eligibility Review

Name: Click here to enter text. DOB: Click here to enter a date.

Date of Review: Click here to enter a date.

Documentation ☐ HAS ☐ HAS NOT been provided for each required item in criteria below.

"Developmental disability" means a severe, chronic disability of an individual that:

a) ☐ Is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness;
List diagnosis(es), date of diagnosis(es) and credentialed professional (including, but not limited to a medical doctor, OT/PT, psychologist)
Click here to enter text.
AND

b) ☐ Is manifested *before* the individual reaches 22 years of age;
***Evidenced by*:** Click here to enter text.
AND

c) ☐ Is likely to continue indefinitely;
AND

d) ☐ Results in substantial functional limitations in three or more of the following areas of major life activity *(These could be substantiated by school testing, Part C assessments, psychological, OT/PT/SLP assessments, Vineland or other adaptive assessment , SSA determination, as well as others and should include the credentialed professional's name and date. This is not an inclusive list.)*

☐ Self-care, ***substantiated by*:** Click here to enter text.
☐ Receptive and expressive language, ***substantiated by:*** Click here to enter text.
☐ Learning, ***substantiated by*:** Click here to enter text.
☐ Mobility, ***substantiated by:*** Click here to enter text.
☐ Self-direction, ***substantiated by****:* Click here to enter text.
☐ Capacity for independent living, ***substantiated by:*** Click here to enter text.
☐ Economic self-sufficiency, ***substantiated by:*** Click here to enter text.
AND

e) ☐ reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated;
Substantiated by*:* Click here to enter text.

If appropriate:

Diagnostic Eligibility Review

☐ **An individual from birth to age 9, inclusive,** who has a substantial developmental delay or a specific or congenital acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in numbers 1 through 5 if the individual without services and supports, has a high probability of meeting those criteria later in life. *(See examples for documentation to substantiate this diagnosis above.)*
***Substantiated by**:* Click here to enter text.

Print QDDP Name: Click here to enter text. Date of Review: Click here to enter a date.

QDDP Signature _____

Division of Developmental Services

Annual Risk Assessment

Individual's Name: Click here to enter text. **ISP Date**: Click here to enter a date. To Click here to enter a date.
Last SIS Completed: Click here to enter a date. **Last Annual Risk Assessment Completed**: Click here to enter a date.

To complete this form as intended, read and follow the accompanying instructions.

Section 3A: Describe any changes in scoring of Section 3A since the last SIS or last Annual Risk Assessment, (whichever was completed most recently).If no changes occurred, write "no changes": Click here to enter text.

Would the individual currently score a 2 on any Exceptional MEDICAL Needs items? YES ☐ NO☐
If yes, list **all items** with a score of 2 in section 3A: Click here to enter text.

Health Risks:		**YES**	**NO**
1. ***Required***	*The Individual requires exceptionally high levels of staff support to address severe medical risks related to: inhalation or oxygen therapy; postural drainage; chest PT, suctioning; oral stimulation and/or jaw positioning; tube feeding; parenteral feeding; skin care turning or positioning; skin care dressing of open wounds; protection from infectious diseases due to immune system impairment; seizure management; dialysis; ostomy care; medically-related lifting and/or transferring; therapy services, and/or other critical medical supports?*	☐	☐
If YES to #1, answer questions a-e. If No to #1, do not answer questions a-e.			
a.	In Section 3A, Medical Supports Needed, it is determined that extensive support is needed to manage the Individual's medical risk. How many days per week and approximately how many hours per day is the extensive support required? **# of days per week = ___ # hours per day = ___**	☐	☐
b.	The Individual requires frequent hands-on staff involvement to address critical health and medical needs?	☐	☐
c.	The Individual's severe medical risk currently requires direct 24-hour professional (licensed nurse) supervision? Nurse may supervise trained staff.	☐	☐
d.	Individual's ISP has medical care plans, in place, that are documented within the ISP process?	☐	☐
e.	Description of the imminent **(i.e. within the next 30 to 60 days**) consequences if no support is provided to address the Individual's severe medical risk provided: Click here to enter text.		

Section 3B: Describe any changes in scoring of Section 3B since the last SIS or Annual Risk Assessment, (whichever was completed most recently).If no changes occurred, write "no changes": Click here to enter text.

Would the individual currently score a 2 on any Exceptional BEHAVIORAL Needs items? YES ☐ NO☐
If yes, list **all items** with a score of 2 in section 3B: Click here to enter text.

Severe Community Safety Risks- Convicted:		**YES**	**NO**
2 ***Required***	*The Individual is currently a severe community safety risk to others related to actual or attempted assault and/or injury to others; property destruction due to fire setting and/or arson; and/or sexual aggression and has been **CONVICTED,** through the criminal justice system, of a crime related to these risks?*	☐	☐
If YES to #2, answer questions a-d. If No to #2, do not answer questions a-e			
a.	The Individual's severe community safety risk to others requires a specially controlled home environment, direct supervision at home, and/or direct supervision in the community?	☐	☐

b.	In Section 3B, Behavioral Supports Needed, it was determined that extensive support is needed to manage the Individual's community safety risk. How many days per week and approximately how many hours per day is the extensive support required? **# of days per week =____ # hours per day = ____**	☐	☐
c.	The Individual has documented restrictions in place, related to these risks, through a legal requirement or order?	☐	☐
d.	Description of the imminent **(i.e. within the next 30 to 60 days)** consequences <u>if no support</u> is provided to address the Individual's severe community safety risk provided. Click here to enter text.		
Severe Community Safety Risks – Not Convicted:		**YES**	**NO**
3. ***Required***	*The Individual is currently a severe community safety risk to others related to actual or attempted assault and/or injury to others; property destruction due to fire setting and/or arson; and/or sexual aggression and has **NOT BEEN CONVICTED** of a crime related to these risks, but displays the same severe community safety risk as a person found guilty through the criminal justice system?*	☐	☐
If YES to #3, answer questions a-d. If No to #3, <u>do not</u> answer questions a-d.			
a.	The Individual's severe community safety risk to others requires a specially controlled home environment, direct supervision at home, and/or direct supervision in the community?	☐	☐
b.	In Section 3B, Behavioral Supports Needed, it was determined that extensive support is needed to manage the Individual's community safety risk. How many days per week and approximately how many hours per day is the extensive support required? **# of days per week =____, # hours per day =____**	☐	☐
c.	The Individual has documented restrictions in place related to these risks, within the ISP Process?	☐	☐
d.	Description of the imminent (**i.e. within the next 30 to 60 days**) consequences if no support is provided to address the Individual's severe community safety risk provided. Click here to enter text.		
Severe Risk or Injury to Self:		**YES**	**NO**
4. ***Required***	*The Individual displays self-directed destructiveness related to self-injury; pica; and/or suicide attempts which seriously threatens their own health and/or safety?*	☐	☐
If YES to #4, answer questions a-d. If No to #4, <u>do not</u> answer questions a-d.			
a.	The Individual's severe risk of injury to self currently requires direct supervision during all waking hours?	☐	☐
b.	In Section 3B, Behavioral Supports Needed, it was determined that extensive support is needed to manage the Individual's risk of injury to self. How many days per week and approximately how many hours per day is the extensive support required? **# of days per week = ____, # hours per day = ____**	☐	☐
c.	The Individual has prevention and intervention plans, in place, that are documented within the ISP process?	☐	☐
d.	Description of the imminent (**i.e. within the next 30 to 60 days**) consequences if no support is provided to address the Individual's severe risk of injury to self-provided. Click here to enter text.		
FALL RISK:		**YES**	**NO**
5. ***Required***	*Individual displays a risk of falling, as demonstrated by an unsteady gait, active seizures, documented history of falling or other issue that affects falling.*	☐	☐
a	If Yes, describe specifics and frequency of falls in the past 12 months: Click here to enter text.		

SC/CM Name: _____ Signature: _____ Date: _____

Division of Developmental Services
Annual Risk Assessment Instructions

A SIS® assessment is completed for individuals receiving ID Waiver services every 3 years for adults, aged 16 years and over, and every 2 years for children between the ages of 5–15 years. The Virginia Supplemental Questions will be completed by the SIS® Interviewer during this assessment.

In addition, an Annual Risk Assessment (ARA) will be completed by the Support Coordinator/Case Manager at or prior to the initial Waiver meeting and annually thereafter.

- The ARA is completed after determining the person's current support needs as compared to their ratings on the most recent SIS or the prior year's ARA, whichever was completed most recently.
- Completion of the ARA is based on the same numeric scale used on Sections 3A-Exceptional Medical Supports and 3B-Exceptional Behavioral Supports.
- <u>This means that the Annual Risk Assessment will reflect changes in the person's level of support needs from year to year.</u> The Annual Risk Assessment is a review of the person's current level of support needs based on the instructions below.

<u>The scale used for rating the support needs is as follows:</u>

- 0-No Support Needed
  No support needed because the medical condition or behavior is not an issue, or no support is needed to manage the medical condition or behavior.
- 1-Some Support Needed
  Some support is needed to address the medical condition and/or behavior. People who support the person must be cognizant continuously of the condition to assure the individual's health and safety.
- 2-Extensive Support
  Extensive support is needed to address the medical condition and/or behavior. Significant physical/hands on contribution. Support is intense and/or requires significant support time.

Any changes in the support needs of the individual which affect the ratings of Sections 3A and 3B since the last SIS or latest Annual Risk Assessment, whichever was completed most recently, will be described on the *current* Annual Risk Assessment in the text box at the top of Sections 3A and 3B.
Example: Johnny received extensive supports and a rating of 2-Extensive Supports for several items in Section 3 A last year. This year his support needs were reduced and he received a rating of 1-Some Support Needed on these items. The specific reasons for the change in these ratings should be entered on the Annual Risk Assessment.

All primary questions must be answered for all individuals. If the answer for any primary question is "Yes", the sub-questions for that section must also be answered. If the answer for any primary question is "No", the sub-questions for that section should not be answered.

A BRIEF OVERVIEW OF PSYCHOTROPIC MEDICATION USE FOR PERSONS WITH INTELLECTUAL DISABILITIES

INTRODUCTION

Individuals with intellectual disabilities are not uncommonly prescribed psychotropic medications. Too often, historically, such agents have been used to try to improve behavioral control without adequate understanding of the antecedents, purpose, and reinforcement of the problematic behavior. While an individual with an intellectual disability may experience a depressive, anxiety, or psychotic disorder in the more typical sense some individuals experience a pattern of anxiety/alarm/arousal leading to affective dysregulation and impulsive behavior. The anxiety can be stimulated by environmental change, physical discomfort, cues related to past trauma, overstimulation, boredom, confusion, or other unpleasant states. Addressing what is causing the distress or reinforcing the behavioral response is the most important thing (though not always easy).

Psychotropic medications may be useful for treating more typically presenting psychiatric illnesses as well as being part of more comprehensive plans to attenuate risk behaviors. An individual with intellectual disabilities who seems sad, is withdrawn, shows low energy and lack of interest, is eating or sleeping more or less, or may be more irritable could be suffering from a depression that needs medication treatment. On the other hand an individual with intellectual disabilities who demonstrates aggression, property destruction, self-injury, or other forms of "dyscontrol" may be helped by medication aimed at blunting the anxiety/alarm and/or blocking its escalation into aggression or other dangerous behaviors. In such instances the medications are just part of an overall strategy or plan to help the individual avoid the "need" to engage in such behavior.

However, some of the psychotropic medications we use have more risk for individuals with cognitive dysfunction and intellectual disabilities than for others. Some medications do not pose risks, but managing them for an individual with an intellectual disability may be more complicated due to limits related to education, cooperation with labs and other tests, dietary restrictions, and so forth. Below is a brief summary of more commonly prescribed agents and the risks they may pose for individuals with intellectual disabilities.

COMMONLY USED PSYCHOTROPIC MEDICATIONS

Below is information regarding psychotropic medications commonly used for individuals with an intellectual disability. It does not cover all of the potential side effects, but is focused on those of particular attention with this group of individuals.

ANTICHOLINERGIC/ANTIHISTAMINIC AGENTS: benztropine (Cogentin), trihexyphenidyl (Artane), diphenhydramine (Benadryl) and hydroxyzine (Vistaril) are the agents used most often**. Diphenhydramine and hydroxyzine,** primarily antihistaminic agents, are used to treat extrapyramidal side effects from antipsychotics**.** They are also used to treat agitation, anxiety, and aggression. **Benztropine and trihexyphenidyl are used to treat** extrapyramidal/parkinsonian side effects from antipsychotic medications. The problem with all of these agents is that they can impede cognitive function and the anticholinergic agents can cause constipation. Decreasing the ability of an individual with an intellectual disability to attend, learn, and remember potentially adds to an already compromised cognitive functioning. The risk of bowel obstruction is more serious for individuals with an intellectual disability and adding an agent with constipating effects adds to this risk.

Anticholinergics	Indication	Possible Side Effects
benztropine (Cogentin)	anxiety	sedation, decreased cognition, constipation
trihexyphenidyl (Artane)	EPS stiffness, tremors	sedation, decreased cognition, constipation
diphenhydramine (Benadryl)	anxiety	sedation, decreased cognition
hydroxyzine (Vistaril)	insomnia	sedation, decreased cognition

Note: All antipsychotics and antidepressants have anticholinergic properties too. However older tricyclic antidepressant medications such as **amitriptyline, doxepin, imipramine, and nortriptyline** and lower potency typical antipsychotics (chlorpromazine, thioridazine, mesoridazine, loxapine) and some atypical antipsychotics (clozapine, quetiapine) have more anticholinergic effects compared to other agents in their categories.

BENZODIAZEPINES: Lorazepam (Ativan), clonazepam (Klonopin), diazepam (Valium), alprazelam (Xanax), and others. These agents may compromise cognition either directly or by their sedating effects. In individuals who already have cognitive limits this can render them more limited, decreasing their ability to learn or remember. In addition, such agents can be disinhibiting, more so in individuals with cognitive dysfunction. While often used to try to control behavior, the combination of further cognitive impediment and/or disinhibition can make things worse. Further, they can create an addiction and the added risks related to both habituation and acute withdrawal if the medication is stopped suddenly.

Benzodiazepines	Indication	Possible Side Effects
lorazepam (Ativan)	anxiety	sedation, decreased cognition, disinhibition, addiction, risk with sudden withdrawal
clonazepam (Klonopin)	insomnia	sedation, decreased cognition, disinhibition, addiction, risk with sudden withdrawal
diazepam (Valium)	seizures	sedation, decreased cognition, disinhibition, addiction, risk with sudden withdrawal addiction,
alprazelam (Xanax)		sedation, decreased cognition, disinhibition, addiction, risk with sudden withdrawal, shorter acting (so blood levels more rapidly increase then decrease)

LITHIUM: Lithium can produce cognitive disturbances, carries the risk of being nephrotoxic, can produce hypothyroidism, and must be regularly monitored for drug levels, thyroid function, and renal function. While it can be effective for affective instability and bipolar disorder, experience has shown that it can be difficult to manage in individuals with an intellectual disability.

Lithium	Indication	Possible Side Effects
Lithium	bipolar disorder recurring depression emotional instability	confusion, decreased cognition kidney damage thyroid dysfunction regular lab work required; levels can increase with dehydration slow heart rate (bradycardia) nausea, vomiting excessive thirst weight gain dry skin, rash and inflammation of hair follicles (folliculitis), common

TRADITIONAL ANTIPSYCHOTIC AGENTS: Haloperidol, fluphenazine, thioridazine, perphenazine, trifuoperazine, chlorpromazine, etc. The high-potency neuroleptics (haloperidol, fluphenazine, trifluoperazine) have the benefits of causing less weight gain/metabolic syndrome or anticholinergic risks. However, they can produce movement disorders, which often lead to the use of an anticholinergic agent which can compromise already limited cognitive function. The low-potency agents such as chlorpromazine and thioridazine have significant anticholinergic effects and a higher risk of sedation, both of which compromise cognitive functioning. The anticholinergic effects also decrease bowel motility which is a risk for individuals with intellectual disabilities. All of these drugs can be sedating and therefore suppress cognition. Chlorpromazine appears to have more risk of lowering the seizure threshold whereas haloperidol and fluphenazine are less likely to do so.

Traditional Antipsychotic Agents: High Potency	Indication	Possible Side Effects
haloperidol (Haldol)	psychosis	sedation constipation stiffness, tremors tardive dyskinesia
fluphenazine (Prolixin)	pervasive dev. d/o	sedation constipation stiffness, tremors tardive dyskinesia
trifuoperazine (Stelazine)		sedation constipation stiffness, tremors tardive dyskinesia
thiothixene (Navane)		sedation constipation stiffness, tremors tardive dyskinesia

Traditional Antipsychotic Agents: Mid-Potency	Indication	Possible Side Effects
perphenazine (Trilafon)	psychosis	sedation constipation stiffness, tremors tardive dyskinesia

Traditional Antipsychotic Agents: Low Potency	Indication	Possible Side Effects
thioridazine (Mellaril)	psychosis	More sedating, cognitive decrease, constipation dysphasia confusion tremors tardive dyskinesia
chlorpromazine (Thorazine)		More sedating, cognitive decrease, constipation dysphasia confusion tremors tardive dyskinesia

"ATYPICAL" ANTIPSYCHOTIC AGENTS: olanzapine, risperidone, clozapine, aripiprazole,quetiapine, etc. These agents are more gentle with regard to extrapyramidal side effects, but may also decrease cognition in individuals with intellectual disabilities as well as carry risks associated with metabolic syndrome, some more than others. These risks require the regular monitoring of weight, lipids, and glucose as well as HgA1C in some cases. Clozapine has more risk of lowering the seizure threshold whereas risperidone has less.

Atypical Antipsychotic Agents	Indication	Possible Side Effects
olanzapine (Zyprexa)	psychosis	Sedation, weight gain, increased cholesterol, increased blood sugar/diabetes
risperidone (Risperidol)	bipolar disorder	Sedation, weight gain, increased cholesterol, increased blood sugar/diabetes
clozapine (Clozapine)		Sedation, weight gain, increased cholesterol, increased blood sugar/diabetes. **May decrease white blood cells/weekly labs needed.**
quetiapine (Seraquel)		Sedation, weight gain, increased cholesterol, increased blood sugar/diabetes

SSRIs: Fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), etc., and SNRIs venlafaxine (Effexor), and duloxetine (Cymbalta): These agents can be useful in helping individuals with an intellectual disability who have symptoms of depression or anxiety, both of which may present in atypical fashion especially in individuals lacking effective verbal capacities. Generally, they can be used without suppressing cognition, although there is a low risk of lowering the seizure threshold. All have risk of precipitating mania or lesser variations. The SSRIs may cause a kind of "wooziness" when going up or down on the doses that settles with time. All may result in some gastrointestinal symptoms for some people.

SSRIs	Indication	Possible Side Effects
fluoxetine (Prozac)	depression	Activating for some. May increase anxiety, restlessness, irritability.
sertraline (Zoloft)	anxiety	irritability
paroxetine (Paxil)	panic disorder	May be more calming/sedating
fluvoxamine (Luvox)	OCD	
SNRIs	PTSD	nausea, diarrhea, weight gain
venlafaxine (Effexor)		
duloxetine (Cymbalta)		

ANTICONVULSANTS: A number of individuals with intellectual disabilities have seizure disorders and I will not address all of the anticonvulsants that may be used for his purpose. **Carbamazepine (Tegretol), oxcarbazepine (Trileptal) and divalproex (Depakote, Depakote ER)** are more commonly used for mood instability and affective dysregulation than the others. The risks related to these agents are not distinct for individuals with intellectual disabilities. The risks associated with hyponatremia, decreased WBC counts, and liver function with carbamazepine and oxcarbazepine are the same though their management can be more complicated. Divalproex can affect platelets, liver function, and, occasionally the pancreas as well as cause weight gain. All can cause sedation that impedes cognitive functioning. Valproic

acid (except for the oral liquid preparation) should not be used for persons with intellectual disabilities due to the 33% risk in GI bleeding and other GI related complications.

Anticonvulsants	Indication	Possible Side Effects
carbamazepine (Tegretol)	bipolar disorder	Sedation, decreased sodium (delirium/seizures) decrease liver function decreased white blood cells regular lab work
oxcarbazepine (Trileptal)	emotional instability	Sedation, decreased sodium (delirium/seizures) decrease liver function decreased white blood cells regular lab work
divalproex (Depakote, Depakote ER)	bipolar disorder	sedation emotional instability weight gain decreased platelets pancreatitis

DOSAGES: As with all patients dosages have to be individualized to get the best balance of clinical benefit versus unwanted side effects. As with geriatric individuals, individuals with intellectual disabilities may require lower doses to achieve the needed clinical benefit and avoid cognitive or gastrointestinal side effects. It is also important to discontinue medications that have not produced the anticipated benefit. Too often, more medications are added while behaviors continue and side effects increase.

DOCUMENTATION OF INDIVIDUAL CHOICE BETWEEN INSTITUTIONAL CARE OR HOME AND COMMUNITY-BASED SERVICES

Individual's Name: _____

The following has been presented and discussed with me (the individual) and, if applicable, my parent, legal guardian or authorized representative at my initial screening for the Developmental Disability (DD) waivers *(please check)*:

- ❑ The findings and results of the individual's evaluations and stated needs;
- ❑ The 3 DD waivers: Building Independence (BI); Family & Individual Supports (FIS); Community Living (CL); and the services available in each, including Consumer-Directed services;
- ❑ The plan for providing services to meet the individual's needs;
- ❑ A choice between institutional care and DD Waivers' services. Institutional care for persons with DD is typically provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) which is an institution that is primarily for the diagnosis, treatment, or rehabilitation of the person with DD, and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services.
- ❑ Information that the individual may be placed on the Statewide Waiting List for DD waivers and/or ICF-IID waiting lists;
- ❑ Information that the individual may be placed on the Statewide Waiting List for DD waivers and receive services in an ICF-IID at the same time;
- ❑ The individual's right to a fair hearing and the appeal process.

The individual and, if applicable, the parent, legal guardian or authorized representative, has:

_____ selected DD waiver services (may require placement on the Statewide Waiting List for DD waivers);

AND/OR

_____ selected to be served in an ICF-IID or placed on an ICF-IID wait list, **and** be placed on the Statewide Waiting List for DD waivers at the same time OR;

_____ selected ICF-IID services (may require placement on an ICF-IID wait list).

← *To remain on the DD Waivers Waiting List you must check one of these options* ←

_____ _____

Signature of Individual Date

_____ _____

Signature of Parent, Legal Guardian, Authorized Rep. Date
(Circle the applicable designation)

Your current email address: _____

Name of your local CSB: _____

_____ _____

Signature of Support Coordinator/Case Manager Date

DOCUMENTO DE ELECCIÓN INDIVIDUAL ENTRE ATENCIÓN INSTITUCIONAL O SERVICIOS EN EL HOGAR Y COMUNITARIOS

Nombre del individuo: _____

Lo siguiente ha sido presentado y discutido conmigo (el individuo) y, si aplica, mi padre, tutor legal o representante autorizado en mi evaluación inicial para las exenciones de Discapacidad de Desarrollo (Developmental Disability, DD) *(seleccione las opciones que apliquen)*:

- ❑ Las conclusiones y los resultados de las evaluaciones del individuo y las necesidades declaradas;
- ❑ Las 3 exenciones de DD: Establecimiento de Independencia (Building Independence, BI); Apoyos Familiares e Individuales (Family & Individual Supports, FIS); Vida Comunitaria (Community Living, CL) y los servicios disponibles en cada uno, incluidos los servicios dirigidos al consumidor.
- ❑ El plan de suministros de servicios para satisfacer las necesidades del individuo.
- ❑ Una elección entre la atención institucional y los servicios de Exención de DD. Normalmente las personas con DD reciben la atención institucional en una Instalación de Atención Intermedia para Individuos con Discapacidades Intelectuales (Intermediate Care Facility for Individuals with Intellectual Disabilities, ICF-IID), la cual es una institución destinada principalmente al diagnóstico, tratamiento o rehabilitación de una persona con DD y proporciona, en un entorno residencial seguro, evaluación continua, planificación, supervisión las 24 horas, coordinación e integración de los servicios médicos y de rehabilitación.
- ❑ Información de que el individuo puede ser colocado en la Lista de espera estatal para exenciones de DD o las listas de espera de las ICF-IID.
- ❑ Información de que el individuo puede ser colocado en la Lista de espera estatal para exenciones de DD y al mismo tiempo, recibir servicios en una ICF-IID.
- ❑ El derecho del individuo a una audiencia imparcial y a un proceso de apelación.

El individuo y, si aplica, su padre, tutor legal o representante autorizado:

_____ ha seleccionado recibir los servicios de exención de DD (puede requerir la colocación en la Lista de Espera Estatal para exenciones de DD)

O

_____ ha seleccionado recibir los servicios en una ICF-IID o ser colocado en una lista espera para una ICF-IID **y,** al mismo tiempo, ser colocado en la Lista de Esper Estatal para exenciones de DD; O

_____ ha seleccionado recibir los servicios de una ICF-IID (puede requerir la colocación en una lista de espera de una ICF-IID).

← *Para permanecer en la Lista de Espera de Exenciones de DD debe seleccionar una de estas opciones.* ←

_____ _____

Firma del individuo Fecha

_____ _____

Firma del padre, tutor legal o representante autorizado Fecha
(Haga un círculo sobre la denominación que aplique)

Su dirección de correo electrónico actual: _____

Nombre de su Junta de Servicios Comunitarios (Community Services Board, CSB) local:
_____

_____ _____

Firma del Coordinador de Apoyo/Administrados de Casos Fecha

Developmental Disabilities Waivers' Priority Criteria Checklist

Name: Click here to enter text. **Date of Completion:** Click here to enter text.
Priority Status: Click here to enter text.
For all categories, it is essential to determine and document that if offered a slot, the individual would accept it within 30 days. The following is a means of "triaging" current needs; however, it is recognized that an individual in any of these categories could present for services at any time due to changes in needs/circumstances.

Priority One:
It is anticipated that the individual will need waiver services *within one year* and the individual meets one of the following criteria:

☐ An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.

☐ There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions:

☐ The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports; **or**

☐ There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports;

☐ The individual lives in an institutional setting and has a viable discharge plan; OR

☐ The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.

Priority Two:
It is anticipated that the individual may require waiver services *in one to five years* and the individual meets one of the following criteria:

☐ The health and safety of the individual is likely to be in future jeopardy due to
- The unpaid primary caregiver or caregivers having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limit his ability to care for the individual;
- There are no other unpaid caregivers available to provide supports; and
- The individual's skills are declining as a result of lack of supports;

☐ The individual is at risk of losing employment supports;

☐ The individual is at risk of losing current housing due to a lack of adequate supports and services; or

☐ The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

Priority Three:

Priority Three shall be assigned to individuals who meet one of the following criteria and will need a waiver slot in five years or longer as long as the current supports and services remain:

☐ The individual is receiving a service through another funding source that meets current needs;

☐ The individual is not currently receiving a service but is likely to need a service in five or more years**;** or

☐ The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

SAMPLE 12/2010

AGENCY LETTERHEAD

NOTIFICATION OF RIGHT TO APPEAL

_____ (Date)

_____ (Individual's name/address)

_____

_____

This letter is notification of your right to appeal the following action:

_____**A.** Your request for Medicaid MR/ID Waiver Services has been denied.

_____ You have been placed on the Statewide Waiting List – Urgent status
_____ You have been placed on the Statewide Waiting List – Non-urgent status
_____ You have been placed on the CSB's Planning List

_____**B.** Your status on the Medicaid MR/ID Waiver Waiting List has been changed:

	From Urgent to Non-Urgent		From Urgent to Planning
	From Non-Urgent to Planning		Removed from MR/ID Waiver Waiting List

_____**C.** Your enrollment in Medicaid MR/ID Waiver Services has been terminated.

_____**D.** The following Medicaid MR/ID Services have been:

	Terminated		Decreased
	Suspended		Denied a request for increase
.	Denied		

	Residential Support – In Home Services		Environmental Modification
	Residential Support – Congregate		Assistive Technology
	Day Support		Crisis Stabilization
	Prevocational		Skilled Nursing
	Supported Employment		Transition Services
	Personal Assistance – Agency ☐ CD☐		Therapeutic Consultation – List below:
	Companion – Agency ☐ CD☐		
	Respite – Agency ☐ CD☐		
	Personal Emergency Response System (PERS)		Targeted Case Management

CD = Consumer Directed Services

SAMPLE 12/2010

_____ (Individual)
Notification of Right to Appeal
Page 2
_____ (Date)

The projected date for this action is:_____

The reason for the above action(s) is:

_____Diagnostic eligibility was not met.
_____ICF-MR Level of Functioning eligibility was not met.
_____Medicaid eligibility was not met.
_____No MR/ID Waiver slots were available for assignment.
_____Urgent Criteria were not met.
_____No desire/need for waiver services within 30 days.
_____Other:

If you are not in agreement with the above-related action(s), you may appeal this decision. In order to do so, you must send written notification within thirty (30) days of receipt of this letter to:

APPEALS DIVISION
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, VA 23219

If this is a termination or reduction in services and if you file an appeal before the effective date of this action, _____ , (date) services may continue during the appeal process. However, if you appeal and the Appeals Division upholds this decision, you may be required to reimburse the Medical Assistance Program for the waiver services provided after _____. (date) Additionally, if you file an appeal, you must inform your Support coordinator/case manager of this action in order for your services to continue beyond the above stated end date.

This agency is required to inform you of your right to appeal, based upon State and Federal codes. (12 VAC [Virginia Administrative Code] 30-110-70 through 12 VAC 30-110-90) and Federal regulations (42 CFR [Code of Federal Regulations] 431).

If you have any questions regarding the actions noted in this letter, you may contact your Support coordinator/case manager: _____.
(Support coordinator/case manager's name and phone number)

{**Signature**}

Employment and Day Options

Self-Directed and Agency-Directed Options

My Life, My Community

Developmental Disability Waivers Services and Support Options

Crisis and Behavioral Support Options

Residential Options

Additional Options

Health Support Options

Developmental Disability Waiver Services and Support Options

DD Waiver Service and Support Options

Assistive Technology

Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living (ADLs), or to perceive, control, or communicate with the environment in which they live, or which are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.

In order to qualify for these services, the individual shall have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. AT shall be covered in the least expensive, most cost-effective manner.

Equipment or supplies already covered by the State Plan may not be purchased under the waiver. The Support Coordinator is required to ascertain whether an item is covered through the State Plan before requesting it through the waiver.

Applicable Waivers
Building Independence
Family and Individual
Community Living
Limits
Up to $5000/ calendar year

+Benefits Planning Services

Benefits Planning Services is a service that results in the development of documents or guidance that assist individuals receiving Social Security benefits (SSI, SSDI, SSI/SSDI) to better understand the impact of working on all benefits.

Benefits Planning enable individuals to make informed choices about work and support working individuals to make a successful transition to financial independence.

The allowable activities include but are not limited to developing documents related to the following:

- Benefits planning and analysis.
- Pre-employment benefits analysis.
- Employment change benefits analysis.
- Work incentives plan development and revisions.
- Resolving SSA benefits issues.
- Medicaid Works (Virginia's Medicaid Buy-In Program).

+Anticipated start date after 7/1/2018

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 hour

DD Waiver Service and Support Options

Companion (Self* and /or Agency-Directed)

*Self-Directed (known as "Consumer-Directed") Services require the use of a Services Facilitator. See pg. 43

Companion services provide nonmedical care, socialization, or support to adults, ages 18 and older. This service is provided in an individual's home or at various locations in the community.

The allowable activities include, but are not limited to:

1. Assistance or support with tasks such as meal preparation, laundry, and shopping;
2. Assistance with light housekeeping tasks;
3. Assistance with self-administration of medication;
4. Assistance or support with community access and recreational activities;
5. Support to assure the safety of the individual.

Unlike personal assistance and residential support, companion services do not permit routine support with activities of daily living (such as toileting, bathing, dressing, grooming). The allowable activities center on "instrumental activities of daily living" (meal prep, shopping, community integration, etc.).

Applicable Waivers
Family and Individual
Community Living
Unit
1 hour
Limits
Up to 8 hours per day
For individuals 18 and older

Personal Assistance Services (Self* and/or Agency-Directed)

*Self-Directed (known as "Consumer-Directed") Services require the use of a Services Facilitator. See page 43.

Personal assistance services mean direct support with activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance. These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

Each individual/family/caregiver shall have a back-up plan for the individual's needed supports in case the personal assistant does not report for work as expected or terminates employment without prior notice.

Allowable activities include:

- Support with activities of daily living (ADLs), such as: bathing or showering, using the toilet, routine personal hygiene skills, dressing, transferring, etc.
- Support with monitoring health status and physical condition
- Support with medication and other medical needs
- Supporting the individual with preparation and eating of meals
- Support with housekeeping activities, such as bed making, dusting, and vacuuming, laundry, grocery shopping, etc.
- Support to assure the safety of the individual
- Support needed by the individual to participate in social, recreational and community activities
- Assistance with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when properly trained and supervised by an RN
- Accompanying the individual to appointments or meetings

Applicable Waivers
Family and Individual
Community Living
Unit
1 hour
Limits
Personal assistance is not compatible with residential services in licensed homes.

DD Waiver Service and Support Options

Respite (Self* and/or Agency-Directed)

*Self-Directed (known as "Consumer-Directed") Services require the use of a service facilitator. See page 43.

Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. Services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary caregiver. Such services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. When specified, such supportive services may include assistance with IADLs.

Applicable Waivers
Family and Individual
Community Living
Unit
1 hour
Limits
Up to 480 hours per fiscal year
For unpaid primary caregivers only

Self-Directed Options: CD Services Facilitation

The Consumer-Directed (CD) Services model

The individual or a representative is the employer-of-record (EOR) and is responsible for hiring, training, supervising, and firing. There are three consumer-directed (CD) services (listed above), which may also be agency-directed.

CD Services Facilitation

Services facilitation assists the individual or the individual's family/caregiver, or Employer of Record (EOR), as appropriate, in arranging for, directing, and managing services provided through the consumer-directed model of service delivery. The services facilitator is responsible for supporting the individual or the individual's family/caregiver, or EOR, as appropriate, by collaborating with the support coordinator to ensure the development and monitoring of the CD services plan for supports, providing employee management training, and completing ongoing review activities as required by the *Department of Medical Assistance Services (DMAS)* for consumer-directed companion, personal assistance, and respite services.

Applicable Waivers
Family and Individual
Community Living
Unit
Per Visit
Limits
Initial and 6 month reassessments

Center-Based Crisis Supports

Center-based Crisis Supports provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through utilization of assessments, close monitoring, and a therapeutic milieu. Services are provided through planned and emergency admissions. Planned admissions will be provided to individuals who are receiving ongoing crisis services and need temporary, therapeutic interventions outside of their home setting in order to maintain stability. Crisis stabilization admissions will be provided to individuals who are experiencing an identified behavioral health need and/or a behavioral challenge that is preventing them from experiencing stability within their home setting.

The allowable activities include but are not limited to:

- Assessments and stabilization techniques
- Medication management and monitoring
- Behavior assessment and positive behavior support
- Intensive care coordination
- Training of others in Positive Behavioral Supports
- Assisting with skill-building as related to the behavior
- Supervision of the individual in crisis to ensure safety

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 day
Limits
Up to six months per year in 30 day increments

DD Waiver Service and Support Options

Community-Based Crisis Supports

Community-based crisis supports are ongoing supports to individuals who may have a history of multiple psychiatric hospitalizations; frequent medication changes; enhanced staffing required due to mental health or behavioral concerns; and/or frequent setting changes. Supports are provided in the individual's home and community setting. Crisis staff work directly with and assist the individual and their current support provider or family. Techniques and strategies are provided via coaching, teaching, modeling, role-playing, problem solving, or direct assistance. These services provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement.

The allowable activities include but are not limited to:

- Assessments and stabilization techniques
- Medication management and monitoring
- Behavior assessment and positive behavior support
- Intensive care coordination
- Training of others in positive behavioral supports
- Assisting with skill building as related to the behavior

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 day
Limits
Up to 6 months per year in 30 day increments

Community Coaching

Community Coaching is a service designed for individuals who need one to one support in order build a specific skill or set of skills to address a particular barrier(s) preventing a person from participating in activities of Community Engagement.

The allowable activities include but are not limited to:

Skill building through participation in community activities and opportunities such as outlined in Community Engagement and encompassing:

- Activities and events in the community, volunteering, etc.
- Community, educational, or cultural activities and events
- Skill-building and support in building positive relationships
- Routine needs while in the community
- Supports with self-management, eating, and personal needs of the individual while in the community
- Assuring the individual's safety through 1:1 supervision in a variety of community settings

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 hour
Limits
Up to 66 hours/week alone or in combination with other day options

DD Waiver Service and Support Options

Community Engagement

Community Engagement supports and fosters the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities.

Community engagement provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). The activities enhance the individual's involvement with the community and facilitate the development of natural supports. Community Engagement must be provided in the least restrictive and most integrated settings according to the individual's person-centered plan and individual choice.

The allowable activities include but are not limited to:

- Activities and events in the community
- Community, educational or cultural activities and events
- Unpaid work experiences (i.e., volunteer opportunities)
- Employment readiness activities including discovery of interests, abilities and skills
- Maintaining contact with family and friends
- Skill building and education in self-direction designed to achieve outcomes particularly through community collaborations and social connections developed by the program (e.g., partnerships with community entities such as senior centers, arts councils, etc.)

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 hour
Limits
Up to 66 hours/week alone or in combination with other day options

+ Community Guide

Community Guide Services include direct assistance to persons in brokering community resources. Community Guides provide information and assistance that help the person in problem solving and decision making and developing supportive community relationships and other resources that promote implementation of the person-centered plan. This service involves face to face contact with the individual to determine the interests of the individual. In addition to direct service, there is a component of supporting the individual that may occur without him/her present.

Includes Peer Mentor Services

Peer Mentor Support Services are person-centered services offered to individuals by specifically trained Peer Support Mentors, who are or have been service recipients and have a developmental disability. Peer support is meant to assist with empowering the individual to advocate for opportunities and experiences in community living, working, socializing, and staying healthy and safe.

+Anticipated start date after 7/1/2018

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 hour
Limits
Up to six month authorization period per year
Different rate for Community Guide and Peer Mentor

DD Waiver Service and Support Options

Crisis Support Services

Crisis Support services provide intensive supports by appropriately trained staff in the area of crisis prevention, crisis intervention, and crisis stabilization to an individual who may experience an episodic behavioral or psychiatric cri- sis in the community which has the potential to jeopardize their current com- munity living situation. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

Crisis Support Services Includes:

Crisis Prevention Services—Provides ongoing assessment of an individual's medical, cognitive, and behavioral status as well as predictors of self-injurious, disruptive, or destructive behaviors, with the initiation of positive behavior supports to prevent occurrence of crisis situations.

Crisis Intervention Services—Used in the midst of the crisis to prevent the further escalation of the situation and to maintain the immediate personal safety of those involved.

Crisis Stabilization Services—Begin once the acuity of the situation has re- solved and there is no longer an immediate threat to the health and safety of those involved. Geared toward gaining a full understanding of all of the factors that precipitated the crisis and may have maintained it until trained staff from outside the immediate situation arrived.

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 day
Limits
Limits vary by component

Electronic Home-Based Services

Goods and services based on Smart Home© technology. This includes purchases of electronic devices, software, services, and supplies not otherwise provided through this waiver or through the State Plan, that would allow an individual to access technology that can be used in the individual's residence to support greater independence and self-determination.

The service will support the assessment for determining appropriate equipment/devices, acquisition, training in the use of these goods and services, ongoing maintenance and monitoring services to address an identified need in the individual's person-centered service plan (including improving and maintaining the individual's opportunities for full participation in the community) and meet the following requirements: the item or service will decrease the need for other Medicaid services (e.g., reliance on staff supports); AND/OR promote inclusion in the community; AND/OR increase the individual's safety in the home environment.

Applicable Waivers
Building Independence
Family and Individual
Community Living
Limits
Up to $5000 annually

DD Waiver Service and Support Options

Environmental Modifications

Environmental modifications are physical adaptations to the individual's primary home or primary vehicle that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence. Such adaptations may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the individual. Modifications may be made to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of services.

Applicable Waivers
Building Independence
Family and Individual
Community Living
Limits
Up to $5000 annually

Group Day

Group Day Services include skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability and adaptive skills. They provide opportunities for peer interactions, community integration, and enhancement of social networks. Supports may be provided to ensure an individual's health and safety.

Skill building is a required component of this service unless the individual has a documented degenerative condition, in which case day support may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills.

Group Day Services should be coordinated with any physical, occupational, or speech/language therapies listed in the person-centered plan.

The allowable activities include but are not limited to skill development and support in order to:

- Develop self, social, and environmental awareness skills
- Develop positive behavior, using community resources
- Volunteer and connect with others in the community
- Engage in career planning to include establishing a career goal
- Develop skills required for paid employment in a community setting

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 hour
Limits
Up to 66 hours/week alone or in combination with other day options

DD Waiver Service and Support Options

Group Home Residential

Applicable Waivers
Community Living
Unit
1 day

These services shall consist of skill-building, routine supports, general supports, and safety supports, provided primarily in a licensed or approved residence that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Group home residential services shall be authorized for Medicaid reimbursement in the person-centered plan only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider.

Group home residential services may be in the form of continuous (up to 24 hours per day) services performed by paid staff who shall be physically present in the home. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support. These supports are typically provided to an individual living (i) in a group home or (ii) in the home of an adult foster care provider.
This service includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed.

Group Supported Employment

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 hour
Limits
Up to 40 hours per week

Supported employment services are ongoing supports to individuals who need intensive ongoing support to obtain and maintain a job in competitive, customized employment, or self-employment (including home-based self-employment) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Group supported employment is defined as continuous support provided by staff in a regular business, industry and community settings to groups of two to eight individuals with disabilities and involves interactions with the public and with co-workers without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group supported employment must be provided in a manner that promotes integration into the workplace and interaction between people with and without disabilities in those workplaces.

The allowable activities include but are not limited to:

- Job-related discovery or assessment
- Person-centered employment planning
- Negotiation with prospective employers
- On-the-job training, evaluation and support
- Developing work-related skills
- Coverage for transportation when necessary

DD Waiver Service and Support Options

Independent Living Supports

A service provided to adults (18 and older) that offers skill building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.

The allowable activities include but are not limited to:

- Skill-building and support to promote community inclusion
- Increasing social abilities and maintaining relationships
- Increasing or maintaining health, safety and fitness
- Improving decision-making and self-determination
- Promoting meaningful community involvement
- Developing and supporting with daily needs

Applicable Waivers
Building Independence
Unit
1 month
Limits
Up to 21 hours/week
Not provided in licensed homes

Individual and Family/Caregiver Training

Individual and Family/Caregiver Training is a service that provides training and counseling services to individuals, families, or caregivers of individuals receiving waiver services. For purposes of this service, "family" is defined as the unpaid people who live with or provide supports to an individual receiving waiver services, and may include a parent, spouse, children, relatives, foster family, authorized representative, or in-laws. All individual and family/caregiver training must be included in the individual's written person-centered plan.

Allowable activities:

- Participation in educational opportunities designed to improve the family's or caregiver's ability to give care and support
- Participation in educational opportunities designed to enable the individual to gain a better understanding of his/her disability or increase his/her self- determination/self-advocacy abilities

Applicable Waivers
Family and Individual
Limits
Up 80 hours per ISP

DD Waiver Service and Support Options

Individual Supported Employment

Supported employment services are ongoing supports to individuals who need intensive ongoing support to obtain and maintain a job in competitive, customized employment, or self-employment (including home-based self-employment) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Individual supported employment is support usually provided one-on-one by a job coach to an individual in an integrated employment or self-employment situation. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

The allowable activities include but are not limited to:

- Job-related discovery or assessment
- Person-centered employment planning
- Job development
- Negotiation with prospective employers
- On-the-job training, evaluation and support
- Developing work-related skills
- Coverage for transportation when necessary

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 hour
Limits
Up to 40 hours/week

In-Home Support Services

In-Home Support services are residential services that take place in the individual's home, family home, or community settings and typically supplement the primary care provided by the individual, family or other unpaid caregiver. In-Home Support services are designed to ensure the health, safety and welfare of the individual.

These services shall consist of skill-building, routine supports, and safety sup- ports, that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Applicable Waivers
Family and Individual
Community Living
Unit
1 hour
Limits
Support to no more than three individuals.

DD Waiver Service and Support Options

+Non-Medical Transport

Service offered in order to enable individuals to gain access to waiver and other community services or events, activities and resources, inclusive of transportation to employment or volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the service plan and when no other means of access is available. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan.

+Anticipated start date after 7/1/2018

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
Per Mile

Personal Emergency Response System (PERS)

Personal Emergency Response System (PERS) is an electronic device and monitoring service that enable certain individuals to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

PERS is a service that monitors individuals' safety in their homes, and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individuals' home telephone system. PERS may also include medication monitoring devices.

PERS services may be authorized when there is no one else in the home with the individual who is competent or continuously available to call for help in an emergency.

Medication monitoring units must be physician ordered and are not considered a stand-alone service. Individuals must be receiving PERS services and medication monitoring service simultaneously.

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
One month

DD Waiver Service and Support Options

Private Duty Nursing

Applicable Waivers
Family and Individual
Community Living
Unit
15 minutes

Individual and continuous care (in contrast to part-time or intermittent care) for individuals with a serious medical condition and/or complex health care need, certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital, nursing facility or ICF-IID. Care is provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse.

These services are provided to an individual at their place of residence or other community settings.

The allowable activities include, but are not limited to:

- Monitoring of an individual's medical status
- Administering medications and other medical treatment

Shared Living

Applicable Waivers
Building Independence
Family and Individual
Community Living
Unit
1 month
Limits
For individuals 18+

Shared Living means an arrangement in which a roommate resides in the same household as the individual receiving waiver services and provides an agreed- upon, limited amount of supports in exchange for Medicaid funding the portion of the total cost of rent, food, and utilities that can be reasonably attributed to the live-in roommate.

Shared Living supports include:

Fellowship such as conversation, games, crafts, accompanying the person on walks, errands, appointments and social and recreational activities;

Enhanced feelings of security which means necessary social and emotional support inside or outside of the residence;

Personal care and routine daily living tasks that **do not exceed 20%** of companionship time such as meal preparation, light housework, assistance with and the physical taking of medications.

DD Waiver Service and Support Options

Skilled Nursing

Applicable Waivers
Family and Individual
Community Living
Unit
15 Minutes

Skilled nursing is defined as part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. These services shall be provided for individuals enrolled in the waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel. Skilled nursing services may be provided in the individual's home or other community setting on a regularly scheduled or intermittent basis. It may include consultation, nurse delegation as appropriate, oversight of direct support staff as appropriate, and training for other providers.

The allowable activities include, but are not limited to:

- Monitoring of an individual's medical status
- Administering medications and other medical treatment

Training, consultation, nurse delegation or oversight of family members, staff, and other persons responsible for carrying out an individual's support plan for the purpose of monitoring the individual's medical status and ad- ministering medications and other medically- related procedures consistent with the Nurse Practice Act [18VAC90-20-10 et seq., by statutory authority of Chapter 30 of Title 54.1, Code of Virginia]

Sponsored Residential

Applicable Waivers
Community Living
Unit
1 day
Limits
Support to no more than two individuals

Sponsored Residential Services take place in a licensed or DBHDS authorized sponsored residential home. These services shall consist of skill-building, routine supports, general supports, and safety supports, provided in a licensed or approved residence that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Sponsored residential services shall be authorized for Medicaid reimbursement in the person-centered plan only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider.

Sponsored residential services to the individual in the form of continuous (up to 24 hours per day) services performed by the sponsor family. These supports may be provided individually or simultaneously to up to two individuals living in that home, depending on the required support.

Sponsored residential support includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed.

DD Waiver Service and Support Options

Supported Living

Applicable Waivers
Family and Individual
Community Living
Unit
1 day
Limits
Only in provider-controlled settings

Supported living takes place in an apartment setting operated by a DBHDS licensed provider. These services shall consist of skill-building, routine supports, general supports, and safety supports, that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Supported Living residential services to the individual in the form of 'round the clock availability of staff services performed by paid staff who have the ability to respond in a timely manner. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support.

The allowable activities include, but are not limited to:

- Using community resources
- Personal care activities
- Developing friends and having positive relationships
- Building skills
- Daily activities in the home and community
- Supporting to be healthy and safe

Transition Services

Applicable Waivers
Building Independence
Family and Individual
Community Living
Limits
Up to $5000/ Lifetime
Expended within 9 months of authorization

Transition services are nonrecurring set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable costs include, but are not limited to:

- Security deposits that are required to obtain a lease on an apartment or home
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens
- Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water
- Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy
- Moving expenses
- Fees to obtain a copy of a birth certificate or an identification card or driver's license
- Activities to assess need, arrange for, and procure needed resources

Transition services are furnished only to the extent that they are reasonable and necessary as determined and clearly identified in the service plan, and the person is unable to meet such expenses or when the services cannot be obtained from another source.

DD Waiver Service and Support Options

Therapeutic Consultation

Applicable Waivers
Family and Individual
Community Living
Unit
1 hour

Therapeutic consultation is designed to assist the individual's staff and/or the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the individual enrolled in the waiver.

The specialty areas are:

* psychology
* occupational therapy
* speech and language pathology
* physical therapy
* behavioral consultation
* rehabilitation engineering
* therapeutic recreation

The need for any of these services shall be based on the Individual Support Plan and shall be provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their abilities to function in the community. Therapeutic consultation services may be provided in individuals' homes and in appropriate community settings (such as licensed or approved homes or day support programs) as long as they are intended to advance individuals' desired outcomes as identified in their Individual Support Plans.

Workplace Assistance

Applicable Waivers
Family and Individual
Community Living
Unit
1 hour
Limits
Up to 40 hours/week

Workplace Assistance services are supports provided to someone who has completed job development and completed or nearly completed job placement training but requires more than typical job coach services to maintain stabilization in his/her employment.

Workplace Assistance services are supplementary to the services rendered by the job coach; the job coach still provides professional oversight and job coaching intervention.

The provider provides on-site habilitative supports related to behavior, health, time management or other skills that otherwise would endanger the individual's continued employment. The provider is able to support the person related to personal care needs as well; however, this cannot be the sole use of Workplace Assistance services.

- The activity must not be work skill training related which would normally be provided by a job coach.
- Services are delivered in their natural setting (where and when they are needed)
- Services must facilitate the maintenance of and inclusion in an employment situation
- The staff to individual ratio is 1:1

Critical Needs Summary Guidance

Criteria for Rating	Scoring Key	Explanation
1. An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports	5	*The primary caregiver demonstrates that he/she has an ongoing physical or psychiatric condition that has been determined will likely result in immediate jeopardy within the next year. There is evidence to substantiate this.* *Only if no other unpaid caregiver is available may points be assigned for this item.*
2. Primary caregiver can no longer provide care	3	*Primary, unpaid caregiver demonstrates that he/she cannot continue to provide care much longer (within the next year) due to physical, mental, emotional, financial burden of care giving which will result in immediate jeopardy, should it occur. There is evidence to substantiate this.*
3. Clear risk of abuse, neglect, exploitation of the individual	5	*There is documentation that the individual has been referred to the Dept. of Social Services (DSS) Child or Dept. of Aging and Rehabilitative Services (DARS) Adult Protective Services (as appropriate to his age) for investigation of a situation involving suspected abuse, neglect or exploitation as defined in the DBHDS Human Rights Regulations [12 VAC 35-115]. Further examples of instances of abuse, neglect and exploitation are contained in the DSS document, "Indicators of Abuse, Neglect and Exploitation" found at: http://www.dss.virginia.gov/family/as/aps.cgi.*
4. The individual lives in an institutional setting and has a viable discharge plan	18	*The individual lives in an ICF-IID or a nursing facility.*
5. Currently homeless (i.e., does not have a home)	10	*This item requires that homelessness has already occurred. Individuals meeting this criterion may be living in a homeless shelter, on the street or just*

		discharged/removed from their present living situation with nowhere else to go.
6. Facing imminent (within the next 90 days) homelessness (e.g., terminally ill caregiver)	5	*The individual is anticipated to be homeless within the next 90 days due to anticipated discharge from a time-limited residential service, the imminent death of the present caregiver, etc.* ***NOTE**: The Centers for Medicare & Medicaid Services expect that "there is reasonable indication that the individual would need services in the appropriate level of care within the near future (one month or less)."*
7. Immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions:	**A. Behaviors** HIGH: Serious safety risk to self/others = 5 MODERATE: Moderate/occasional risk to self/other = 3 LOW: minimal risk to self/others = 1 **B. Physical care needs (such as lifting or bathing), or medical needs** HIGH: Must address serious or life threatening concerns and/or individual cannot perform ADLs without physical assistance = 5 MODERATE: Medical, physical care needs that require active support = 3 LOW: Medical, physical care needs that require occasional assistance = 1	*The health and safety of the individual, caregiver or others is endangered due to documented, current behaviors such as aggression (towards others or self), fire-setting, running into traffic, etc.* *The health/safety of the individual is at risk due to the seriousness of his/her medical needs. The health/safety of the caregiver/others in the home is at risk due to the demands of the individual's physical care (e.g., lifting, carrying an individual larger than the caregiver, demanding 'round the clock needs which jeopardize the health and safety of the caregiver.)*
8. The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.	5	

<table>
<tr><td>Number of caregivers</td><td colspan="2">No caregiver = 5
1 caregiver = 3</td><td></td></tr>
<tr><td rowspan="2">Number of areas met on VIDES</td><td>Adults</td><td>Infants & Children through 17</td><td rowspan="2">See most recent VIDES</td></tr>
<tr><td>3 = 1
4 = 2
5-6 = 3
7-8 = 4</td><td>2-3 = 1
4 = 2
5-6 = 3
7-8 = 4</td></tr>
<tr><td>Environmental concerns (e.g., poor condition of the current living situation, primary caregiver has ongoing caretaking responsibilities for other dependents)</td><td colspan="2">3</td><td>Home/neighborhood conditions threaten the health and safety of the individual. For example; unsanitary home conditions that have been reported to APS or CPS, verified violent or criminal elements in the neighborhood, or a primary and only caregiver stressed with the care of multiple disabled individuals, etc.)</td></tr>
</table>

Needed Services

Name of Individual on the DD Waivers Waiting List:

Name of Person Completing the Form:

Relationship of the above to the Individual on the waiting List: Choose an item.

Community Services Board:

Date:

Directions: Please check all of the services/supports that are needed **now** by you or your family member and ***would be used in the next 90 days*** if available (clicking on the box will allow you to indicate "checked"). Check all that apply, but only those that apply.

Supports for the individual within the family home, such as

☐Help with activities of daily living

☐Help to learn new things in the home and community

☐Respite for the primary caregiver

☐Supports for the individual in his/her own apartment or home

☐Residential services outside the family home in a licensed group home or family home

☐Services to help the individual obtain and/or keep a job

☐Services to help the individual to explore his/her community and have meaningful activities during the day

☐Nursing services to support the individual's medical needs

☐Training for the family or individual about the individual's disability(ies) and the best ways to handle related challenges

☐Technology, devices, and modifications to the home to make it more accessible or safe

☐Services to help support the individual through mental health or behavioral crises

DOCUMENTATION OF INDIVIDUAL CHOICE BETWEEN INSTITUTIONAL CARE OR HOME AND COMMUNITY-BASED SERVICES

Individual's Name: _____

The following has been presented and discussed with me (the individual) and, if applicable, my parent, legal guardian or authorized representative at my initial screening for the Developmental Disability (DD) waivers *(please check)*:

- ❑ The findings and results of the individual's evaluations and stated needs;
- ❑ The 3 DD waivers: Building Independence (BI); Family & Individual Supports (FIS); Community Living (CL); and the services available in each, including Consumer-Directed services;
- ❑ The plan for providing services to meet the individual's needs;
- ❑ A choice between institutional care and DD Waivers' services. Institutional care for persons with DD is typically provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) which is an institution that is primarily for the diagnosis, treatment, or rehabilitation of the person with DD, and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services.
- ❑ Information that the individual may be placed on the Statewide Waiting List for DD waivers and/or ICF-IID waiting lists;
- ❑ Information that the individual may be placed on the Statewide Waiting List for DD waivers and receive services in an ICF-IID at the same time;
- ❑ The individual's right to a fair hearing and the appeal process.

The individual and, if applicable, the parent, legal guardian or authorized representative, has:

_____ selected DD waiver services (may require placement on the Statewide Waiting List for DD waivers);

AND/OR

_____ selected to be served in an ICF-IID or placed on an ICF-IID wait list, **and** be placed on the Statewide Waiting List for DD waivers at the same time OR;

_____ selected ICF-IID services (may require placement on an ICF-IID wait list).

← *To remain on the DD Waivers Waiting List you must check one of these options* ←

_____ _____

Signature of Individual Date

_____ _____

Signature of Parent, Legal Guardian, Authorized Rep. Date
(Circle the applicable designation)

Your current email address: _____

Name of your local CSB: _____

_____ _____

Signature of Support Coordinator/Case Manager Date

DOCUMENTO DE ELECCIÓN INDIVIDUAL ENTRE ATENCIÓN INSTITUCIONAL O SERVICIOS EN EL HOGAR Y COMUNITARIOS

Nombre del individuo: _____

Lo siguiente ha sido presentado y discutido conmigo (el individuo) y, si aplica, mi padre, tutor legal o representante autorizado en mi evaluación inicial para las exenciones de Discapacidad de Desarrollo (Developmental Disability, DD) *(seleccione las opciones que apliquen)*:

- ❑ Las conclusiones y los resultados de las evaluaciones del individuo y las necesidades declaradas;
- ❑ Las 3 exenciones de DD: Establecimiento de Independencia (Building Independence, BI); Apoyos Familiares e Individuales (Family & Individual Supports, FIS); Vida Comunitaria (Community Living, CL) y los servicios disponibles en cada uno, incluidos los servicios dirigidos al consumidor.
- ❑ El plan de suministros de servicios para satisfacer las necesidades del individuo.
- ❑ Una elección entre la atención institucional y los servicios de Exención de DD. Normalmente las personas con DD reciben la atención institucional en una Instalación de Atención Intermedia para Individuos con Discapacidades Intelectuales (Intermediate Care Facility for Individuals with Intellectual Disabilities, ICF-IID), la cual es una institución destinada principalmente al diagnóstico, tratamiento o rehabilitación de una persona con DD y proporciona, en un entorno residencial seguro, evaluación continua, planificación, supervisión las 24 horas, coordinación e integración de los servicios médicos y de rehabilitación.
- ❑ Información de que el individuo puede ser colocado en la Lista de espera estatal para exenciones de DD o las listas de espera de las ICF-IID.
- ❑ Información de que el individuo puede ser colocado en la Lista de espera estatal para exenciones de DD y al mismo tiempo, recibir servicios en una ICF-IID.
- ❑ El derecho del individuo a una audiencia imparcial y a un proceso de apelación.

El individuo y, si aplica, su padre, tutor legal o representante autorizado:

_____ ha seleccionado recibir los servicios de exención de DD (puede requerir la colocación en la Lista de Espera Estatal para exenciones de DD)

O

_____ ha seleccionado recibir los servicios en una ICF-IID o ser colocado en una lista espera para una ICF-IID **y,** al mismo tiempo, ser colocado en la Lista de Esper Estatal para exenciones de DD; O

_____ ha seleccionado recibir los servicios de una ICF-IID (puede requerir la colocación en una lista de espera de una ICF-IID).

← *Para permanecer en la Lista de Espera de Exenciones de DD debe seleccionar una de estas opciones.* ←

_____ _____

Firma del individuo Fecha

_____ _____

Firma del padre, tutor legal o representante autorizado Fecha
(Haga un círculo sobre la denominación que aplique)

Su dirección de correo electrónico actual: _____

Nombre de su Junta de Servicios Comunitarios (Community Services Board, CSB) local:
_____

_____ _____

Firma del Coordinador de Apoyo/Administrados de Casos Fecha

COMMONWEALTH of VIRGINIA
DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
S. HUGHES MELTON, MD, MBA
FAAFP, FABAM
COMMISSIONER
Post Office Box 1797
Richmond, VA 23218-1797
Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

Dear DD Waiver Waiting List Individual/Family Member,

You or your family member is currently on the DD Waivers waiting list. **To remain on the waiting list, you must tell us once a year that you still want to receive services in the community through a Medicaid Developmental Disabilities waiver rather than receive services in an institution.**

If you still want to receive DD waiver services in the community, choose "DD waiver services" and sign the enclosed ***Individual Choice form***. You will be asked to make this choice when we send a letter each year.

Please also quickly review and check the boxes of services that best describe your needs on the ***Needed Services form***.

After completing and signing these forms, please return them both within two weeks. These may be returned through any of the following methods:

- scan and email back to *WaiverWaitlist@dbhds.virginia.gov* [preferred method], or
- send through postal mail to Waiver Wait List/DBHDS, 1220 Bank Street, Richmond, VA 23219

DO NOT MAIL OR BRING THESE FORMS TO YOUR SUPPORT COORDINATOR! PLEASE SEND THEM AS INSTRUCTED ABOVE.

If you have any questions, please contact your support coordinator at your local Community Services Board (CSB). If you do not have an assigned support coordinator, you should contact the support coordination (case management) division of your local CSB.

NOTE: If you do not return these forms in a timely manner, your name will be removed from the DD waivers waiting list. Before that happens, you will receive notification and offered the right to appeal; however, your prompt return of the enclosed forms will prevent the need for further action and maintain your waiting list status.

If, at any point during the year, your or your family's situation changes significantly, you should contact your support coordinator/local CSB so that the CSB may update your DD waiver waiting list Priority Needs level. This helps the CSB to have the most up-to-date information to share with the committee that assigns DD waiver slots when they are available.

Thank you for responding quickly to this request.

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Estimado miembro familiar/individual en lista de espera para la exención por Discapacidad del Desarrollo (Developmentally Disabled, DD):

Usted o su familiar se encuentran actualmente en lista de espera para la exención por DD. **Para permanecer dentro de la lista de espera deberá indicarnos, una vez al año, que todavía desea recibir los servicios en la comunidad, a través de una exención por discapacidades del desarrollo de Medicaid en vez de en una institución.**

La forma de hacerlo es escogiendo una exención y firmar el ***formulario de Elección Individual*** que está adjunto. Esto demuestra que usted todavía desea ser considerado para una exención por DD.
Por favor, revise brevemente y verifique la lista de servicios que mejor describa sus necesidades en el ***formulario de Servicios Necesarios.***

Después de completar y firmar ambos formularios, regréselos dentro de dos semanas. Puede hacerlo a través de cualquiera de los siguientes métodos:

- escanéelos y envíelos por correo electrónico a *WaiverWaitlist@dbhds.virginia.gov* [método de preferencia], o
- envíelos a través del servicio postal a Waiver Wait List/DBHDS, 1220 Bank Street, Richmond, VA 23219

¡NO LE ENVÍE NI ENTREGUE ESTOS FORMULARIOS A SU COORDINADOR DE APOYO! POR FAVOR, ENVÍESELOS SEGÚN LAS INSTRUCCIONES ANTERIORES.

Si tiene alguna pregunta, contacte al coordinador de apoyo en su Junta de Servicios Comunitarios (Community Services Board, CSB) local. Si no tiene asignado un coordinador de apoyo, deberá contactar a la división de coordinación de apoyo (gestión de casos) en su CSB local.

NOTA: Si usted no devuelve estos formularios puntualmente, se le eliminará su nombre de la lista de espera de las exenciones DD. Antes de occurir eso, usted recibirá una notificación y se le ofrecerá el derecho a apelar; sin embargo, si usted devuelve los formularios contenidos de manera puntual, no habrá necesidad de tomar más acción y usted mantendrá su lugar en la lista de espera.

Si, en algún momento del año, la situación de usted o de su familiar cambia de manera significativa, deberá contactar a su coordinador de apoyo o CSB local para que la CSB pueda actualizar su nivel de necesidades prioritarias en la lista de espera de exención por DD. De esta forma ayuda a la CSB a tener la información más actualizada para compartirla con el comité que asigna las vacantes de exención por DD cuando están disponibles.

Gracias por su pronta respuesta a esta solicitud.

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Dear DD Waiver Waiting List Individual/Family Member,

About a month ago you received a letter asking you to complete and sign the enclosed forms in order for the Department of Behavioral Health and Developmental Services to keep you or your family member on the DD Waivers waiting list. **This is your second and last reminder that to remain on the waiting list, you must tell us that you still want to receive services in the community through a Medicaid Developmental Disabilities waiver rather than services in an institution.** The way you do that is to choose waiver and sign the enclosed ***Individual Choice form***. This shows you still want to be considered for a DD waiver. You must sign and return this form once a year.
Please also quickly review and check the boxes of services that best describe your needs on the ***Needed Services form***.

After completing and signing these forms, please return them both within two weeks. These may be returned through any of the following methods:

- scan and email back to *WaiverWaitlist@dbhds.virginia.gov* [preferred method], or
  or
- send through postal mail to Waiver Wait List/DBHDS, 1220 Bank Street, Richmond, VA 23219

If you have any questions, please contact your support coordinator at your local Community Services Board (CSB). If you do not have an assigned support coordinator, you should contact the support coordination (case management) division of your local CSB.

NOTE: If you do not return these forms in a timely manner, your name will be removed from the DD waivers waiting list.

If, at any point during the year, your or your family's situation changes significantly, you should contact your support coordinator/local CSB so that the CSB may update your DD waiver waiting list Priority Needs level. This helps the CSB to have the most up-to-date information to share with the committee that assigns DD waiver slots when they are available.

Thank you for responding quickly to this request.

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Estimado individuo de la Lista de espera de Exención de Discapacidades de Desarrollo (Developmental Disabilities, DD) o familiar:

Hace aproximadamente un mes recibió una carta solicitándole que completara y firmara los formularios adjuntos para que el Departamento de Salud Conductual y Servicios de Desarrollo lo mantuviera, a usted o su familiar, en la lista de espera de Exención de DD. **Este es su segundo y último recordatorio para permanecer en la lista de espera, para ello debe informarnos que aún desea recibir los servicios en la comunidad a través de la Exención de Discapacidades de Desarrollo de Medicaid, en vez de recibir los servicios en una institución.** Para hacer esto, debe elegir exención y firmar el ***formulario de Elección Individual*** adjunto. Esto muestra que aún desea ser considerado para una exención de DD. Debe firmar y entregar este formulario una vez al año.

También revise rápidamente y seleccione los recuadros de servicios que mejor describan sus necesidades en el ***formulario de Servicios Necesarios***.

Luego de completar y firmar estos formularios, debe entregar ambos en un período de dos semanas. Puede entregar los formularios a través de cualquiera de los siguientes métodos:

- escanearlos y enviarlos por correo a *WaiverWaitlist@dbhds.virginia.gov* [método preferido]; o
- enviarlos a través de correo postal a Waiver Wait List/DBHDS, 1220 Bank Street, Richmond, VA 23219.

En caso de tener alguna pregunta, debe contactar a su Coordinador de Apoyo a la Junta de Servicios Comunitarios (Community Services Board, CSB) local. Si no tiene un Coordinador de Apoyo asignado, debe contactar a la División de Coordinación de Apoyo (administración de casos) de su CSB local.

NOTA: Si no entrega los formularios de manera oportuna, se retirará su nombre de la lista de espera de exenciones de DD.

Si, en cualquier momento del año, cambia considerablemente su situación o la de su familia, debe contactar a su Coordinador de Apoyo/CSB local para que la CSB pueda actualizar su nivel de Necesidades Prioritarios en la lista de espera de exención de DD. Esto ayuda a la CSB a tener la información más actualizada para compartirla con el comité que asigna los puestos de exención de DD cuando están disponibles.

Gracias por responder rápidamente esta solicitud.

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Dear Waiver Slot Assignment Committee Nominee:

As part of the administration of Virginia's Medicaid waivers for people with intellectual and developmental disabilities (IDD), each locality/region is responsible for establishing a committee to determine which individuals are eligible for available IDD waiver slots. This is accomplished by reviewing individuals' needs and prioritizing those with the greatest need for assignment of the available slot(s). Committees may meet to determine the assignment of one or many slots at a time, depending on slot availability. Some meetings may be scheduled as in-person events, requiring travel to the designated meeting location. Others (particularly for the assignment of a single slot) may be arranged as conference calls. While committee members are technically volunteers, the Department of Behavioral Health and Developmental Services (DBHDS) will provide stipends for time/travel (see end of this document).

Qualifications
Waiver Slot Assignment Committee (WSAC) members will be knowledgeable of or have experience with services for persons with disabilities.

Community Services Boards (CSBs) identify community members who are willing to serve on a WSAC. DBHDS staff will review applications and appoint members to ensure that the committee is comprised of people with diverse personal and professional backgrounds, as well as varied knowledge and expertise, and ensure that the nominees do not have a conflict of interest.

Nominated members may be:

- Family members of an individual currently receiving services
- Graduate students studying a human services field (e.g., psychology, social work) or special education
- University professors of a human services field
- Member/staff member/board member of an advocacy agency that does not provide any direct services (e.g., Center for Independent Living, local Arc, autism advocacy agency)
- Current special education teachers/transition coordinators
- Nurses/physicians
- Retired or former (for over one year) CSB, private provider, or Health and Human Services state employees
- Clergy members

At least one member of each committee shall have experience with individuals with developmental disabilities other than intellectual disability.

Nominated members may **not** be any person with a direct or indirect interest in the outcome of the proceedings such as:

- Current CSB employees or board members
- Current employees, owners, or board members of any agency providing waiver services, unless serving on a WSAC in an area in which the provider does not provide services
- Family members of individuals seeking waiver services
- DBHDS employees

Waiver Slot Assignment Committee Make-up

1. It is recommended that WSACs maintain a roster of no less than 5 members though meetings may proceed with a quorum of three members present.

2. Each committee will be led by one member designated as the group's facilitator. The facilitator will be required to attend each meeting of the committee. In order to ensure consistency between committee processes and outcomes, it is desirable for WSACs in neighboring localities to share a single facilitator.

3. DBHDS will support WSAC members with training and technical assistance on the slot assignment process and relevant waiver elements.

Waiver Slot Assignment Committee Responsibilities

Responsibilities of WSAC members

- Participate in DBHDS training
- Review information presented regarding nominees for vacant waiver slots
- Hold confidential all information reviewed

Responsibilities of WSAC Facilitators

- Notify other WSAC members of the need to meet after receiving notification from the CSB that they have a slot(s) to assign
- In concert with the relevant CSB(s), establish a meeting date, time, and place, or telephonic/video conferencing as appropriate
- Ensure that the parameters of the slot assignment process are carried out each time
- Collect all distributed information and documentation of committee meetings/recommendations and relay to the appropriate CSB point person
- Hold confidential all information reviewed

Stipends for WSAC Members:

- $75 - $100 to facilitators for participating in multiple jurisdictions' WSACs
- $50 - $75 for facilitators participating in face-to-face WSAC meetings which require travel
- $25 - $50 for WSAC members participating in face-to-face committee meetings which require travel
- $25 - $50 for facilitators participating in meetings conducted via telephone
- $25 for WSAC members participating in meetings conducted via telephone

WSAC members are encouraged to make use of available technology located at CSBs or other DBHDS funded locations such as secure video conferencing and conference calling to minimize the need for travel, particularly when assigning a single slot.

Waiver Slot Assignment Committee (WSAC) Volunteer Application

Name: Click here to enter text. Date: Click here to enter a date.

Address: Click here to enter text.

Phone number: Click here to enter text. Email address: Click here to enter text.

WSAC Community Services Board: Choose an item.

Qualifications: Choose an item.

If "other," please describe: Click here to enter text.

Please note that WSAC members may **not** be any person with a direct or indirect interest in the outcome of the proceedings such as:

- Current CSB employees or board members
- Current employees, owners, or board members of any agency providing waiver services, unless serving on a WSAC in an area in which the provider does not provide services
- Family members of individuals seeking waiver services

Please provide a synopsis of your knowledge of and/or experience with persons with intellectual/developmental disabilities (IDD) and/or the IDD service system:

Click here to enter text.

Waiver Slot Assignment Committee Procedures

1. All WSACs will be comprised of community members who will not be employees of a CSB or a private provider of either case management or waiver services. This will create the needed separation (per CMS) between the entity that determines who is eligible for waiver services (i.e., CSBs) from the entity that decides who is assigned a slot. WSAC members will be knowledgeable and have experience in the I/DD service system. CSBs are requested to identify community members who are willing to serve on a WSAC. DBHDS will review applications and appoint members to ensure that the committee is comprised of individuals with diverse personal and professional backgrounds as well as varied knowledge and expertise; and ensure that the individuals do not have a conflict of interest. DBHDS will maintain a list of approved WSAC members who can substitute for members who are unable to attend a meeting and serve on more than one committee where possible. These approved individuals can also be rotated in and out of committee roles.

2. At least 3 members will constitute an official WSAC, but committees should maintain five or more members to allow flexibility for absences.

3. A DBHDS-trained facilitator will serve each WSAC committee. In order to ensure consistency between committee processes and outcomes, several WSACs will share a single facilitator. DBHDS will support committee members with training and technical assistance on the slot assignment process and relevant waiver elements. DBHDS Regional Support Specialists (RSS) will attend each meeting and monitor to ensure decision making is in accordance with identified priorities.

4. DBHDS will work with adjoining CSBs to form unified committees to promote additional consistency. Neighboring CSBs are strongly encouraged to form a single committee to cover more than one CSB area. For example, three CSBs could form one committee to assign available slots. **It is not necessary for combining CSBs to be solely from the same HPR.** Combining is advantageous for the following reasons:

    - To minimize the number of community members that are required to participate on the WSACs;
    - To enhance uniformity in slot assignment decisions through multi-CSB and or regional groupings with committee facilitators serving on multiple WSACs; and
    - To create increased efficiencies for DBHDS in the support of fewer than 40 WSACs.
    - To ensure that individuals with the highest need are accessing slots

Nominated members may **not** be any person with a direct or indirect interest in the outcome of the proceedings:

- Current CSB employees or board members
- Current employees, owners, or board members of any agency providing waiver services, unless serving on a WSAC in an area in which the provider does not provide services
- Family members of individuals seeking waiver services

Nominated members may be:

- Family members of an individual currently receiving services
- Graduate students studying a human services field (e.g., psychology, social work) or special education
- University professors of a human services field
- Member/staff member/board member of an advocacy agency that does not provide any direct services (e.g., Center for Independent Living, local Arc, autism advocacy agency)
- Current special education teachers/transition coordinators
- Nurses/physicians
- Retired or former (for over one year) CSB, private provider or Health and Human Services state employees
- Clergy members

Especially recommended is that at least one member of each committee have experience with individuals with a developmental disability other than ID.

Responsibilities of WSAC Members

- Participate in DBHDS training
- Review information presented regarding nominees for vacant slots
- Hold confidential all information reviewed

Responsibilities of WSAC Facilitators

- Notify **the RSS** and other WSAC members of the need to meet after receiving notification from the CSB that they have a slot(s) to assign
- In concert with the relevant CSB(s), establish a meeting date, time, and place, or telephonic/video conferencing as appropriate
- Ensure that the parameters of the slot assignment process are carried out each time
- Collect all distributed hard copy information and documentation of committee meeting/recommendations and relay to the appropriate CSB point person and the RSS
- Hold confidential all information reviewed

Stipends for WSAC Members:

- $75 - $100 to facilitators for participating in multiple jurisdictions' WSACs
- $50 - $75 for facilitators participating in face-to-face WSAC meetings which require travel
- $25 - $50 for WSAC members participating in face-to-face committee meetings which require travel
- $25 - $50 for facilitators participating in meetings conducted via telephone
- $25 for WSAC members participating in meetings conducted via telephone

CSBs are encouraged to make use of available technology such as secure video conferencing and conference calling to minimize the need for WSAC members to travel, particularly when assigning a single slot.

Waiver Slot Assignment Committee (WSAC) Session Operations

1. When a new or existing slot becomes available for assignment/reassignment, the Community Services Board/Behavioral Health Authority (CSB/BHA) will contact the Regional Support Specialist (RSS) to verify the number of slots available and to initiate a new *WSAC Session.*
    - The CSB/BHA and RSS may discuss potential timeframes for the meeting with awareness that the length of the meeting cannot be determined until the individuals to be reviewed have been identified.

2. Once slots are confirmed by the RSS, the CSB/BHA will use the slot review formula to determine the number of individuals that must be reviewed by the WSAC.
    - Using the Wait List function in WaMS, the CSB/BHA and RSS will confirm individuals in Priority 1 status whose Critical Needs Score places them in the group of individuals to be reviewed by the WSAC.
        - This list of names is referred to as a *review pool*.
            - ✓ A copy of the review pool will be saved by the CSB/BHA and the RSS for future reference, should any changes occur.
        - If an individual comes to the attention of the CSB/BHA after the review pool has been set (and up to 2 business days before the scheduled WSAC meeting), whose Critical Needs Score places them in the range of individuals for review, the CSB will promptly contact the RSS to inform him/her of this situation and any needed changes to the review pool will be made.
            - If the individual is tied for the lowest Critical Needs Score, no one will be removed from the pool.
            - If the individual's Critical Needs Score is higher than the cut off point of the review pool, the lowest ranked person(s) will be removed.

3. In coordination with steps 1 and 2 above, the RSS will inform the WSAC facilitator that a meeting is needed and preferred meeting dates. The WSAC facilitator will coordinate with WSAC members to identify dates for which a quorum of members (3) is available.
    - When a WSAC has more than the minimum 3 members, the first 3-5 members that respond confirming their availability (this includes the WSAC facilitator) will constitute the committee for that session.
    - If a WSAC member knows, or suspects they know, someone being considered for a waiver slot, they will report this to the facilitator immediately so that this conflict of interest can be addressed. If the facilitator knows, or suspects they know, someone being considered for a waiver slot, they will report this to the RSS immediately and, based on the conflict of interest that exists, an alternative and temporary facilitator will be identified from among those members that are scheduled to participate in the WSAC session.
    - The WSAC facilitator will confirm meetings dates and times with those members participating in the WSAC session.

- Members selected for participation in the session must be available and present each day of that session (i.e., the same group reviews all of the persons in the review pool for those slots, regardless of the number of meeting days that are required.)
- The WSAC facilitator is charged with overseeing equitable attendance among all WSAC members over the long term.

4. The CSB/BHA will arrange for room availability and conference call capability for the meeting dates and convey this information to the RSS and WSAC facilitator.

5. In advance of the session, the CSB/BHA will:

    - Complete a ***Slot Assignment Review form*** (free of PHI) for each individual in the review pool and distribute these to the RSS and WSAC members no fewer than 5 business days prior to the session date. If individuals are added to the review pool after this date, it is expected the Slot Assignment Review form will be submitted no fewer than 2 business days in advance of the WSAC meeting.

    - Complete a ***WSAC Review Schedule*** (without PHI) designating the order of reviews, the CSB staff person that will be available to answer questions, if needed, and a unique identifier for each person listed. A copy of the review schedule will be made available to the RSS and facilitator 2 business days in advance of the meeting.

    - Complete the ***Name-Identifier Key,*** linking the "unique identifier" with the full name of the individual and provide it **to the RSS only** 2 business days in advance of the meeting.

    - Provide the WSAC facilitator with sufficient blank copies of the ***Slot Assignment Scoring Summary-Step 2 Review*** *forms* on the day of the meeting (based on the number of members and persons to be reviewed).

6. In advance of the meeting, WSAC Members will thoroughly review the ***Slot Assignment Review Forms*** and prepare his/her questions for the CSB/BHA representative.

7. At the WSAC session:
    - No formal presentation by the CSB/BHA will occur.

    - A CSB/BHA representative (may be the SC, SC Supervisor or another designee), as identified on the ***WSAC Review Schedule***, will be available to provide information, if requested by the WSAC. The CSB/BHA representative is not expected to attend the meeting but should be available at the review time by phone, in the event questions arise. It is anticipated that the review form will provide the majority of information required for a decision.

    - If questions cannot be fully answered by the CSB/BHA representative when the individual's profile is reviewed, members will rank the individual based on the information that is available at that time.

8. WSAC members will independently score each individual's situation using the ***Slot Assignment Scoring Summary-Step 2 form***, and provide these to the RSS.

    - After all individual ***Slot Assignment Review forms*** have been discussed and scored, the individual's total score will be tabulated by the RSS and divided by the number of voting members, resulting in an *average score*.

    - The RSS will enter the average score for each individual reviewed, as well as the rankings of the highest scoring individuals (up to the number of available slots), to the ***WSAC Review Schedule.*** A copy of this ***WSAC Review Schedule*** will be provided to the CSB/BHA at the close of the meeting. It is incumbent that these results not be shared with the individual until he/she is assigned to projected enrollment status in WaMS.

9. At the close of the meeting, WSAC members will return all materials to the RSS. Slot Assignment Scoring Summary-Step 2 forms will be retained by DBHDS.

10. The RSS will assign recommended individuals to projected enrollment status in WaMS.

11. If a slot becomes available for assignment within 30 days of the WSAC meeting and there has been no change in the status of any individual in the review pool nor has anyone been assigned to priority 1 status on the wait list whose Critical Needs Score is within the review pool range, the slot may be assigned by the RSS to the next highest ranked person in the review pool.

Glossary of Terms Used in WSAC Session Operations

WSAC Session – The event initiated when an RSS is informed a waiver slot is available and which ends with the assignment of individuals to those slots by the RSS. A single session includes all meetings that are required for consideration of the review pool for an identified and available slot.

Review Pool – List of names/unique identifiers that are being considered for a slot during the WSAC session. The number of names in the review pool is directly related to the number of slots available. See ***DD Waiver Waitlist Slot Assignment Process*** for further explanation.

Slot Assignment Review Form – Form that is completed by the CSB/BHA for each individual in the review pool, to be reviewed by the WSAC. This form shall be the primary source of information regarding the individual and shall not include any private health information (PHI).

Profile – A Slot Assignment Review Form as well as any information provided by the CSB/BHA in response to questions from the WSAC members for one individual

Waiver Slot Assignment Committee (WSAC) Session Operations

WSAC Review Schedule – Completed by the CSB/BHA to identify the order of review of all profiles, and to indicate the CSB/BHA representative who will be available to answer any questions from the committee members

Slot Assignment Scoring Summary-Step 2 – Scoring form completed by WSAC members during each meeting for each profile reviewed.

Name-Identifier Key – A key listing the unique identifier used on each Slot Assignment Review Form and the name of the individual to whom it pertains from the review pool. This is completed by the CSB/BHA and only made available to the RSS.

Average Score – Score resulting after totaling each members' total score and dividing by the number of members present. The average score is then ranked, and the profiles with the top average scores are recommended for a waiver slot.

Slot Assignment Review Form

WSAC: Click here to enter text. **WSAC Date:** Click here to enter text.
CSB: Click here to enter text.
Support Coordinator/Case Manager (SC/CM): Click here to enter text.

Non-PHI Identifier: Click here to enter text.

I. Age: Click here to enter text.

II. Current Diagnoses: Click here to enter text.

III. Indicate which of the Priority 1 criteria were met and describe how the individual's situation meets the criteria:

☐ An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports. Click here to enter text.

☐ There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions:

☐ The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports; or

☐ There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports;

☐ The individual lives in an institutional setting and has a viable discharge plan; or Click here to enter text.

☐ The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply. Click here to enter text.

IV. Risks to the individual's safety in his/her present environment:

Challenge	Intensity	Frequency
☐ Physical aggression	Click here to enter text.	Click here to enter text.
☐ Self-injurious	Click here to enter text.	Click here to enter text.
☐ Sexually inappropriate	Click here to enter text.	Click here to enter text.
☐ Property damage	Click here to enter text.	Click here to enter text.
☐ Verbal aggression	Click here to enter text.	Click here to enter text.

Slot Assignment Review Form

☐ Leaves a safe setting putting self in jeopardy	Click here to enter text.	Click here to enter text.
☐ Other	Click here to enter text.	Click here to enter text.

V. Community integration needs/social isolation issues
List all current challenges, such as residence in an institution, homebound due to lack of services, impact of elderly caregiver, etc: Click here to enter text.

VI. What resources have been sought and/or are received to address the needs of the individual?

Resource	Applied	If no application made, why not?	Received	If applied for but not received, why not?
Early and Periodic Screening, Testing and Diagnosis Treatment (EPSDT)	☐	Click here to enter text.	☐	Click here to enter text.
Elderly or Disabled with Consumer Directed (EDCD) Waiver	☐	Click here to enter text.	☐	Click here to enter text.
Individual and Family Support (IFSP)	☐	Click here to enter text.	☐	Click here to enter text.
Summer camp	☐	Click here to enter text.	☐	Click here to enter text.
Comprehensive Services Act (CSA)	☐	Click here to enter text.	☐	Click here to enter text.
Housing voucher	☐	Click here to enter text.	☐	Click here to enter text.
Other-Name any locally funded services received	☐	Click here to enter text.	☐	Click here to enter text.

VII. Describe the primary caregiver(s)' ability and challenges to providing natural supports such as transportation, supervision, promotion of community integration, etc.): Click here to enter text.

VIII. Are there other natural supports in the person's life such as family members, neighbors, friends, other community members?
Click here to enter text.

IX. A. In the person's own words where would he/she like to live and with whom?
Click here to enter text.

Slot Assignment Review Form

B. In the person's own words, what would he/she like to do during the day? Click here to enter text.

C. Does the person have a legal guardian and if so, does the legal guardian agree with the person's wishes? Click here to enter text.

X. A. What, if anything, will occur in the next 30 days if this individual is not awarded a waiver slot? Click here to enter text.

B. Describe indicators that support this statement: Click here to enter text.

XI. Identify only those waiver services that best meet <u>immediate</u> needs.
How would this/these service(s) be used to address immediate needs?

- ☐ Assistive Technology Click here to enter text.
- ☐ Benefits Planning Click here to enter text.
- ☐ Center-Based Crisis Supports Click here to enter text.
- ☐ Community Coaching Click here to enter text.
- ☐ Community Engagement Click here to enter text.
- ☐ Community Guide Click here to enter text.
- ☐ Community-Based Crisis Supports Click here to enter text.
- ☐ Companion Click here to enter text.
- ☐ Crisis Support Services Click here to enter text.
- ☐ Environmental Modification Click here to enter text.
- ☐ Group Day Click here to enter text.
- ☐ Group Home Residential Click here to enter text.
- ☐ Group Supported Employment Click here to enter text.
- ☐ In-Home Support Click here to enter text.
- ☐ Independent Living Supports Click here to enter text.
- ☐ Individual & Family/Caregiver Training Click here to enter text.
- ☐ Individual Supported Employment Click here to enter text.
- ☐ Non-Medical Transportation Click here to enter text.
- ☐ Electronic Home-Based Supports Click here to enter text.
- ☐ PERS Click here to enter text.
- ☐ Personal Assistance Click here to enter text.
- ☐ Private Duty Nursing Click here to enter text.
- ☐ Respite Click here to enter text.
- ☐ Services Facilitation Click here to enter text.
- ☐ Shared Living Click here to enter text.
- ☐ Skilled Nursing Click here to enter text.
- ☐ Sponsored Residential Click here to enter text.
- ☐ Supported Living Residential Click here to enter text.
- ☐ Therapeutic Consultation Click here to enter text.
- ☐ Transition Services Click here to enter text.
- ☐ Workplace Assistance Click here to enter text.

Slot Assignment Review Form

XII. **Any other information** about the individual that would help the Waiver Slot Assignment Committee determine if this individual is most in need of a slot:
Click here to enter text.

Support Coordinator completing this form:
Click here to enter text.

Date:
Click here to enter a date.

CSB:_____ WSAC Session WSAC: _____

Slots Available: ___CL ___FIS Review Schedule Meeting Date(s):_____

Order of Review	Unique Identifier	CSB Representative	Average Score	Recommended for Slot (by ranking number)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				

CSB:________________ **WSAC Session** WSAC: _________________

Slots Available: ___CL ___FIS **Name-ID Key** Meeting Date(s):_______________

Unique Identifier	Last Name	First Name

Virginia Department of Behavioral Health & Developmental Services

Request for Emergency Access to Waiver Services

Prior to submitting a request for emergency access to waiver services the CSB should thoroughly explore the availability of slots at the CSB and if there are other resources that could be sought to support this individual. The following steps must also be taken:

Referral to Regional Support Team. *Date of referral:* Click here to enter a date.

Referral to the DBHDS Critical and Complex Consultation Team (C3T). *This form should accompany the referral to C3T and the request will be considered if C3T is unable to resolve.*

CSB:

Support Coordinator completing the form:

Date completed: Click here to enter a date.

Individual requiring emergency access:

Medicaid number:

Emergency access to waiver services is subject to available funding and a finding of eligibility for waiver services. Eligible individuals may currently be on the Priority 1, 2, or 3 waiting lists or may be newly known as needing supports resulting from an emergent situation. Please indicate below which emergency access criteria the individual meets.

☐ Child Protective Services has substantiated abuse/neglect against the primary caregiver and has removed the individual from the home.

☐ Adult Protective Services has found that the individual needs and accepts protective services.

☐ Adult Protective Services has not found abuse/neglect, but corroborating information from other sources (agencies) indicate that there is an inherent risk present and there are no other caregivers available to provide support services to the individual.

☐ Death of primary caregiver or lack of alternative caregiver, coupled with the individual's inability to care for him/herself and danger to self or others without supports.

Comments:

Please forward this form along with the referral to C3T to Linda Bassett (linda.bassett@dbhds.virginia.gov) via secure email.

NOTE: Individuals and family/caregivers shall have the right to appeal the application of the emergency criteria to their circumstances pursuant to 12 VAC 30-110. All notifications of appeal shall be submitted to DMAS.

Additional information about emergency slots may be found in the DD waivers' emergency regulations at 12VAC30-120-580.

Virginia Department of Behavioral Health & Developmental Services

Request for a Reserve Slot

An individual may be able access a reserve slot to transition from one DD waiver to another DD waiver in order to access needed services.

CSB:

Support Coordinator completing the form:

Date completed: Click here to enter a date.

Individual requiring a reserve slot:

Medicaid number:

Current waiver: Choose an item.

Requested waiver: Choose an item.

Describe the change in the individual's assessed needs, as documented in the individual's record, which requires a service or services that are not available in the waiver in which the individual is presently enrolled:

Please forward this form to Vivian Stevenson (vivian.stevenson@dbhds.virginia.gov) via secure email.

GUIDANCE PER REGULATIONS: The assignment of reserve slots is managed by DBHDS. In the event that all reserve slots have been assigned, a chronological list of individuals in need of a reserve slot will be maintained.

The waiver slot that is vacated by the individual transitioning to a reserve slot shall remain with the vacated slot's CSB/BHA. The assignment of the vacated slot will be made by DBHDS after review and recommendations from the local Waiver Slot Assignment Committee.

Individuals and family/caregivers shall have the right to appeal the application of the reserve criteria to their circumstances pursuant to 12 VAC 30-110. All notifications of appeal shall be submitted to DMAS.

Additional information about reserve slots may be found in the DD waivers' emergency regulations at 12VAC30-120-580.

Virginia Department of Behavioral Health and Developmental Services

Division of Developmental Services
Virginia Standard Operating Procedures for the SIS® and Review Process

What is the Supports Intensity Scale® (SIS®)?

The Supports Intensity Scale® is a standardized and norm-referenced assessment which was developed in 2004 by the American Association on Intellectual and Developmental Disabilities (AAIDD). This assessment has been tested nationwide to ensure validity and reliability. More information can be found on the AAIDD web site: www.aaidd.org.

The SIS® is an assessment of an individual's support needs at the time of the interview. The SIS® gathers information through a face-to-face interview with the individual and people who know the individual well, and with whom they have frequent contact. The people who answer interview questions are called "Respondents."

A "Primary Respondent" is defined as a person who has known the individual well for at least the last 3 months and has observed the individual closely in one or more environments for substantial periods of time. A trained Interviewer collects information from respondents and/or the individual on many aspects of community living. The interview questions focus on the supports an individual would need if he/she were to do these activities like any other person his/her age living in the community without a disability.

A copy of the SIS® report, which includes explanation and background on the SIS®, is sent to the family and providers within 15 business days of the SIS® interview by the Support Coordinator/Case Manager (SC/CM). A copy of the SIS® report is maintained in the individual's record by the Support Coordinator/Case Manager and providers.

Virginia Standard Operating Procedures for the SIS®

1. The SIS® is administered by an AAIDD endorsed SIS® Interviewer. Only an AAIDD SIS® with the Virginia Supplemental Questions will be utilized.
2. Unless otherwise indicated, it is expected that the individual participate as a respondent in his/her interview. The individual is free to choose his or her level of participation in the interview. Regardless of the individual's participation level, the SIS® Interviewer must meet the individual. Guardians must be invited to participate in the SIS® interview.
3. The SIS® Interviewer will explain the reason for the SIS®, the assessment process, and the role of respondents prior to starting the interview.
4. The SIS® interview must be conducted face-to-face with at least two primary respondents who are defined as people who have known the individual well for at least the last 3 months and have observed the individual closely in one or more environments for substantial periods of time.
5. At least two of the primary respondents must be present throughout the full SIS® interview.
6. Each question on the assessment must be asked and opportunity for discussion given during the assessment. Each item in the assessment must be described before it is rated.
7. The individual's support needs will be described and discussed for each question. The Interviewer will guide the discussion. An overall consensus is sought, but not required, for each question. Based upon the information shared by respondents and the Interviewer's professional training, the Interviewer will make an item rating determination. The final rating of each question will be shared with the respondents.
8. Individuals' medical or behavioral support needs are identified in Sections 1A and 1B of the SIS®. The Virginia SIS® Supplemental Questions will be completed as indicated by specific medical and behavioral support needs identified.
9. Everyone at the interview will be asked to sign the Virginia SIS® Interview Attendance Log before the interview and the Virginia SIS® Interview Standard Operating Procedures (SOPs) Checklist immediately following the session. If a respondent must leave before the interview has ended, he/she will be asked to sign the form before leaving, indicating his/her agreement or disagreement that SOPs were followed while he/she was present.

Division of Developmental Services
Virginia Standard Operating Procedures for the SIS® and Review Process

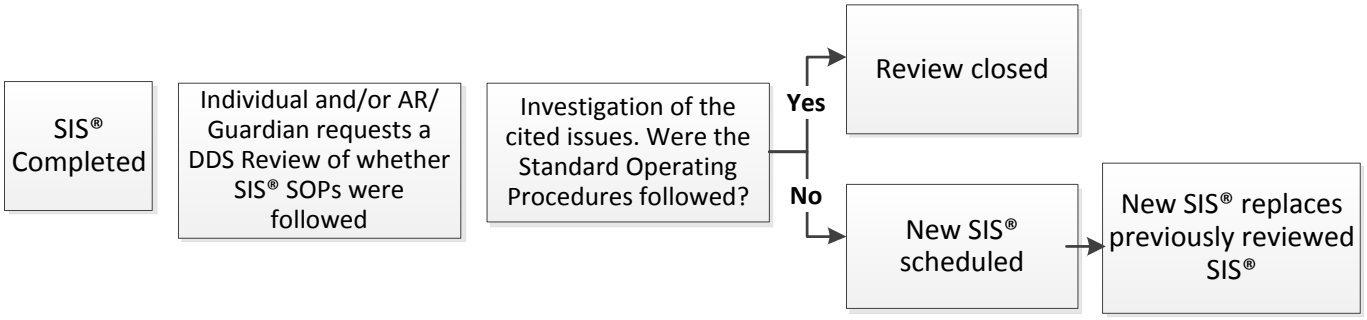
What if there are concerns about how the SIS® was conducted?

The individual, and/or his/her guardian/authorized representative who were in attendance at the interview may request DBHDS to review whether the Virginia Standard Operating Procedures for administration of the SIS® were followed. A SIS® score itself is not appealable as professional training is required to assign an accurate rating.

Process for Individuals and Guardians to Seek Review of Compliance with the Virginia Standard Operating Procedures:

1. If a review is desired, the individual, and/or his/her guardian/authorized representative who were in attendance at the interview, shall request review within 30 business days of the date of receipt of the SIS® results by submitting a completed and signed copy of the Virginia SIS® Review form along with a letter that details the specific ways in which the requestor believes the Virginia Standard Operating Procedures were not followed.
2. The Review form, letter, and any supporting documentation shall be mailed to the SIS® Review Unit DBHDS Division of Developmental Services (DDS), PO Box 1797, Richmond, Virginia 23218-1797.
3. The DDS SIS® Regional Support Supervisor for Virginia, in consultation with Ascend, the SC/CM, and the Virginia State SIS® Coordinator will investigate the issues raised. DDS will issue a decision finding that the Virginia Standard Operating Procedures were either followed or not followed. A final decision will be rendered within 60 business days of the date the Review form is received by DBHDS. Notification to the requestor and SC/CM will be sent within 3 business days of the decision.
4. If it is found by DDS that the Virginia Standard Operating Procedures for the administration of the SIS® were not followed, a new SIS® will be requested and scheduled with an AAIDD endorsed Interviewer within 90 business days of the decision rendered by DDS. If it is found by DDS that the Virginia Standard Operating Procedures were followed, the review will be closed with no further action.
5. The DDS determination regarding compliance with the Virginia Standard Operating Procedures is final.

Review Process Flow Chart



DBHDS/Division of Developmental Services

Virginia SIS® Review Form

Please send a completed and signed copy of this form with a letter detailing the specific ways in which the Virginia Standard Operating Procedures for the administration of the SIS® were not followed to DDS SIS® Review Unit at the address listed below. Information about the Review process is available at www.dbhds.virginia.gov under Individuals and Families/Developmental Services/Supports Intensity Scale

Name of individual who receives services: _____

CSB/Training Center/Support Coordination Agency: _____

Please check the item(s) that were not followed during the SIS® interview in which you present and participated.

☑ Check those items that were NOT followed during the SIS®	Standard Operating Procedures for Conducting a SIS®
	The SIS® Interviewer met the individual.
	The SIS® Interviewer explained the reason for the SIS®, the assessment process, and the role of respondents prior to starting the interview.
	The SIS® interview was conducted face-to-face with at least two primary respondents who are defined as persons who have known the individual well for at least the last 3 months and have observed the individual closely in one or more environments for substantial periods of time. (Phone calls might be necessary to get additional information for a SIS®, but the SIS® should never be completed in its entirety via telephone.)
	Each question on the SIS® was asked and opportunity for discussion was given during the assessment.
	Each item in the assessment was described before it was rated.
	Based upon the information shared by respondents, the SIS® Interviewer made an item rating determination.
	The final rating of each question was shared with the respondents.
	Medical and behavioral support needs were discussed with the respondents.

_____ _____ _____

Print Name **Signature** **Date**

_____

Relationship to Individual Receiving Service

_____

Contact Information: Phone number, mailing address

Mail this form, letter and any supporting documentation to:

DDS SIS® Review Unit
DBHDS
PO Box 1797
Richmond, VA 23218

DBHDS/Division of Developmental Services

SIS® Interview Information for Respondents

- In order to achieve a current and accurate picture of needed supports, it is requested that respondents not bring the following:
  - Copies of old SISs®
  - Copies of SIS® expanded clarifications or
  - Other assessments like the Virginia Individual Developmental Disabilities Eligibility Survey (VIDES), Inventory for Client and Agency Planning (ICAP), etc., as they are not needed.

- In order to assure the interview is conducted with full attention on accurate and timely completion of the SIS®, any laptops or tablets that are brought to the interview should be turned off and put away for the duration of the interview, unless being utilized as a personal communication device. The one exception to this policy is that the interviewer may use a laptop to conduct the interview.

- All cell phones should be turned off or set to vibrate and should not be answered unless the respondent has informed the interviewer, prior to the interview, that he expects to receive an emergency call. Texting is not permitted during any part of the interview.

- No audio or video recording is permitted at the SIS® interview unless authorized with prior approval by DBHDS for training purposes and with the individual's or his authorized representative's consent.

- During the interview, it is the responsibility of the respondent to answer questions asked by the interviewer in order to ensure that accurate and complete information is reflected in the results.

- To ensure that the interviewer has a clear picture of the supports needed for the individual, he/she will ask follow-up questions. The interviewer, based on the answers of the respondents and his/her training and knowledge of the SIS®, will determine the appropriate rating. It is the respondent's responsibility to accurately and honestly describe needed/provided supports so the interview may determine an accurate rating.

- Important To's and Important For's should be identified for this coming plan year only. Additional or replacement To's and For's will be addressed at subsequent Individual Support Plan meetings.

- At least 2 primary respondents must remain for the entire interview or it will be rescheduled.

- Everyone at the interview will be asked to sign the Virginia SIS® Interview Attendance Log before the interview and the Virginia SIS® Interview Standard Operating Procedures (SOPs) Checklist immediately following the session. If a respondent must leave before the interview has ended, he/she will be asked to sign the form before leaving, indicating his/her agreement or disagreement that SOPs were followed while he/she was present.

ASCEND
A MAXIMUS COMPANY

SUPPORT COORDINATOR USER GUIDE
VIRGINIA SIS®

Developed: 04.03.15
Revised: 07.31.17

Contents

Ascend provides this user guide as an overview of system operations. If you have specific questions about how to perform a function of your responsibilities, speak with your supervisor. If you have a specific question about how to maneuver through the system that is not outlined in this user guide, contact your Regional Support Supervisor.

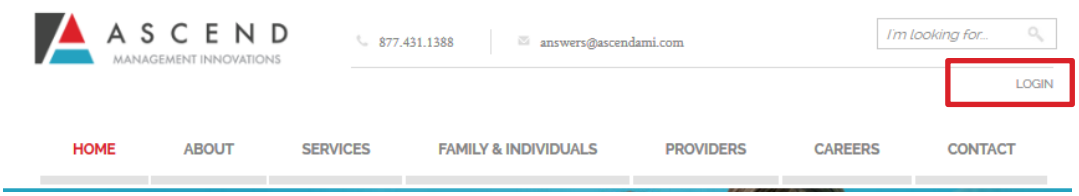
Ascend will always support the current and most recent versions of Internet Explorer and Mozilla Firefox.
Ascend recommends Adobe Reader 10 or later.

Ensure that your firewall does not block our URL.

Log In

Visit www.ascendami.com.

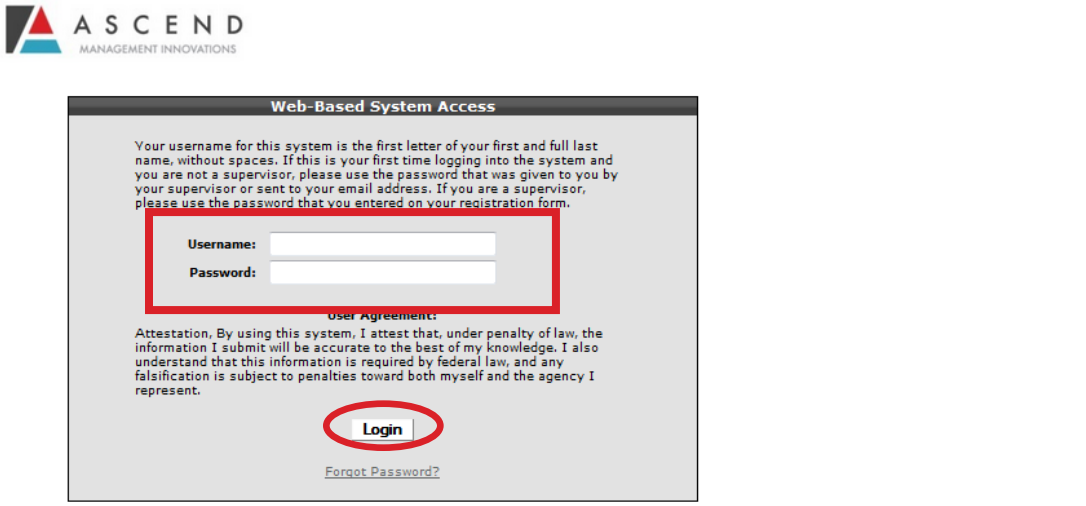
Click ***Log In*** to access the login screen **(Fig. 2)**



Ascend Management Innovations Home Page—Figure 1

Enter **Username** and **Password.**

Click ***Login***.

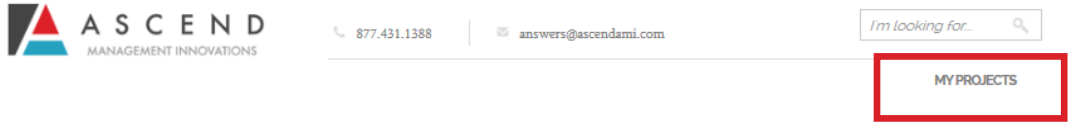


Login Screen—Figure 2

The system will bring you back to the Ascend Management Innovations Home page **(Fig. 1).**
The **Log In** link becomes the **My Projects** menu **(Fig. 3).**

Click ***My Projects.***

Select ***Virginia Support Coordinator*** to open the **VA SIS CSB Support Coordinator Queue** (home page) **(Fig. 7).**



Ascend Management Innovations Home Page—Figure 3

Navigation

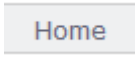


Figure 4

Return to the CSB Point Person Queue

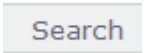


Figure 5

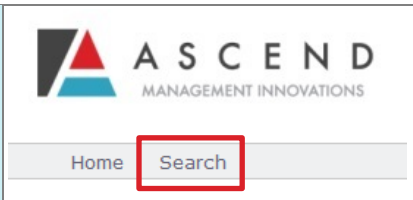
Search for an Individual

Sorting: Click any table column header to sort the table by that field.

Search for Individual

To search for a specific person

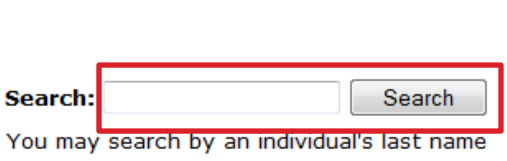
Click ***Search*** in the navigation menu to open the search query **(Fig. 12).**



Navigation Menu—Figure 6

Enter the **Individual's last name to search.**

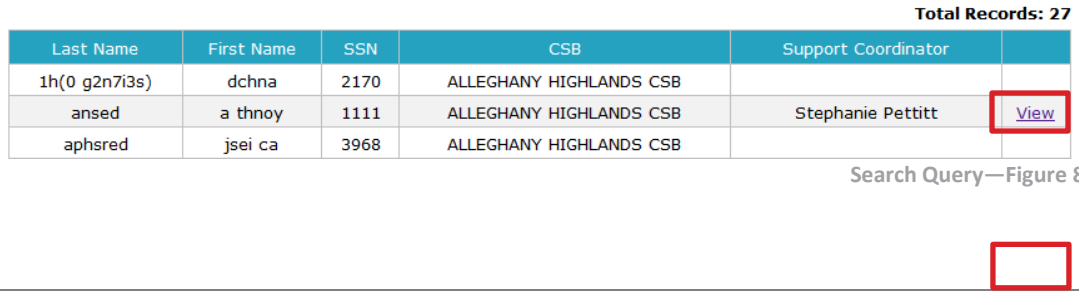
Click ***Search*** to run the search.



Search Query—Figure 7

All records associated with your search will appear. Only those you have access to will have a **View** link to open the record.

Click ***View*** to open the individual's record.



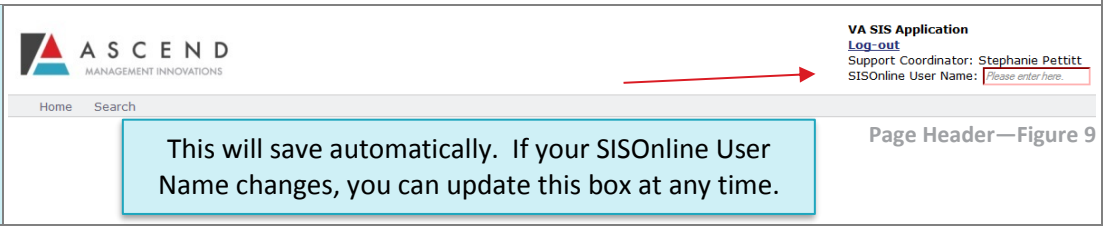
Search Query—Figure 8

Enter SISOnline User Name

Only complete once or with a change

Enter your **SISOnline User Name** in the **red box** in the upper right corner of the page.

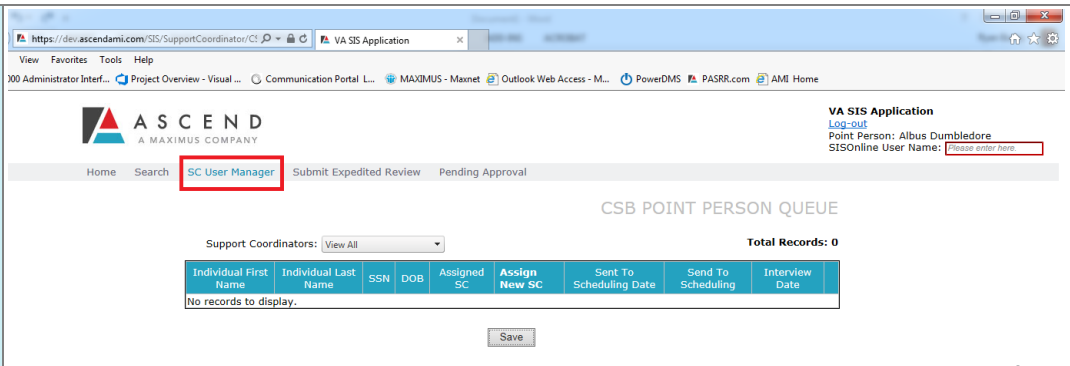
This will save automatically.



Page Header—Figure 9

Adding Multiple CSBs/DD Agencies through the SC User Manager

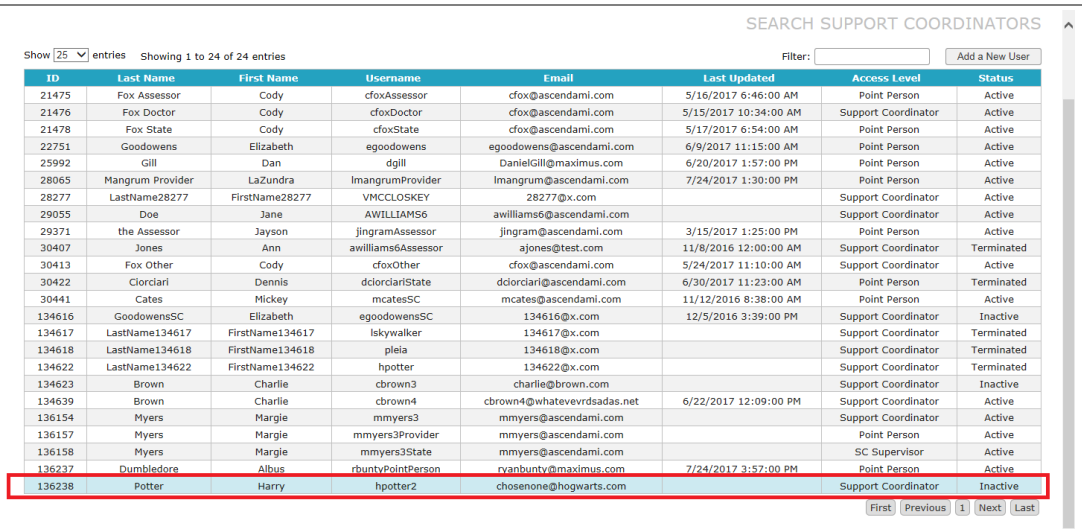
Click the ***SC User Manager*** link in the navigation menu.



Home Page—Figure 10

Locate the **Support Coordinator.**

Click the **row** to update the person's information.

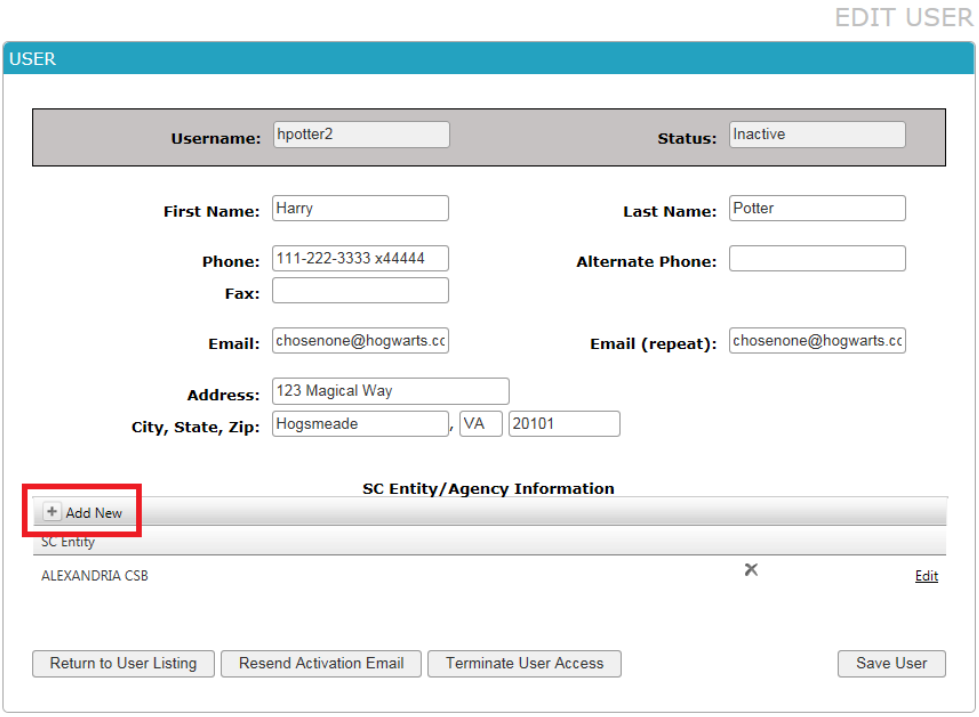


Support Coordinator Queue—Figure 11

Click the ***Add New*** button in the **SC Entity/Agency Information grid** to add a new entity/agency.

You may add as many as necessary.

This will open a list of identified entities/agencies.

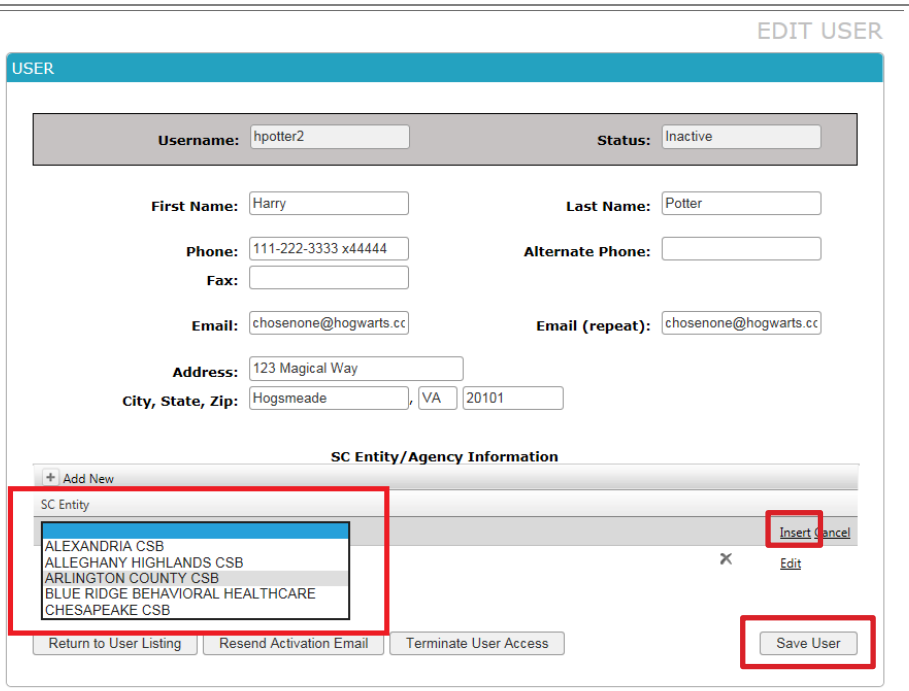


Edit User Page—Figure 12

Select the appropriate **CSB/DD Agency** from the **SC Entity** dropdown.

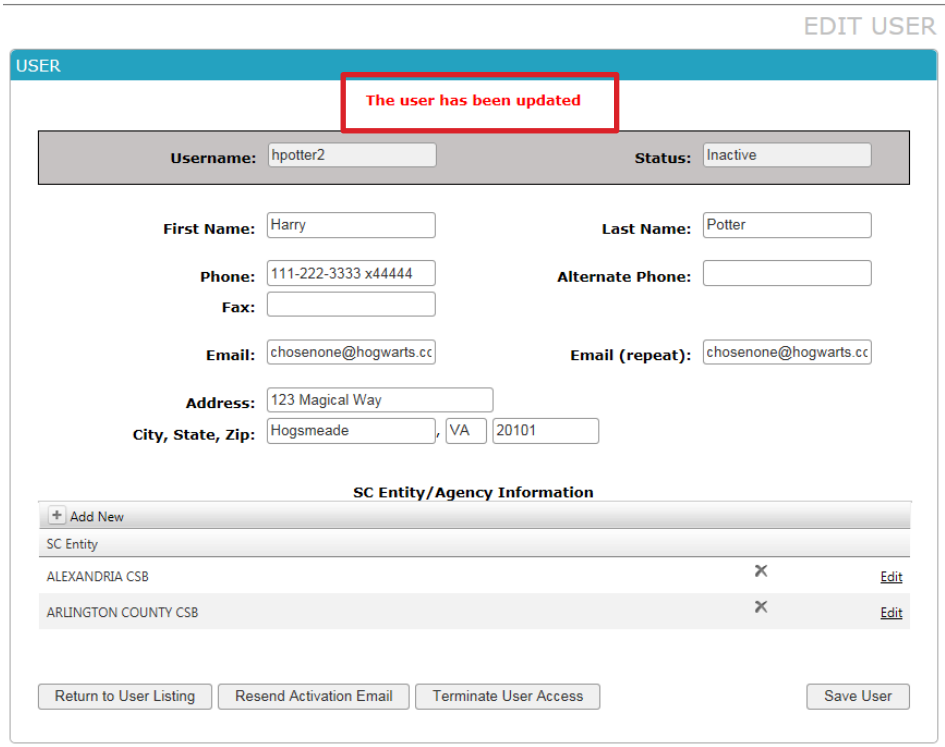
Click ***Insert*** at the end of the row to save the new CSB/DD Agency record. *You **must** click this before clicking Save User.*

Click ***Save User*** to save the changes to the user's access.



Edit User Page—Figure 13

Note the confirmation the user has been updated.



Edit User Page—Figure 14

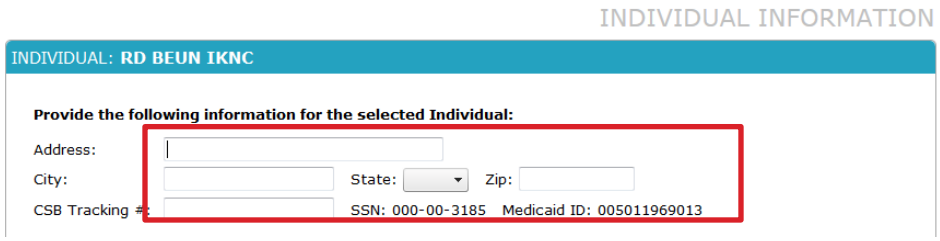
Accessing the Individual's Record

From the CSB Support Coordinator Queue (Home page):

Click ***View*** to open the record.

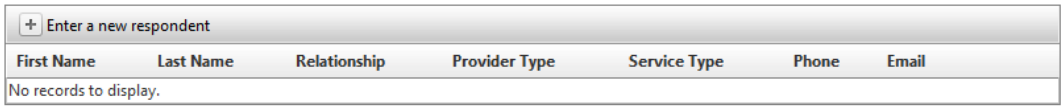
CSB Support Coordinator Queue—Figure 15

Complete the **demographic information.**



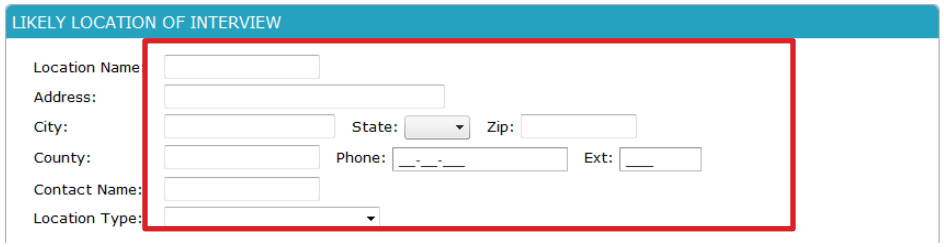
Individual Information—Figure 16

Enter a new **respondent.** Follow the instructions in the ***Enter Respondent Information*** section **(Figs. 17–23).**



Individual Information—Figure 17

Enter the **Likely Location of Interview** information.

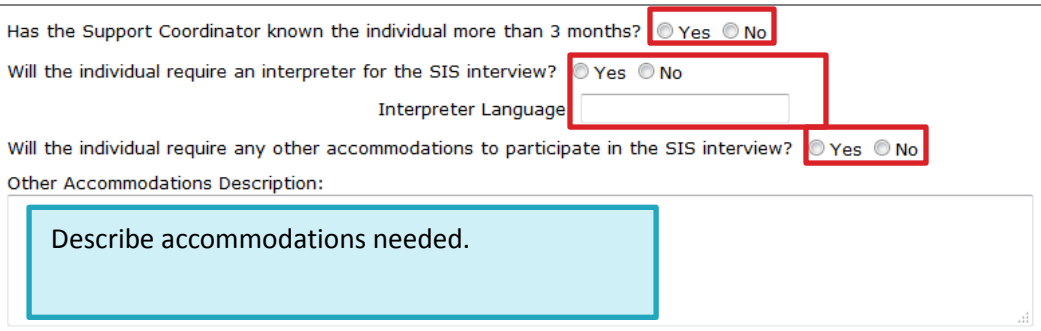


Individual Information—Figure 18

Indicate if you have **known the person** more than 3 months.

Indicate if an **interpreter** is needed, and for **which language.**

Indicate if **other accommodations** are needed and **describe the accommodations.**

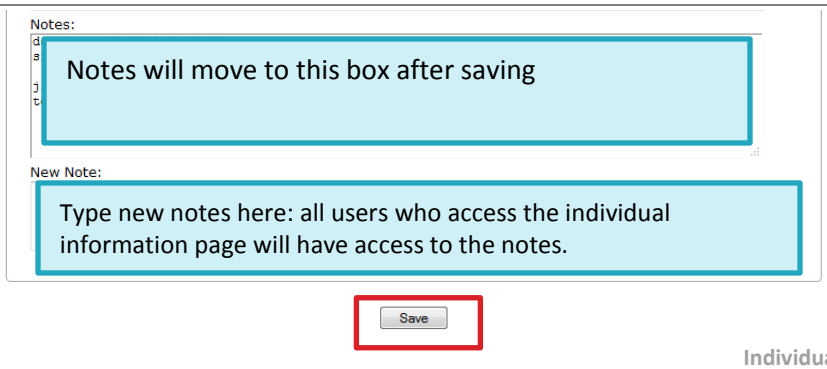


Individual Information—Figure 19

Enter any **notes** to save to the record.

*Type the note in the **New note:** box. After saving, the note will move to the **Notes:** box above.*

Click ***Save*** to save all added information.

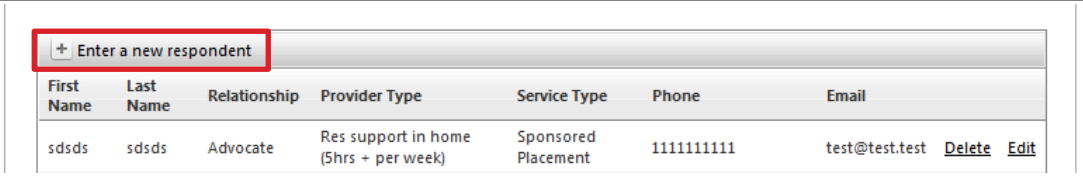


Individual Information—Figure 20

Enter Respondent Information

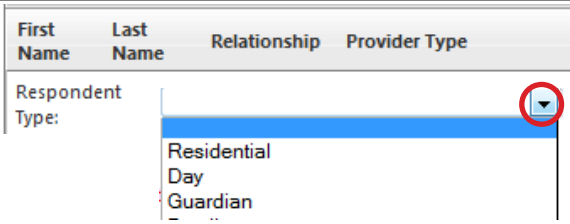
From the Individual Record

Click ***Enter a new respondent*** to open the respondent grid **(Fig. 17)** to add respondent information.



Individual Information—Figure 21

Select the ***Respondent Type*** from the dropdown.



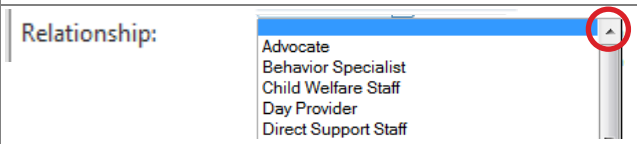
The form options are dynamic, and will change based on the respondent type selected. **Be sure to complete all fields.**

Respondent Grid—Figure 22

Enter the respondent's **first and last name.**

Respondent Grid—Figure 23

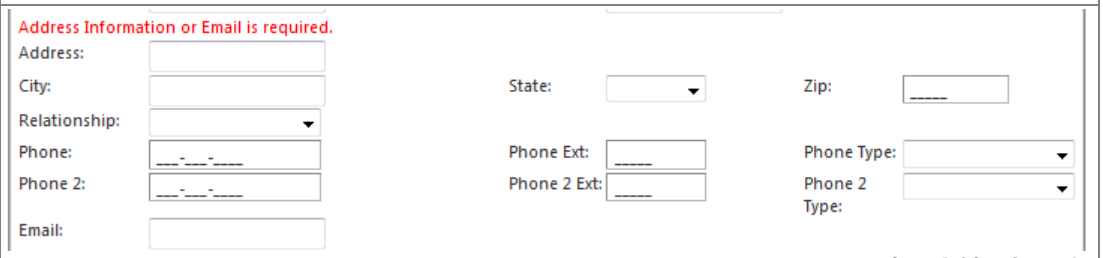
Select the respondent's **relationship** to the individual from the dropdown.



Respondent Grid—Figure 24

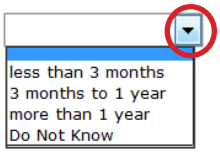
Enter the respondent's **contact information.**

Ascend will confirm and schedule the Respondents participating in the SIS® using the provided contact information.



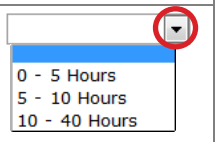
Respondent Grid—Figure 25

Indicate how long the respondent has **known the individual.**



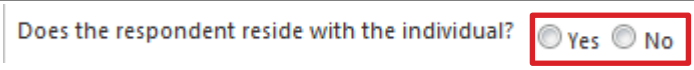
Respondent Grid—Figure 26

Select the number of **direct contact hours** with the individual over the past 3 months.

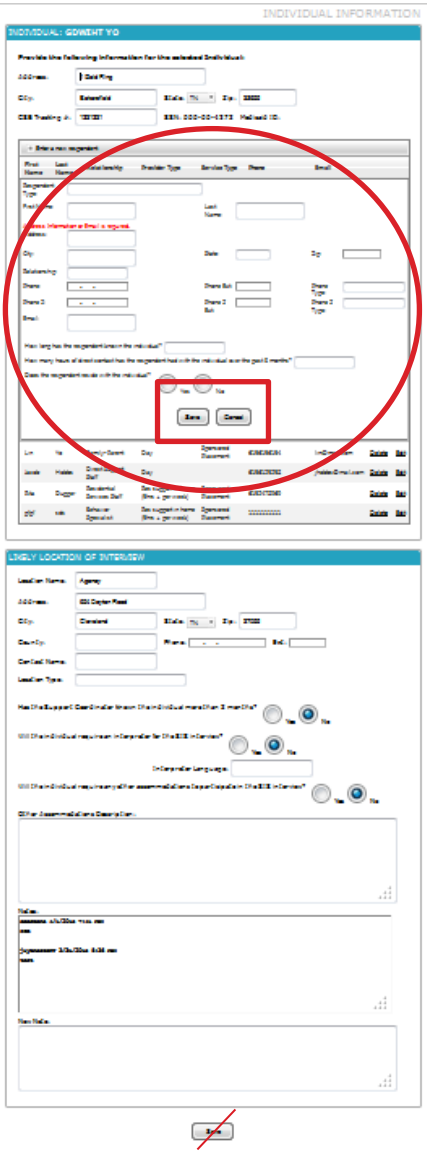


Respondent Grid—Figure 27

Indicate if the respondent **resides** with the individual.



Click ***Save*** to insert the respondent information in the respondent grid.



You must click ***Save*** to insert the respondent information in the grid.

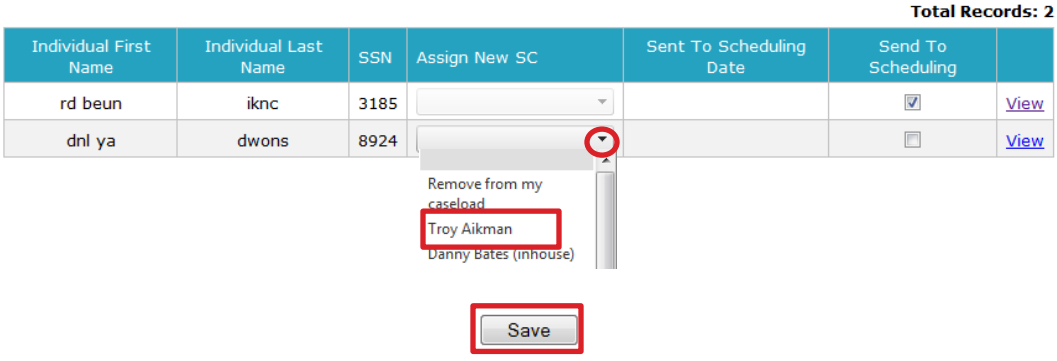
Respondent Grid—Figure 28

Changing Assigned SC

From the CSB Support Coordinator Queue (home page).

Select the **new SC** from the ***Assign New SC*** dropdown.

Click ***Save*** to remove the individual from your queue and send the record to the newly identified SC.



CSB Support Coordinator Queue—Figure 29

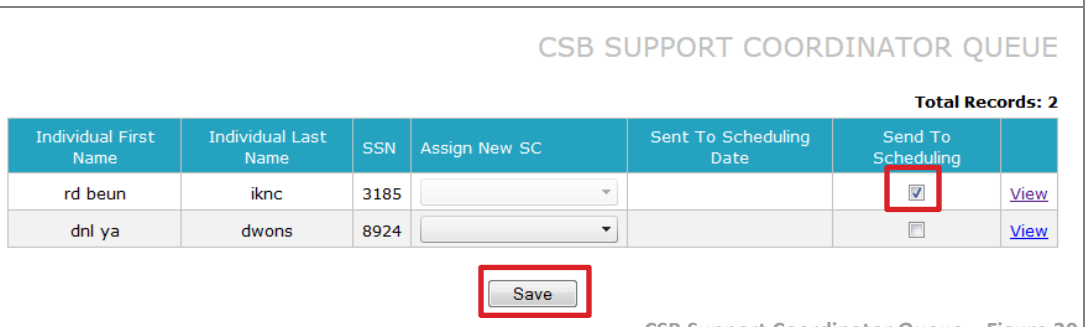
Submit Record for Scheduling

From the CSB Support Coordinator Queue (home page).

After entering demographics, respondent information, and likely location of interview, submit the information to Ascend scheduling using these steps:

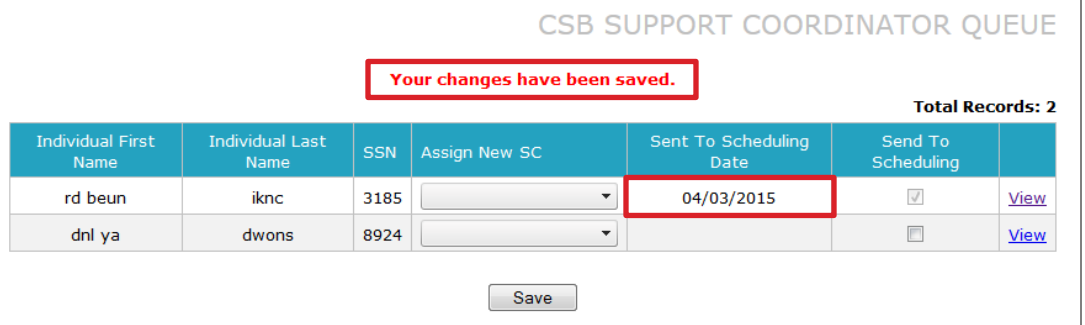
Click the ***Send to Scheduling*** checkbox in the **CSB Support Coordinator Queue** (home page).

Click ***Save*** to send the completed information to Ascend for scheduling.



CSB Support Coordinator Queue—Figure 30

The ***Sent to Scheduling Date*** will be saved on the grid.



CSB Support Coordinator Queue—Figure 31

Log Out

Click ***Log-out*** to end your session.

Failure to logout can cause a record to remain locked for up to two hours. *This means that no one else can work in the individual's record during that time.*

Page Header—Figure 32

Failure to logout can cause a record to remain locked for up to **two hours.**

DBHDS/Division of Developmental Services

Virginia SIS® Review Form

Please send a completed and signed copy of this form with a letter detailing the specific ways in which the Virginia Standard Operating Procedures for the administration of the SIS® were not followed to DDS SIS® Review Unit at the address listed below. Information about the Review process is available at www.dbhds.virginia.gov under Individuals and Families/Developmental Services/Supports Intensity Scale

Name of individual who receives services: _____

CSB/Training Center/Support Coordination Agency: _____

Please check the item(s) that were not followed during the SIS® interview in which you present and participated.

☑ Check those items that were NOT followed during the SIS®	Standard Operating Procedures for Conducting a SIS®
	The SIS® Interviewer met the individual.
	The SIS® Interviewer explained the reason for the SIS®, the assessment process, and the role of respondents prior to starting the interview.
	The SIS® interview was conducted face-to-face with at least two primary respondents who are defined as persons who have known the individual well for at least the last 3 months and have observed the individual closely in one or more environments for substantial periods of time. (Phone calls might be necessary to get additional information for a SIS®, but the SIS® should never be completed in its entirety via telephone.)
	Each question on the SIS® was asked and opportunity for discussion was given during the assessment.
	Each item in the assessment was described before it was rated.
	Based upon the information shared by respondents, the SIS® Interviewer made an item rating determination.
	The final rating of each question was shared with the respondents.
	Medical and behavioral support needs were discussed with the respondents.

_____ _____ _____

Print Name **Signature** **Date**

_____

Relationship to Individual Receiving Service

_____

Contact Information: Phone number, mailing address

Mail this form, letter and any supporting documentation to:

DDS SIS® Review Unit
DBHDS
PO Box 1797
Richmond, VA 23218

DBHDS/Division of Developmental Services

SIS® Interview Information for Respondents

- In order to achieve a current and accurate picture of needed supports, it is requested that respondents not bring the following:
  - Copies of old SISs®
  - Copies of SIS® expanded clarifications or
  - Other assessments like the Virginia Individual Developmental Disabilities Eligibility Survey (VIDES), Inventory for Client and Agency Planning (ICAP), etc., as they are not needed.

- In order to assure the interview is conducted with full attention on accurate and timely completion of the SIS®, any laptops or tablets that are brought to the interview should be turned off and put away for the duration of the interview, unless being utilized as a personal communication device. The one exception to this policy is that the interviewer may use a laptop to conduct the interview.

- All cell phones should be turned off or set to vibrate and should not be answered unless the respondent has informed the interviewer, prior to the interview, that he expects to receive an emergency call. Texting is not permitted during any part of the interview.

- No audio or video recording is permitted at the SIS® interview unless authorized with prior approval by DBHDS for training purposes and with the individual's or his authorized representative's consent.

- During the interview, it is the responsibility of the respondent to answer questions asked by the interviewer in order to ensure that accurate and complete information is reflected in the results.

- To ensure that the interviewer has a clear picture of the supports needed for the individual, he/she will ask follow-up questions. The interviewer, based on the answers of the respondents and his/her training and knowledge of the SIS®, will determine the appropriate rating. It is the respondent's responsibility to accurately and honestly describe needed/provided supports so the interview may determine an accurate rating.

- Important To's and Important For's should be identified for this coming plan year only. Additional or replacement To's and For's will be addressed at subsequent Individual Support Plan meetings.

- At least 2 primary respondents must remain for the entire interview or it will be rescheduled.

- Everyone at the interview will be asked to sign the Virginia SIS® Interview Attendance Log before the interview and the Virginia SIS® Interview Standard Operating Procedures (SOPs) Checklist immediately following the session. If a respondent must leave before the interview has ended, he/she will be asked to sign the form before leaving, indicating his/her agreement or disagreement that SOPs were followed while he/she was present.

American Association on Intellectual and Developmental Disabilities

Family-Friendly Report (SIS-A)

Confidential Interview and Profile Results for the Supports Intensity Scale Adult Version™ : SIS-A™

Person Being Assessed:

Last:	Duck
First:	Daffney
Middle:	I am a Sample
Language Spoken at Home:	English
Gender:	F
Address:	12 Lillipad Blvd
City:	Richmond
State/Province:	VA
Zip Code:	23230
Phone:	8045556666
D.O.B. (mm/dd/yyyy):	7/5/1981 0:00
Age:	32
Tracking Number:	123456
Medicaid Number:	*******2156
SSN:	*******2147

Interviewer Data:

Interviewer:	Cheri Stierer
Agency/Affiliation:	Merritt Consulting
Interviewer Addr:	123 River Street
City:	Richmond
State/Province:	VA
Zip Code:	23230
Position:	
Phone:	(804)219-1234
Ext.:	
Interviewer Email:	cheri.stierer@comcast.net

Assessment Data:

Interview Date (mm/dd/yyyy):	9/25/2013 0:00
ISP Begin Date:	05/12/2016
SIS ID:	348066

Support Providers - Essential supports for this individual are being provided by the following

Name	Relationship	Phone	Ext.
Happy Homes In Home	Residential Support	8041112222	
Donald Duck	Father	8042223333	
Does Support Services	Case Management Agency	8046667777	

Respondent Data - Information for the SIS ratings was provided by the following respondents:

First Name	Last Name	Relationship	Agency	Email	Language
Delores	Hubert	direct_support			
Donald	Duck	parent			
Mary	Jones	service_coordinator_case_manager			

Person who entered this information:

First Name:	Cheri
Last Name:	Stierer

Other Pertinent Information - Daffy has beautiful red hair and a wonderfully shy smile. She loves to talk about her day at workl and is a good advocate for others at her job.

Introduction to the SIS Report:

The Supports Intensity Scale Adult Version (SIS-A) profile information is designed to assist in the service planning process for the individual, their parents, family members, and service providers. The profile information outlines the type and intensity of support the individual would benefit from to participate and be successful in his or her community. The SIS-A profile report is best applied in combination with person-centered planning to achieve the desired outcome in creating individual goals.

Rating Key for Sections 2 and 3

This describes the rating for Type of Support, Frequency and Daily Support time for each of the six areas discussed in your SIS-A profile

Type of Support	Frequency	Daily Support Time
What help do you need to do the (item) on your own or by yourself If engaged in the activity over the next several months, what would the nature of the support look like? Which support type dominates the support provided?	How frequently is supported needed for this activity?	If engaged in the activity over the next several months, in a typical 24-hour day, how much total, cumulative time would be needed to provide support?
0 = None No support needed at any time **1 = Monitoring (reminders). For example** * Encouragement, general supervision * Checking in, observing, telling, &/or giving reminders to complete the activity * Asking questions to trigger the individual to complete steps within the activity **2 = Verbal/Gesture Prompting (demonstration). For** example: * Step by step instruction Walking a person through required steps * Providing visual prompts, showing * Modeling, teaching, role play, social stories **3 = Partial Physical Assistance (help through)** doing). For example: * Individual participates in some parts of the activity * Some, essential steps are required to be completed for the person **4 = Full Physical Support (doing for). For example:** * All essential steps need to be completed for the person	**0 = None or less than monthly** **1 = At least once a month, but not once a week** **2 = At least once a week, but not once a day** **3 = At least once a day, But not once an hour** **4 = Hourly or more frequently**	**0 = None** **1 = Less Than 30 Minutes** **2 = 30 Minutes to Less Than 2 Hours** **3 = 2 Hours to Less Than 4 Hours** **4 = 4 Hours or More**

Section 2. Supports Needs Index

2A. Home Living

Item	Type of Support	Frequency	Daily Support Time	Total Score
5. Preparing food	3 - Partial Physical Assistance	3 - At Least Once a Day, But Not Once an Hour	3 - 2 Hours to Less Than 4 Hours	9
She likes to be in the kitchen to assist with the meal.				
7. Taking care of clothes (includes laundering)	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	3 - 2 Hours to Less Than 4 Hours	8
Daffney will sort colors and turn on the washer if it is color coded. Support is needed to use the dryer settings. She will always turn it to the far right which is a hot setting.				
1. Operating home appliances/electronics	2 - Verbal/Gesture Prompting	3 - At Least Once a Day, But Not Once an Hour	2 - 30 Minutes to Less Than 2 Hours	7
2. Bathing and taking care of personal hygiene and grooming needs	2 - Verbal/Gesture Prompting	2 - At Least Once a Week, But Not Once a Day	2 - 30 Minutes to Less Than 2 Hours	6
It is important to provide support during hair washing so that she gets hair thoroughly clean. She support to remind her to wash her hair every other day. It is important to her to smell nice and look good.				
4. Dressing	2 - Verbal/Gesture Prompting	2 - At Least Once a Week, But Not Once a Day	2 - 30 Minutes to Less Than 2 Hours	6
Daffney likes to wear pink. She needs support to dress for the weather in the winter months.				
6. Eating Food	2 - Verbal/Gesture Prompting	3 - At Least Once a Day, But Not Once an Hour	1 - Less Than 30 Minutes	6
She needs prompting to eat slowly so she will not choke.				
8. Housekeeping and cleaning	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	6
She does not like to dust or sweep the floor, but loves to run the vacuum. She needs support not to suck up items into the vacuum.				
3. Using the toilet	2 - Verbal/Gesture Prompting	1 - At Least Once a Month, But Not Once a Week	1 - Less Than 30 Minutes	4
She needs support during her monthly cycle.				
N/A	N/A	N/A	N/A	N/A

2B. Community Living

Item	Type of Support	Frequency	Daily Support Time	Total Score
2. Participating in recreation/leisure activities in the community settings	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	3 - 2 Hours to Less Than 4 Hours	8
She likes bowling and to watch roller derby.				
3. Participating in preferred community activities (church, volnteer, etc.)	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	3 - 2 Hours to Less Than 4 Hours	8
She enjoys church and the women's group at her church.				
6. Shopping and purchasing goods and services	3 - Partial Physical Assistance	1 - At Least Once a Month, But Not Once a Week	3 - 2 Hours to Less Than 4 Hours	7
1. Getting from place to place throughout the community (transportation)	2 - Verbal/Gesture Prompting	2 - At Least Once a Week, But Not Once a Day	2 - 30 Minutes to Less Than 2 Hours	6
8. Going to visit friends and family	3 - Partial Physical Assistance	1 - At Least Once a Month, But Not Once a Week	2 - 30 Minutes to Less Than 2 Hours	6
She uses supports to plan to make visits. She is close to her sister and has a friend at work she likes to socialize with occasionally.				
5. Using public services in the community	1 - Monitoring	3 - At Least Once a Day, But Not Once an Hour	1 - Less Than 30 Minutes	5
4. Accessing public buildings and settings	1 - Monitoring	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	4
She does well accessing with prompting by support staff.				
7. Interacting with community members	1 - Monitoring	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	4
N/A	N/A	N/A	N/A	N/A

2C. Lifelong Learning

Item	Type of Support	Frequency	Daily Support Time	Total Score
1. Learning and using problem-solving strategies	2 - Verbal/Gesture Prompting	2 - At Least Once a Week, But Not Once a Day	4 - 4 Hours or More	8
3. Learning health and physical education skills	2 - Verbal/Gesture Prompting	3 - At Least Once a Day, But Not Once an Hour	3 - 2 Hours to Less Than 4 Hours	8
She is working on losing weight and walks several times a week with support.				
5. Learning self-management strategies	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	3 - 2 Hours to Less Than 4 Hours	8
9. Using technology for learning	3 - Partial Physical Assistance	3 - At Least Once a Day, But Not Once an Hour	2 - 30 Minutes to Less Than 2 Hours	8
Daffney is learning to use an I Pod. She enjoys the music apps.				
2. Learning functional academics (reading signs, counting change, etc.)	2 - Verbal/Gesture Prompting	2 - At Least Once a Week, But Not Once a Day	3 - 2 Hours to Less Than 4 Hours	7
She can knows signs, but cannot read.				
4. Learning self-determination skills	1 - Monitoring	2 - At Least Once a Week, But Not Once a Day	3 - 2 Hours to Less Than 4 Hours	6
6. Participating in training/educational decisions	3 - Partial Physical Assistance	1 - At Least Once a Month, But Not Once a Week	2 - 30 Minutes to Less Than 2 Hours	6
7. Accessing training/educational settings	3 - Partial Physical Assistance	1 - At Least Once a Month, But Not Once a Week	2 - 30 Minutes to Less Than 2 Hours	6
8. Interacting with others in learning activities	1 - Monitoring	2 - At Least Once a Week, But Not Once a Day	2 - 30 Minutes to Less Than 2 Hours	5
N/A	N/A	N/A	N/A	N/A

2D. Employment

Item	Type of Support	Frequency	Daily Support Time	Total Score
1. Learning and using specific job skills	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	3 - 2 Hours to Less Than 4 Hours	8
5. Completing work-related tasks with acceptable speed	2 - Verbal/Gesture Prompting	3 - At Least Once a Day, But Not Once an Hour	2 - 30 Minutes to Less Than 2 Hours	7
6. Completing work-related tasks with acceptable quality	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	2 - 30 Minutes to Less Than 2 Hours	7
3. Interacting with coworkers	1 - Monitoring	3 - At Least Once a Day, But Not Once an Hour	1 - Less Than 30 Minutes	5
She will talk a lot while working and sometimes needs support to stop agitating others.				
4. Interacting with supervisors/coaches	2 - Verbal/Gesture Prompting	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	5
Daffney likes to talk with the supervisor and ask how she is doing.				
7. Changing job assignments	2 - Verbal/Gesture Prompting	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	5
8. Seeking information and assistance from an employer	4 - Full Physical Support	0 - None or Less Than Monthly	1 - Less Than 30 Minutes	5
2. Accessing/receiving job/task accommodations	0 - None	0 - None or Less Than Monthly	0 - None	0
N/A	N/A	N/A	N/A	N/A

2E. Health and Safety

Item	Type of Support	Frequency	Daily Support Time	Total Score
3. Avoiding health and safety hazards	3 - Partial Physical Assistance	3 - At Least Once a Day, But Not Once an Hour	2 - 30 Minutes to Less Than 2 Hours	8
Daffney is not always aware of the health related safety issues. She knows no strangers which poses a safety issue on her walks and in the community.				
7. Maintaining physical health and fitness	3 - Partial Physical Assistance	3 - At Least Once a Day, But Not Once an Hour	2 - 30 Minutes to Less Than 2 Hours	8
She likes to walk and is trying to lose weight. Needs support to stay on track and keep up pace. She is willing to try other activities.				
1. Taking medications	3 - Partial Physical Assistance	3 - At Least Once a Day, But Not Once an Hour	1 - Less Than 30 Minutes	7
Daffney needs support to remember to take her medicaation				
2. Ambulating and moving about	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	2 - 30 Minutes to Less Than 2 Hours	7
6. Maintaining nutritious diet	3 - Partial Physical Assistance	3 - At Least Once a Day, But Not Once an Hour	1 - Less Than 30 Minutes	7
She needs support to select sugar free options for her diabetic diet. She loves sweets.				
8. Maintaining emotional well-being	2 - Verbal/Gesture Prompting	3 - At Least Once a Day, But Not Once an Hour	2 - 30 Minutes to Less Than 2 Hours	7
She benefits from support to control her temper when frustrated. She will follow the plan she helped develop with some support from others.				
4. Obtaining health care services	4 - Full Physical Support	0 - None or Less Than Monthly	2 - 30 Minutes to Less Than 2 Hours	6
5. Learning how to access emergency services	3 - Partial Physical Assistance	1 - At Least Once a Month, But Not Once a Week	1 - Less Than 30 Minutes	5
N/A	N/A	N/A	N/A	N/A

2F. Social

Item	Type of Support	Frequency	Daily Support Time	Total Score
8. Engaging in volunteer work	3 - Partial Physical Assistance	1 - At Least Once a Month, But Not Once a Week	3 - 2 Hours to Less Than 4 Hours	7
She volunteers with a singing group that performs at senior complexes in the city.				
4. Making and keeping friends	3 - Partial Physical Assistance	1 - At Least Once a Month, But Not Once a Week	2 - 30 Minutes to Less Than 2 Hours	6
She would like to go out on a date.				
1. Using appropriate social skills	1 - Monitoring	3 - At Least Once a Day, But Not Once an Hour	1 - Less Than 30 Minutes	5
She wants to be liked by others.				
5. Engaging in loving and intimate relationships	2 - Verbal/Gesture Prompting	1 - At Least Once a Month, But Not Once a Week	2 - 30 Minutes to Less Than 2 Hours	5
6. Socializing within the household	1 - Monitoring	3 - At Least Once a Day, But Not Once an Hour	1 - Less Than 30 Minutes	5
She benefits from reminders not to be too bossy with certain housemates.				
2. Participating in recreation/leisure activities with others	2 - Verbal/Gesture Prompting	1 - At Least Once a Month, But Not Once a Week	1 - Less Than 30 Minutes	4
She loves swim class and wants to go to some baseball games.				
3. Socializing outside the household	1 - Monitoring	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	4
7. Communicating with others about personal needs	2 - Verbal/Gesture Prompting	1 - At Least Once a Month, But Not Once a Week	1 - Less Than 30 Minutes	4
Daffney reports to staff when not feeling well, but struggles with identifying symptoms other than where the hurt is found on her body.				
N/A	N/A	N/A	N/A	N/A

Section 3. Supplemental Protection and Advocacy Scale

Protection and Advocacy Activities

Item	Type of Support	Frequency	Daily Support Time	Total Score
2. Making choices and decisions	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	2 - 30 Minutes to Less Than 2 Hours	7
She benefits from supports for long term life impacting decisions such as selecting appropriate clothing to purchase.				
4. Exercising legal/civic responsibilities	4 - Full Physical Support	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	7
7. Managing money and personal finances	3 - Partial Physical Assistance	2 - At Least Once a Week, But Not Once a Day	2 - 30 Minutes to Less Than 2 Hours	7
She understands simple coins and dollar additions and wants support to make a budget for herself.				
5. Belonging to and participating in self-advocacy/support organizations	2 - Verbal/Gesture Prompting	1 - At Least Once a Month, But Not Once a Week	3 - 2 Hours to Less Than 4 Hours	6
She likes to go the the monthly SABA meetings.				
6. Obtaining legal services	4 - Full Physical Support	0 - None or Less Than Monthly	2 - 30 Minutes to Less Than 2 Hours	6
3. Protecting self from exploitation	1 - Monitoring	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	4
She needs support mostly when in the community as she is very flirtatious with males.				
8. Advocating for others	1 - Monitoring	2 - At Least Once a Week, But Not Once a Day	1 - Less Than 30 Minutes	4
1. Advocating for self	1 - Monitoring	1 - At Least Once a Month, But Not Once a Week	1 - Less Than 30 Minutes	3
N/A	N/A	N/A	N/A	N/A

Support Needs Profile - Graph

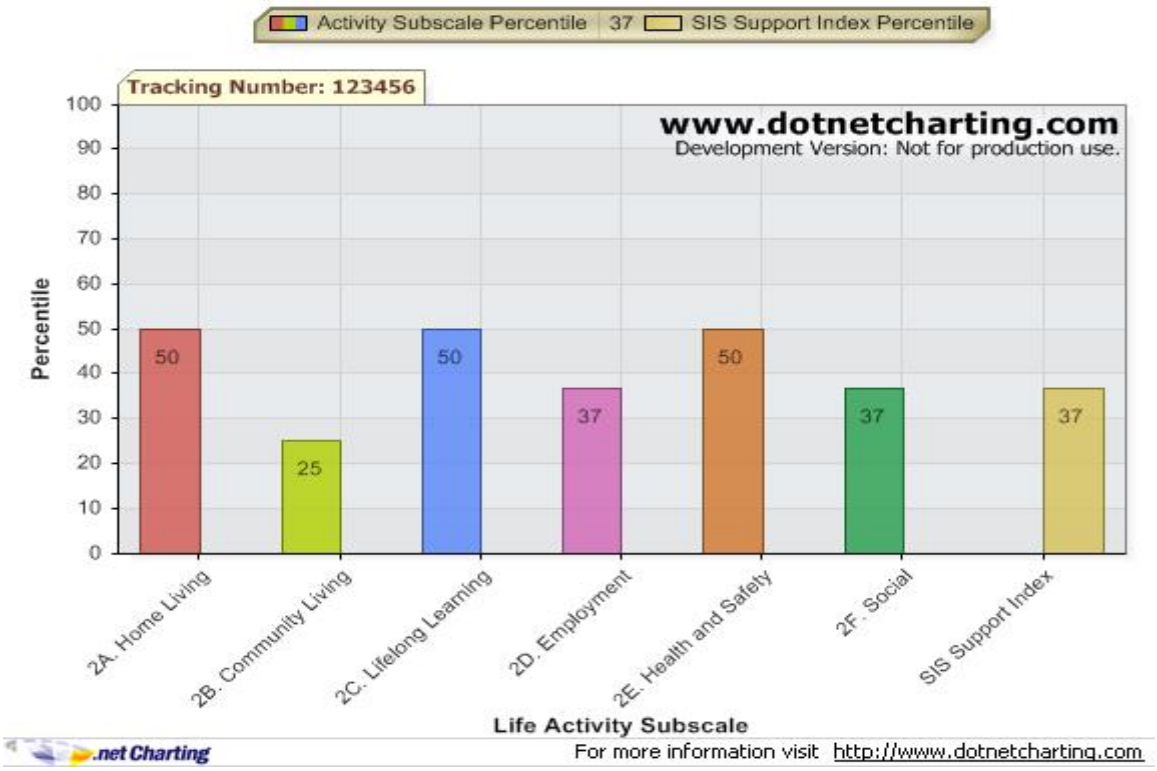
The graph provides a visual presentation of the six life activity areas from section 2.

The graph reflects the pattern and intensity of the individual s level of support. The intent of the graph is to provide an easy means to prioritize the life activity areas in consideration of setting goals and developing the Individual Support Plan.

Activities Subscale	Total Raw Score	Standard Score	Percentile	Confidence Interval (95%)
2A. Home Living	52	10	50	9-11
2B. Community Living	48	8	25	7-9
2C. Lifelong Learning	62	10	50	9-11
2D. Employment	42	9	37	8-10
2E. Health and Safety	55	10	50	9-11
2F. Social	40	9	37	8-10
Total:	**299**	**56**		

SIS Support Needs Index: 95

Percentile: 37



Section 3: Supplemental Protection and Advocacy Scale

Protection and Advocacy Activities	Raw Score
Advocating for self	3
Making choices and decisions	7
Protecting self from exploitation	4
Exercising legal/civic responsibilities	7
Belonging to and participating in self-advocacy/support organizations	6
Obtaining legal services	6
Managing money and personal finances	7
Advocating for others	4

The support needs profile reflects the pattern and intensity of the individual s support. The information provided in sections 1, 2, and 3, can be beneficial in the development of the individual s support plan.

Rating Key For Section 1

Type of Support		
0 = No Support Needed	1 = Some Support Needed	2 = Extensive Support Needed
No support needed because the medical condition or behavior is not an issue, or no support is needed to manage the medical condition or behavior.	Support is needed to address the medical condition and/or behavior. People who support must be cognizant continuously of the condition to assure the individual's health and safety. For example: Checking in and observing Monitoring and providing occasional assistance Minimal physical/hands on contribution Support is episodic and/or requires minimal devoted support time	Extensive support is needed to address the medical condition and/or behavior. For example: Significant physical/hands on contribution Support is intense and/or requires significant support time

Any rating of 2 in this area indicates an exceptional need with Medical conditions and/or Behaviors.

It should be noted that a high total score in section 1 clearly identifies additional support that is required for living safely in the community. The information from section 1 is considered separately from section 2.

Each item under Exceptional Medical and Behavioral is listed and presented from highest to lowest level of support.

Exceptional Medical and Behavioral key items are outlined and may be helpful in the development of the individual's support plan.

Section 1A: Exceptional Medical Support Needs

Item	Support Needed	Comments
18. Diabetes	2 - Extensive Support Needed	Daffney needs support to take her sugar in the am and in the p.m. daily. It takes 3 minutes to assist her.
1. Inhalation or oxygen therapy	0 - No Support Needed	
2. Postural drainage	0 - No Support Needed	
3. Chest PT	0 - No Support Needed	
4. Suctioning	0 - No Support Needed	
5. Oral Stimulation or jaw positioning	0 - No Support Needed	
6. Tube feeding (e.g., nasogastric)	0 - No Support Needed	
7. Parenteral feeding (e.g., IV)	0 - No Support Needed	
8. Turning or positioning	0 - No Support Needed	
9. Dressing of open wound(s)	0 - No Support Needed	
10. Protection from infectious diseases due to immune system impairment	0 - No Support Needed	
11. Seizure management	0 - No Support Needed	
12. Dialysis	0 - No Support Needed	
13. Ostomy Care	0 - No Support Needed	
14. Lifting and/or transferring	0 - No Support Needed	
15. Therapy services	0 - No Support Needed	
16. Hypertension	0 - No Support Needed	
17. Allergies	0 - No Support Needed	
19. Other - Specify :	0 - No Support Needed	
Total Score	2	

Section 1B: Exceptional Behavioral Support Needs

Item	Support Needed	Comments
1. Prevention of emotional outbursts	1 - Some Support Needed	Daffney gets upset when others get into her work space. The job coach will intervene to stop escalation.
4. Prevention of stealing	1 - Some Support Needed	She needs support when shopping as she will take things she wants, but does not have money to for at the time. This happens once a week on her shopping outings.
10. Prevention of substance abuse	1 - Some Support Needed	Daffney talks about going out to a bar, but has a low tolerance for alcohol. She drinks some wine at her father's house every time she visits. She frequently says "I am having a rough day and I need a glass of wine." She is not allowed to buy wine and bring it home because of her diabetes.
11. Prevention of wandering	1 - Some Support Needed	She likes to take walks, but will get distracted if not watched by staff and occasionally will wander off to look at something. This happens every couple of weeks. She walks 3-4 times per week in her neighborhood.
2. Prevention of assaults or injuries to others	0 - No Support Needed	
3. Prevention of property destruction (e.g., fire setting, breaking furniture)	0 - No Support Needed	
5. Prevention of self-injury	0 - No Support Needed	
6. Prevention of suicide attempts	0 - No Support Needed	
7. Prevention of pica ingestion of inedible substances	0 - No Support Needed	
8. Prevention of nonaggressive, but inappropriate sexual behavior (e.g., exposes self in public, exhibitionism, inappropriate touching or gesturing)	0 - No Support Needed	
9. Prevention of sexual aggression	0 - No Support Needed	
12. Maintaining mental health treatments	0 - No Support Needed	
13. Other - Specify :	0 - No Support Needed	
Total Score	4	

Most Important To the Individual

Section 3, Item 5:	Belonging to and participating in self-advocacy/support orga...	2	1	3

Notes: She likes to go the the monthly SABA meetings.

Section 2A, Item 2:	Bathing and taking care of personal hygiene and grooming nee...	2	2	2

Notes: It is important to provide support during hair washing so that she gets hair thoroughly clean. She support to remind her to wash her hair every other day. It is important to her to smell nice and look good.

Section 2A, Item 4:	Dressing	2	2	2

Notes: Daffney likes to wear pink. She needs support to dress for the weather in the winter months.

Section 2A, Item 5:	Preparing food	3	3	3

Notes: She likes to be in the kitchen to assist with the meal.

Section 2B, Item 2:	Participating in recreation/leisure activities in the commun...	3	2	3

Notes: She likes bowling and to watch roller derby.

Section 2B, Item 3:	Participating in preferred community activities (church, vol...	3	2	3

Notes: She enjoys church and the women's group at her church.

Section 2B, Item 8:	Going to visit friends and family	3	1	2

Notes: She uses supports to plan to make visits. She is close to her sister and has a friend at work she likes to socialize with occasionally.

Section 2C, Item 3:	Learning health and physical education skills	2	3	3

Notes: She is working on losing weight and walks several times a week with support.

Section 2C, Item 9:	Using technology for learning	3	3	2

Notes: Daffney is learning to use an I Pod. She enjoys the music apps.

Section 2D, Item 4:	Interacting with supervisors/coaches	2	2	1

Notes: Daffney likes to talk with the supervisor and ask how she is doing.

Section 2E, Item 7:	Maintaining physical health and fitness	3	3	2

Notes: She likes to walk and is trying to lose weight. Needs support to stay on track and keep up pace. She is willing to try other activities.

Section 2F, Item 1:	Using appropriate social skills	1	3	1

Notes: She wants to be liked by others.

Section 2F, Item 2:	Participating in recreation/leisure activities with others	2	1	1

Notes: She loves swim class and wants to go to some baseball games.

Section 2F, Item 4:	Making and keeping friends	3	1	2

Notes: She would like to go out on a date.

Most Important For the Individual

Section 2A, Item 2:	Bathing and taking care of personal hygiene and grooming nee...	2	2	2

Notes: It is important to provide support during hair washing so that she gets hair thoroughly clean. She support to remind her to wash her hair every other day. It is important to her to smell nice and look good.

Section 2E, Item 1:	Taking medications	3	3	1

Notes: Daffney needs support to remember to take her medicaation

Section 2E, Item 3:	Avoiding health and safety hazards	3	3	2

Notes: Daffney is not always aware of the health related safety issues. She knows no strangers which poses a safety issue on her walks and in the community.

Section 2E, Item 6:	Maintaining nutritious diet	3	3	1

Notes: She needs support to select sugar free options for her diabetic diet. She loves sweets.

Section 2E, Item 8:	Maintaining emotional well-being	2	3	2

Notes: She benefits from support to control her temper when frustrated. She will follow the plan she helped develop with some support from others.

Section 1A, Item 18:	Diabetes	2

Notes: Daffney needs support to take her sugar in the am and in the p.m. daily. It takes 3 minutes to assist her.

Section 1B, Item 0:	Prevention of emotional outbursts	1

Notes: Daffney gets upset when others get into her work space. The job coach will intervene to stop escalation.

Section 1B, Item 3:	Prevention of stealing	1

Notes: She needs support when shopping as she will take things she wants, but does not have money to for at the time. This happens once a week on her shopping outings.

Section 1B, Item 10:	Prevention of substance abuse	1

Notes: Daffney talks about going out to a bar, but has a low tolerance for alcohol. She drinks some wine at her father's house every time she visits. She frequently says "I am having a rough day and I need a glass of wine." She is not allowed to buy wine and bring it home because of her diabetes.

Section 1B, Item 11:	Prevention of wandering	1

Notes: She likes to take walks, but will get distracted if not watched by staff and occasionally will wander off to look at something. This happens every couple of weeks. She walks 3-4 times per week in her neighborhood.

Supplemental Questions

1. **The Individual requires exceptionally high levels of staff support to address severe medical risks related to inhalation or oxygen therapy; postural drainage; chest PT, suctioning; oral stimulation and/or jaw positioning; tube feeding; parenteral feeding; skin care turning or positioning; skin care dressing of open wounds; protection from infectious diseases due to immune system impairment; seizure management; dialysis; ostomy care; medically-related lifting and/or transferring; therapy services, and/or other critical medical supports? To answer "yes" requires at least one 2 rating in Section 1A.**
   yes

   The Individual requires frequent hands-on staff involvement to address critical health and medical needs?
   yes

   The Individual's severe medical risk currently requires direct 24-hour professional (licensed nurse) supervision?
   no

   The Individual has medical care plans, in place, that are documented within the ISP process?
   yes

   How many days per week is the extensive support required?
   7

   Approximately how many hours per day?
   2

   Describe the imminent (i.e. within the next 30 to 60 days) consequences if no support is provided to address the Individual's severe medical risk.
   as above

   Specific SIS Section 1A items marked "2":
   18. Needs assistance managing diabetes, including monitoring blood sugar levels and administering insulin shots if needed

   Notes

2. **The Individual is currently a severe community safety risk to others related to actual or attempted assault and/or injury to others; property destruction due to fire setting and/or arson; and/or sexual aggression and has been convicted of a crime related to these risks? To answer "yes" requires at least one 2 rating in any of these Section 1B items: "Prevention of assaults or injuries to others", "Prevention of property destruction (e.g., fire setting, breaking furniture)", "Prevention of sexual aggression".**
   no

3. **The Indvidual is currently a severe community safety risk to others related to actual or attempted assault and/or injury to others; property destruction due to fire setting and/or arson; and/or sexual aggression and has not been convicted of a crime related to these risks? To answer "yes" requires at least one 2 rating in any of these Section 1B items: "Prevention of assaults or injuries to others", "Prevention of property destruction (e.g., fire setting, breaking furniture)", "Prevention of sexual aggression".**
   no

4. **The Individual displays self-directed destructiveness related to self-injury; pica; and/or suicide attempts which seriously threatens their own health and/or safety? To answer "yes" requires at least one 2 rating in any of these Section 1B items: "Prevention of self-injury", "Prevention of pica ingestion of inedible substances", "Prevention of suicide attempts".**
   no

5. **Individual displays a risk of falling, as demonstrated by an unsteady gait, active seizures, documented history of falling, or other issue that effects falling. Describe specifics and frequency of falls in the past 12 months.**
   yes

   Notes
   Daffney wobbles at times in her walker and when she gets tired will ask for her wheelchair. She has fallen 2X in the last 3 months. She has fallen at her fathers and has admitted that was after she had 2 glasses of wine,

Page Notes

How Information from My Support Profile Can Be Used in Supports Planning Approaches

Everyone benefits from supports that allow them to take part in everyday life activities and maintain a healthy lifestyle. The Supports Intensity Scale Adult Version (SIS-A) assesses a person's pattern and intensity of support needs across life activities and exceptional medical and behavioral support need areas. The attached 'My Support Profile' summarizes information from the SIS-A that can be used in planning for individuals based on their support needs and the individuals' life goals and personal interests.Thus, the SIS informs the planning process and should be completed prior to the annual planning meeting.

Planning for individuals requires the collective wisdom of a Support Team that is made up of the individual, his/her parents or family members, a case manager or supports coordinator, direct support staff who work with the individual, and one or more professionals depending on the support needs. The purpose of this attachment to the 'My Support Profile' is to provide answers to six questions asked frequently by the individual and his/her support team members as collectively they engage in the development, implementation, and monitoring of the individual's support planning.

1. How do we determine what is important to the individual and what is important for the individual?

Identifying support needs that are important to the individual is based on the individual's goals, desires, and preferences or what they may indicate or say in their own words. (or what he/she communicates to the Support Team - JTP)

Identifying support needs that are important for the individual is based on:

- higher support need scores from the 'My Support Profile' in the most relevant life activity areas
- needed supports to be healthy and safe
- interventions prescribed by a professional.

2. How do we focus on the whole person and the individual's quality of life?

The concept of quality of life reflects a holistic approach to an individual and includes areas that are valued by all persons.

Eight core quality of life areas reflect this holistic approach:

- Personal Development
- Self-determination
- Interpersonal Relations
- Social Inclusion
- Rights
- Emotional Well-being
- Physical Well-being
- Material Well-being

These eight quality of life areas can be used to develop an ISP.

3. What are the responsibilities of support team members?

Determine what is important to and for the individual

Identify specific support strategies to address the individual's personal goals and assessed support needs

Specify a specific support outcome for each support strategy and indicate who is responsible for implementing each support strategy. Develop specific instructions for the direct support staff.

Implement and monitor the Individual Supports Plan

4. What supports can we use to enhance the individual's well-being?

Natural support resources (e.g. family, friends, and community resources)

Technology-based (e.g. assistive technology, information technology, smart technology, and prosthetics)

Environment-based (e.g. environmental accommodation)

Staff directed (e.g. incentives, skills/knowledge, and positive behavior supports)

Professional services (e.g. medical, psychological, therapeutic services)

5. How does information obtained from the SIS-A relate to professional recommendations?

Professional recommendations such as those from a doctor focus on lessening the impact of the individual's disability-related condition.

SIS information focuses on the supports an individual needs in order to be more successful in everyday life activities and have a life like ours.

Both types of information need to be a part of planning supports for individuals.

6. How do we know if the supports provided have an effect on the individual?

Informally, people will see an increased involvement of the individual in everyday life activity areas and an improvement in exceptional medical and behavioral support need areas.

Formally, people will see enhanced personal quality of life-related outcomes on one or more quality of life areas.

Supports Intensity Scale (SIS®) Frequently Asked Questions

1. **What does the SIS® determine?**
   The SIS® is a validated assessment tool for people with intellectual and developmental disabilities, specifically designed to measure the pattern and intensity of supports needed by people with disabilities to be successful in areas of life, similar to their peers without disabilities in the community.

2. **I was recently called by Ascend about an interview. Who is Ascend?**
   Ascend is the agency with which the state has a contract to complete the SIS® assessments across the state. This was done to assure there is no conflict of interest between the interviewers and your Support Coordinator. Ascend interviewers are all endorsed by the American Association on Intellectual and Developmental Disabilities (AAIDD), the organization that developed the SIS®, for administering both the adult and children's SIS®.

3. **What do the scores and the percentages listed on the SIS® report mean?**
   Each section of the SIS® is scored to reflect a person's current support needs. The higher the scores on the chart, the higher the support needs. The same with the percentiles - the higher the percentile from 0% to 100%, the more support a person needs.

4. **I keep hearing about levels and tiers; what are these?**
   Funding for some DD waiver services is set based on how much support a person needs. This information is gathered through the SIS® and additional questions asked at the interview. Support needs are then categorized into seven support needs levels and funding tiers (with 1 being low support needs and higher numbers for significant support needs).

5. **When will I know my level and tier?**
   Your Support Coordinator should provide this information to you and your supporters once it is posted in the Waiver Management System (WaMS). Levels and tiers are updated in WaMS approximately every 2 weeks. If you have not been notified of the level and tier a month or more after the interview you are welcome to contact your support coordinator for this information.

6. **I just had my SIS® interview and received my interview report. What should I do with it?**
   Your report is designed to assist you and your supporters in the DD waiver service planning process. Please bring the report to your next planning meeting as your person-centered Individual Support Plan will include information gathered from the SIS® interview.

7. **The individual ratings on the SIS® do not agree with what I said in the interview.**
   SIS® interviewers are given extensive training on how to score the SIS®. The scores in the SIS® are based on the interviewer's assignment of the correct rating based on the information you, your family, and/or your paid service providers provided to the interviewer.

8. **Why wouldn't the interviewer include the historical information I shared about my son/daughter?**
   While information about a person's whole life is important, the intent of the SIS® is to capture information regarding the current support needs of your son/daughter over the past 6 months. The SIS® is a snapshot in time. Feel free to bring historical information to the person-centered Individual Support Plan (ISP) meeting.

9. **My son/daughter has made a lot of progress with the help of his/her current DD waiver provider. I am concerned that this support won't be counted during his/her next SIS® interview.**
   All supports currently provided are considered during the SIS® assessment. The SIS® interviewer will ask questions about activities and tasks your son or daughter can complete on his/her own and with help.

10. **The interviewer would not count the supports we reported for each item on the SIS®. She said the support had already been counted by another item. This is not fair and does not reflect his/her complete support needs.**
    Generally, the same activity is not rated in more than one item. The SIS® is designed to be conducted by interviewers endorsed by AAIDD. SIS® endorsed interviewers follow required steps for assigning ratings that may not always be apparent to respondents.

11. **Is the SIS® optional?**
    No. The SIS® is required for anyone who receives DD waiver services. Adult SIS® assessments are required every 3 years. The Children's SIS® is required every 2 years.

12. **If I speak for myself do I need respondents during my SIS® interview?**
    Your participation is valued and critical in creating an accurate picture of your support needs. The observations of those who provide you with supports, such as family members or paid service providers, are equally important to create a whole picture of the type, duration, and frequency of your support needs.

Support Levels & Tiers: Adults

There are seven supports needs levels for adults determined by Supports Intensity Scale and Supplemental Questions and four reimbursement tiers. A number of services (group home, sponsored residential, supported living, independent living supports, group day, community engagement, and group supported employment) will be reimbursed according to these tiers. This process provides greater reimbursement for smaller settings and for supporting individuals with more intensive needs.

Reimbursement Tier 1		**Mild Support Needs** Individuals have some need for support, including little to no support need for medical and behavioral challenges. They can manage many aspects of their lives independently or with little assistance.
Reimbursement Tier 2		**Moderate Support Needs** Individuals have modest or moderate support needs, but little to no need for medical and behavioral supports. They need more support than those in Level 1, but may have minimal needs in some life areas.
Reimbursement Tier 3		**Mild/Moderate Support Needs with Some Behavioral Support Needs** Individuals have little to moderate support needs as in Levels 1 and 2. They also have an increased, but not significant, support needed due to behavioral challenges.
		**Moderate to High Support Needs** Individuals have moderate to high need for support. They may have behavioral support needs that are not significant but range from none to above average.
Reimbursement Tier 4		**Maximum Support Needs** Individuals have high to maximum personal care and/or medical support needs. They may have behavioral support needs that are not significant but range from none to above average.
		**Intensive Medical Support Needs** Individuals have intensive need for medical support but also may have similar support needs to individuals in Level 5. They may have some need for support due to behavior that is not significant.
		**Intensive Behavioral Support Needs** Individuals have intensive behavioral challenges, regardless of their support needs to complete daily activities or for medical conditions. These adults typically need significantly enhanced supports due to behavior.

Division of Developmental Services | Virginia SIS® Initial Request Form
DO NOT USE FOR ROUTINE SIS®

1. **Date request submitted:** Click to enter date

2. **Reason for assessment request** (select one main category only):
   - ☐ New to Waiver
   - ☐ Training Center Post Discharge— 3–6 month review (Optional and only if needed)

3. **Type of assessment being requested** (select one):
   - ☐ Child (ages 5–15)
   - ☐ Adult (ages 16 and over)

4. **What is the likely location of the interview?**

Location Name:		**Agency:**
Address*:*		**Phone #***:*
City:	**State:**	**Zip***:*
County Name:		
Location Type:		

5. **Will the individual require an interpreter for the SIS® Interviewer?** Choose an item

   Interpreter Language:

6. **Will the individual require other accommodations to participate in the SIS® interview?** Choose an item

   Other accommodations descriptions:

7. **Was this request reviewed by your CSB SIS® Administrator** (select one)? ☐ Yes ☐ No

8. **Individual's Information:**

Name:	**Address:**	**Date of Birth:**
CSB Tracking: #	**SSN:**	**Medicaid: #**
ISP Dates: **to**	**Date of Last SIS® (if completed by TC):**	**SIS® ID Number (if completed by TC):**

9. **Support Coordinator/Case Manager Information (ONLY ENTER INFO HERE):**

Name:	**Agency:**
Phone: #	**Phone: #**
Email Address:	
Has SC/CM known Individual for 3 months? Choose an item	

Division of Developmental Services | Virginia SIS® Initial Request Form
DO NOT USE FOR ROUTINE SIS®

10. Enter a new Respondent: If Individual has a Guardian they must be entered as a Respondent.

Respondent:	**Respondent Type:** Choose an item	**Type of Service:** Choose an item
Relationship: Guardian	**How long has Respondent known Individual?** Choose an item	**Direct Contact Hours over past 3 months:** Choose an item
Phone: #	**Email:**	**Does the Respondent Reside with the Individual:** ☐ **Yes** ☐ **No**
Address (number street, city, state, zip):		
Respondent:	**Respondent Type:** Choose an item	**Type of Service:** Choose an item
Relationship: Choose an item	**How long has Respondent known Individual?** Choose an item	**Direct Contact Hours over past 3 months:** Choose an item
Phone: #	**Email:**	**Does the Respondent Reside with the Individual:** ☐ **Yes** ☐ **No**
Address (number street, city, state, zip):		
Respondent:	**Respondent Type:** Choose an item	**Type of Service:** Choose an item
Relationship: Choose an item	**How long has Respondent known Individual?** Choose an item	**Direct Contact Hours over past 3 months:** Choose an item
Phone: #	**Email:**	**Does the Respondent Reside with the Individual:** ☐ **Yes** ☐ **No**
Address (number street, city, state, zip):		
Respondent:	**Respondent Type:** Choose an item	**Type of Service:** Choose an item
Relationship: Choose an item	**How long has Respondent known Individual:** Choose an item	**Direct Contact Hours over past 3 months:** Choose an item
Phone #*:*	**Email:**	**Does the Respondent Reside with the Individual:** ☐ **Yes** ☐ **No**
Address (number street, city, state, zip):		
General Notes:		

—SECTION BELOW FOR DDS USE ONLY—

1. **Date Request Received:** Click to enter date
2. **SIS® to be Completed By:** Click here to enter a date
3. **Date of DDS Review:** Click to enter date
4. **Outcome:** ☐ Approved ☐ Denied
5. **Notes:** Click here to enter text
6. **DDS Reviewer Name/Title:**

—SECTION BELOW FOR ASCEND USE ONLY—

1. **Date Request Received:** Click to enter date **Time Request Received:** Click to enter text

Virginia Department of Behavioral Health & Developmental Services

Division of Developmental Services

Virginia SIS® Instructions: Initial Request

This form is used to request that an individual new to DD Waiver services be assessed with the Supports Intensity Scale (SIS®). The form is completed by the assigned Community Services Board (CSB) and submitted to the Regional Support Specialist.

1. The Support Coordinator/Case Manager fills in the form and submits it to the SIS® Point Person at the CSB to ensure the information is accurate.

2. The Point Person (or designee) submits the form (via secure email) to the Regional Support Specialist.

3. The Regional Support Specialist reviews the submission and verifies the information submitted in WaMS.

4. The Regional Support Specialist submits the form (via secure email) to Ascend for processing.

5. Ascend processes the form and adds the individual's name to the Ascend Portal.

6. The Support Coordinator/Case Manager enters respondent information in to the Ascend Portal and submits for scheduling.

7. Ascend begins the process of contacting identified respondents and scheduling of the assessment.

Virginia Department of Behavioral Health & Developmental Services

Division of Developmental Services

Virginia SIS® Instructions: Reassessment Request

This form is used to request a reassessment of the Supports Intensity Scale® for an individual currently enrolled in DD Waiver services. The form is completed by the assigned Community Services Board (CSB) and submitted to the Regional Support Specialist.

1. The Support Coordinator/Case Manager completes the form and selects the appropriate category for reassessment.

    a. The SC/CM provides a brief description of reason for reassessment.
    b. The SC/CM reviews the required documentation for reassessment and submits it along with the Reassessment Request Form. (*Required documentation for each category may be found on the Reassessment Request Form dated 03/02/2017).
    c. The SIS® Point Person at the CSB reviews entire submission to ensure accuracy.

2. The Point Person (or designee) submits the form and required documentation (via secure email) to the Regional Support Specialist.

3. The Regional Support Specialist reviews the full submission to ensure all required documentation is included. If the required documentation is not included in the submission, the request is rejected and the form is return to the CSB for follow up.

4. The Regional Support Specialist submits complete requests to the State SIS® Coordinator for comprehensive review.

5. Following a comprehensive review of submitted documentation, the request is either:

    a. Approved: The Regional Support Specialist notifies the requesting CSB of the outcome. The Regional Support Specialist submits the approved request to Ascend (via secure email). Ascend adds the individual's name to the Portal.
    b. Denied: The Regional Support Specialist notifies the requesting CSB of the outcome.

6. For approved requests, the Support Coordinator/Case Manager enters respondent information in to the Ascend Portal and submits for scheduling.

7. Ascend begins the process of contacting identified respondents and scheduling of the reassessment.

Division of Developmental Services

Virginia Supports Intensity Scale® Administration

Quick Reference: Virginia SIS® Process Flow and Timeframes for Providers

Steps	Timing & Communication
1. Ascend uploads names of persons targeted for upcoming SIS® assessments to the online portal at the Ascend website.	It is anticipated first cycle SIS® interviews will be completed early in FY 2018.
2. CSB/ Private SC Agency Point Person: A. Logs into the portal and confirms the individual's CSB unique identifier, correct SSN and Medicaid number, ISP date B. Assigns each individual to the appropriate Support Coordinator (SC).	The Point Person will log in at least weekly and assign any unassigned individuals to the SC. Method: web-based data entry.
3. SC : A. Logs into the portal and, for each person assigned to his/her caseload, identifies **all required items** which include: 1. likely location for the interview 2. need for interpretation services and/or other accommodations 3. the name, address, and contact information for the individual and the **guardian**, if there is one. 4. a minimum of two primary respondents for SIS ®® interview and contact information for each. a. If the individual receives residentially-oriented or day services, the SC must identify a respondent/participant from each of these services. b. If the individual does not receive residentially-oriented or day services, respondents/participants will be identified for each service providing more than 5 hours of support to the person weekly. B. When contacted by Ascend, the SC will report any changes in the respondent pool and confirm the SSN, Medicaid number, and the ISP date. C. At the interview, the SC will: 1. Confirm the information above is correctly reflected on the SIS® form. 2. Confirm the username to which the SIS® report should be assigned (without assignment to a SIS® username, the SIS® report will be unavailable for viewing by the CSB/Private SC Agency).	The SC should log in and check his/her portal queue a minimum of once weekly, to enter respondent information, requesting revisions to his/her caseload as needed. Method: web-based data entry.
4. Ascend scheduler: A. Contacts the SC for at least 3 available dates and times to conduct the SIS®® interview. B. Contacts potential primary respondents to identify an interview date	Ascend finalizes scheduling at least two weeks before the interview date. Primarily accomplished

Steps	Timing & Communication
and time. C. Confirms that at least two primary respondents and the individual are committed to attending the interview. D. Must invite the guardian. If not able to reach the guardian by phone, an email invitation must be sent. If no email address is available, written notice of the interview time and date must be sent via USPS. E. After the interview time, date, and location are determined and all respondents are notified: 1. Ascend arranges interpretation services as requested by the SC 2. Ascend issues reminders to required respondents 5-7 business days prior to the interview.	through phone contacts and by email as addresses are available. Reminders will be sent by email when an email address is available. A written invitation to the interview is issued to the guardian, if there is one, via USPS when no email address is available.
5. Ascend conducts scheduled interviews. A. DDS requires 48 hours' notice to Ascend for cancellation of confirmed participation in a scheduled SIS® assessment, except in the event of unsafe travel conditions or illness of the individual or unpaid caregiver. B. DDS has determined that scheduled SIS® interviews will proceed as long as two primary respondents are available. Active participation by the individual is strongly encouraged. The individual must meet with the interviewer. The individual may choose his or her level of participation in the interview. C. Respondents are asked to sign the *Virginia Standard Operating Procedures Checklist for the SIS® Interview.*	Ideally 180 to 54 days before the ISP end date.
After the interview, Ascend: A. Interviewer finalizes scoring and comments. B. Ascend Quality Reviewers finalize SIS® in SIS® Online, assigning the SIS® Report to the username provided.	Within 7 business days of SIS®
SC: A. Accesses the completed SIS® in SIS Online, 1. Distributes a copy of the Family Version SIS® Report to family members, guardians, and providers that support the individual. 2. Saves a copy of the Family Version SIS® Report to the individual record. 3. Downloads the signed *Respondent Information Form/SIS® Checklist***.** Ensures a copy is saved as part of the individual's electronic service record.	Between 8 and 15 business days after the date of the SIS® interview

CSB/Private SC Agency Responsibilities

1. Each CSB/Private SC agency will appoint a primary SIS® Point Person and a back-up. The DDS Regional Supports Specialist and Ascend should be informed of changes in point person assignments.

2. SCs and SIS® Point Persons should respond to requests for information from Ascend in a timely manner.

SC Responsibilities

1. Ideally, the SIS® interview is completed prior to the ISP meeting, based on the ISP date entered by the SC in WaMS. If an ISP date is not available, scheduling will be based on the SIS® due date.

2. When an individual is newly assigned to a waiver, search the Ascend portal for the individual. If the individual's name is listed in the portal, promptly complete the required information and click "Send to scheduling." If the individual is **not** listed in the portal, submit a SIS® Initial Request form to the appropriate DDS Regional Supports Specialist via secure email.

3. Submit SIS® Reassessment Requests with required justification to the appropriate DDS Regional Supports Specialist via secure email.

4. Educates the individual and family about the SIS® assessment and its role in supports planning.

5. At the SIS® interview, the SC should be prepared to facilitate introductions.

6. Ensure completion of required information in the portal in a timely manner.

Ascend Responsibilities

1. Maintain master list of persons to be assessed and set assessment rotation.

2. Set rotation such that assessments typically occur between 90 days and 45 days prior to ISP end date as recorded in WaMS. Initial year assessments occur according to multiple criteria set forth by DDS.

3. Most interviews will be scheduled during typical work hours, though evenings and Saturday times can be scheduled to accommodate individuals' needs.

4. Interviewers will be identified by Ascend badges.

Virginia Department Of Developmental Services	
Contact Info	**Contact About**
www.dbhds.virginia.gov	General project information posted
Joan Bender, DDS Regional Supports Supervisor 804-774-4469, joan.bender@dbhds.virginia.gov	Questions concerning DDS SIS® procedures or requirements
DDS Regional Supports Specialists **Central Region:** Maureen Kennedy, 804-774-2276 maureen.kennedy@dbhds.virginia.gov **Northern Region:** Melissa Sullivan, 804-221-2454 melissa.sullivan@dbhds.virginia.gov **Northern Region:** Stephanie Mote, 804-205-6767 stephanie.mote@dbhds.virginia.gov **Southeastern Region:** Brandy Martin, 804-221-2749 brandy.martin@dbhds.virginia.gov **Southwestern Region:** Jason Perkins, 804-221-2454 jason.perkins@dbhds.virginia.gov **Western Region:** Ken Haines, 804-337-5709 kenneth.haines@dbhds.virginia.gov	• Requests for SIS® assessment or re-assessment • Requests for removal of individuals from Ascend portal and SIS Online • Troubleshooting SIS® issues • Requests for provider and SC Respondent Training. • Requests for SIS® Admin or Super-user training
Cheri Stierer, Waiver Data and Assessment Manager , cheri.stierer@dbhds.virginia.gov, 804-786-0803	Questions concerning the SIS® and DDS SIS® policies
DBHDS-SIS® Standard Operating Procedures and Review Process (with forms) is available through your Regional Support Specialist.	Review Process of the SIS®

Ascend Management Innovations	
Contact Info	**Contact About**
Ascend Main SIS® Scheduling Phone Number: 877-431-1388 x 3465	Confirm scheduling
Ascend Scheduling Manager Phone Number: 877.431.1388 x 3236	After contacting the Regional Supports Specialist for their area, changes in CSB assignments or contact numbers
Ascend Manager of Interviewers Ascend Quality Division Phone Number: 877.431.1388 x 3447	Feedback, Commentary, Quality Concerns
vasis@ascendami.com	General inquiries about Ascend and the SIS® program in Virginia; issues or concerns
www.ascendami.com	General information about Ascend; SIS® resources

- The *Virginia Informed Choice (VIC) is required* for individuals who are newly enrolled or currently have a DD Waiver
- Retain a copy of the signed document in the individual's file
- Review and complete the VIC with the individual and/or substitute decision-maker (SDM) at the following times:
  - ***Annually***
  - *At Enrollment into the Developmental Disability (DD) Waivers:*
    - *Building Independence (BI)*
    - *Family and Individual Supports (FIS)*
    - *Community Living (CL)*
  - *When there is a request for a change in waiver provider(s)*
  - *When new services are requested*
  - *When the individual wants to move to a new location and/or is dissatisfied with the current provider*
  - *When making a Regional Support Team (RST) referral for individuals with a DD Waiver*
    - *Submit the VIC with the RST Referral to the secure RST mailbox: RST.Referrals@DBHDS.virginia.gov*

Date Completed: _____ Individual's Name: _____

DD Waiver Type: _____ Substitute Decision Maker: _____

1. *Discuss each applicable HCBS service **prior to** assisting the individual with identifying Waiver service options*
2. *Confirm discussion of all applicable waiver service options by checking the options listed below*

Residential Options N/A ☐	***Employment and Day Options*** N/A ☐	***Additional Options*** N/A ☐	
☐ Independent Living Supports *(BI Waiver Only)*	☐ Individual Supported Employment	☐ Peer Mentoring	☐ Community Guide
☐ Shared Living	☐ Group Supported Employment	☐ Assistive Technology	☐ Benefits Planning
☐ Supported Living	☐ Workplace Assistance Services	☐ Transition Services	☐ Support Coordination
☐ In-home Support Services	☐ Community Engagement	☐ Environmental Modifications	
☐ Sponsored Residential		☐ Electronic Home-Based Services	
☐ Group Home Residential 4 beds or less	☐ Community Coaching	☐ Employment and Community Transportation	
☐ Group Home Residential 5 beds or more (RST req'd)	☐ Group Day Services	☐ Individual and Family/Caregiver Training *(FIS Waiver Only)*	
Medical and Behavioral Support Options N/A ☐	***Crisis Support Options*** N/A ☐	***Agency-Directed*** ☐ ***Consumer-Directed*** ☐ N/A ☐	
☐ Skilled Nursing *(FIS & CL Waivers Only)*	☐ Community-Based Crisis Supports	☐ Consumer-Directed Services Facilitation *(FIS & CL Only)*	
☐ Private Duty Nursing *(FIS & CL Waivers Only)*	☐ Center-Based Crisis Supports	☐ Personal Assistance Services *(FIS & CL Waivers Only)*	
☐ Therapeutic Consultation *(FIS & CL Waivers Only)*	☐ Crisis Support Services	☐ Respite *(FIS & CL Waivers Only)*	
☐ Personal Emergency Response System (PERS)		☐ Companion *(FIS & CL Waivers Only)*	
SC has provided the opportunity to talk with other individuals receiving BI/FIS/CL Waiver services who live and work successfully in the community or with their family members Yes ☐ No ☐	*You may contact a DBHDS Family Resource Consultant at (804) 894-0928 or (804) 201-3833 to connect with individuals and families who have waiver services*	*Provider options are available on the DBHDS Licensing website and the DBHDS Provider Survey* http://lpss.dbhds.virginia.gov/LPSS/LPSS.aspx http://ejiujiu0.wixsite.com/providersurvey	

3. List multiple providers in each section if applicable and indicate option selected
   In making a decision, I/we considered the following Options:

Options	Provider Agency, Location (City) and Bed Capacity	Option Selected	Reason(s) Selected/Denied (Be specific)
Support Coordination			

3. List multiple providers in each section if applicable and indicate option selected
   In making a decision, I/we considered the following Options:

Options	Provider Agency, Location (City) and Bed Capacity	Option Selected	Reason(s) Selected/Denied (Be specific)

I may contact my Support Coordinator/Case Manager (SC/CM) to seek assistance with resolving provider-related issues. I have the option of changing providers, including my SC/CM. I have the right to a fair hearing and appeal process. I may be responsible for some service cost (patient pay), based on my income. If I chose Consumer-Directed Services, I am responsible for employing my own personal assistants and know there are services in the BI/FIS/CL Waivers that require a backup plan if there is a lapse in services. I will actively participate in the development of my Person-Centered Individual Support Plan.

My SC/CM discussed the above information with me.

_____ _____ _____

Individual Signature/Date SDM Signature (if applicable)/Date SC/CM Signature/Date

Regional Support Team referral is REQUIRED if any of the following criteria apply:

Community:

☐ Difficulty finding services in the community within 3 months of receiving a slot
☐ Moving to a group home of five or more individuals
☐ Moving to a nursing home or ICF
☐ Pattern of repeatedly being removed from home

Training Center:

☐ Moving to a nursing home, ICF/ID or group home with five or more individuals
☐ Difficulty finding particular type of community supports within 30 days of discharge plan
☐ PST cannot agree on a discharge plan outcome within 15 days of the annual PST meeting, or within 30 days after the admission to the Training Center
☐ Individual or AR opposes moving despite PST recommendation
☐ Individual or AR refuses to participate in the discharge planning process
☐ Hasn't moved within three months of selecting a provider
☐ Recommendation to remain in a Training Center

DMAS 225

Support Coordination Responsibilities

Notify the LDSS worker using the DMAS 225 of the following:

- A new address
- A different provider of case management services (in the event of a transfer to another CSB)
- An increase or decrease in monthly income (wages or other benefits)
- Change in collector of patient pay
- Discharge form all DD Waiver services
- An interruption in all DD Waiver services for more than 30 days
- Death of a person

For anyone currently using a DD Waiver, the Support Coordinator is responsible for regular communication with the LDSS worker to ensure patient pay determination.

- Complete a DMAS 225 at least annually and when there are changes in income
- Send DMAS 225 to LDSS worker
- If a patient pay obligation has been determined:
    - Identify the provider with the highest potential billing amount and inform that provider, in writing, that they are responsible for collecting the monthly patient pay amount
- Scan an electronic copy of the DMAS 225 into the electronic medical record

Medicaid LTC Communication Form	**Individual Name:** **Medicaid ID#:** **SSN:**

Provider Name: **Address:**

Provider NPI#: **Provider Rep.:** **Title:**

Telephone: **Fax:** **Date: / /**

Patient Information: DMAS-96 ☐ attached ☐ unavailable

☐ Individual admitted to this facility/service on / / (date), from ☐Home ☐Hospital ☐ Other Facility

☐ Patient Pay determination requested ☐ Patient Funds Account balance $ as of / / (date).

☐ Individual discharged / / (date), to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Deceased

☐ Change in income, deductions, health insurance or other: RUGS Score _____ (*NF individuals only*)

*Individual Residential Address:

Medicaid Per Diem Rate: $ ***Enrollee FIPS: (*Waiver Individuals Only*)

CBC Provider Hourly Rate: $ Hours received in the month of Discharge:

If discharging from services, please include all Service Authorization #(s):

LDSS: **FIPS Code:** **Eligibility Worker:**

Telephone: **Fax :** **Date: / /**

Eligibility Information:

☐ Eligible, full Medicaid services beginning / / (date) ☐ Eligible, QMB Medicaid only

☐ Eligible Medicare premium payment only

☐ Ineligible for Medicaid ☐ Ineligible for Medicaid payment of LTC services from / / to / /

☐ Medicare Part A insurance Other health insurance: LTC insurance:

☐ Change in deductions, health insurance or other:

Medicaid LTC Communication Form **DMAS-225**

PURPOSE OF FORM--To allow the local Department of Social Services (LDSS) and nursing facility (NF) or Community Based Care (CBC) Waiver Providers to exchange information regarding:

- The Medicaid eligibility status of an individual;
- A change in the individual's level of care;
- Admission or discharge of an individual to an institution or Medicaid CBC services, or death of an individual;
- Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM--Initiated by either the LDSS or the provider of care. A new form must be prepared by the LDSS whenever there is any change in the individual's circumstances that results in a change in eligibility status or information needs to be given to the provider. The provider must use the form to document admission date, request Medicaid eligibility status, and notify the LDSS of changes in the individual's circumstances, discharge or death.

NUMBER OF COPIES--Original and one copy for NF individuals; original and two copies for waiver individuals.

DISTRIBUTION OF COPIES--For NF individuals, send the original to the nursing facility. For PACE individuals send the original to the PACE provider. For Medicaid CBC, send the original to the following individuals:

- Case Manager at DMAS for Tech Waiver, DMAS, Division of LTC, Waiver Unit, 600 E. Broad St., Richmond, VA 23219
- Case Manager at the Community Service Board for the ID and DS waivers
- Case Manager (Support Coordinator) at DBHDS for DD Waiver
- Service Facilitator for EDCD with consumer-directed service,
- Case Manager for any individual w/case management services which includes those receiving services through CCC or other managed Medicaid plans, and
- Personal Care Provider for EDCD-personal care services and other services.

Place a copy of this form in the eligibility case file.

INSTRUCTIONS FOR PREPARATION OF THE FORM--Complete either the Provider or LDSS section as appropriate. At the top of the form, enter the Individual's name, Social Security number and Medicaid identification number, if known.

Provider Section-Complete all data elements in the gray section. Check the appropriate boxes and complete all data elements as appropriate in the white section to the individual's circumstances. Providers should attach a copy of the DMAS-96 to this form when the individual is first admitted to care.
Waiver providers must advise the LDSS of the individual residential address when different from the address from which this form originates and provide the individual FIPS code.

Providers should ensure that the individual understands that they may have a patient pay, which is the amount of their income that must be paid to the provider every month for the cost of long-term care services they receive. The long-term care provider who is responsible for collection of any portion of the patient pay will directly bill the individual or your representative. A portion of patient pay may be paid to more than one provider when services are received from multiple providers.

LDSS Section-Complete all data elements of the gray section. Check the appropriate boxes and complete all data elements in the white section as appropriate to the individual's circumstances. Do not provide the source of an individual's income. If the individual is ineligible for Medicaid payment of long-term care due to imposition of a penalty period, send a copy of this memo to the DMAS, Long-Term Care Division, 600 E. Broad St., Suite 1300, Richmond, Va. 23219

Support Coordination Manual
Developmental Disabilities
Chapter 6
Developmental Disability Waivers & Services

- Introduction
    - Brief History of DD Waivers
    - Description of DD Waivers
- Services in Waivers
    - Assistive Technology
    - Benefits Planning Services
    - Center-based Crisis Supports
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    - Community Engagement
    - Community Guide
    - Companion
    - Consumer Directed Services Facilitation CDSF
    - Crisis Support Services
    - Electronic Home-Based Services
    - Employment and Community Transportation
    - Environmental Modifications
    - Family/Caregiver Training
    - Group Home Residential
    - Group Day Services
    - Independent Living Support

    - In-home Support Services
    - Personal Assistance
    - Personal Emergency Response System (PERS)
    - Private Duty Nursing
    - Respite
    - Shared Living
    - Skilled Nursing
    - Sponsored Residential
    - Supported Employment
    - Supported Living
    - Therapeutic Consultation
    - Transition Services
    - Workplace Assistance
- Patient Pay
- Commonwealth Coordinated Care Plus (CCC+) Waiver
    - How to access
    - Coordination/Collaboration with Managed Care Organization Care Coordinators
        - Health Risk Assessment
        - Care Coordinator's Individual Care Plan
        - Assisting with referrals to CCC+ Waiver
- Addiction and Recovery Treatment Services
- At-a-Glance
    - Waiver Services
    - Building Independence Waiver

- Family & Individual Supports Waiver
- Community Living Waiver

Support Coordination Manual
Developmental Disabilities
Chapter 6
Developmental Disability Waivers & Services

Introduction

Virginia's Medicaid Waivers combine federal and state money to provide long-term community based supports for people who are elderly or have disabilities. Waivers allow Virginia to offer a variety of standard medical and non-medical services without the requirement that someone live in an institution in order to use those same services. These Waivers, which are referred to as Home and Community Based Services (HCBS), can cover supports a person needs to live independently in their home and in the community. Medicaid Waivers expand Medicaid eligibility to those who may not otherwise qualify for services based on Medicaid financial requirements. Medicaid Waivers provide an opportunity for people to transition from institutions and large settings to community based settings. As a result, Waivers allow people to be active in and live in their own community, connect with people without disabilities, and have greater independence and flexibility in their lives.

The state agency that administers the Developmental Disabilities (DD) Waivers in Virginia is the Department of Medical Assistance Services (DMAS). Day-to-day DD Waiver operations are managed by the Department of Behavioral Health and Developmental Services (DBHDS). Locally, DD Waiver services are coordinated by Community Services Boards and a Behavioral Health Authority. Support Coordination services are delivered by Support Coordinators (SC) employed by CSBs and private providers under contract with the CSBs and BHA across the state.

The proportion of cost the state must pay for Medicaid Waivers services varies from state to state based on the per capita income and other factors related to revenue capacity. In Virginia, the Commonwealth pays 50% and the federal government pays 50% of the cost of each waiver slot.

Brief History of Developmental Disability Waivers

HCBS Waivers were established by the U.S. Congress in 1981 to slow the growth of Medicaid spending for nursing facility care and to address criticism of Medicaid's institutional bias. Congress was responding to the growth in institutional costs and to people with disabilities who preferred to live in their own homes with services such as personal care and community living supports. States were given the option to develop waiver programs as alternative services for people who are eligible for placement in an institution.

Virginia first applied for a waiver for those with an intellectual disability in 1990, with the federal Medicaid agency, known as the Center for Medicare and Medicaid Services (CMS). In

early 1991, Virginia's waiver application was accepted by CMS and Virginia was able to begin offering services through what was then called the Mental Retardation Waiver. This waiver, which was renamed the Intellectual Disability (ID) Waiver, was amended several times over the next 20 years increasing the scope of community support services.

In 2000, the Individual and Family Developmental Disabilities Support Waiver was established to serve people with developmental disabilities not meeting the diagnostic criteria for the Intellectual Disability (ID) Waiver. In 2005, Virginia began the Day Support Waiver, which focused on day support and employment activities, allowing for additional people to be supported while waiting to use more comprehensive services offered through the ID Waiver.

Description of Developmental Disability Waivers

The DD Waiver program provides supports and service options for successful living, learning, physical and behavioral health, employment, recreation, and community inclusion.

The DD Waiver program is designed to serve individuals of any age with a developmental disability and children (birth through age 9) with a substantial developmental delay or specific congenital or acquired condition. There are three DD waivers, the Building Independence Waiver, the Family and Individual Supports Waiver and The Community Living Waiver.

- **The Building Independence Waiver** (BI) is for adults (18+) who are able to live independently in the community. Individuals own, lease, or control their own living arrangements and supports are complemented by non-waiver-funded rent subsidies. BI Services at a glance (link)
- **The Family and Individual Supports Waiver** (FIS) is for individuals living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs. This is available to both children and adults. FIS Services at a glance (link)
- **The Community Living Waiver** (CL) includes residential supports and a full array of medical, behavioral, and non-medical supports. This is available to adults and children and may include 24/7 supports for individuals with complex medical and/or behavioral support needs through licensed services. CL Services at a glance (link)

Services in Waivers

The Department of Medical Assistance Services (DMAS) is working on the revision of the Individual and Family Developmental Disabilities Support Waiver Services Provider Manual which includes service descriptions, criteria, service units & limitations, provider requirements and documentation requirements for each service provided under the Waivers.

Until then, each service is listed below in alphabetical order and provides the most current information available about each service. As new information is obtained about each service, the manual will be updated. A listing of each service and the waiver(s) that provide it may be found at Waiver services at a glance. (link)

Assistive Technology

Service Description Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living (ADLs), or to perceive, control, or communicate with the environment in which they live, or which are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.

In order to qualify for these services, the individual shall have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. AT shall be covered in the least expensive, most cost-effective manner. Equipment or supplies already covered by the State Plan may not be purchased under the waiver. The Support Coordinator is required to ascertain whether an item is covered through the State Plan before requesting it through the waiver.

Service Units and Service Limitations Maximum $5000 per the calendar year

Benefits Planning Services

Service Description Benefits planning is an individualized analysis and consultation service provided to assist individuals receiving waiver services and social security benefits (SSI, SSDI, SSI/SSDI) to understand their benefits and explore the possibility of work, to start work, and the effect of work on local, state, and federal benefits. For more information about this service go to the link provided.

http://www.vaaccses.org/vendorimages/vaaccses/MEDICAID_MEMO_DD_WAIVER_NewServices_090418.pdf

Center-Based Crisis Supports

Service Description Center-based crisis supports provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through utilization of assessments, close monitoring, and a therapeutic milieu. Services are provided through planned and emergency admissions. Planned admissions will be provided to individuals who are receiving ongoing crisis services and need temporary, therapeutic interventions outside of their home setting in order to maintain stability. Crisis stabilization admissions will be provided to individuals who are experiencing an identified behavioral health need and/or a behavioral challenge that is preventing them from experiencing stability within their home setting.

Allowable activities include but are not limited to:

1. Psychiatric, neuropsychiatry, and psychological assessment, and other assessments and stabilization techniques;

2. Medication management and monitoring;

3. Behavior assessment and positive behavior support;

4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual;

5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community

6. Assisting with skill building in the Crisis Therapeutic Home as related to the behavior creating the crisis in areas such as self-care/ADLs, independent living skills, self-esteem building activities, appropriate self-expression, coping skills, and medication compliance

7. Supervision of the individual in crisis to ensure his or her safety and that of others in the environment.

Service Units and Service Limitations 1 day unit up to 6 months in 30 day increments

Community-Based Crisis Supports

Service Description Community-based crisis supports are ongoing supports to individuals who may have a history of multiple psychiatric hospitalizations; frequent medication changes; enhanced staffing required due to mental health or behavioral concerns; and/or frequent setting changes. Supports are provided in the individual's home and community setting. Crisis staff work directly with and assist the individual and their current support provider or family. Techniques and strategies are provided via coaching, teaching, modeling, role-playing, problem solving, or direct assistance. These services provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement.

Allowable activities include but are not limited to:

1. Psychiatric, neuropsychiatry, and psychological assessment, and other assessments and stabilization techniques;
2. Medication management and monitoring;
3. Behavior assessment and positive behavior support;
4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual;
5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community;

6. Assisting with skill building as related to the behavior creating the crisis in areas such as self-care/ADLs, independent living skills, self-esteem building activities, appropriate self-expression, coping skills, and medication compliance.

Service Units and Service Limitations 1 day unit up to 6 months in monthly increments

Community Coaching

Service Description Community coaching is a service designed to assist people in acquiring a specific skill or set of skills to address a particular barrier(s) preventing a person from participating in activities of Community Engagement.

Allowable activities include but not limited to: (determined with age sensitivity in mind and reflective of the person's interests):
Skill building through participation in community activities and opportunities such as outlined in Community Engagement and encompassing:

- Activities and events in the community, volunteering, etc
- Community, educational or cultural activities and events
- Skill-building and support in building positive relationships
- Routine needs while in the community
- Supports with self-management, eating, and personal needs of the individual while in the community
- Assuring safety

Community coaching requires 1:1 support and must take place solely in community settings.

Service Units and Service Limitations 1 hour unit, up to 66 hours/week alone or in combination with other day options

Community Engagement

Service Description Community engagement supports and fosters the ability of a person to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities.

Community engagement provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning

environment. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). The activities enhance involvement with the community and facilitate the development of natural supports.

Allowable Activities:
Skill building, education, support and monitoring that assists with the acquisition and retention of skills in the following areas:

- Activities and public events in the community
- Community educational activities and events
- Interests and activities that encourage meaningful use of leisure time (e.g., through participating in sports/exercise, a club or other social group, a class to learn a new hobby)
- Unpaid work experiences (i.e., volunteer opportunities)
- Maintaining contact with family and friends
- Skill building and education in self-direction designed to enable achievement in one or more of the following outcomes particularly through community collaborations and social connections developed by the program (e.g., partnerships with community entities such as senior centers, arts councils, etc.)

Community engagement must be provided in the least restrictive and most integrated settings according to the individual's person-centered plan and individual choice.

Service Units and Service Limitations 1 hour unit, up to 66 hours alone or in combination with other day options; no more than a ratio of 1:3 and must take place solely in the community

Community Guide

Service Description Community guide services include direct assistance to promote individuals' self-determination through brokering community resources that lead to connection to and independent participation in integrated, independent housing or community activities so as to avoid isolation.

To read about details of the service description and requirements for Community Guide Services, go to the Medicaid memo dated September 4, 2018 found at
http://www.vaaccses.org/vendorimages/vaaccses/MEDICAID_MEMO_DD_WAIVER_NewServices_090418.pdf

Companion Services

Service Description Companion services provide nonmedical care, socialization, or support to adults, ages 18 and older. This service is provided in an individual's home or at various locations in the community.

Allowable activities include, but are not limited to:

1. Assistance or support with tasks such as meal preparation, laundry, and shopping;
2. Assistance with light housekeeping tasks;
3. Assistance with self-administration of medication;
4. Assistance or support with community access and recreational activities;
5. Support to assure the safety of the individual.

Unlike personal assistance and residential support, companion services do not permit routine support with activities of daily living (such as toileting, bathing, dressing, grooming). The allowable activities center on "instrumental activities of daily living" (meal prep, shopping, community integration, etc.).

Companion services may be self-directed or agency-directed.

Service Units and Service Limitations: 1 hour unit consumer directed or agency directed up to 8 hours a day 18 and older

Consumer Directed Services Facilitation

Service Description Consumer directed services facilitation uses the support of a Services Facilitator who is a Medicaid-enrolled provider. A Services Facilitator can be enrolled as an independent Medicaid provider or as an employee of a Medicaid-enrolled Services Facilitation agency provider. The Services Facilitator supports eligible individuals, and sometimes their families, in properly using consumer-directed services (CD Services). CD services, empowers the person with a disability to have greater control over the services they use. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services they use. CD services may be used in differing degrees and may span different types of services. They range from independently making all decisions and managing services directly, to using a representative to manage needed services. The underlying principle of CD services is that people with disabilities have the primary authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services.

Service Units and Service Limitations Per visit, initial and 6 month re-assessments
The online training may be found at https://partnership.vcu.edu/servicesfacilitators/

Crisis Support Services

Service Description Crisis support services provide intensive supports by appropriately trained staff in the area of crisis prevention, crisis intervention, and crisis stabilization to a person who may experience an episodic behavioral or psychiatric crisis in the community which has the potential to jeopardize their current community living situation. This service shall be designed

to stabilize a person and strengthen their current living situation so they can be supported in the community during and beyond the crisis period.

This service includes: crisis prevention, crisis intervention, crisis stabilization

- **Crisis prevention services** provide ongoing assessment of medical, cognitive, and behavioral status as well as predictors of self-injurious, disruptive, or destructive behaviors, with the initiation of positive behavior supports to prevent occurrence of crisis situations. Crisis prevention also encompasses providing support to the family and the individual through facilitating team meetings, revising the behavior plan, etc. as they implement changes to the plan for support and address any residual concerns from the crisis situation. Staff will arrange to train and mentor staff or family members who will support the individual long term once the crisis has stabilized in order to minimize or prevent recurrence of the crisis. Crisis support staff will deliver such support in a way that maintains the individual's typical routine to the maximum extent possible.

- **Crisis intervention services** are used in the midst of the crisis to prevent the further escalation of the situation and to maintain the immediate personal safety of those involved. Crisis Intervention is a relatively short term service that provides a highly structured intervention that may include temporary changes to the person's residence, removal of certain items from the setting, changes to the person's daily routine and emergency referrals to other care providers. Those providing crisis intervention services must also be well-versed and fluent in verbal de-escalation techniques, including active listening, reflective listening, validation, and suggestions for immediate changes to the situation.

- ***Crisis stabilization* services** begin once the acuity of the situation has resolved and there is no longer an immediate threat to the health and safety of those involved. Crisis stabilization services are geared toward gaining a full understanding of all of the factors that precipitated the crisis and may have maintained it until trained staff from outside the immediate situation arrived. Crisis stabilization plans are developed by staff trained in basic behavioral treatment and crisis management. These plans may include modifications to the environment, interventions to enhance communication skills, or changes to the individual's daily routine or structure. Staff developing these plans must be able to train support staff, family, and other significant persons in the individual's life.

Service Units and Service Limitations 1 day unit; limits vary by component

Electronic Home-Based Services

Service Description Electronic home-based services are goods and services based on Smart Home© technology. This includes purchases of electronic devices, software, services, and

supplies not otherwise provided through the waiver or through the State Plan, that would allow access to technology that can be used in a person's residence to support greater independence and self-determination.

The items and services must:

- decrease the need for other Medicaid services (e.g., reliance on staff supports), and/or
- promote inclusion in the community, and/or
- increase the individual's safety in the home environment

Allowable activities include:

- the assessment for determining appropriate equipment/devices, acquisition, training in the use of these goods and services,
- acquisition, training and use of goods and services
- ongoing maintenance and monitoring services to address an identified need in the individual's person-centered service plan (including improving and maintaining the individual's opportunities for full participation in the community

Service Units and Service Limitations up to $5000 annually
Not available to individuals using residential supports that are reimbursed on a daily basis (e.g., group home, sponsored or supported living residential services).

Employment and Community Transportation

Service Description Employment and community transportation is offered in order to enable individuals to gain access to waiver and other community services or events, activities and resources, inclusive of transportation to employment or volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the service plan and when no other means of access is available. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan.

Environmental Modifications

Service Description Environmental modifications are physical adaptations to the individual's primary home or primary vehicle that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence. Such adaptations may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the individual. Modifications may be made to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing

contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of services.

Service Units and Service Limitations Up to $5000 calendar year

Group Day Services

Service Description Group day services include skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability and adaptive skills. They provide opportunities for peer interactions, community integration, and enhancement of social networks. Supports may be provided to ensure an individual's health and safety.

Skill building is a required component of this service unless the individual has a documented degenerative condition, in which case day support may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills.

Group Day Services should be coordinated with any physical, occupational, or speech/language therapies listed in the person-centered plan.

Allowable activities include but are not limited to skill development and support in order to:

- Develop self, social, and environmental awareness skills
- Develop positive behavior, using community resources
- Volunteer and connect with others in the community
- Engage in career planning to include establishing a career goal
    - Develop skills required for paid employment in a community setting

Service Units and Service Limitations 1 hour unit up to 66 hours/week alone or in combination with other day options; Maximum 1:7 ratio

Group Home Residential

Service Description Group home residential consists of skill-building, routine supports, general sup- ports, and safety supports, provided primarily in a licensed or approved residence that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Group home residential services may be in the form of continuous (up to 24 hours per day) services performed by paid staff who shall be physically present in the home. These supports

may be provided individually or simultaneously to more than one individual living in that home, depending on the required support. These supports are typically provided to an individual living (i) in a group home or (ii) in the home of an adult foster care provider.
This service includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed.

Group home residential services shall be authorized for Medicaid reimbursement in the person-centered plan only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider.

Supports may be provided individually or simultaneously to more than one person living in the home, depending on the required support.

Service Units and Service Limitations 1 day

Independent Living Support

Service Description Independent living support is provided to adults (18 and older) and offers skill building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.

Individuals typically live alone or with roommates in their own homes or apartments.

These services are not provided in licensed homes. The supports are provided in a person's residence or in community settings. There must be a backup plan for times when Independent Living Supports cannot be provided as regularly scheduled.

Allowable activities include but are not limited to:

- Skill-building and support to promote community inclusion
- Increasing social abilities and maintaining relationships
- Increasing or maintaining health, safety and fitness
- Improving decision-making and self-determination
- Promoting meaningful community involvement
- Developing and supporting with daily needs

Service Units and Service Limitations 1 month unit up to 21 hours a week;

Individual and Family/Caregiver Training

Service Description Family/caregiver training provides training and counseling services to families or caregivers of those who use waiver services. For purposes of this service, "family" is defined as the unpaid people who live with or provide care to an individual served on the

waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include people who are employed to care for the individual. All family/caregiver training must be included in the individual's written plan of care.

Allowable activities include:

- Participation in educational opportunities designed to improve the family's or caregiver's ability to give care and support
- Participation in educational opportunities designed to enable the individual to gain a better understanding of his/her disability or increase his/her self-determination/self-advocacy abilities."

The need for the training and the content of the training in order to assist family or caregivers with maintaining the individual at home must be documented in the plan of care. The training must be necessary in order to improve the family or caregiver's ability to give care and support.

Service Units and Service Limitations 80 hours per plan of care year, billed hourly

In-Home Support Services

Service Description In-home support services are residential services that take place in someone's home, family home, or community settings and typically supplement the primary care provided by the individual, family or other unpaid caregiver. In-Home Support services are designed to ensure the health, safety and welfare of the individual.

Allowable services include:

- skill-building,
- routine supports, and
- safety supports, any of which enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

It is permissible to bill this service for up to three people at a time (e.g., siblings); however, the per person reimbursement rate decreases with each additional individual. A backup plan for times when In-Home Supports cannot be provided as regularly scheduled must be in place.

Service Units and Service Limitations 1 hour; up to 3 people during a single time period

Peer Mentor Supports

Service Description Peer mentor supports provide information, resources, guidance, and support from an experienced, trained peer mentor to an individual using Community Living, Family & Individual Support or Building Independence Waiver supports.

To read about details of the service description and requirements for Peer Mentor Supports, go to the Medicaid memo dated September 4, 2018 found at http://www.vaaccses.org/vendorimages/vaaccses/MEDICAID_MEMO_DD_WAIVER_NewServices_090418.pdf

Personal Assistance

Service Description Personal assistance services provide direct support with activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance. These services may be provided in home and community settings to maintain the health status and functional skills necessary to live in the community or participate in community activities.

Personal Assistance services may be consumer/self-directed (CD) or agency directed. If self-directed, a Services Facilitator is needed.

Each individual and family/caregiver, family, or caregiver shall have a back-up plan for needed supports in case the personal assistant does not report for work as expected or terminates employment without prior notice.

Allowable activities include:

1. Support with activities of daily living (ADLs), such as: bathing or showering, using the toilet, routine personal hygiene skills, dressing, transferring, etc.;
2. Support with monitoring health status and physical condition;
3. Support with medication and other medical needs;
4. Supporting the individual with preparation and eating of meals;
5. Support with housekeeping activities, such as bed making, dusting, and vacuuming, laundry, grocery shopping, etc.;
6. Support to assure the safety of the individual;
7. Support needed by the individual to participate in social, recreational and community activities;
8. Assistance with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when properly trained and supervised by an RN;
9. Accompanying the individual to appointments or meetings.

Personal Assistance is not available to those who …

- x Use group home residential services
- x Use sponsored residential services

x live in Assisted Living Facilities
x have comparable services through another program

Service Units and Service Limitations Ratio 1:1; 1 hour unit; not compatible with congregate services

Personal Emergency Response System

Service Description Personal Emergency Response System (PERS) is an electronic device and monitoring service that enable certain individuals to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

PERS services may be authorized when there is no one else in the home with the individual who is competent or continuously available to call for help in an emergency. Medication monitoring units must be physician ordered and are not considered a stand-alone service. Individuals must be receiving PERS services and medication monitoring service simultaneously.

Service Units and Service Limitations One month unit

Private Duty Nursing

Service Description Private Duty Nursing is individual and continuous care (in contrast to part-time or intermittent care) for individuals with a serious medical condition and/or complex health care need, certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital, nursing facility or ICF-IID. Care is provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse.

These services are provided at a person's place of residence or other community settings.

Allowable activities include, but are not limited to:

- Monitoring of an individual's medical status
- Administering medications and other medical treatment

Service Units and Service Limitations 15 minutes

Respite

Service Description Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver. Services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary caregiver.
Such services may be provided in home and community settings to maintain health status and functional skills necessary to live in the community or participate in community activities. When specified, such supportive services may include assistance with instrumental activities of daily living (IADLs).

Respite services may be consumer/self-directed or agency directed. If self-directed a Services Facilitator must be used.

Service Units and Service Limitations 1 hour unit up to 480 hours per fiscal year, for unpaid primary caregivers only

Shared Living

Service Description Shared Living means an arrangement in which a roommate resides in the same household as the person who uses waiver services and provides an agreed-upon, limited amount of supports in exchange for Medicaid funding the portion of the total cost of rent, food, and utilities that can be reasonably attributed to the live-in roommate.

Shared Living supports include:

- Fellowship such as conversation, games, crafts, accompanying the person on walks, errands, appointments and social and recreational activities;
- Enhanced feelings of security which means necessary social and emotional support inside or outside of the residence;
- Personal care and routine daily living tasks that do not exceed 20% of companionship time such as meal preparation, light housework, assistance with and the physical taking of medications.

For those 18+

Service Units and Service Limitations 1 month

Skilled Nursing

Service Description Skilled nursing is defined as part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. These services shall be provided for individuals enrolled in the waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel. Skilled nursing services may be provided in the individual's home or other community setting on a regularly scheduled or intermittent basis. It may include consultation, nurse delegation as appropriate, oversight of direct support staff as appropriate, and training for other providers.

Allowable activities include, but are not limited to:

- Monitoring of an individual's medical status
- Administering medications and other medical treatment

Training, consultation, nurse delegation or oversight of family members, staff, and other persons responsible for carrying out an individual's support plan for the purpose of monitoring the individual's medical status and ad- ministering medications and other medically- related procedures consistent with the Nurse Practice Act [18VAC90-20-10 et seq., by statutory authority of Chapter 30 of Title 54.1, Code of Virginia]

Service Units and Service Limitations 15 minutes;

Sponsored Residential

Service Description Sponsored residential services take place in a licensed or DBHDS authorized sponsored residential home. These services shall consist of skill-building, routine supports, general supports, and safety supports, provided in a licensed or approved residence that enable a person to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Sponsored residential services shall be authorized for Medicaid reimbursement in the person-centered plan only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider.

Sponsored residential services to the individual in the form of continuous (up to 24 hours per day) services performed by the sponsor family. Sponsored residential support includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed. These supports may be provided individually or simultaneously to up to two individuals living in that home, depending on the required support.

Service Units and Service Limitations 1 day; support to no more than 2 individuals

Supported Employment

Service Description Supported employment services are ongoing supports to those who need intensive ongoing support to obtain and maintain a job in competitive, customized employment, or self-employment (including home-based self-employment) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

- **Individual supported employment** is support usually provided one-on-one by a job coach in an integrated employment or self-employment situation. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

- **Group supported employment** is defined as continuous support provided by staff in a regular business, industry and community settings to groups of two to eight people with disabilities and involves interactions with the public and with co-workers without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group supported employment must be provided in a manner that promotes integration into the workplace and interaction between people with and without disabilities in those workplaces.

Allowable activities include but are not limited to:

- Job-related discovery or assessment
- Person-centered employment planning
- Negotiation with prospective employers
- On-the-job training, evaluation and support
- Developing work-related skills
- Coverage for transportation when necessary

Both the individual and group model must be in an integrated setting

Service Units and Service Limitations Individual model is 1:1; group model in groups with 8 or less; 1 hour up to 40 hours per week

Supported Living

Service Description Supported living takes place in an apartment setting operated by a DBHDS licensed provider. These services shall consist of skill-building, routine supports, general supports, and safety supports, that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Supported living residential services to the individual in the form of 'round the clock availability of staff services performed by paid staff who have the ability to respond in a timely manner. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support.

Allowable activities include, but are not limited to:

- Using community resources
- Personal care activities
- Developing friends and having positive relationships
- Building skills
- Daily activities in the home and community
- Supporting to be healthy and safe

Service Units and Service Limitations 1 day; only in provider owned/leased settings; may be provided individually or simultaneously to more than one individual living in that home, depending on the required support.

Therapeutic Consultation

Service Description Therapeutic consultation is designed to assist the individual's staff and/or the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the individual enrolled in the waiver.

The specialty areas are:

- psychology
- occupational therapy
- speech and language pathology
- physical therapy
- behavioral consultation
- rehabilitation engineering
- therapeutic recreation

The need for any of these services shall be based on the PC ISP and shall be provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their abilities to function in the community. Therapeutic consultation services may be provided in individuals' homes and in appropriate community settings (such as licensed or approved homes or day support programs) as long as they are intended to advance individuals' desired outcomes as identified in their ISPs.

Service Units and Service Limitations 1 hour

Transition Services

Service Description Transition services are nonrecurring set-up expenses for those who are transitioning from an institution or licensed/certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses.

Transition services are furnished only to the extent that they are reasonable and necessary as determined and clearly identified in the service plan, and the person is unable to meet such expenses or when the services cannot be obtained from another source. Transition services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household items that are intended for purely diversional/recreational purposes. This service does not include services or items that are covered under other waiver services such as environmental modifications or assistive technology.

Allowable costs include, but are not limited to:

- Security deposits that are required to obtain a lease on an apartment or home;

- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens;
- Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;
- Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;
- Moving expenses;
- Fees to obtain a copy of a birth certificate or an identification card or driver's license; and
- Activities to assess need, arrange for, and procure needed resources.

Service Units and Service Limitations Up to $5000 lifetime expended within 9 months of authorization

Workplace Assistance

Service Description Workplace Assistance services are supports provided to someone who has completed job development and completed or nearly completed job placement training but requires more than typical job coach services to maintain stabilization in his/her employment.

Workplace Assistance services are supplementary to the services rendered by the job coach; the job coach still provides professional oversight and job coaching intervention.

The provider provides on-site habilitative supports related to behavior, health, time management or other skills that otherwise would endanger the individual's continued employment. The provider is able to support the person related to personal care needs as well; however, this cannot be the sole use of Workplace Assistance services.

- The activity must not be work skill training related which would normally be provided by a job coach.
- Services are delivered in their natural setting (where and when they are needed)
- Services must facilitate the maintenance of and inclusion in an employment situation

Service Units and Service Limitations Ratio is 1:1; 1 hour up to 40 hours per week;

Commonwealth Coordinated Care Plus (CCC+) Waiver

A new Medicaid Managed Care Program includes the CCC Plus Waiver (CCC+). This Waiver combined what was formerly the Elderly and/or Disabled with Consumer Direction Waiver (EDCD) and the Assisted Technology (AT) Waiver. The CCC+ Waiver is administered by the Department of Medical Assistance Services (DMAS).

CCC+ is an integrated delivery model that includes medical services, behavioral health services and long term
services and supports (LTSS).

People eligible are those who:

- Meet the Nursing Facility (NF) level of care criteria that is determined using the Uniform Assessment Instrument (UAI) or are dependent upon technological support and require substantial, ongoing skilled nursing care
- if under age 65, must also have a disability, (Note: mental illness solely does not qualify as a disability for this waiver)
- Can have their health, safety, welfare safely maintained in the home when the nurse or personal care aide is not present
- Are determined to be at imminent risk of NF placement; and
- Are determined that community- based care services under the waiver are the critical services that enable them remain at home rather than being placed in a NF

Access

Representatives from the Virginia Department of Health and local Department of Social Services screen people to determine if they meet the qualifications to use this waiver. The screening team includes a Health Department nurse and a Social Services representative. They use a tool called the Uniform Assessment Instrument (UAI) to determine if someone meets the required functional dependencies, medical/nursing needs and are at risk of nursing home placement. Screenings may also take place when someone is hospitalized.

Working with Managed Care Organizations (MCOs) Care Coordinators

Virginia has six (6) Managed Care Organizations available for the CCC+ Waiver. A list of them may be found at http://www.dmas.virginia.gov/#/cccplushealthplans under the link entitled CCC Plus MCO Member Services Contact Information.

Each health care plan offered under the CCC+ Waiver, will provide a Care Coordinator to work with the participant and their doctors to create an individualized health care plan that includes among other things, individual outcomes and needed supports and services.

Each person using CCC+ will also take part in a Health Risk Assessment that entails a survey in which the participant is asked health questions. The questions are meant to better serve a person and the information gathered guides the Care Coordinator/MCO when providing health related education.

If someone uses the CCC+ Waiver, it is important that the Support Coordinator and Care Coordinator collaborate and coordinate supports and services. In addition, if a Support Coordinator believes someone would qualify for the CCC+ Waiver, they can assist them and their family with the application process.

Two approvals need to happen:

- A financial application for Adult Medicaid and Appendix D must be completed requesting Long Term Care and given to the local Department of Social Services and

- The UAI needs to be completed by the Department of Health (DOH). A social worker from DSS or nurse from the local DOH contact the applicant to schedule an appointment.

For more information about the CCC+ Waiver, go to https://vacsb.org/wp-content/uploads/2017/10/Provider-Quick-Reference-for-CCC-Plus-Aug-2017.pdf.

Addiction and Recovery Treatment Services

Along with providing supports and services to people with Developmental and Intellectual Disabilities, Community Services Boards (CSBs) are the primary point of entry for services to treat substance use disorders. Support Coordinators need to familiarize themselves with how these services at their particular CSB operate and how referrals are made. It is vitally important to collaborate with the Substance Abuse Professional (SAP) when someone supported is seen by both the Support Coordinator and a (SAP).

For more information about the services provided in Virginia, go to: http://dbhds.virginia.gov/developmental-services/substance-abuse-services

Waiver Services At a Glance

BI	FI	CL	Employment and Day Options
x	x	x	Supported Employment, Individual
x	x	x	Supported Employment, Group
	x	x	Workplace Assistance
x	x	x	Community Engagement
x	x	x	Group Day
BI	FI	CL	Crisis Support Options
x	x	x	Center-based crisis supports
x	x	x	Community-based crisis supports
x	x	x	Crisis support services
BI	FI	CL	Residential Options
x			Independent Living Supports
x	x	x	Shared Living
	x	x	In-Home Supports
	x	x	Supported Living
		x	Group Home Residential
		x	Sponsored Residential Services
BI	FI	CL	Self-Directed and Agency-Directed Options
	x	x	Consumer-Directed Services Facilitation *(self-directed only)*
	x	x	Companion
	x	x	Personal Assistance Services
	x	x	Respite
BI	FI	CL	Medical and Behavioral Support Options
	x	x	Private Duty Nursing
	x	x	Skilled Nursing
	x	x	Therapeutic consultation
x	x	x	Personal Emergency Response System (PERS)
BI	FI	CL	Additional Options
x	x	x	Assistive technology
x	x	x	Benefits Planning
x	x	x	Community Guide
x	x	x	Electronic Home-Based Services
	x		Individual and Family/Caregiver Training
x	x	x	Environmental modifications
x	x	x	Employment and Community Transportation
x	x	x	Transition services

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Support Coordination Manual

Developmental Disabilities

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Support Coordination Manual
Developmental Disabilities
Chapter 7
Support Coordination Process:
Plan Development and Implementation

Introduction

Support Coordination services aim to assist people with disabilities to utilize services, while also becoming more independent and active in community life. Support Coordinators (SC) establish a positive and respectful relationship with people and their support networks. Support Coordination starts with a person-directed planning process based on the needs of the people using services.

Person-centered planning is a set of approaches designed to assist someone to plan their life and supports. It is used most often as a life planning model, to enable individuals with disabilities or otherwise requiring support to increase their personal self-determination and improve their own independence.

The key areas for consideration in person centered planning are:

- What are the things that are important to and for a person?
- Who are the important people in a person's life?
- What are the person's strengths or gifts?
- What is important to the person now and in the future (their dreams)?
- What kinds of support does the person need to achieve the future they want?
- What do we need to do to support the life they want?

Foundational Beliefs in Person Centered Planning

Person centered planning (PCP) is a process-oriented approach to empowering people with disabilities. It focuses on the people and their needs by putting them in charge of defining the direction for their lives, not on the systems that may or may not be available to serve them. This ultimately leads to greater inclusion as valued members of both community and society. (Cornell University Person Centered Planning Education Site)

Box

Foundational Beliefs in Person Centered Planning

- The person is at the focus of planning, and is the primary authority on his or her life direction.
- The purpose of person centered planning is learning through shared action. People who engage in person centered planning may produce documentation of their meetings, but these are only footprints: ***the path is made by people walking together.***
- Honest person centered planning can only come from respect for the dignity and completeness of the person who owns the plan.
- Assisting people to define and pursue a desirable future tests one's clarity, commitment, and courage. Person centered planning engages powerful emotional and ethical issues and calls for sustained search for effective ways to deal with difficult barriers and conflicting demands.

"Those who treat PCP simply as a technique, and those who fail to provide for their own development and support will offer little benefit to the people they plan with."
Resource: John O'Brien and Herbert Lovett in **Finding a Way Toward Everyday Lives**

Supported Decision Making

Each person has a right to participate meaningfully in decisions regarding all aspects of services affecting him or her. This includes the right to consent or not consent to receive or participate in services, as well as the right to give or not give informed consent to the fullest extent possible, to receive or participate in treatment or services. It may be determined that some persons lack capacity to make informed decisions and they receive support from an authorized representative or legal guardian to make decisions. However, it is important to respect, protect, and help develop each person's ability to participate meaningfully in decisions regarding all aspects of services affecting him.

According to the National Guardianship Association's Standards of Practice and Ethical Principles, a guardian:

- Treats the person with dignity.
- Involves the person to the greatest extent possible in all decision making.
- Selects the option that places the least restrictions on the person's freedom and rights.
- Identifies and advocates for the person's goals, needs, and preferences.

It is important for SCs to support people in having a voice to express their preferences in services, providers, and plans, even when they have a substitute decision maker.

More information about supported decision making can be found in the Code of Virginia § 64.2-2000.
https://law.lis.virginia.gov/vacodefull/title64.2/subtitleIV/partD/

Participation in Decision Making and Consent At-A-Glance
Virginia Supported Decision Making Study 2015 At-A-Glance

Linking to Services

When a person receives a DD waiver slot, SCs need to have conversations with them about the life they want to live, and the supports they might need to access in order to achieve their vision of a good life. In order to link people with appropriate resources, Support Coordinators must be knowledgeable about community resources that are available and should maintain regular contact with these resources in order to facilitate access and stay informed. Many CSBs create and maintain shared information files internally about available resources and service providers, including medical, housing, residential, vocational and employment, community and civic, and spiritual resources. The SC should check with their supervisor to obtain access to resource guides. DBHDS and DMAS also maintain online lists of providers throughout the state of Virginia for persons seeking services outside their region. SCs can also access the provider survey (http://ejiujiu0.wixsite.com/providersurvey), the DBHDS Licensed Provider Location Search (http://www.dbhds.virginia.gov/quality-management/Licensed-Provider-Location-Search), or the DMAS provider search (https://www.virginiamedicaid.dmas.virginia.gov >> Provider Resources >> Search for Providers) to look for service providers in their region.

Touring/Visiting Providers

When a person expresses interest in exploring new services, they may be ready to begin touring and visiting potential service providers, and the SC can play a key role by doing the following:

- Provide the person with information about all available services and qualified providers
- Provide contact information for reaching the organization
- Support the person in making the initial contact
- As necessary, contact the organization and accompany the person to the first meeting
- Make sure the person has the ability to access and utilize the service or resource
- Follow-up as needed to address any barriers to access and ensure a successful connection

Virginia Informed Choice form (DMAS 460)

When a person who uses a DD waiver is considering their options for services, the Support Coordinator must offer the person a choice of all services available to them, as well as a choice of all of the providers qualified and willing to provide the desired services, including SC services. After making sure that the person has been given the opportunity to make an informed choice, the SC must document this by reviewing and completing the Virginia Informed Choice Form (DMAS 460). More information and a copy of the DMAS 460 can be found in Chapter 5. (link)

An SC can ensure informed choice by doing the following:

- Identify the needed resource and the person's preferences.
- Review of existing services and providers and person's satisfaction
- Discuss all available options and choices (especially more integrated options such as independent living, employment, and community engagement).

Referrals

A referral is the process by which an SC helps a person apply to use a service or other resource. Once a person has made a choice of service providers, the SC will work with the person and the service provider to share pertinent documentation, such as assessment information, service preference, and any other documentation the provider may request. The SC needs to ensure that a signed consent to exchange information has been completed for each new service provider before providing information about the individual. More information about the Consent to Exchange Information process can be found in Chapter 5. (link)

How to Utilize Assessment Information to Begin Plan Development

In Chapter 5 of this manual, the elements of the assessment process were described. The assessment process includes the completion of the SIS®, Annual Risk Assessment, and Parts I and II of the PC ISP (Essential Information and Personal Profile). Other assessments that should be reviewed include medical reports and psychological evaluations.

Effective assessments start with prioritizing the person's immediate concerns. It is important for an SC to pay attention to any immediate health and safety issues, risk, or risks of harm which can include:

- Medical conditions,
- At risk behavior,
- Restrictive protocols
- Special supervision requirements
- Other presenting needs, as expressed by the person and / or their team and as documented in the referral information; and
- The strengths and preferences of the person and resources that might be available

Conducting an assessment is really about eliciting someone's personal story. Since they are the expert on their life, most information gathered should be from them, and supporters who know the person best, which may include their substitute decision maker, if applicable. When using the assessment to begin plan development, it is important to:

- Listen to concerns without interrupting,
- Respect preferences, needs, and values,
- Use the assessment interview to begin to engage the person served,
- Assist the person to understand reasonable alternatives,
- Help them identify strengths, resources, interests, and preferences,
- Include the family and other supporters with the person's permission,
- Determine together the person's current level of support needs, and
- Share the findings from the assessment with the person seeking services.

Once the assessment is complete, it is time to move on to the development of the plan.

Person Centered Planning and the Team Meeting

Once a person has chosen their initial services and supports, and again on an annual basis, the SC should arrange for a team meeting. The team consists of the person and the SC, at a minimum, and should also include people who are chosen by the person and who know the person best. The person with whom a plan is being developed is always at the center of the planning process. The degree of their involvement depends on their desire to participate, along with the extent to which they are able to participate. When planning with someone, it is best to bring together a group of people that want to contribute their time and talents because they know and care about the person and want to help them identify and achieve their goals. The Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings (HCBS) Regulations require that the person centered planning process:

- Is driven by the individual
- Includes people chosen by the individual
- Provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Is timely and occurs at times/locations of convenience to the individual

Given these requirements, it is not acceptable for the SC or any provider to schedule meetings and *inform* the person, rather, SCs and providers should work with the person to support them to drive the scheduling process. This may require some flexibility on the part of the SCs and providers, but remember that meetings and plans belong to the people using services.

Annual person centered planning meetings should ideally be held approximately six weeks prior to the due date of the Person Centered Individual Support Plan (PC ISP). This time frame allows for last minute rescheduling, as well as time for SCs and providers to write their parts of the plan, individuals (and substitute decision makers, as appropriate) to approve the written plans, and submission for service authorization approvals. Service authorization requests should be submitted 30 days prior to the requested start date.

SCs, providers, and people using services (and their chosen planning partner, as appropriate) should **draft** Part I Essential Information and Part II Personal Profile prior to the meeting. All team members contribute to its completion during the annual meeting with a draft or notes, or in writing before the meeting. The SC/CM combines the information that is then discussed and finalized at the annual meeting, with the final product shared by the support coordinator with all team members following the meeting. The information included in the sections of the Personal Profile is intended to be gathered through conversations with the person and those that know him or her best.

Person centered planning meetings can often feel like an overwhelming amount of work, and it is tempting to conduct a meeting as if checking everything off of a list. However, the only way to write a true person centered plan is to have robust discussions and gather information about the person and their needs and preferences first.

Facilitating Conversation

In his Keynote presentation for the conference "The Promise of Opportunity", March 2000, Michael Kendrick says that person centered work begins ***within*** each of those involved in the plan and includes:

- A commitment to know and seek to understand
- A conscious resolve to be of genuine service
- An openness to being guided by the person who owns the plan
- A willingness to struggle for difficult goals
- Flexibility, creativity, and openness to trying what might be possible
- A willingness to enhance the humanity and dignity of the person
- To look for the good in people and help to bring it out

Having conversations is the primary mechanism used in planning and often it is the SC who facilitates these conversations. It is important to know that gathering information from people who know a person well, professionally or personally, may be done outside of a meeting as long as it is done with informed consent. The documents listed in the box below offer guidance in gathering information for a plan and having conversations with a person with a disability, family members, and professionals.

As the facilitator, the SC must always keep the person as the focus of the discussion. Starting the meeting with asking team members what they like and admire about the person sets a positive tone for a meeting and allows everyone to be heard and recognized. It is also good to talk first about the good things that have happened in the person's life since the last meeting (person centered planning does not mean we ignore the things that are of concern, but it should not be the initial or primary topic of discussion). While facilitating the meeting, talk directly with the person, rather than talking around and about the person. Ask questions, and gather information. When possible, the person can share their personal profile with the team and include information about things that are important to them, what is working and needs to stay the same, and what is not working and needs to change. Team members can offer ideas and suggestions, which can be added to the

profile with agreement from the person. SCs should also facilitate a discussion about what the person's vision for a good life is. A person's dreams and goals should be a driving force in the plan.

The person and their team should also discuss things that are important for a person (issues of health and safety and being a valued member of one's community), as well as any risks that have been identified. After ensuring that the person's needs and preferences have been identified and that the team is supporting the person to find a balance between what is important to and for them, the discussion can address specific, measurable outcomes to include in the shared plan.

Box

A Checklist for Person Centered Information Gathering and ISP Development Mary Lou Bourne 2008 (link at a glance)

A Guide for Developing Preliminary Essential Lifestyle Plans: Conversation with the Person with Whom You are Planning Smull & ASA 2001 (link at a glance)

A Guide for Developing Preliminary Essential Lifestyle Plans: Conversations with Family and Support Services Smull & ASA 2001 (link at a glance)

BOX

Myths and Misconceptions about Person Centered Planning
To read about myths and misconceptions about Person Centered Planning, click on this link and read pages 69 through 73 https://rtc.umn.edu/docs/pcpmanual1.pdf

Completing the Person Centered Individual Support Plan (PC ISP) Trainings in the Virginia Learning Center

Prior to completing PC ISP documentation, all Support Coordinators should complete the PC ISP Training Modules in the Virginia Learning Center. Here, SCs will learn how to complete Virginia's PC ISP documentation. https://covlc.virginia.gov/Default.aspx

Parts of Virginia's PC ISP

Virginia's Person Centered ISP has 5 distinct parts:

Part I- Essential Information

Part I of the PC ISP, or Essential Information, contains a wide variety of information necessary to provide supports to an individual. Part I provides information across the following areas:

- Contact information,
- Representation
- Emergency Contacts
- Healthcare Contacts
- Friends and Community Contacts
- Eligibility
- Non-Waiver Agency Paid Supports

- Self-Directed and Agency-Directed Personal Assistance, Respite, and Companion
- Health Information
- Social Developmental Behavioral Family History
- Communication, Assistive Technology, and Modifications
- Education
- Employment

Part II- Personal Profile

Part II of the PC ISP, or Personal Profile, looks at the life the person wants to have- hopes, dreams, aspirations, and plans, and then compares it to their life today. This enables the team to work with the individual to determine a path to get the life he or she wants for their future. Facilitating a conversation with the individual, with input from the rest of the team, is essential in order to gather the information necessary in this part of the plan. The Personal Profile then looks at eight different life areas to determine what is working and not working for the individual from their own perspective in each life area, and what others need to know or do to support them in each of those life areas. This information can then be used as a tool to determine what is important to a person in those areas of their life, and acts as a bridge to developing the outcomes in Part III of the PC ISP, Shared Planning.

Part III- Shared Planning

Part III of the PC ISP, or Shared Planning, lists outcomes shared across providers, as necessary, in order to help the person on a path to the life they want. The Part III contains measurable outcomes listing an achievement the individual wants to pursue, the steps to get there, when it will be accomplished, and who is responsible for helping the person reach that achievement. The Shared Plan is completed at the annual meeting and holds the outcomes that lead to the life the person wants. (LINK TO DBHDS PC ISP GUIDANCE DOCUMENT)

Part IV- Agreements

Part IV, or the Agreements section, is an evaluation of the annual planning meeting. It contains questions for the individual and team, as well as a signature page that is signed by all present at the meeting. Answer all questions and record any plans to address or resolve objections. This is also a place to record any inability to meet a request and the related team decision. All parties involved in planning will sign the Part IV, and it will serve as the signature page for the plan.

Part V- Plan for Support (PFS)

Part V, or the Plan for Supports (also called a PFS) is the provider-completed part of the ISP. All service providers must have a PFS that details the activities and instructions that are expected to lead toward the agreed upon outcomes. The PFS includes:

- *Support Instructions* that are constant in a person's life,
- The individual's *Desired Outcomes* from the *Shared Planning* (or a PFS revision),
- The *Support Activities* the provider has agreed to provide to support the person with each outcome,
- What will be seen or obtained to resolve each activity,
- Any additional *Support Instructions* needed to complete activities,
- A *General Schedule of Supports*, and

- When applicable, documentation of consent for any safety restrictions.

Box

Avoid Jargon –

When writing plans, use ordinary language rather than professional jargon. The SC can use themselves as a yardstick. If they would not use the same words or descriptions for themselves, then they should not be used to describe someone else. Also remember, the language needs to be understood by the plan owner. Here are just a few examples:

Instead of 'interpersonal skills,' use 'easy to get along with.'

Instead of 'ambulates independently,' use 'walks on her own'—or consider whether this needs to be said at all.

Instead of 'verbal cues or prompts,' use 'remind her by saying…'

Instead of 'auditory monitoring distance,' use 'within earshot.'

Instead of 'off-task behaviors,' use 'distractions.'

Instead of 'on-task behaviors,' use 'pays attention.'

How to Write Measureable Outcomes

An individual's desired outcomes should be based on what is important to the person with regards to their personal preferences; however, outcomes need to also be written in a way that is measurable. For example, having more spending money might be important to a person but in no way establishes what this means in measurable terms. In addition to being observable, a few additional considerations can increase measurability of outcomes – the frequency of the outcome, the target date, and the steps that lead to the outcome.

The statement "John has more money" can be improved by considering how this could describe an achievement that John would find meaningful such as: "John saves 50 dollars per month so that he can go on vacation next year," or "John earns at or above minimum wage for 12 months so that he has more shopping money."

Each outcome in the PC ISP will have a target date noted as "by when," which indicates that the outcome is expected to be accomplished or will be reassessed by that date. When desired, a frequency should be included in the wording of the outcome statement.

The next step for planners and teams to increase measurability is to describe the basic steps that lead to the outcome. These steps are shared across the planning team to contribute to achieving the outcome. To make an outcome measurable, we would ask, "What are the steps to get there?" These steps lay out the plan to pursue the achievement which is in line with action planning, a foundational person-centered practice. These steps should be logical and when considered together be expected to result in the time-bound achievement that is defined in the outcome.

For support teams who struggle with forming outcomes, we have previously utilized a formula, which has been noted as helpful and should remain an option to support meaningful outcomes. This formula has been slightly

modified as follows for the examples provided. The asterisk* is a reminder to include a frequency when desired:

[Person's name] [activity/event/important FOR]* so that/in order to [important TO achievement]

(From DBHDS Person Centered ISP Guidance Document. For more detailed information and examples, see this document http://townhall.virginia.gov/L/ViewGDoc.cfm?gdid=6379)

DBHDS Person Centered ISP Guidance at a glance

How to Evaluate and Document Implementation of a PC ISP

Once a PC ISP is complete, it is time to work towards completion of support activities in the SC's Part V, complete documentation regarding progress towards completion of the outcomes, and review that documentation quarterly in a Person Centered Review.

Throughout the plan year, the SC will work to complete tasks related to supporting a person reach their outcomes as specified in the SC's Plan for Support.

Progress Notes

An SC is required to complete documentation regarding contacts with the person and significant others in regards to the individual, progress towards outcomes, and significant events, health and safety concerns, such as falls, hospitalizations, etc. This documentation, called progress notes, should occur in a timely manner from the time the contact was made, task was completed, or the information was received. Progress notes should include specific details, such as full date of contact, who reported the information to you (name, title, and/or relationship to the individual), place of contact, type of contact, summary of contact- including what the SC did in regards to linking, coordinating, and advocating, and should always have a signature/electronic signature and title of the SC completing the note, as well as date.

Person Centered Review (PCR)

Quarterly, the SC will complete a Person Centered Review (PCR). This will include not only progress on outcomes for which the SC is responsible, but also a summary of the PCRs received from all service providers. Because of this, a provider has a 10-day grace period after the end of a quarter to complete their PCR and submit to the SC, then the SC has a 30-day grace period after the end of a quarter to complete their PCR.

The PCR includes information regarding outcome status, including a summary of significant events from the quarter in regards to each outcome. If a change to the plan is needed, this will be documented in the PCR. Additionally, the PCR will include information regarding safety risks identified over the quarter, changes desired or needed regarding supports and services, satisfaction with supports and services, as well as plans to address any dissatisfaction, whether or not all Medicaid Services were implemented and how to address if not, and finally, any other significant events not included elsewhere in the PCR.

Information in progress notes and PCRs, as well as in continued conversations throughout the year with the individual and team members, will be helpful in preparation for the upcoming plan year.

BOX

Required ISP Documentation: SC responsibilities

- Begin preparing for an ISP several weeks before it is due
- Use the Annual ISP Required Documentation Spreadsheet to ensure all required documentation has been completed or addressed.
    - Annual ISP Required Documentation Spreadsheet At-A-Glance

Timelines and Documentation Related to PC ISP/DMAS Service Requirements

Support Coordinators are subject to a number of state and federal laws, rules, and regulations. The following agencies fund and regulate services to individuals with behavioral health or developmental disabilities, including Support Coordination:

- Department of Behavioral Health and Developmental Services (DBDHS)
- Department of Medical Assistance Services (DMAS)

SCs are responsible for knowing and applying a variety of guidelines and regulations. It is important for SCs to have access to the following guidelines:

- DMAS DD Community Services manual (link will be provided upon completion of manual update)
    - Chapters include DMAS regulations specific to General Information, Provider Participation Requirements, Member Eligibility, Covered Services and Limitations, and Billing instructions.
- DBHDS Case Management Licensing Regulations http://dbhds.virginia.gov/assets/doc/QMD/OL/ch.105.full.wemergcompliance.9.01.18docx.pdf
    - Licensing regulations include information specific to case management eligibility, definition, qualifications, knowledge, skills and abilities.

Documentation is an important part of support coordination. According to the CMS, “General Principles of Medical Record Documentation,” medical record documentation is required to record pertinent facts, findings, and observations about a person’s health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the individual’s care and is an important element contributing to high quality care. It also facilitates:

- Assessment, evaluation, and planning
- Communication and continuity of care among providers
- Accurate and timely review and payment
- Appropriate utilization review and quality of care evaluations

SCs can ensure ideal record keeping by amending the record as needed, entering information into the record in a timely manner, and ensuring accuracy of documentation. More information regarding required documentation standards and practices can be located in the DMAS DD Community Services Operations Manual. (link will be provided upon completion manual update)

Box

Annual ISP Required Documentation Spreadsheet At-A-Glance

Regional Support Teams

At times, an SC may encounter difficulties or barriers to community supports for someone. In this instance, the Regional Support Team (RST) may offer assistance to the support team. RSTs can provide recommendations and assistance in resolving barriers in the most integrated community setting consistent with someone's needs and informed choice. Submission of RST referrals are required to ensure informed choice and availability of services. Through referrals, the RST will monitor, track, and trend choice, integrated option availability, and challenges that require further system development. The SC shall notify the Community Resource Consultant (CRC) and RST in the following circumstances: a.) within five calendar days of an individual being presented with any of the following residential options: i. an intermediate care facility, ii. a nursing facility, iii. a training center, or iv. a group home with a licensed capacity of five beds or more; b.) if the CSB is having difficulty finding services within 30 calendar days after the individual's enrollment in the waiver; or c.) immediately when an individual is displaced from his or her residential placement for a second time. Recommendations from the RST are explored by the individual receiving services and their authorized representative/substitute decision maker with assistance of the Support Coordinator. The recommendations provide opportunities for the individual to choose more integrated options. For more information on RSTs please see the links provided below.

BOX

Regional Support Teams: SC Responsibilities

If a referral to RST has been recommended, the SC should:

- Use the RST Referral Flowchart to identify required steps and documentation requirements.
    - RST Referral Flowchart At-A-Glance
- Complete the RST Referral Form
    - RST Referral Form At-A-Glance
- Document the referral to RST in the person's record

What Are Regional Support Teams? At-A-Glance

Service Authorizations to Initiate Services

Once a person has made an informed decision about support options and chosen service providers, the SC can begin the process of authorizing services in WaMS. It the responsibility of the SC to ensure that the information in WaMS is up to date, add all service providers into WaMS, review all requests, modify the amount or type of services as needed, and submit the service authorization for processing. More detailed information about the initiation of Service Authorizations can be found in section 12 of the WaMS User Guide.

WaMS User Guide At-A-Glance
"When to Submit What" At-A-Glance
Service Authorization Guidance At-A-Glance

Participation in Decision-making and Consent

Karen A. Taylor,
Office of the Attorney General

March 2017

How Consent Obtained

- Human Rights Regulations (12 VAC 35-115)
- Health Care Decisions Act (§ 54.1-2981 et seq.)
- Judicial Authorization (§§ 37.2-1100 through -1109)
- Guardianship (§§ 64.2-2000 through -2029)
- Two Physician/Dentist Rule (§ 54.1-2970)

Participation in Decision-Making 12 VAC 35-115-70

- Rights & Duties
- Consent
- Informed Consent
- Capacity
- Surrogate Decision-Making

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Each individual has a right to participate meaningfully in decisions regarding all aspects of services affecting him. This includes the right to:

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Consent or not consent to receive or participate in services.
  - ISP and discharge plan shall incorporate the individual's preferences consistent with his condition and need for service and the provider's ability to address them;
  - Services record shall include evidence that the individual has participated in the development of his ISP and discharge plan, in changes to these plans, and in all other significant aspects of his treatment and services; and
  - Services record shall include the signature or other indication of the individual's or his authorized representative's consent.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Give or not give **informed consent** to receive or participate in treatment or services that pose a risk of harm greater than ordinarily encountered in daily life and to participate in human research except research that is exempt under § 37.2-162.17 of the Code of Virginia.
- Informed consent is always required for surgical procedures, electroconvulsive treatment, or use of psychotropic medications.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- To be informed, consent for any treatment or service must be based on disclosure of and understanding by the individual or his authorized representative of the following information:

1. An explanation of the treatment, service, or research and its purpose;
2. When proposing human research, the provider shall describe the research and its purpose, explain how the results of the research will be disseminated and how the identity of the individual will be protected, and explain any compensation or medical care that is available if an injury occurs;

Participation in Decision-making and Consent. 12 VAC 35-115-70

3. Description of adverse consequences and risks associated with the research, treatment, or service;
4. Description of benefits that may be expected from the research, treatment, or service;
5. Description of alternative procedures that might be considered, along with their side effects, risks, and benefits;
6. Notification that the individual is free to refuse or withdraw his consent and to discontinue participation in any treatment, service, or research requiring his consent at any time without fear or reprisal against or prejudice to him; and

Participation in Decision-making and Consent. 12 VAC 35-115-70

7. Description of the ways in which the individual or his authorized representative can raise concerns and ask questions about the research, treatment, or service to which consent is given.

- **Evidence of informed consent shall be documented** in an individual's services record and indicated by the signature of the individual or his authorized representative on a form or the ISP.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- **Informed consent for electroconvulsive treatment** requires the following additional components:

  (1) Informed consent shall be in writing, documented on a form that shall become part of the individual's services record. This form shall:

  (a) Specify the maximum number of treatments to be administered during the series;

  (b) Indicate that the individual has been given the opportunity to view an instructional video presentation about the treatment procedures and their potential side effects; and

  (c) Be witnessed in writing by a person not involved in the individual's treatment who attests that the individual has been counseled and informed about the treatment procedures and potential side effects of the procedures.

Participation in Decision-making and Consent. 12 VAC 35-115-70

(2) Separate consent, documented on a new consent form, shall be obtained for any treatments exceeding the maximum number of treatments indicated on the initial consent form.

(3) Providers shall inform the individual or his authorized representative that the individual may obtain a second opinion before receiving ECT and the individual is free to refuse or withdraw his consent and to discontinue participation at any time without fear of reprisal against or prejudice to him. The provider shall document such notification in the individual's services record.

Participation in Decision-making and Consent. 12 VAC 35-115-70

(4) Before initiating ECT for any individual under age 18 years, two qualified child psychiatrists must concur with the treatment. The psychiatrists must be trained or experienced in treating children or adolescents and not directly involved in treating the individual. Both must examine the individual, consult with the prescribing psychiatrist, and document their concurrence with the treatment in the individual's services record.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Have an authorized representative make decisions for him in cases where the individual has been determined to lack capacity to consent or authorize the disclosure of information.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- If an individual who has an authorized representative who is not his legal guardian objects to the disclosure of specific information or a specific proposed treatment or service, the director or his designee shall immediately notify the human rights advocate and authorized representative. A petition for LHRC review of the objection may be filed under 12 VAC 35-115-200.
- If the authorized representative objects or refuses to consent to a specific proposed treatment or service for which consent is necessary, the provider shall not institute the proposed treatment, except in an emergency in accordance with this section or as otherwise permitted by law.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Be accompanied, except during forensic evaluations, by a person or persons whom the individual trusts to support and represent him when he participates in services planning, assessments, evaluations, including discussions and evaluations of the individual's capacity to consent, and discharge planning.
- Request admission to or discharge from any service at any time.

Participation in Decision-making and Consent. 12 VAC 35-115-70

The provider's duties:

- Providers shall respect, protect, and help develop each individual's ability to participate meaningfully in decisions regarding all aspects of services affecting him. This shall be done by involving the individual, to the extent permitted by his capacity, in decision making regarding all aspects of services.
- Providers shall ask the individual to express his preferences about decisions regarding all aspects of services that affect him and shall honor these preferences to the extent possible.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers shall give each individual the opportunity, and any help he needs, to participate meaningfully in the preparation of his services plan, discharge plan, and changes to these plans, and all other aspects of services he receives. Providers shall document these opportunities in the individual's services record.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers shall obtain and document in the individual's services record the individual's or his authorized representative's consent for any treatment before it begins.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- For **minors** in the legal custody of a natural or adoptive parent:
  - Provider shall obtain this consent from at least one parent.
  - Consent of a parent not needed if a court has ordered or consented to treatment or services pursuant to § 16.1-241 D, 16.1-275, or 54.1-2969 B of the Code of Virginia, or a local department of social services with custody of the minor has provided consent.
  - Reasonable efforts must be made, however, to notify the parent or legal custodian promptly following the treatment or services.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Additionally, a competent minor may independently consent to treatment for sexually transmitted or contagious diseases, family planning or pregnancy, or outpatient services or treatment for mental illness, emotional disturbance, or substance use disorders pursuant to § 54.1-2969 E of the Code of Virginia.

Participation in Decision-making and Consent. 12 VAC 35-115-70

Emergencies:

- Providers may initiate, administer, or undertake a proposed treatment without the consent of the individual or the individual's authorized representative in an emergency. All emergency treatment or services and the facts and circumstances justifying the emergency shall be documented in the individual's services record within 24 hours of the treatment or services.

  a. Providers shall immediately notify the authorized representative of the provision of treatment without consent during an emergency.

Participation in Decision-making and Consent. 12 VAC 35-115-70

b. Providers shall continue emergency treatment without consent beyond 24 hours only following a review of the individual's condition and if a new order is issued by a professional who is authorized by law and the provider to order treatment.

c. Providers shall notify the human rights advocate if emergency treatment without consent continues beyond 24 hours.

d. Providers shall develop and integrate treatment strategies into the ISP to address and prevent future emergencies to the extent possible following provision of emergency treatment without consent.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers shall obtain and document in the individual's services record the consent of the individual or his authorized representative to continue any treatment initiated in an emergency that lasts longer than 24 hours after the emergency began.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers may provide treatment in accordance with a court order or in accordance with other provisions of law that authorize such treatment or services including the Health Care Decisions Act (§ 54.1-2981 et seq. of the Code of Virginia).
- Provisions of these regulations are not intended to be exclusive of other provisions of law but are cumulative.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Providers shall respond to an individual's **request for discharge** and shall make sure that the individual is not subject to punishment, reprisal, or reduction in services because he makes a request.
  - However, if an individual leaves a service against medical advice, any subsequent billing of the individual by his private third party payer shall not constitute punishment or reprisal on the part of the provider.

Participation in Decision-making and Consent. 12 VAC 35-115-70

Discharge of Voluntary admissions:

- Individuals admitted under § 37.2-805 of the Code of Virginia to state hospitals operated by the department who notify the director of their intent to leave shall be discharged when appropriate, but no later than eight hours after notification, unless another provision of law authorizes the director to retain the individual for a longer period.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- Minors admitted under § 16.1-338 or 16.1-339 of the Code of Virginia shall be released to the parent's or legal guardian's custody within 48 hours of the consenting parent's or legal guardian's notification of withdrawal of consent, unless a petition for continued hospitalization pursuant to § 16.1-340 or 16.1-345 of the Code of Virginia is filed.

Participation in Decision-making and Consent. 12 VAC 35-115-70

Discharge of Involuntary admissions:

- When a minor involuntarily admitted under § 16.1-345 of the Code of Virginia no longer meets the commitment criteria, the director shall take appropriate steps to arrange the minor's discharge.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- When an individual involuntarily admitted under § 37.2-817 has been receiving services for more than 30 days and makes a written request for discharge, director shall determine whether the individual continues to meet the criteria for involuntary admission.
- If the director denies the request for discharge, he shall notify the individual in writing of the reasons for denial and of the individual's right to seek relief in the courts. The request and reasons for denial shall be included in the individual's services record.
- Anytime the individual meets any of the criteria for discharge set out in § 37.2-837 or 37.2-838 of the Code of Virginia, the director shall take all necessary steps to arrange the individual's discharge.

Participation in Decision-making and Consent. 12 VAC 35-115-70

- If at any time it is determined that an individual involuntarily admitted under Chapter 11 (§ 19.2-167 et seq.) or Chapter 11.1 (§ 19.2-182.2 et seq.) of Title 19.2 of the Code of Virginia no longer meets the criteria under which the individual was admitted and retained, the director or commissioner, as appropriate, shall seek judicial authorization to discharge or transfer the individual. Further, pursuant to § 19.2-182.6 of the Code of Virginia, the commissioner shall petition the committing court for conditional or unconditional release at any time he believes the acquittee no longer needs hospitalization.

Participation in Decision-making and Consent. 12 VAC 35-115-70

Discharge of Certified admissions:

- If an individual certified for admission to a state training center or his authorized representative requests discharge, the director or his designee shall contact the individual's community services board to finalize and implement the discharge plan.

Substitute Decision Making

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

- If the capacity of an individual to consent to treatment, services, or research or authorize the disclosure of information is in doubt, the provider shall obtain an evaluation ~~from a professional who is qualified by expertise, training, education, or credentials and~~ **conducted by or under the supervision of a licensed professional** not directly involved with the individual to determine whether the individual has capacity to consent or to authorize the disclosure of information.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

1. Capacity evaluations shall be obtained for all individuals who may lack capacity, even if they request that an authorized representative be designated or agree to submit to a recommended course of treatment.
2. In conducting this evaluation, the professional may seek comments from representatives accompanying the individual pursuant to 12 VAC-35-115-70 A 4 about the individual's capacity to consent or to authorize disclosure.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

3. Providers shall determine the need for an evaluation of an individual's capacity to consent or authorize disclosure of information and the need for a substitute decision maker whenever the individual's condition warrants, the individual requests such a review, at least every six months, and at discharge, except for individuals receiving acute inpatient services.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

a. If the individual's record indicates that the individual is not expected to obtain or regain capacity, the provider shall document annually that it has reviewed the individual's capacity to make decisions and whether there has been any change in that capacity.

b. Providers of acute inpatient services shall determine the need for an evaluation of an individual's capacity to consent or authorize disclosure of information whenever the individual's condition warrants or at least at every treatment team meeting. Results of such reviews shall be documented in the treatment team notes and communicated to the individual and his authorized representative.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

- **Capacity evaluations** shall be conducted in accordance with accepted standards of professional practice and shall indicate the specific type of decision for which the individual's capacity is being evaluated (e.g., medical) and shall indicate what specific type of decision the individual has or does not have the capacity to make. Capacity evaluations shall address the type of supports that might be used to increase the individual's decision-making capabilities.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

- If the individual or his family objects to the results of the licensed professional's determination, the provider shall immediately inform the human rights advocate.

  a. If the individual or family member wishes to obtain an **independent evaluation** of the individual's capacity, he may do so at his own expense and within reasonable timeframes consistent with his circumstances. If the individual or family member cannot pay for an independent evaluation, the individual may request that the LHRC consider the need for an independent evaluation pursuant to 12 VAC 35-115-200 B.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

- The provider shall take no action for which consent or authorization is required, except in an emergency, pending the results of the independent evaluation. The provider shall take no steps to designate an authorized representative until the independent evaluation is complete.

Determination of capacity to give consent or authorization. 12 VAC 35-115-145

b. If the independent evaluation is consistent with the provider's evaluation, the provider's evaluation is binding, and the provider shall implement it accordingly.

c. If the independent evaluation is not consistent with the provider's evaluation, the matter shall be referred to the LHRC for review and decision under 12 VAC 35-115-200.

Authorized Representatives

Authorized Representatives. 12 VAC 35-115-146

- When it is determined in accordance with 12 VAC-35-115-145 that an individual lacks the capacity to consent or authorize the disclosure of information, the provider shall recognize and obtain consent or authorization for those decisions for which the individual lacks capacity from the following if available:
  1. An attorney-in-fact who is currently empowered to consent or authorize the disclosure under the terms of a durable power of attorney;
  2. A health care agent appointed by the individual under an advance directive or power of attorney in accordance with the laws of Virginia; or

Authorized Representatives. 12 VAC 35-115-146

3. A legal guardian of the individual, or if the individual is a minor, a parent with legal custody of the minor or other person authorized to consent to treatment pursuant to § 54.1-2969 A of the Code of Virginia.

- If an attorney-in-fact, health care agent or legal guardian is not available, the director shall designate a substitute decision maker as authorized representative in the following order of priority:

Authorized Representatives. 12 VAC 35-115-146

- The individual's **family member**. In designating a family member, the director shall honor the individual's preference unless doing so is clinically contraindicated.

  a. If the director does not appoint the family member chosen by the individual, the individual shall be told of the reasons for the decision and information about how to request LHRC review according to 12 VAC 35-115-200.

Authorized Representatives. 12 VAC 35-115-146

b. If the individual does not have a preference or if the director does not honor the individual's preference in accordance with these regulations, the director shall select the best qualified person, if available, according to the following order of priority unless, from all information available to the director, another person in a lower priority is clearly better qualified.

(1) A spouse;

(2) An adult child;

(3) A parent;

(4) An adult brother or sister; or

(5) Any other relative of the individual.

Authorized Representatives. 12 VAC 35-115-146

- **Next friend** of the individual. If no other person specified above is available and willing to serve as authorized representative, a provider may designate a next friend of the individual, after a review and finding by the LHRC that the proposed next friend has, for a period of six months within two years prior to the designation either:

  a. Shared a residence with the individual; or

  b. Had regular contact or communication with the individual and provided significant emotional, personal, financial, spiritual, psychological, or other support and assistance to the individual.

Authorized Representatives. 12 VAC 35-115-146

- In addition to the conditions set forth above, the individual must have no objection to the proposed next friend being designated as the authorized representative.
- The person designated as next friend also shall:

a. Personally appear before the LHRC, unless the LHRC has waived the personal appearance; and

b. Agree to accept these responsibilities and act in the individual's best interest and in accordance with the individual's preferences, if known.

Authorized Representatives. 12 VAC 35-115-146

- The LHRC shall have the discretion to waive a personal appearance by the proposed next friend and to allow that person to appear before it by telephone, video, or other electronic means of communication as the LHRC may deem appropriate under the circumstances. Waiving the personal appearance of the proposed next friend should be done in very limited circumstances.
- If, after designation of a next friend, an appropriate family member becomes available to serve as authorized representative, the director shall replace the next friend with the family member.

Authorized Representatives. 12 VAC 35-115-146

- No director, employee, or agent of a provider may serve as an authorized representative for any individual receiving services delivered by that provider unless the authorized representative is a relative or the legal guardian
- When a provider, or the director, an employee, or agent of the provider is also the individual's guardian, the provider shall assure that the individual's preferences are included in the services plan and that the individual can make complaints about any aspect of the services he receives.

Authorized Representatives. 12 VAC 35-115-146

- The provider shall document the recognition or designation of an authorized representative in the individual's services record, including evidence of consultation with the individual about his preference, copies of applicable legal documents such as the durable power of attorney, advance directive, or guardianship order, names and contact information for family members, and, when there is more than one potential family member available for designation as authorized representative, the rationale for the designation of the particular family member as the authorized representative.

Authorized Representatives. 12 VAC 35-115-146

- If a provider documents that the individual lacks capacity to consent and no person is available or willing to act as an authorized representative, the provider shall:
  1. Attempt to identify a suitable person who would be willing to serve as guardian and ask the court to appoint that person to provide consent or authorization; or
  2. Ask a court to authorize treatment (See § 37.2-1101 of the Code of Virginia).
- Court orders authorizing treatment shall not be viewed as substituting or eliminating the need for an authorized representative.

Authorized Representatives. 12 VAC 35-115-146

- Providers shall review the need for court-ordered treatment and determine the availability of and seek an authorized representative whenever the individual's condition warrants, the individual requests such a review, or at least every six months except for individuals receiving acute inpatient treatment.
- Providers of acute inpatient services shall review the need for court-ordered treatment and determine the availability of and seek an authorized representative whenever the individual's condition warrants or at least at every treatment team meeting. All such reviews shall be documented in the individual's services record and communicated to the individual.

Authorized Representatives. 12 VAC 35-115-146

- When the provider recognizes or designates an authorized representative, the provider shall notify the court that its order is no longer needed and shall immediately suspend its use of the court order.

Authorized Representatives. 12 VAC 35-115-146

- Conditions for **removal of an authorized representative**. Whenever an individual has regained capacity to consent as indicated by a capacity evaluation or clinical determination, the director shall immediately remove any authorized representative designated pursuant to the above, notify the individual and the authorized representative, and ensure that the services record reflects that the individual is capable of making his own decisions.

Authorized Representatives. 12 VAC 35-115-146

- Whenever an individual with an authorized representative who is his legal guardian has regained his capacity to give informed consent, the director may use the applicable statutory provisions to remove the authorized representative. (See § 37.2-1012 of the Code of Virginia.) If powers of attorney and health care agents' powers do not cease of their own accord when a clinician has determined that the individual is no longer incapacitated, the director shall seek the consent of the individual and remove the person as authorized representative.

Authorized Representatives. 12 VAC 35-115-146

- The director shall remove the family or next friend authorized representative if the authorized representative becomes unavailable, unwilling, or unqualified to serve.
- The individual or the advocate may request the LHRC to review the director's decision to remove an authorized representative under the procedures set out at 12 VAC-35-115-180, and the LHRC may reinstate the authorized representative if it determines that the director's action was unjustified.

Authorized Representatives. 12 VAC 35-115-146

- Prior to any removal under this authority, the director shall notify the individual of the decision to remove the authorized representative, of his right to request that the LHRC review the decision, and of the reasons for the removal decision. This information shall be placed in the individual's services record.
- If the individual requests, the director shall provide him with a written statement of the facts and circumstances upon which the director relied in deciding to remove the authorized representative.

Authorized Representatives. 12 VAC 35-115-146

- The director may otherwise seek to replace an authorized representative who is an attorney-in-fact currently authorized to consent under the terms of a durable power of attorney, a health care agent appointed by an individual under an advance directive, a legal guardian of the individual, or, if the individual is a minor, a parent with legal custody of the individual, only by a court order under applicable statutory authority.

Special procedures for LHRC reviews involving consent and authorization

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- The individual, his authorized representative, or anyone acting on the individual's behalf may request in writing that the LHRC review the following situations and issue a decision:

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

1. If an individual objects at any time to the appointment of a specific person as authorized representative or any decision for which consent or authorization is required and has been given by his authorized representative, other than a legal guardian, he may ask the LHRC to decide whether his capacity was properly evaluated, the authorized representative was properly appointed, or his authorized representative's decision was made based on the individual's basic values and any preferences previously expressed by the individual to the extent that they are known, and if unknown or unclear in the individual's best interests.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- The provider shall take no action for which consent or authorization is required if the individual objects, except in an emergency or as otherwise permitted by law, pending the LHRC review.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC determines that the individual's capacity was properly evaluated, the authorized representative is properly designated, or the authorized representative's decision was made based on the individual's basic values and any preferences previously expressed by the individual to the extent that they are known, or if unknown or unclear in the individual's best interests, then the provider may proceed according to the decision of the authorized representative.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC determines that the individual's capacity was not properly evaluated or the authorized representative was not properly designated, then the provider shall take no action for which consent is required except in an emergency or as otherwise required or permitted by law, until the capacity review and authorized representative designation is properly done.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC determines that the authorized representative's decision was not made based on the individual's basic values and any preference previously expressed by the individual to the extent known, and if unknown or unclear, in the individual's best interests, then the provider shall take steps to remove the authorized representative pursuant to 12 VAC 35-115-146.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If an individual or his family member has obtained an independent evaluation of the individual's capacity to consent to treatment or services or to participate in human research or authorize the disclosure of information under 12 VAC 35-115-80, and the opinion of that evaluator conflicts with the opinion of the provider's evaluator, the LHRC may be requested to decide which evaluation will control.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC agrees that the individual lacks the capacity to consent to treatment or services or authorize disclosure of information, the director may begin or continue treatment or research or disclose information, but only with the appropriate consent or authorization of the authorized representative. The LHRC shall advise the individual of his right to appeal this determination to the SHRC under 12 VAC 35-115-210.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If the LHRC does not agree that the individual lacks the capacity to consent to treatment or services or authorize disclosure of information, the director shall not begin any treatment or research, or disclose information without the individual's consent or authorization, or shall take immediate steps to discontinue any actions begun without the consent or authorization of the individual. The director may appeal to the SHRC under 12 VAC 35-115-210 but may not take any further action until the SHRC issues its opinion.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- If a director makes a decision that affects an individual and the individual believes that the decision requires his personal consent or authorization or that of his authorized representative, he may object and ask the LHRC to decide whether consent or authorization is required.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- Regardless of the individual's capacity to consent to treatment or services or authorize disclosure of information, if the LHRC determines that a decision made by a director requires consent or authorization that was not obtained, the director shall immediately stop such action unless and until such consent or authorization is obtained. The director may appeal to the SHRC under 12 VAC 35-115-210 but may not take any further action until the SHRC issues its opinion.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- Before making such a decision, the LHRC shall review the action proposed by the director, any determination of lack of capacity, the opinion of the independent evaluator if applicable, and the individual's or his authorized representative's reasons for objecting to that determination.
- To facilitate its review, the LHRC may ask that a physician or licensed clinical psychologist not employed by the provider evaluate the individual at the provider's expense and give an opinion about his capacity to consent to treatment or authorize disclosure of information.

Special procedures for LHRC reviews involving consent and authorization 12 VAC 35-115-200

- The LHRC shall notify all parties and the human rights advocate of the decision within 10 working days of the initial request.

For Further Information

- Check the Department web site
- http://www.dbhds.virginia.gov/professionals-and-service-providers/human-rights-for-service-providers
  - Frequently Asked Questions (FAQ)

REPORT OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES

Supportive Decision-Making Study (HJR 190, 2014)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 6

COMMONWEALTH OF VIRGINIA
RICHMOND
2015

Supportive Decision Making Study
House Joint Resolution 190

To the Governor and the General Assembly

Prepared by the
Secretary of Health and Human Resources

November 2014

Executive Summary

The attached report contains information about the background and context for the alternative to guardianship known as Supported Decision Making. Below is an executive summary that provides specific responses to the three elements of HJR 90 as written.

i) examine the use of supported decision-making for individuals with intellectual and developmental disabilities in the Commonwealth;

At the present time, the Commonwealth has no official position on Supported Decision Making. Its use as an alternative to guardianship and other forms of substitute decision making is not codified in code, policy, or documents detailing appropriate standards of care. It is not formally or widely used within the Commonwealth at this time. While it is true that the concept of using natural supports, such as family and friends, to aid in the decision making process is discussed as a strategy for implementing guardianship arrangements, this occurs more by happenstance than by any conscious orchestration.

ii) compare the Commonwealth's policies and practices related to supported decision-making and informed choice to the policies and practices used in other jurisdictions; and

The Commonwealth currently has no defined policies or practices related to Supported Decision Making. Other jurisdictions have no structured mechanism in place to implement the Supported Decision Making model; states are in the process of exploring the utility of the model for their communities. One state is presently conducting research on the application of Supported Decision Making within the disability community. Other countries are exploring the model as well.

iii) after consultation with The Arc of Virginia, Voices of Virginia, the Autism Society, the Down Syndrome Association, the Jenny Hatch Justice Project, and other stakeholders, recommend strategies to improve the use of supported decision-making in the Commonwealth and ensure that individuals with intellectual and developmental disabilities are consistently informed about and receive the opportunity to participate in their important life decisions.

Recommendations based upon consultation with the above referenced agencies may be found at the end of the full report.

Background

The State of Virginia has developed extensive plans to close all but one training center in the Commonwealth. While these efforts have been guided by the tenets of the settlement agreement with the Department of Justice, they also reflect a broader understanding within the disability community that persons with intellectual disabilities are entitled to live lives that are as independent and self-directed as possible. As a result, the entire array of services offered to those with cognitive deficits is under review, from employment practices, to housing options, to crisis response systems. In ensuring that changes to the system meet the needs, preferences, and values of the individuals served, those practices and legal codes related to decision making capacity are likely to move to a prominent position in the process.

The issue of decision making capacity and what should be done to support those who need assistance in exercising this capacity has taken a position of prominence in the state in recent years. The case of Ms. Jenny Hatch has challenged disability providers, the guardianship system, and, perhaps, the legal community to reconsider the notion that individuals with more than a very mild intellectual disability cannot make effective decisions on their own behalf. In the case of Ms. Hatch, a petition to codify a guardianship relationship between Ms. Hatch and her parents was denied by the Virginia Circuit Court in Newport News, with Judge Pugh opting instead for a limited, time-restricted guardianship relationship between Jenny and her long-time friends, Kelly Morris and James Talbert. During the course of that trial, the practice of Supported Decision Making was presented as the rational, ethical, and most healthy psychological approach for assisting individuals with disabilities, such as Ms. Hatch, to be as autonomous as possible.

In understanding the relationship between Supported Decision Making and legal decision making capacity, it is important to understand that plenary decision making capacity does not exist. Capacity is specific to the type of decision that needs to be made. Generally, decision-making capacity falls within certain areas of a person's life including medical care, housing, finances, support services, and personal decisions (i.e., whether to get married, vote, or live with a friend). A person may have capacity to make one type of decision, yet lack the capacity to make decisions within another life arena. Therefore, any evaluation of an individual's decision making capacity must be determined in the context of the issue at hand. Supported Decision Making assumes that the individual has some ability to participate in and communicate about decisions that will influence their own lives. It assumes capacity while buttressing this skill with input from trusted friends, relatives, or support providers. Supported Decision Making replicates what we all do naturally: talk to our support system when confronting an important life decision and, when needed, ask professionals to present information to us in "layman's terms".

The theory behind Supported Decision Making is consistent with the state's vision for a system of care that is person-centered, community-based, and rooted in respect for the rights of the individual. To be consistent with this vision, the Supported Decision Making model should be used in any case where the issue of decision making capacity has been legitimately raised. This process will allow the individual to continue to use and improve their ability to make good decisions, while ensuring that they understand the relevant elements that need to be considered.

Virginia's Position on Supported Decision Making

The Commonwealth appears to have no formal position on the use of Supported Decision Making. Virginia continues to adopt the approaches as defined in the Commonwealth's Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, and Operated by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (i.e., the *Blue Book*). But at least one court in Virginia has positively evaluated the utility of the model as an alternative to guardianship as evidenced by the Jenny Hatch case. Given the legal outcome in the case of Jenny Hatch, it appears that Virginia may be in a unique position to assume a leadership role in this area of human rights, translating the model of Supported Decision Making into a defined standard of care.

Other states are also exploring supported decision making. For example, Pennsylvania's Disability Rights Network has published a booklet entitled *Consent, Capacity, and Substitute Decision Making*. While helpful, this resource primarily offers definitions and explanations about types of decision making and types of substitute decision making. The concept of Supported Decision Making as a specific practice is not mentioned in the document. The State of Massachusetts has initiated a small pilot study to offer supported decision making to a group of 10 individuals currently under guardianship. North Carolina and Maryland are also exploring the value of Supported Decision Making within their communities.

Other countries such as Australia, Canada, Sweden and England are also examining Supported Decision Making as an alternative to guardianship or other court-sanctioned substitute decision making arrangements. Indeed, reviews of these efforts have been published in Australia and Canada.

Initial Recommendations

1. In an effort to begin to formalize Supported Decision Making as a legitimate alternative to Guardianship, add Supportive Decision Making to the less restrictive alternatives in guardianship and conservatorship statute as well as to DBHDS code concerning Authorized Representatives.
2. Individuals who are appointed to positions as guardians or authorized representatives should be required to receive training in Supported Decision Making and Person Centered Planning. They should espouse their commitment to incorporating such practices into their roles. Failure to participate in designated training would be grounds for removal of the individual from their decision making role.
3. Because a capacity evaluation should always be the first step in any discussion of programs or processes that seek to impact a person's right to make a decision freely and at will, it is recommended that the Commonwealth develop a standardized procedure for completing capacity evaluations. Additionally, it is recommended that a minimum standard relative to the written report summarizing the findings of the capacity evaluation be developed.
4. Capacity is a poorly understood concept among providers and some mental health professionals. It is recommended that a general training on capacity and Supported Decision Making be developed and offered. It is recommended that part of this training include a discussion of all types of decision making assistance commonly in use and what type of clinical presentation is appropriate for each.

These recommendations in whole or in part were endorsed by representatives of The Arc of Virginia, the Down Syndrome Association of Northern Virginia, Voices of Virginia, the Autism Society of America- Central Virginia Chapter and the Autism Society of America- Northern Virginia Chapter. Quality Trust (Jenny Hatch Justice Project) and Down Syndrome Association of Greater Richmond are also in agreement with the recommendations.

Conclusion:

The Commonwealth may be in a distinct position to build momentum for the development of a formal position on supported decision making due to the national news coverage of the Jenny Hatch case and the on-going involvement of the Quality Trust for Individuals with Disabilities. Supported Decision Making is consistent with current expectations from the Centers for Medicare and Medicaid Services in their final rule around Home and Community Based Waiver Services as it relates to person centered practices. Developing some standardized expectations around assessing and reporting on capacity as well as training both provider staff and potential legal guardians and authorized representatives regarding supported decision making will only serve to enhance

and improve the way Virginia supports and respects the rights of individuals with developmental disabilities.

A Checklist for Person Centered Information Gathering and ISP Development

Developed by
Mary Lou Bourne 2008
Based on the work of
Smull, Bourne, & Allen 2005

A Checklist for Information Gathering and Assessment

Based on the work provided by

A Checklist for Developing A Plan

A Check List for Information Gathering

Stage 1 - Thinking about what you want to learn and how to learn it

Before you begin to gather information for a plan with anyone, you should learn what the person and those around them want the plan to accomplish. If you are working with someone to develop a plan that is the annual ISP make sure you are helping people to look at what is going on in the person's life and discovering what needs to change and what needs to stay the same. Service plans have rules to conform to but this does not require empty rituals that do not help the person move forward with their life.

Make sure that you are planning in partnership, that you are planning smarter. Look to see how the person can best participate in each phase. How about family members? Are there others in the person's life that can assist? How are you collaborating with all service providers involved in the person's life? Remember, the more you support others in developing a good plan the more likely it will be used and acted on.

Have you answered the following questions?

- ☐ What does the plan need to accomplish?
- ☐ What results does the person want in his or her life, after this plan is implemented?
- ☐ Who else needs to participate/agree so that the plan is implemented?

Learning who to talk to

- ☐ Do a simple "relationship map" with the person (if the person does not communicate with words fill it out as you think they would, ask others who are also close to the person if they agree with your information)
- ☐ Start gathering information from the people closest to the person.

Before you gather information ask -

- ☐ How can the person with whom you are planning best participate in the development of the plan?
  - Are there parts of the process that they can do or support?
- ☐ Are there family members who can take a lead role in gathering information or in putting the information into the plan
- ☐ Are there people who are not related but who know and care about the person? If yes
  - How will you gather information from those people?
- ☐ How do you plan to make sure that the process feels respectful to the person with whom you are planning?
- ☐ Who knows what it takes for the person to be happy?
- ☐ Who best understands any issues of health or safety?
- ☐ What is the best method for gathering information from the people who know the person best?

Develop an information gathering strategy from the answers to the above questions. Determine which questions you will ask of which people and at what time? Use a chart to keep track of who will provide what information.

Who Should be contacted?	What questions should we ask?	Who will talk with them and when?

Stage 2 - Gathering information

Using what you learned in the previous section, gather information using either conversations/meetings face-to-face, or phone calls. We know that the least effective method of assessment and information gathering is to mail out blank ISP pages or forms and ask people to complete them and return them to you. Be sure you have had conversations using the guidelines listed below. Record information from conversations on either the conversation packs found at www.elpnet.net, or the handouts from Facilitator Training. Look at what you have and see if you have information recorded in several of the following areas:

Learning from the person:

- ☐ Great things about you
- ☐ What you like to do (favorite things/things you don't like to do)
- ☐ The best/worst week day information sheets
- ☐ The best/worst weekend information sheets
- ☐ The positive rituals survey

Learning from those who know the person:

- ☐ Learning who to listen to: Using "Talking with people who know and care: an individual interview"
- ☐ The "unlimited power" questions;
- ☐ Two minute drill;
- ☐ Great things about this person;
- ☐ What he or she likes to do (favorite things/things he or she doesn't like to do);
- ☐ The best/worst week day information sheets;
- ☐ The best/worst weekend information sheets;
- ☐ The positive rituals survey.
- ☐ Additional Health and Safety Rituals or Routines
- ☐ The *communication chart* (when the person does not use words to talk or communicates in other ways)

Learning from other information gathered about the person:

- ☐ Is there information that a regulatory requirement dictates must be gathered? If so, who will provide it to the ISP facilitator?
- ☐ Does an agency policy or funding source policy require certain administrative information be included in the person's plan in order to provide funding for services? If so, have you collected it?

- ☐ Assessment information collected by a provider to complete the Health and Safety focus areas or other information regarding skill/ability requirements.
- ☐ Previous Notes/Medical History information regarding contacts/medical appointments, follow up, etc.
- ☐ Quarterly reports indicating Health or Safety issues addressed during the year.
- ☐ Information reported through the Incident Management system of your state, which may be necessary to plan for the person's health or safety during the upcoming year.
- ☐ Other information required by your state administrative agencies

☐ Stage 3 – Developing a draft first plan

After you have completed some parts of stage 2, you will be ready to start this stage.

Write a first draft based on what you have learned.

- ☐ Look at the answers to the "like the most", "admire the most", and "great things about you" questions and see which answers should be in the section called *What Others Admire About* . . .
- ☐ Look at the "people" or relationship map and see who is important to the person and how important.
- ☐ Look at the favorite things, best day/worst day, and positive rituals information and ask what that tells you about what is important to the person and how important each item is.
- ☐ Look at the answers to the "unlimited power" questions and ask what that tells you about what/who should be present or absent in the person's life and how important those things/activities/people are.
- ☐ Look for agreement among the people that you interviewed. Where there is agreement you can feel more comfortable that the information is probably accurate.
- ☐ Look for information that provides details of how to support someone – begin to make a list of "you need to know this… and when that occurs, you need to do this…" to provide clear simple directions for how to successfully provide support to the person.
- ☐ Who else do you need to talk to/get information from? What is the easiest and best way to get that information
- ☐ What questions do you still have? What issues still need to be resolved? Make a list of the things to be figured out.

Did you remember to:

- ☐ Separate what is important <u>for</u> the person from what is important <u>to</u> the person?
- ☐ Include what needs to be absent from the person's life, what they dislike?
- ☐ Include all of the details of rituals/routines, only if the person needs a lot of assistance in getting things done and can't tell people how they want it to happen.
- ☐ See if the plan has information that the person does not want everyone to know. If it does, you may need to develop "public" and "private" sections of the plan. Include critical health information if the person will be supported by people other than family members?

Guidelines to use in writing each section of the plan

Going from first draft to first plan

When you have a draft you think meets first plan criteria ask someone you are comfortable with to read the plan to see how well it communicates (be sure to follow all confidentiality requirements of your agency). Ask the reader to share all of his/her questions. This will help you with clarity. Don't forget to review your draft with the person. It is very important that the plan respectfully convey the information necessary so that people who provide support understand what matters the most to the person. It is also important that the plan convey how to achieve that while also balancing health, safety and issues necessary to be valued by the community. This requires language that is respectful and demonstrates the person's gifts and talents, yet is easily understood by the reader.

General rules for your next draft are:

- Use complete thoughts; short, concise sentences are better than single phrases.
- Use common, everyday language rather than the terms and abbreviations used by government and community agencies that support people ; (avoid jargon)
- Make sure that each item listed has enough detail and/or enough examples that someone newly present in the person's life would understand what was meant;
- There are no long "laundry lists" of items; those that fit together are grouped together, with a space between groups; and
- Where there are 4 or more things grouped together there is a topic statement followed by the group of items with bullets.

In the **administrative section** (or cover page) the reader should learn:

- Whose plan is it;
- When it was done;
- Who the support coordinator is
- Where the person lives;
- Who the person lives with
- Anything else that is required by your local administrative entity.

Introduction – What Others Like and Admire about the person: should list what other people like and admire about the person and:

- It should list things that we might like or admire about anyone of roughly the same age.
- It should not include things that we only say about people who need support or is "faint praise".
- It should use the same type of language we use to introduce new friends or neighbors.
- Where there are more than 6 or so items listed, related items should be grouped to make it more likely that they all will be read.

What Others Need to Know or do to Support, this section of the plan clearly describes what people who provide support are expected to do so that the person is likely to have more good days, balanced with what is important for them. Where there are four or more items that are similar, use one statement to introduce the 'theme' followed by bullets with the details. Separate distinct thoughts.
In this section, the reader learns what others need to know or do:

- So that the person has what is important *to* him or her; and
- There is a good balance between what is important to and what is important for the person.
- This section of the plan is written with sufficient detail so that those responsible for providing the support will get it right.
- It includes directions on preferences and approach that are not found otherwise in the ISP

"**Characteristics of People who Best Support**" informs the reader about who or what type of people should work with the person.

- What are the characteristics that you should look for? For example, Katherine's section includes: "enjoys being silly; and, comfortable with sharing personal space." These are things that a support person must "come with" and cannot be "trained to do". For the ISP you will need to include this information in the section titled *What people Should Know and Do to support.*

What is important to the person, this section describes what the person perceives as being important to him or her. This section represents the person's perspective.

- It must not include items that others think *should* be important to the person. (These are things that are important *for* the person and may be used in the next "support" section.)
- It should only include those things that the person "tells" us are important (with words or behavior).
- These should include what the person views as important in -
    - Relationships,
    - Things to do
    - Places to be
    - Rituals and routines
    - Rhythm or pace of life
    - Items to have available
    - Other things which are likely to contribute to the presence of more good days than bad days in the person's life.
- They should be sorted by those that are the most important and those that are important (but not critical).

Desired Activities these include things to do from the person's perspective. They provide a basis for community connections, either building on those that already exist, or starting to build them for those who are not currently connected to their community.

- They should include activities the person would like to try, but may not have had a chance to try yet
- They should include activities that the person enjoys doing and would like to do on a regular basis
- This should also include things to do that the person has expressed an interest in and the team has not figured out how to make it happen.

What Makes Sense/What works: What Doesn't Make Sense /Doesn't work
To do this requires 2 separate skills. Those participating need to be able to look at the current situation from the perspectives of the person, those paid to support and (where their perspective is different) family members. The second skill is the ability to tease a situation apart so that both what makes sense about the current situation and what does not make sense about the current situation is clearly described from each perspective.

It is helpful if the "what is and is not working" analysis occurs in a focused manner. If people give general answers, then ask the questions specifically about:

- Where the person lives
- Who lives with the person
- The presence (or absence) of other people in the person's life
- What the person does for fun
- What the person does during the daytime
- Access to, or interest in, financial resources, money
- The amount of control the person has in his/her life

(For example, ask specifically- what is working, what's the upside right now, about who John lives with? What is not working, what's the downside right now, about who John lives with?)

A few additional tips on using What is Working/Not Working as a tool for the team to strategize.

- This is a tool for negotiating differences. The 3 rules of negotiating include
  - Everyone must feel listened to
  - Start with common ground
  - Remain unconditionally constructive – "How Can We….."
- Everything in life has a few upsides and a few downsides; it is the balance between the two as well as the weight of each issue that matters.
- In addition, the person's perspective should come either directly from him or her, or else from only those people who know him or her the best.
- It is NOT a method to change people's opinions, or to even get everyone to agree with one opinion. It is a method to give everyone a chance to have their different perspectives heard.

- It is NOT a list of "What WOULD make sense IF….." It is to be a true picture of CURRENT REALITY for the person's life.
- Where there is agreement, you have an agenda to build your action plan (start with common ground!)
- Using shorthand or one word descriptions is confusing and increases the likelihood support staff will act in the wrong manner. For example, just recording the word "work" under What Makes Sense from the person's perspective could mean many things. It is much more focused and helpful to write "having work that he is paid to do".

Finally there needs to be a description of what is going to be done to maintain those things that do make sense, address those that do not make sense, and answer the questions in the "things to figure out" section. This description of activities is best addressed through the Action Plan section addressed later in this guideline. Using this information is a good bridge to Outcomes Development.

Health and Safety Areas

The sections of the ISP covering Medical Information should include:

- Information about the health professionals involved in the person's life, and recent health appointments.
- Information about medication and side effects that the person has experienced or could experience.
- Information about allergies, current and past diagnoses, and particular health concerns and how they are addressed.

The separate sections on Health and Safety Focus Areas must include specific instructions regarding what the person is able to do for themselves in the specific area. Include instructions regarding how best a person can be supported by others within this area, and any assistance they will need from others.

Be sure to pay attention to:

- **Always start with those things the person is able to do for him or her self; the talents and abilities the person has in the specific area.**
- Special instructions about how a person swallows, or the help they need to avoid choking if this applies, or how a person needs to be positioned
- Any safety issues that the people who provide support must know about. These should include a clear description of the degree to which the person can keep him/her self safe, and the type of support they need from others to stay safe.
- Any other issues that people who will provide support (paid or unpaid) should know about in order to minimize the risks towards the person's health and safety.
- Include in this information general safety information, fire safety, stranger awareness, traffic safety, cooking and appliance use, conveying information about the person's identity, and awareness or understanding of materials or items in the home or outside that may pose a risk or threat.

On-going learning and using what has been learned

Continuing the learning and recording what you learn -

Who else needs to contribute? What is the best and easiest way to get their contribution? Some of the ways listed below may work. Remember that you can use just one of them or combine them –

- Continue to interview people
- Send some of the information gathering pages from the manual
- Send parts of the draft plan for them to write on
- Have an information gathering party

How are you going to record the on-going learning? People change and our understanding of them deepens over time. You need to have easy ways to record this learning or it will be lost. Think about who will be doing the learning and what way(s) of recording it will be easiest for them. Look at the ways that are listed below and think about what will work best for you.

- As you learn new information, write it down. Write down questions on the right margins of the plan, where you think there is learning to do. Make multiple copies of the plan and ask those involved to write their impressions directly on the plan. Gather these copies as makes sense and enter the learning on the typed side.
- Get copies of the plan to the people who will be doing the learning, with questions written on them. Interview them as you write notes and transcribe it on to the plan.
- Have periodic gatherings of those people who care about the person and ask them what they have learned. Take notes and transcribe the learning onto the plan.

Using the plan (acting on what was learned)

The purpose of developing a plan is to help the person move toward the life that they want while addressing any issues of health or safety. For people who are not getting paid services this process can be very informal.

- For people who receive paid services, the process of planning and review often have federal and state requirements. While person centered practices can be (and are) used to meet these requirements, some state requirements may dictate the gathering of specific information. These areas will need to be addressed in the ISP document and should be a collaborative effort among those who provide supports/services to the person.
- Every agency also has its own approach to plan development and updating. Frequently this involves a formal meeting process. However, regardless of the reason for the process, any gathering of people who are looking at the future should seek to answer the following questions:

Since the last time we got together -

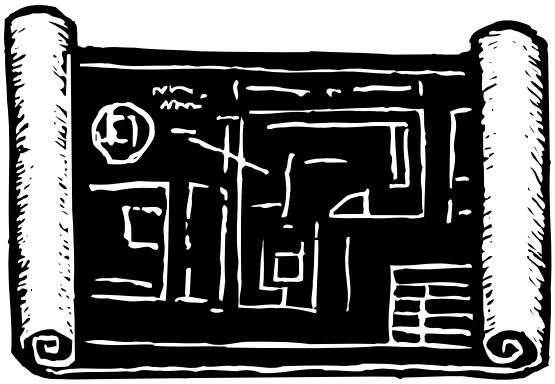
- What have we tried?
- What have we learned?
- What are we pleased about?
- What are we concerned about?

From these answers the team can then answer:

- What do we need to do next?
  - What else might we try?
  - What else do we need to learn?

In many instances there needs to be a process that helps people summarize the learning and then go to a description of how they are going to act on what they have learned (recorded in the outcome action section of the plan). The methods used during this process should be recorded in the "how will we know progress is being made?" section of the Action Plan. It may be necessary to repeat the What's Working and Not Working Section of the plan, after reviewing what has been tried. This information is then compared with Outcomes and Actions, and can be used to document the progress that has been made on the outcomes.

For sample plans, additional Conversation Packets, or other materials to assist you with developing person centered approach toward developing ISP's, please visit the website: www.elpnet.net .



Listen, Learn, Plan

A Guide for Developing Preliminary Essential Lifestyle Plans

Conversation with the Person with Whom You are Planning

Developed by

A Note

This guide was developed for use by facilitators for their work in developing preliminary plans. Those who wish to reproduce it for other purposes should seek permission from Michael Smull or Allen, Shea & Associates.

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References:

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Your Personal Passport
by Allen, Shea & Associates

Getting to Know You
by Claudia Bolton and Bill Allen

Reviewing Essential Lifestyle plans: Criteria for Best Plans
by Michael W. Smull, Helen Sanderson, & Susan Burke Harrison

Learning from the individual

The most important person to 'listen to' is the person with whom you are planning. The following material (from *Listen to Me* which is available on the website) will help you have a conversation that will begin to tell you what is important to someone. If the person does not use words to talk, you still need to spend time with him or her so that you have some ideas about how they would answer these questions. Some people will want to fill this out on their own. Others might need the help of family and friends to complete it.

Name of the person with whom you are planning: _____

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Learning who to talk to

The easiest way to learn who to talk to is to do a simple *relationship map* (this one was developed by Louisa Hext and Leah Holden) with the person.

At the center write the person's name. In the next circle write the names of those people closest to the person. Remember that these may or may not include those who spend the most time with the person, they are the people that the person feels closest to (those whom the person loves, good friends). Put those people who the person feels somewhat less close to in the next circle (friends, people the person cares about). On the outside put those people who are acquaintances, or relatives that the person does not feel close to. Paid staff may be in any of these circles. Ask how the person feels about them. Divide the names into 4 groups:

- *Family* - people who are related to the person
- *Home and supports* - paid or unpaid people, who are not family, who provide support at home or in the community
- *Friends* - people that the person sees as friends (who are not listed under home or in the community)
- *Work/School* - paid or unpaid people who provide support wherever the person spends their days

Please note that although some people have more than one role (for example, they are friends and are paid to provide support), but they should only be listed once. The idea of the map is to have a quick way of looking at relationships and to help you with who you should talk to (who should contribute to the plan).

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People Map

Home and Supports

Family

Friends

Work

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What are some great things about you?

What are some great things about you? What do you like about you? What are some things you're good at? proud of? What are some nice things that people say about you? What do people thank you for?

Note: This is sometimes hard for people to answer, so you might want to start by asking a friend or relative. These are important things to think about when you are figuring out the kinds of services and supports that someone needs and want.

Great Things About You

What things do you like to do?

To help get started, ask:

What things do you like to do? at home? at work? at program? at college? for fun? around town? on vacation? What kind of music do you like? What kind of movies do you like? What kind of food do you like? Do you have any hobbies? Do you collect things? What are the things you don't like or don't like to do? Did you do something before that you liked to do (like a class or a job)?

Your List of Favorite Things . . .

Things You Don't Like or Don't Like to Do . . .

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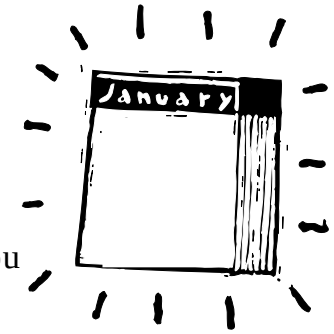
The week day



First, what does your Monday through Friday morning look like right now? What do you do when you first get up? What do you eat for breakfast? When do you leave for work? Next, what would be your best Monday through Friday morning? If you could be doing anything, what would it be? Finally, what would be your worst Monday through Friday morning? What kinds of things make you mad, sad, frustrated in the morning? What kinds of things bug when you first get up?

What does your Monday through Friday day look like right now? What do you do when you first get to work or program? What kinds of work or activities do you do now? Next, what would be your best Monday through Friday day? If you could be doing anything, what would it be? What kinds of activities make you happy? Who would you do it with? Finally, what would be your worst Monday through Friday day? What kinds of things make you mad, sad, frustrated during the day? What places (or people) would you like to stay away from?

Finally, what does your Monday through Friday night look like right now? What do you do when you first get home? What do you have for dinner? What kinds of activities do you do now? Next, what would be your best Monday through Friday night? If you could be doing anything, what would it be? What kinds of activities make you happy? Who would you do it with? Finally, what would be your worst Monday through Friday night? What kinds of things make you mad, sad, frustrated during the evening?

The Best Week Day Would Be

When you first get up

The Week Day Right Now

When you first get up

The Worst Week Day Would Be

When you first get up

The Best Week Day Would Be

During the day

The Week Day Right Now

During the day

The Worst Week Day Would Be

During the day

The Worst Week Day Would Be

At night

The Week Day Right Now

At night

The Best Week Day Would Be

At night

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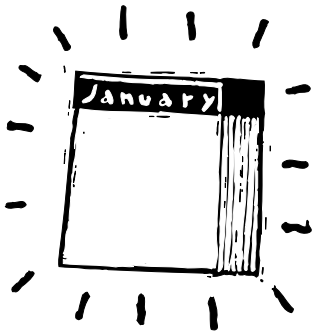
What is different about the weekend?



First, what does your Saturday and Sunday morning look like right now? Is there anything different about the weekend during the morning, in the afternoon, evening?

Next, what would be your best Saturday and Sunday? If you could be doing anything, what would it be?

Finally, what would be your worst Saturday and Sunday?

The Worst Weekend Would Be

The Weekend Right Now

The Best Weekend Would Be

Additional Information (if needed): Positive Rituals Survey

Positive rituals ease us through our days and help us mark special occasions. For each of the following questions, include as much detail as you can. Do not be trapped by the space provided, use extra sheets of paper. Remember that the more physical assistance someone needs and the less they are able to talk about their support needs, the more detail is needed for the positive rituals and routines. Positive rituals that detail intimate personal care can be part of someone's "private" plan that you only show certain people.

1. List some of the individual's daily rituals. Pay particular attention to the beginning of the day and the end of the day rituals. Each of us have specific activities that we do every morning including whether we brush our teeth before bathing, during our shower, before we leave the bathroom, or after breakfast, that comprise our morning rituals.

List morning (getting up) rituals -

List nighttime (going to bed) rituals -

2. List some of your the individual's rituals of transition - What does he or she do everyday when arriving at work, school or training? When arriving home from work, school or training?

List arriving at work, school or training rituals -

List arriving at home rituals -

3. List some of the individual's weekly rituals -

List Sunday rituals (if there are a couple of different ways, list them all)-

List any regular weekly rituals (friends that always visited, TV shows always watched) -

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4. List some of the individual's rituals of celebration and comfort -

Indicate how he/she likes to celebrate when something good happens.-

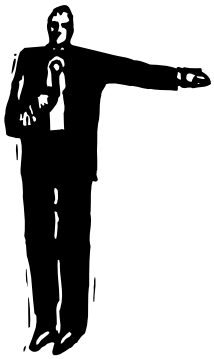
Indicate how he/she comforts him or herself when something unpleasant happens, how does he/she make him or herself feel better?

5. List some holiday rituals -

What has to happen in order for it to be his or her birthday?

What foods have to be on the table at which holidays?

What does he or she have to do during some holidays (e.g., go look at the Christmas lights)?



Listen to Me Communicate

This part of the workbook is to help people understand how you communicate with and without words. Are there special words or ways you act to let others know something. For example, if you laugh when you meet someone new, it may mean you are nervous or are just happy to meet the person.

The space titled **what is happening** tells people about the place, the people around, or the activity.. The space titled **I do this** describes what you do. The space titled **It means** tells people what you mean by the words or actions. The space titled **You should** what to do to support you.

The following page has a sample to help you get started.

What is happening	I do this	It means	You should
I am quiet	I sit with my hands covering my face	Something has happened to upset me	Sit down with me and ask me what's wrong. Encourage me to talk about feelings. Give me time to talk.
I am quiet	I lie down or go to be alone	I do not feel well (I am ill or have a headache)	Ask me what's wrong. I may need encouragement to talk. If I am not well, give me the option to go home for Tylenol and come back or stay home.

It's easiest to start with **I do**, then move on to **It means** and then outward to **what is happening** and **you should**.

What is happening	I do this	It means	You should

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Hopes and Dreams for the Future

What are your hopes and dreams? What would be your best future? For example:

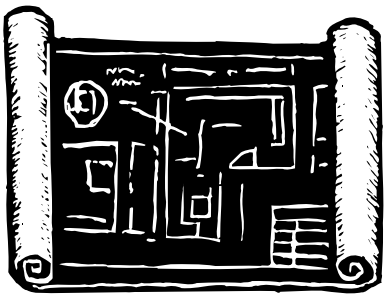
Where would you live? with whom?

What do you do during the day?

What would you do for fun?

Remember, there are no right or wrong answers! Just take a few minutes and think about what could be and don't worry about things that might get in the way.

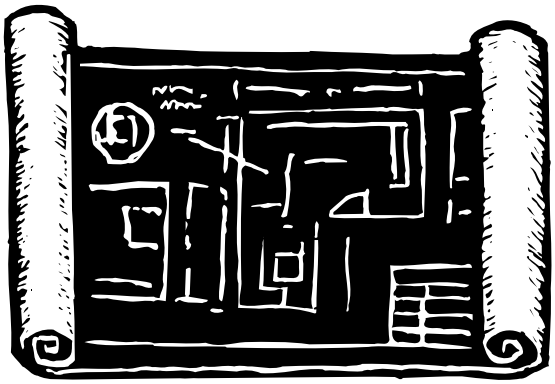
Hopes and Dreams for the Future are . . .



Listen, Learn, Plan

A Guide for Developing Preliminary Essential Lifestyle Plans

Conversation with the Person with Whom You are Planning



Listen, Learn, Plan

A Guide for Developing Preliminary Essential Lifestyle Plans

Conversations with Family and Support Services

Developed by

Listen, Learn, Plan

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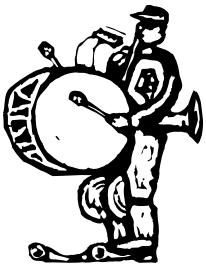

Talking to Family and Support Services

Introduction

This format is used to develop a conversation with close family members and support service providers of the focus person who know and care about him or her and who know about daily routines and rituals in great detail.

Listening to others

Each person you talk to will have important contributions to make and may become important participants in the individual's plan. As you talk with people you need to help them articulate their concerns as specifically as possible. The more general the concern the more difficult it is to address. For example, if someone tells you that they think that the individual is vulnerable and they are worried about safety, try to find out as much as you can about what this means.

Remember, this is a conversation and not an interview

While you should think about what you want to learn you must be prepared to learn things that you did not anticipate. If you just have an interview (by asking a set of prepared questions) you will learn only what you expected to learn. If you have a conversation (and listen carefully) you will learn things that are important and that no-one suggested in advance. In each conversation you want to avoid:

Questions that are close ended. Questions whose answer is yes or no (e.g. Does the individual seem easy to get along with?) and questions whose answer is one or the other (e.g., Do you see the individual living in a house or an apartment?).

Questions that have a built in answer (e.g. Would the individual benefit from having more opportunities to make friends?). Keep in mind that some of the built-in answers are a bit more subtle, they come with a head nod, a change of inflection, etc.

Questions where people who are eager to please simply look to you for the answer.

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Talking to People Who Know and Care:

Name of the Person with Whom You are Planning:

Name of the Person Interviewed:

What is your relationship to the person?

How long have you known him or her?

How much time do you typically spend with him or her?

What are some great things about this individual?

What are some great things about the individual? What do people like about him or her? What do other people like or admire about the individual? What are some things he or she is good at? proud of? What are some nice things that people say about this individual?

These are important things to think about when you are figuring out the kinds of services and supports someone might need.

Great Things About the Individual

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What things do you like to do?

What things does he or she like to do? at home? at work? at program? at college? for fun? around town? on vacation? What kind of music does he or she like? What kind of movies? What kind of food? How about hobbies?

List of Favorite Things . . .

Things He or She Doesn't Like or Doesn't Like to Do . . .

Unlimited Power Questions

If you were given unlimited power, authority and money and you were asked to help him or her have a great day and/or a great week-

What would you do?

What would the day/week be like?

If you had the same power, authority and money but your evil twin took over and was determined to help him or her have a really awful day/ week -

What would you do?

What would the day /week be like?

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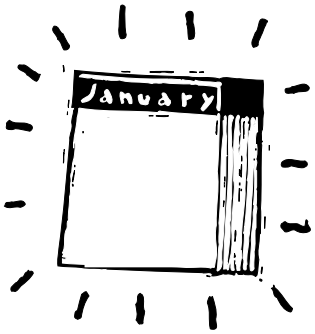
Imagine that you are supporting him or her and you have an emergency that means you suddenly have to leave. The person who will "fill in" has arrived and you have two minutes to give advice, suggestions, or tips about supporting him or her, what would you say?

The week day



What does this individual's Monday through Friday morning look like right now? What does he or she do when first getting up? Eat for breakfast? Leave for work? Next, what would be his or her best Monday through Friday morning? If it could be anything, what would it be? Finally, what would be the worst Monday through Friday morning? What kinds of things make him or her mad, sad, frustrated in the morning? What kinds of things bug him or her when first getting up?

What does Monday through Friday day look like right now? What happens when first getting to work or program? What kinds of work or activities occur now? Next, what would be the best Monday through Friday day? If anything, what would it be? What kinds of activities make him or her happy? Who would he or she do it with? Finally, what would be the worst Monday through Friday day? What kinds of things make this individual mad, sad, frustrated during the day? What places (or people) would he or she like to stay away from?

What does Monday through Friday night look like right now? What happens when first getting home? What's for dinner? What kinds of activities? Next, what would be a best Monday through Friday night? If anything, what would it be? What kinds of activities make this person happy? Who would he or she do it with? Finally, what would be the worst Monday through Friday night? What kinds of things make him or her mad, sad, frustrated during the evening?

Do not do **all** of a typical day, then a good day, then a bad day. Take 'horizontal" slices of time - what is a typical, good, bad, morning like.

Your Notes:

What did you find out? ▪ ▪ ▪ ▪ ▪➔

Best Week Day Would Be

When first get up

Week Day Right Now

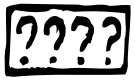
When first get up

Worst Week Day Would Be

When first get up

Best Week Day Would Be

During the day



Week Day Right Now

During the day

Worst Week Day Would Be

During the day

Worst Week Day Would Be

At night

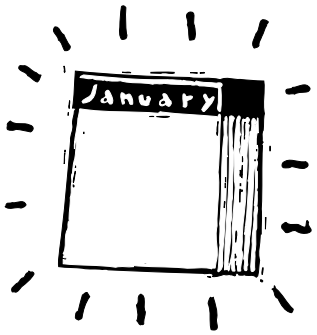
Week Day Right Now

At night

Best Week Day Would Be

At night

What is different about the weekend?



What does Saturday and Sunday morning look like right now? What happens when he or she first gets up? What time is it? Eat for breakfast? Next, what would be the best Saturday and Sunday morning? If anything, what would it be? Finally, what would be the worst Saturday and Sunday morning? What kinds of things make him or her mad, sad, frustrated in the morning?

What does Saturday and Sunday look like right now? What kinds of activities occur now? Next, what would be the best Saturday and Sunday? If anything, what would it be? What kinds of activities make this individual happy? Who would he or she do it with? Finally, what would be the worst Saturday and Sunday? What kinds of things make this person mad, sad, frustrated during the day? What places (or people) would he or she like to stay away from?

What does your Saturday and Sunday night look like right now? What's for dinner? What kinds of activities? Next, what would be the best Saturday and Sunday night? If anything, what would it be? What kinds of activities make him or happy? Who would he or she do it with? Finally, what would be the worst Saturday and Sunday night? What kinds of things make this person mad, sad, frustrated during the evening?

Again, remember not to take a whole, typical Saturday or Sunday. Take pieces of time and ask for the typical, best and worst version of it.

Your Notes:

What did you find out? ▪ ▪ ▪ ▪ ▪ ➔

Best Weekend Would Be

When first get up

Weekend Right Now

When first get up

Worst Weekend Would Be

When first get up

Worst Weekend Would Be

During the day

Weekend Right Now

During the day

Best Weekend Would Be

During the day

Worst Weekend Would Be

At night

Weekend Right Now

At night

Best Weekend Would Be

At night

Additional Information (if needed): Positive Rituals Survey

Positive rituals ease us through our days and help us mark special occasions. For each of the following questions, include as much detail as you can. Do not be trapped by the space provided, use extra sheets of paper. Remember that the more physical assistance someone needs and the less they are able to talk about their support needs, the more detail is needed for the positive rituals and routines. Positive rituals that detail intimate personal care can be part of someone's "private" plan that you only show certain people.

1. List some of the individual's daily rituals. Pay particular attention to the beginning of the day and the end of the day rituals. Each of us have specific activities that we do every morning including whether we brush our teeth before bathing, during our shower, before we leave the bathroom, or after breakfast, that comprise our morning rituals.

List morning (getting up) rituals -

List nighttime (going to bed) rituals -

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2. List some of your the individual's rituals of transition - What does he or she do everyday when arriving at work, school or training? When arriving home from work, school or training?

List arriving at work, school or training rituals -

List arriving at home rituals -

3. List some of the individual's weekly rituals -

List Sunday rituals (if there are a couple of different ways, list them all)-

List any regular weekly rituals (friends that always visited, TV shows always watched) -

4. List some of the individual's rituals of celebration and comfort -

Indicate how he/she likes to celebrate when something good happens.-

Indicate how he/she comforts him or herself when something unpleasant happens, how does he/she make him or herself feel better?

5. List some holiday rituals -

What has to happen in order for it to be his or her birthday?

What foods have to be on the table at which holidays?

What does he or she have to do during some holidays (e.g., go look at the Christmas lights)?

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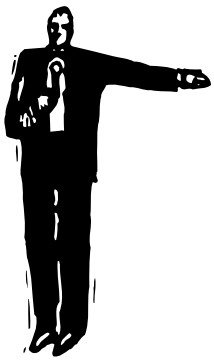


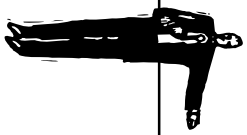
Listen to Me Communicate

This part of the workbook is designed to support people who do not use words to talk, or who have difficulty in communicating with words. This section is also useful for people who do use words to talk but are difficult to understand and as a way of recording how we communicate with people who have difficulty in understanding what we say.

The heading **what is happening** describes the circumstances that seem to affect what the person does. For example, it could be the place, the people around, or the activity that affect someone's behavior. The heading **(person's name) does** describes what the person does in terms that are clear to a reader who has not seen it and would still recognize it. For people where it is something hard to describe (e.g., a facial expression), a picture or even a video recording may be preferred. The heading **We think it means** describes the meaning that people think is present. It is not uncommon for there to be more than one meaning for a single behavior. Where this is the case, all of the meanings should be listed. The heading **And we should** describes what those who provide support are to do in response to what the person is saying with their behavior. The responses under this heading give a careful reviewer a great deal of insight into how the person's communication is perceived and supported.

The following page has a sample to help you get started.

What is happening	Julia does	We think it means	And we should
Julia is quiet and uncommunicative	Sits with her hands covering her face	Something has happened at the program to upset her	Sit down with her and ask her what's wrong. Encourage her to voice her feelings. Give her time to talk.
Julia is quiet and uncommunicative	Lies down or goes to be alone	She does not feel well (is ill or has a headache)	Ask her what's wrong. She may need encouragement to talk. If she is not well, giver her the option to go home for Tylenol and come back or stay home.



It's easiest to start with **what the person does**, then move on to **what we think it means** and then outward to **what is happening** and **we should**.

What is happening	_____ does	We think it means	And we should

What is happening	_____ does	We think it means	And we should

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Hopes and Dreams for the Future

What are your hopes and dreams for this individual? What would be his or her best future? For example:

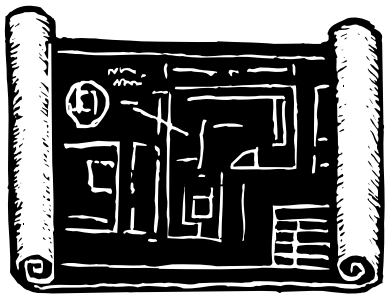
Where does he or she live? with whom? what kind of support?

What does he or she do during the day?

What would the individual do for fun?

Remember, there are no right or wrong answers! Just take a few minutes and think about what could be and don't worry about things that might get in the way.

Hopes and Dreams for the Future are . . .



Listen, Learn, Plan

A Guide for Developing Preliminary Essential Lifestyle Plans

Conversations with Family and Support Services

2018 Person-Centered ISP Guidance

Provider Development

Division of Developmental Services

Department of Behavioral Health and Developmental Services

June 15, 2018

2018 Person Centered ISP Guidance

In response to the need for quality Person-Centered Individual Support Plans (PC ISPs) that meet all regulatory requirements and expectations, DBHDS is issuing the included guidance for writing and reviewing PC ISPs. The methods and practices described here are expected to lead to more success with person-centered planning. Specifically, the measurability of plans is needed for agreement with the Centers for Medicare and Medicaid (CMS) Home and Community Services (HCBS) Settings Regulations, the Settlement Agreement, and DBHDS licensing and Department of Medical Assistance Services developmental disability (DD) waiver regulations. This paper details changes in thinking and writing to improve outcomes for people with DD Waivers in Virginia.

Measuring Progress

In 2009, the principles of Person-Centered (PC) Practices became the foundation of Virginia's Individual Support Plan in DD waivers. Over the past ten years, people with DD have been increasingly supported to make decisions about fundamental aspects of living in ways that matter most to them personally. With the introduction of PC Practices, many providers and Support Coordinators (SCs) expressed appreciation for system changes that more fully implemented practices that they had long valued. The benefits of person-centered practices are evident, but we have struggled to develop person-centered plans that are specific to each person, retain the basics of accountability, and ultimately lead to meaningful changes in a person's life.

At the center of the issue is a philosophical shift in how we plan with people. In moving from a deficit-based planning model to person-centered supports, the ability to show progress through planning has been strained. We have received reports from the independent reviewer for Virginia's Settlement Agreement, from our state Medicaid agency, and from our licensing specialists that plans are not measurable. We can do better. To address these concerns, but maintain the core values of person-center practices, we have to find an effective and simple way to bring measurability to the plans we write with people. This paper has been written to detail how we believe planning can be both measurable and person-centered. It is offered as a means to establish common ground around person-centered planning for all DD stakeholders in Virginia.

"A test for something being person-centered is that it works for humans." Michael Smull

In the 10th and 11th report to the court, the Independent Reviewer for the Settlement agreement stated that the most frequent shortcoming was that ISPs did not have specific and measurable outcomes (p.43). We have established the following processes to address this concern, while making every effort to stay true to the intent and spirit of person-centered practices.

Virginia's Person-Centered Individual Support Plan can be divided into three primary sections:

I. **The assessment:** Part I Essential Information and Part II Personal Profile
II. **The plan for a desirable future:** Part III Shared Planning and Part IV Agreements
III. **The action steps:** Part V Plan for Supports

When reviewing the PC ISP, it's important to look across all parts to gain an understanding of how the plan supports the life the person wants. While it is an integrated whole where each section supports the others, the focus of this paper is on sections II and III listed above.

Shared Planning and Outcome Development

Person-centered planning seeks to identify and achieve changes that bring a person more fully into his or her community and increase quality in the person's life. In changing how we plan with people, we want to keep our values in place, which includes the person directing his process to the extent possible and being surrounded by people of his choosing. The person's vision of a good life is what teams seek to uncover through conversations and in preparations for planning.

In the development of outcomes, it is important not to lose sight of the purpose of planning, discovering and setting in place plans to pursue the life the person wants. In shaping outcome statements, we recommend three considerations. Meaningful outcomes can support a person with achieving *independence*, *integration*, or an increased *quality of life*. As outcomes are developed, teams may benefit from asking if the outcome speaks to one of these three areas in determining if the outcome supports the person in a meaningful way.

We recognize that outcomes should be clearly stated and personally meaningful. For example, the idea that a person "increases independence in his life" is at the center of person-centered practices, but as an outcome it is not specific to an individual or easily observed. Planning teams should ask "how will this person increase independence in his life?" and "What does this mean to him?"

Individual's desired outcomes should be based on what is important to the person with regards to their personal preferences. As such, outcomes that stop with what's important to the person often do not

result in observable statements that are specific to the person. For example, having more spending money might be important to a person, but in no way establishes what this means in measurable terms . In addition to being observable, a few additional considerations can increase measurability of outcomes – the frequency of the outcome, the target date, and the steps that lead to the outcome.

For example, the statement "John has more money" can be improved by considering how this could describe an achievement that John would find meaningful such as: "John saves 50 dollars per month so that he can go on vacation next year" or "John earns at or above minimum wage for 12 months so that he has more shopping money."

Each outcome in the PC ISP will have a target date noted as "by when," which indicates that the outcome is expected to be accomplished or will be reassessed by that date. When desired, a frequency should be included in the wording of the outcome statement.

Additional examples of measurable outcomes:

Not measurable	Measurable	By when
John does things.	John uses the post office in order to send a friend a card each month.	11/30/18
John goes places.	John vacations at the beach this year in order to see the ocean.	8/31/18
John meets people.	John goes to coffee shops weekly so that he meets new people.	11/30/18
John goes out to eat.	John dines at a local restaurant at least weekly in order to enjoy a meal.	11/30/18
John feels good.	John uses his nebulizer as prescribed so that his breathing improves.	11/30/18

The next step for planners and teams to increase measurability is to describe the basic steps that lead to the outcome. These steps are shared across the planning team to contribute to achieving the outcome. To make an outcome more measurable, we would ask what are the "steps to get there." These steps layout the plan to pursue the achievement, which is in line with action planning, a foundational practice in person-centered planning. These steps should be logical and when considered together be expected to result in the time-bound achievement that is defined in the outcome.

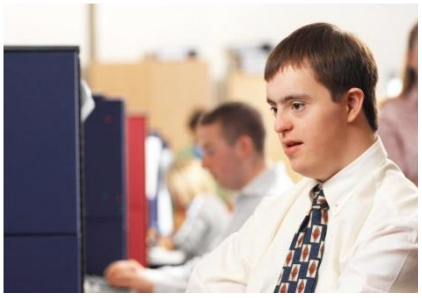
For example:

Outcome	By when	No longer want/need supports when… (steps to get there)
John vacations at the beach this year in order to see the ocean.	8/31/18	John chooses a location, saves money, purchases supplies, makes reservations, and travels to the beach to see the ocean.

For support teams who struggle with forming outcomes, we have previously utilized a formula, which has been noted as helpful and should remain an option to support meaningful outcomes. This formula has been slightly modified as follows for the examples provided. The asterisk* is a reminder to include a frequency when desired:

[Person's name] [activity/event/important FOR]* so that/in order to [important TO achievement]

The following examples demonstrate the concept of formula use to develop outcomes:



Important TO:

Earning money

Outcome (measurable achievement):

John earns at least minimum wage monthly so that he has more shopping money.

Steps to get there:

Complete referral to DARS, complete job development, secure employment and learn job

Important TO:

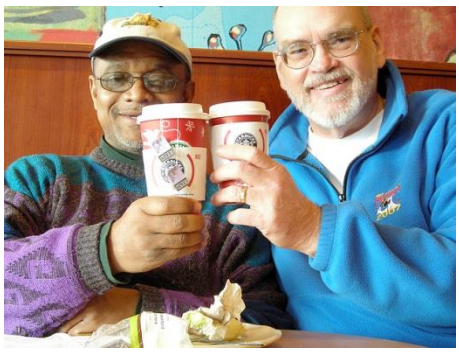
Cooking dinner for family

Outcome (measurable achievement):

Jenny cooks Italian dinners for her family monthly in order to spend time with her family.

Steps to get there:

Menu planning, grocery shopping, inviting family, preparing and serving dinner



Important TO:

Having more friends

Outcome (measurable achievement):

John goes to coffee shops weekly in order to meet new people.

Steps to get there:

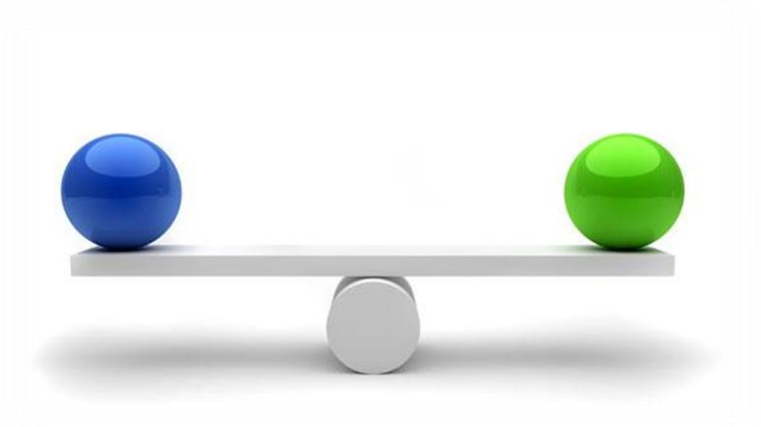
Planning and going to coffee shops, developing comfort talking with new people, sharing contact information, maintaining contact

Each of these examples shows movement from what's important to the person to a more specific achievement that is *time bound*. Without this time bound element, there is decreased focus on making what is desired happen and it is more difficult to track success or establish progress toward the achievement. For example, if Jenny's outcome was just to "prepare Italian dinners for her family" how would we know she is accomplishing this to the degree she wants? By including the time bound measure she wants as monthly, we have better defined what Jenny hopes to accomplish and what is considered by her and her support team to be achievable.

Outcomes may be changed or removed during the person-centered planning process, however if the outcome is part of what's needed for the person to have the life he or she wants, there is no requirement to remove or change the outcome. Some supports will be needed across the lifespan whether they are provided by paid staff or natural supports. We need a planning process that brings about the positive changes desired by the person, while maintaining what is working and ensuring he or she is well supported in the routine course of daily life.

Balancing important TO and important FOR

When developing outcomes, the team should discuss the person's preferences and the things that are important to them, as identified in the Personal Profile. In some instances, an outcome will directly reflect what is important for a person in addition to what is important to them. This helps to assure the whole support team is aware of identified behavioral and/or health needs in order to address associated risk factors and appropriately mitigate risk.



Identified health and behavioral support needs must be clearly included in planning. The inclusion of identified risks or "all essential supports" in plans is an additional concern identified by the Independent Reviewer for the Settlement Agreement in the 10th and 11th report (p.43). Adapting the completion of the Shared Plan as described above with "steps to get there" listed under the "I no longer want or need supports when…" section of the plan should help meet this requirement and reduce the chances key information is lost. The following example shows how multiple, related health supports can be addressed under a single outcome in the Shared Plan.

Important FOR:

Insulin use, diabetic diet, blood sugar monitoring

Important TO:

Feeling good

Outcome:

Jill follows diabetic care each day so that she feels good.

Steps to get there:

Preparing diabetic-friendly meals and snacks, taking insulin as prescribed, monitoring blood sugar, comfort check-ins

In this example, the activities needed to support Jill with diabetes are all included alongside the outcome. This method helps with grouping related supports and better ensures their inclusion in the component plans prepared by providers following the meeting. While these steps will be reflected in the support activities found in each of the support plans, not every provider will be expected to assist with each step. The support coordinator will assure that all steps are addressed across the support team in the various support plans.

Plans for Supports

Support activities should be identified in the planning process as the basic steps in supporting the achievement of the outcomes, but will be more fully developed by providers following shared planning. Support activities can be defined as being *routine*, for *skill-development*, for *health and safety* or to *explore* new opportunities before deciding on the specific nature of the activity. Support activities are developed with individuals by providers, and include action verbs that indicate what specific activities will be supported. Support activities may be groupings of activities (morning routine), but should also be written as individual activities when skills are being built, or when specific medical or behavioral protocols are being used (see examples below).

A basic formula for writing an activity statement is provided below. Each activity should use an action verb and be observable.

Activity Formula

[Person's name] verb [what/when/where]

Support activity examples
Tom uses weights at the gym.
Marshall introduces himself to others.
Joy purchases housewares.

Where skill-building is not being attempted, adding "how often" to the activity statement makes routine activities measurable.

Activity Formula **[Person's name] verb [what/when/where]**	Routine Measure Formula **+ how often**
Tom uses weights at the gym.	Tom uses weights at the gym two days a week.
Marshall introduces himself to others.	Marshall introduces himself to others daily.
Joy purchases housewares.	Joy purchases housewares monthly.

Routine measure examples

Where skill-building is being attempted, more information is needed to determine that the person is developing skills as desired. Notice in the following examples "countable achievement" is used to describe the measure that will be used for each activity and each measure includes both how often and how long to help define the measure.

Activity Formula **[Person's name] verb [what/when/where]**	Skill-building Measure Formula **Name countable achievement how often and how long.**
Tom uses weights at the gym.	Tom does seven types of weight exercises each week for one month.
Marshall introduces himself to others.	Marshall says hello and his name to five people a week for three months.
Joy purchases housewares.	Joy completes a purchase weekly for two months.

Skill-building measure examples

Criteria for the removal of supports for health and safety are based on healthcare guidelines, medical orders, or documented plans for removal.

Activity Formula **[Person's name] verb [what/when/where]**	Health & Safety Measure Criteria **Describe conditions for removal including professional decisions as necessary**
Tom checks his blood pressure before and after each workout.	When his physician removes the need for high blood pressure support.
Jarod eats a pureed diet following his eating protocol.	When Jarod's eating protocols are discontinued by a healthcare professional.
Marshall calls each friend no more than once a day.	Marshall self limits his phone calls for 3 months as identified in his safety restriction plan.

Health & Safety measure examples

When a measure is met, a new learning activity should be considered, explored, and attempted either by changing the skill or changing the measure. It is important to note that activities and sometimes outcomes may end simply because the person is no longer interested in pursuing the activity, or their needs may change such that the activity is no longer appropriate due to unforeseen circumstances. It is also possible – and actually likely – that some activities may be expected to last indefinitely and the person will continue to need the supports.

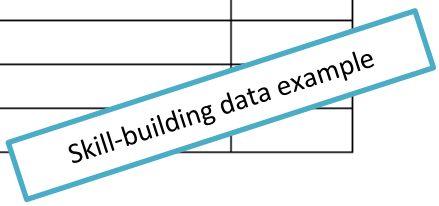
Support Instructions detail how the supports will be provided, in accordance with the individual's needs and preferences, and how the individual will participate in the provision of supports. Ongoing noting in accordance with Medicaid requirements along with simplified data collection can assist providers with ongoing changes and quarterly reporting. While some support instructions may be "standard practice," individualized person-centered instructions should also be woven throughout the plan.

In addition to Medicaid required noting, the following demonstrates data collection for each type of support:

Monday			
Date:	Did John have coffee with friends?		Initials:
	Yes	**No**	

Routine data example

Monday			
Date:	Did Mary respond to 5 classmates with a smile and/or clapping her hands? **Yes**	**No**	Initials:



Monday			
Date:	Were any concerns noted while following Mary's skin and seizure protocols and routine health and safety supports? *if yes identify in support log* **Yes**	**No**	Initials:

To illustrate how health and safety can be adequately addressed in planning, consider the following example:

During the planning meeting, the team discusses Sophie's diabetes. While the team all agrees that daily monitoring of her diabetes is absolutely necessary (important FOR), Sophie is only concerned with the fact that daily finger sticks are painful and what she wants is to be more comfortable (important TO).

Outcome: Sophie is more comfortable while testing her blood sugar each day so that she has less pain.

I no longer need or what support when (steps to get there):

Explore a new glucometer, test glucose daily.

Support Activity: Sophie's blood sugar levels are tested daily.

I no longer need or want support when (measure by providing a clearly stated achievement):

Sophie's physician removes the order for a daily finger sticks.

Support Instructions:

Staff conducts finger sticks every morning according to Sophie's diabetes protocol (attached).

Staff gently reminds Sophie that "it is time." That is all that needs to be said, and she will know. Saying "finger stick" upsets her.

Sophie chooses where to sit; some days she prefers being on her bed, and some days she prefers being on the lounge chair in the living room.

Staff puts smooth jazz music on the radio or tells a joke or a story to distract her during the finger stick.

If upon testing, Sophie's blood sugar is lower than 80 mg/dl or higher than 120 mg/dl, take health and safety steps described in her protocol (attached).

What to record: Was Sophie's blood sugar tested and recorded as stated in her plan (record any concerns in a note)? Yes; No

It is clear in this example that the outcome is truly what is very important to Sophie to have in her life. The support activity addresses the health need, and is clearly measurable, and the instructions are clear and reflective of both what Direct Support Professionals and Sophie will do.

Simply put, the outcome is "WHERE" we want to be, the support activities are "WHAT" we are doing to get there, and the support instructions are the "HOW" we are doing it. In a person-centered planning process, the person is at the center of planning. They let us know about the things they want in their lives; it is our role to support them in achieving what they want.

CMS specifically indicates in their guidance that person centered planning is not about "paper completion." To that end, it may be helpful to envision the process out of order, that is, we are providing the supports (support activities) in this specific manner (support instructions) in order for the person to achieve what they want in their life (outcomes).

This guidance is offered as the basis of expectations as we move forward. Person-centered plans can be measurable and measurability helps to ensure that we are accountable to the people we support. For people to have more independence, more integration, and a better quality of life, we must live up to the promises we make in the planning process. We hope these adjustments lead to better planning and better lives for those we support.

Background Resources

CMS HCBS Settings Regulations Plan Requirements at DMAS: http://www.dmas.virginia.gov/Content_atchs/ltc/CMS%20Minimum%20Requirements%20for%20Person%20Centered%20Service%20Plans%20(PCSP).pdf

DBHDS Office of Licensing: http://www.dbhds.virginia.gov/quality-management/Office-of-Licensing

Emergency DD Waiver Regulations: https://townhall.virginia.gov/L/ViewXML.cfm?textid=10923

Helen Sanderson Associates: http://helensandersonassociates.co.uk/

Independent Reviewers 10th and 11th report and the DOJ Settlement Agreement: http://www.dbhds.virginia.gov/doj-settlement-agreement

The Learning Community for Person-Centered Practices: http://www.learningcommunity.us/home.html

The Oregon ISP: https://oregonisp.org/

UMKC Institute for Human Development: http://www.lifecoursetools.com/planning/

Required Documentation for Individual Service Plans

(consider an option to "hover" over the title of each form in first column for a short narrative of the documentation requirement or build in a link to the regulation/guidelines regarding each specific documentation requirement)

Required Documentation	**DD WVR Targeted Case Management** This includes anyone receiving ECM (Enhanced Case Management)	**Targeted Case Management Includes DD** Waiver waiting list, CCC+ Waiver, anyone NOT eligible for DD Waiver but eligible for Case Management and ECM (Enhanced Case Management)	**Follow along/Tracking/Inactive** Includes anyone NOT receiving TCM however, the person may be on the DD Waiver waiting list, may be ineligible for Medicaid or may NOT qualify for DD Waiver.
PCP parts 1-5 (WaMS) Completed once per year prior to service delivery	✓	✓	Some CSBs may have internal requirements of an abbreviated service plan
Person Centered Quarterly review (WaMS) Completed every 3 months based on Annaul ISP Date (30 day grace period)	✓	✓	
VIDES (WaMS) Completed annually prior to service delivery	✓	✓ Required for anyone on the DD Waiver waiting list	✓ Required for anyone on the DD Waiver waiting list
Notice of Right to Appeal (WaMS) (is this required annually even the waiting list priority status does not change?)		✓ Required for anyone on the DD Waiver waiting list	✓ Required for anyone on the DD Waiver waiting list

Required Documentation for Individual Service Plans

(consider an option to "hover" over the title of each form in first column for a short narrative of the documentation requirement or build in a link to the regulation/guidelines regarding each specific documentation requirement)

Legal Rights Notification form and Legal Rights Signature Form Required annually	✓	✓	
Releases of Information/Consent to Exchange Information (Are hard copies required to be scanned into WaMS) Required annually and as new service providers are added	✓	✓	✓
Fall Risk Assessment (Is this still required? Most CSBs have developed their own protocol or form for this assessment. Are hard copies scanned into WaMS?)	✓	✓	
Physical Exam (is this required to be scanned into WaMS?) Required for initiation of DD WVR and when significant changes occur and/or as needed thereafter	✓		

Required Documentation for Individual Service Plans

(consider an option to "hover" over the title of each form in first column for a short narrative of the documentation requirement or build in a link to the regulation/guidelines regarding each specific documentation requirement)

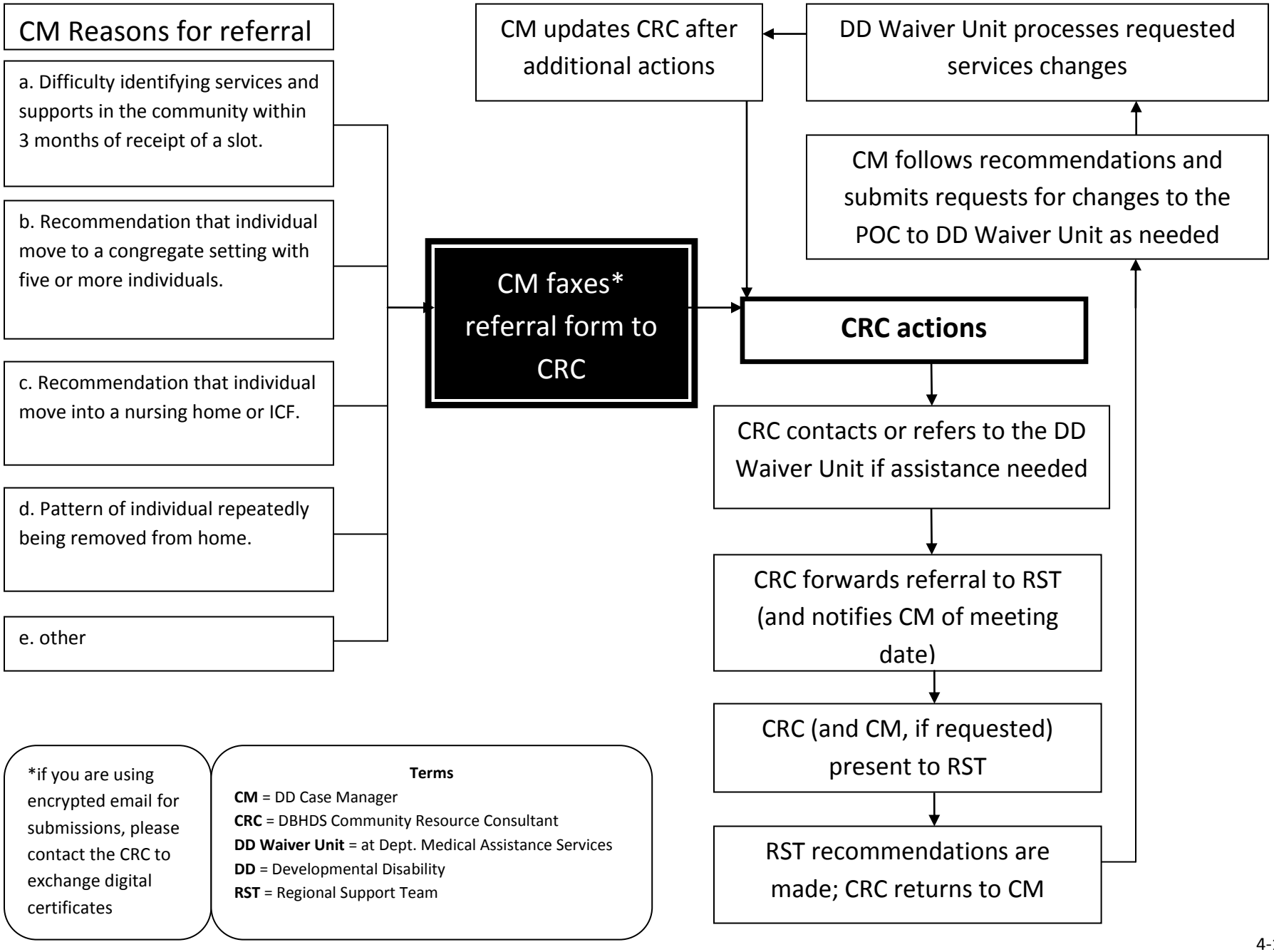
SIS (is this required to be scanned into WaMS?) Completed once every 3 years or when significant changes occur	✓		
Annual Risk Assessment form (Is this required to be scanned into WaMS?) Completed on the second and third year of the full SIS date	✓		
Medication Side Effects (required annually or just as changes occur?)	✓	✓	
Virginia Informed Choice Form (DMAS 460-459a) (Is this required to be scanned into WaMS?) Completed at enrollment into the DD Waiver and when changes to services are requested	✓		

Required Documentation for Individual Service Plans

(consider an option to "hover" over the title of each form in first column for a short narrative of the documentation requirement or build in a link to the regulation/guidelines regarding each specific documentation requirement)

Documentation of Individual Choice Between Institution and Community Based care (DMAS 459c) (Is this required to be scanned into WaMS?) Original choice form from when the person was placed on the DD Waiver waiting list. Not required annually	✓	✓ *Required for anyone on the DD Waiver waiting list*	✓ *Required for anyone on the DD Waiver waiting list*
DMAS 225 (scanned into WaMS?) Updated annually or when there is a change in eligibility	✓		
Priority needs checklist (WaMS)		✓	✓
Critical Needs Summary (WaMS)		✓ *Required for anyone who meets Priority 1 status)*	✓ *Required for anyone who meets Priority 1 status)*

Developmental Disabilities Regional Support Team Referral Process



*if you are using encrypted email for submissions, please contact the CRC to exchange digital certificates

Terms

CM = DD Case Manager
CRC = DBHDS Community Resource Consultant
DD Waiver Unit = at Dept. Medical Assistance Services
DD = Developmental Disability
RST = Regional Support Team

Virginia Department of Behavioral Health & Developmental Services

Regional Support Team Referral

Regional Support Team (RST) Referral Instructions

- *For individuals enrolled or awarded a waiver slot, review and completion of the Virginia Informed Choice (VIC) is required prior to submission of an RST referral. The Support Coordinator/Case Manager/Training Center Designee completes the VIC and retains a signed copy of the document in the individual's file.*
- *The Support Coordinator/Case Manager/Training Center Designee completes the Regional Support Team Referral.*
- *Community Resource Consultant (CRC)/Community Integration Manager (CIM) consultation is required prior to an RST Referral submission.*
- *Submit VIC (if required) and RST Referral to the secure RST mailbox: RST.Referrals@DBHDS.virginia.gov.*

Date completed: Enter date	**Agency:** Enter CSB/BHA/TC	**Region of Agency:** Select region
Individual's full name: Enter name	**Unique ID:** Enter number	**Date of Birth:** Enter DOB
Referring party: Enter referring party	**Phone number:** Enter phone number	**Contact email:** Enter email address
Supervisor: Enter Supervisor	**Phone number:** Enter phone number	**Supervisor's email:** Enter email address
Current Living Situation: Type of home Other	**Provider name:** Enter Provider's name	**# Of Referrals to RST:** Select one

Referral Criteria		
Request for an Emergency Meeting: Select one Reason for Late Referral: Select one	Community Required: Select one	Training Center Required: Select one
Move in date: Enter date Anticipated move in date: Enter date	Other: Select one	If Other is selected, please describe: Description
When services are unavailable within desired region, request RST review in home and/or alternative regions being considered.		
RST review requested in home region: Select Region	RST review requested in alternative region: Select Region	

Unavailable financial support limiting access to resource/s (Check all that apply)

☐ Medicaid ☐ Waiver Slot ☐ Customized Rate ☐ Funds for Crisis support ☐ Housing Assistance ☐ Other please describe

Barriers related to Waiver Service Options or Other (Please use key below to identify barriers)

1.	Employment and Day Options	Select unavailable service	List multiple services and barrier #(s)
2.	Self-Directed Options (may be Agency Directed)	Select unavailable service	List multiple services and barrier #(s)
3.	Residential Options	Select unavailable service	List multiple services and barrier #(s)
4.	Crisis Support Options	Select unavailable service	List multiple services and barrier #(s)
5.	Medical and Behavioral Support Options	Select unavailable service	List multiple services and barrier #(s)
6.	Additional Options	Select unavailable service	List multiple services and barrier #(s)
7.	Other	Description	List corresponding barrier number(s)

Barrier Key (Choose all barrier numbers that apply and place in the applicable list above)	
1	Services not available under currently enrolled waiver
2	Services and activities unavailable in desired location
3	Individual/Substitute Decision Maker (SDM)/Legal Guardian (LG) not interested in discussing/exploring options
4	Individual/SDM/LG chooses less integrated option
5	Individual/SDM/LG does not choose provider after visit
6	Direct Support Staff- may not have experience or demonstrate competency to provide support with behavioral expertise
7	Direct Support Staff- may not have experience or demonstrate competency to provide support with mental health expertise
8	Direct Support Staff- may not have experience or demonstrate competency to provide support with medical expertise
9	Professional Behavioral staff- Psychiatric, PBS facilitator, Applied Behavioral Analyst, or other specialist unavailable
10	Professional Medical staff- Dental, nursing or any medical specialist unavailable
11	Provider has determined placement is not a good match- provider is not willing/able to support individual
12	Frequent hospitalizations- medical and/or mental health hospitalizations
13	Delay in move and/or acceptance to a more integrated setting- due to unexpected or late medical interventions
14	Location is not adapted for physical access- Community locations are not wheelchair accessible or ADA compliant
15	Accessible transportation unavailable
16	Service Development- Construction/Renovations/Environmental Modifications/Staff-development/On-boarding/Licensing
17	Other (please list all other barriers below)

Provide any information you think may be helpful in the RST review process and/or other barriers not identified above.

Click here to enter text

What are Regional Support Teams?

There are five Regional Support Teams (RSTs) in Virginia.

What is their purpose?

To provide recommendations in resolving barriers to the most integrated community settings consistent with an individual's needs and informed choice**.** Referrals by support coordinators (SC)/case managers (CM) and social workers (SW) at the Training Centers are made to the Community Resource Consultants (CRC) or Community Integration Managers (CIM) with the Department of Behavioral Health and Developmental Services (DBHDS) under certain circumstances as described in the SA. The CRC or the CIM will refer to the RST when barriers to most integrated settings for individuals still exist.

Who do they support?

Individuals with intellectual disability (ID) or developmental disabilities (DD), who live in training centers, meet the ID or DD Waiver waitlist criteria or live in a nursing home or intermediate care facility for individuals with ID, and their individual support planning teams.

Who are the RST members?

RSTs include a variety of professionals in the field of intellectual and developmental disabilities with expertise in complex medical and behavioral supports. Members come from state, local and private positions in the community. These members have regular contact through in-person and telephone meetings.

How do I contact the RST?

The CRC or CIM will contact the RST at the request of individuals and team members.

More information and the full Settlement Agreement can be viewed online at:

http://www.dbhds.virginia.gov/Settlement.htm

Waiver Management System (WAMS) Community Services Boards User Guide

January 2018

Version 2.0

Virginia Department of Behavioral Health & Developmental Services (DBHDS)

Created and customized for you by Dee Dee Thomas, WaMS Training Services on January 3, 2018.

Table of Contents

1 Navigating the WaMS Environment

1.1 About WaMS

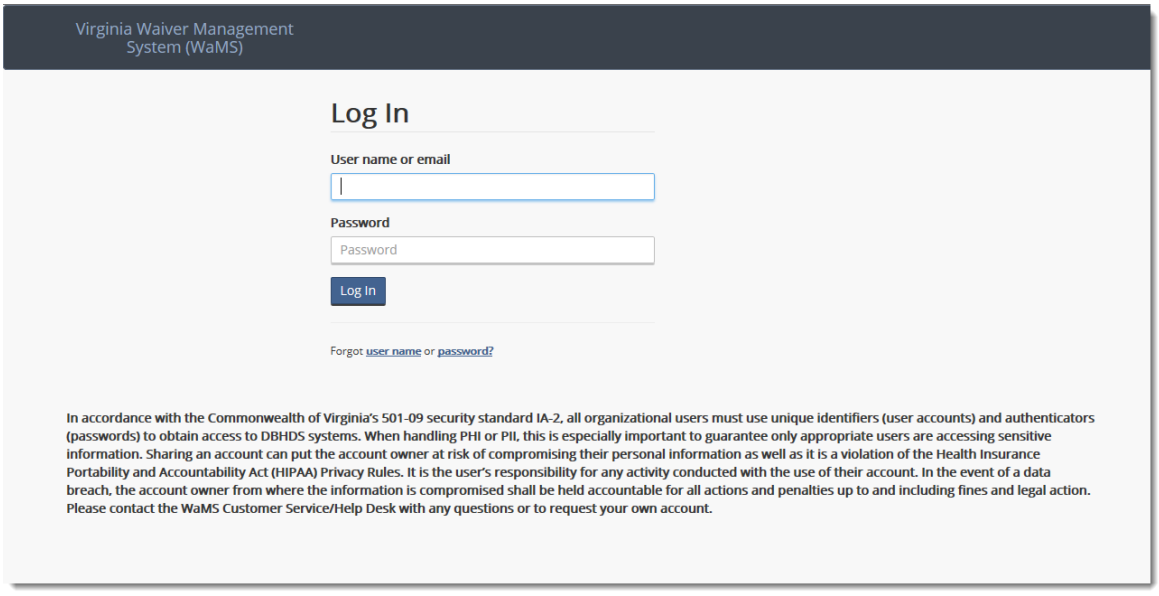
The **Waiver Management System** (WaMS) is a web hosted data management system used to manage waivers. WaMS interfaces with the **Virginia Medicaid Management Information System** (VAMMIS), and establishes the assessment levels (of care) based on an individual's needs and automates the authorization process. WaMS is customized to allow a single process for service authorizations for all three waivers (Community Living, Family and Individual Supports, and Building Independence) supporting individuals with intellectual or developmental disabilities (ID/DD).

1.2 Become familiar with the WaMS environment

The options and view that is available in WaMS is based on the assigned role. Take time to use the various tabs and tools in WaMS to determine how to best support your workstyle by using the *Dashboard*, *Alerts*, *My Lists*, *Assignments* and *Service Authorization* tabs. See more information on using these tabs below.

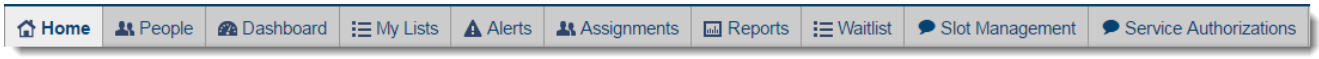
1.3 Log In to WaMS

1. From an internet browser type: ***https://www.wamsvirginia.org*** in the address bar.
2. Type in your **User name** or **Email**.
3. Type in your **password**.
4. Click on **Log In**. *WaMS opens to the Home page. What you see in WaMS is based on the role that has been assigned.*



1.4 Navigating WaMS

The tabs at the top of the WaMS window are useful for high-level navigation through the system. The following tabs are included in the top-level navigation:



1.4.1 Home Tab

The **Home** tab is the landing page upon logging in to WaMS and consists of the following sections:

- Announcements: This section provides important announcements as needed
- Recent Alerts: This section describes systems alerts for WaMS
- Recent System Updates: This section displays announcements regarding WaMS system enhancement based on user requirements.
- Upcoming Events: This section displays information regarding any upcoming events such as training.
- Technical Support: This section contains contact information, such as the helpline number and email for WaMS technical support.
- Training Manuals, Webinars, and FAQs: This section provides detailed instructional materials, user guides, presentations and video recordings on how to use WaMS.

1.4.2 People Tab

The **People** tab is used to search for and add new individuals to the WaMs environment.

1.4.3 Dashboard Tab

The **Dashboard** provides a snapshot of what should be worked on in WaMS. It is divided in to three sections to provide a quick glance of *Calendar* events (manually added and system generated), your 10 most recent *Alerts* and *To-Do List* in WaMS.

1.4.4 My Lists Tab

The **My Lists** tab allows for locating a subset of persons based on a specific criteria or category as defined in the drop down list. For example, view a list of all persons based on the status of *Enrollment, Retain Slot*, *Individual Support Plan* and *Service Authorization*. Lists are available based on the agency and role of the user logged in.

1.4.5 Alerts Tab

Alerts are notifications sent of actions and updates that have been made to a specific person's file.

1.4.6 Assignments Tab

The **Assignments** tab is where the *Support Coordinator* is assigned to a person.

> **Note**: The only information another Support Coordinator or other member of the organization can access for a person who is not assigned to them is the *Personal Summary*, *Personal Profile* and *CSB Assignment*.

1.4.7 Reports Tab

The **Reports** tab provides access to a variety of canned reports available in WaMS based on the staff member's role. Reports can be quickly created. For example, *Waitlist by CSB Detail, Waitlist by CSB Summary* and *Statewide Summary and Detailed Waiver* reports.

> **Note**: Data for all the canned reports is for the day before and is "real time" data for that date.

1.4.8 Waitlist Tab

The **Waitlist** tab is used to view Waitlist status based on search criteria. Search options include searching for a specific individual, individuals with a particular waitlist status, date and/or service requested.

1.4.9 Slot Management Tab

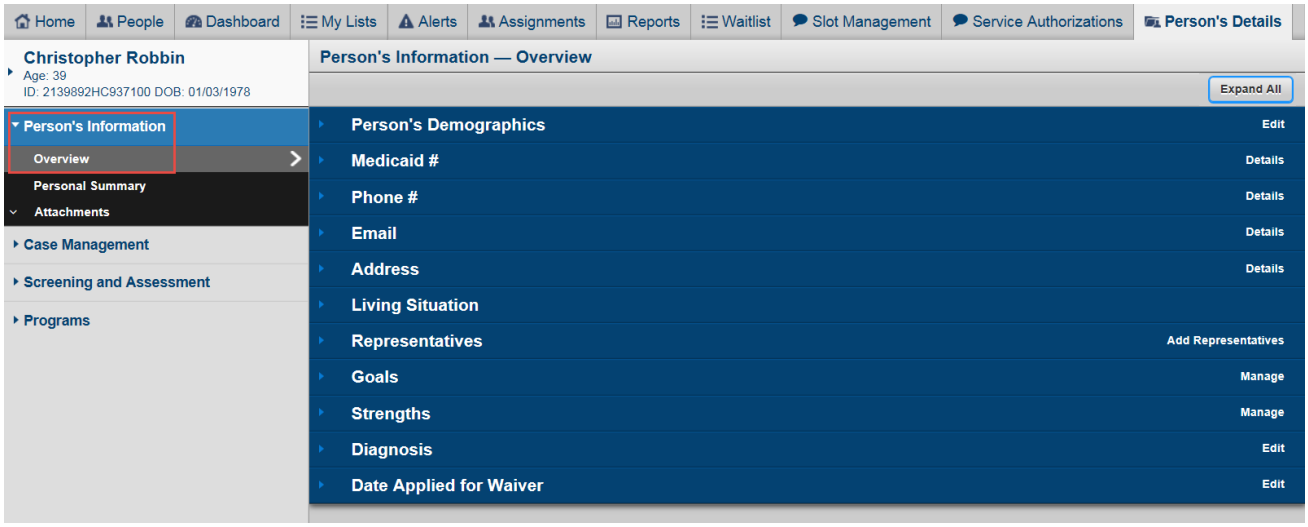
The **Slot Management** tab is used to see if a slot is available by Waiver type. View the slot for a specific individual by typing in their information into the search criteria.

1.4.10 Service Authorizations Tab

The **Service Authorizations** tab provides a more direct access to Service Authorizations. Search by the person's name, the provider, status or by any other available options.

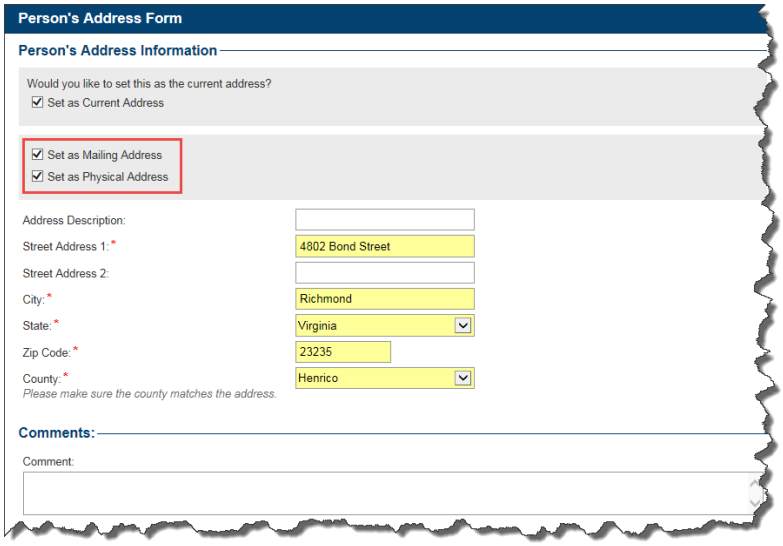
IMPORTANT: While certain features are *required* components of WaMS (i.e., denoted with red asterisks and/or yellow highlights) it is essential that ALL individuals in WaMS (including those currently assigned to a waiver or assigned to active status on the Waitlist) have the following elements completed in their WaMS record for successful Waiver Enrollment:

Each of the following elements can be found and modified under *Person's Information*, *Overview* section in WaMS. (*See Section2.2.9: Update Person's Information/Overview Page, for additional details*).

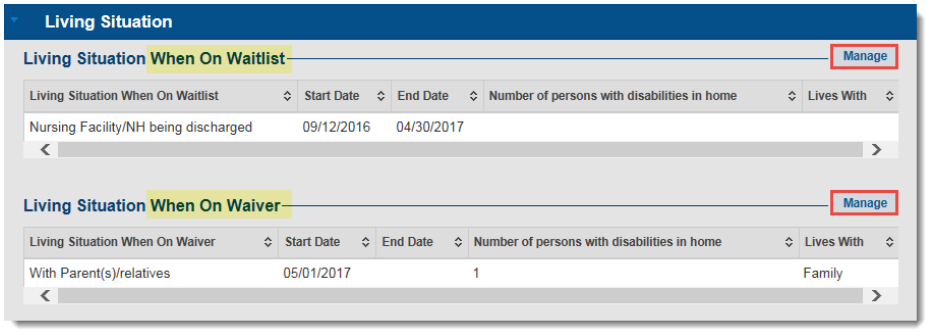


Medicaid #: The Medicaid number is mandatory for all NEW enrollments..

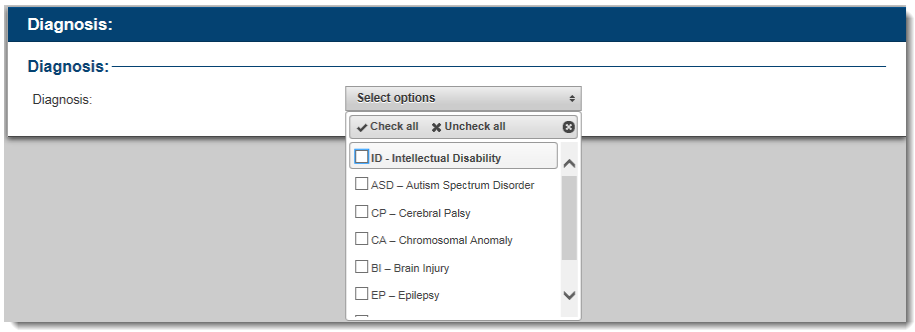
Address: The physical address of where the person resides. This address should be updated when the individual moves to a new residence. (*See Section 2.2.4: Add Person's Address, for additional information).*



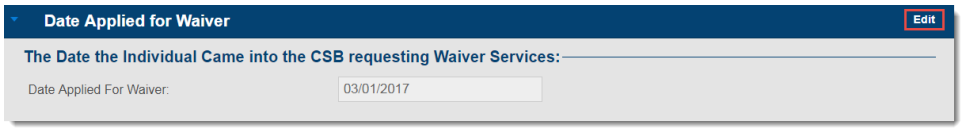
Living Situation: Click on **Manage** to update the person's *Living Situation when on Waitlist* or their *Living Situation when on Waiver*.



Diagnosis: A *diagnosis* is required in WaMS for each individual on the Waitlist and for those individuals that are receiving a Waiver. The diagnosis can be updated in the *Diagnosis* section. *(See Section2.2.6: Add Diagnosis, for additional detail).*



Date Applied for Waiver: Click on **Edit** to add the date the individual came to the CSB to request service.

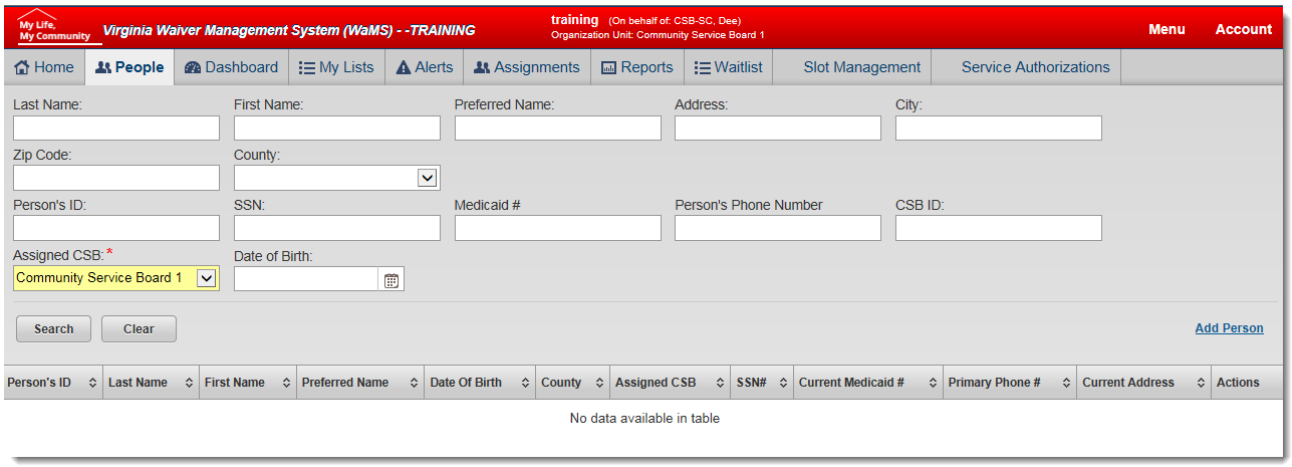


2 The People Tab

The *People* tab is used for searching for current *and* adding new individuals to the WaMs environment.

2.1 Locate an Existing Individual's Profile

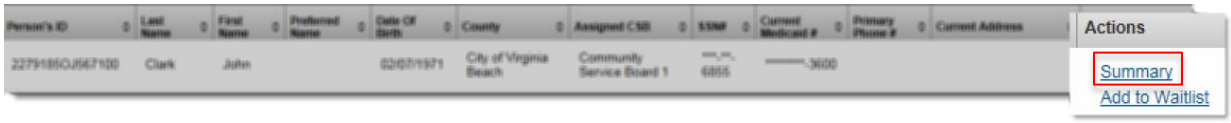
Use the **People** tab to locate individuals in WaMS:



1. Click the **People** tab.
1. Type in the criteria for the individual you are looking for (i.e., **Last Name**, and **First Name)**.

> **Note**: Input as much information as you know in each field to retrieve the most accurate search.

2. Click **Search**. *The search results will display a list of individuals that meet the search criteria. If there is no match, the **Create Person Notice** box will appear indicating that a profile does not currently exist.*
3. Click on **Summary** link under *Actions* to open the person's record.

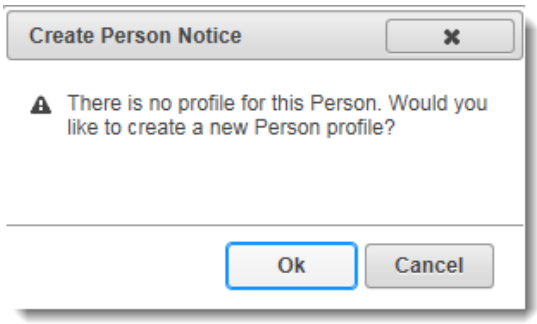


2.2 Add a New Individual to WaMS

Use the **People** tab to add new individuals in WaMS:

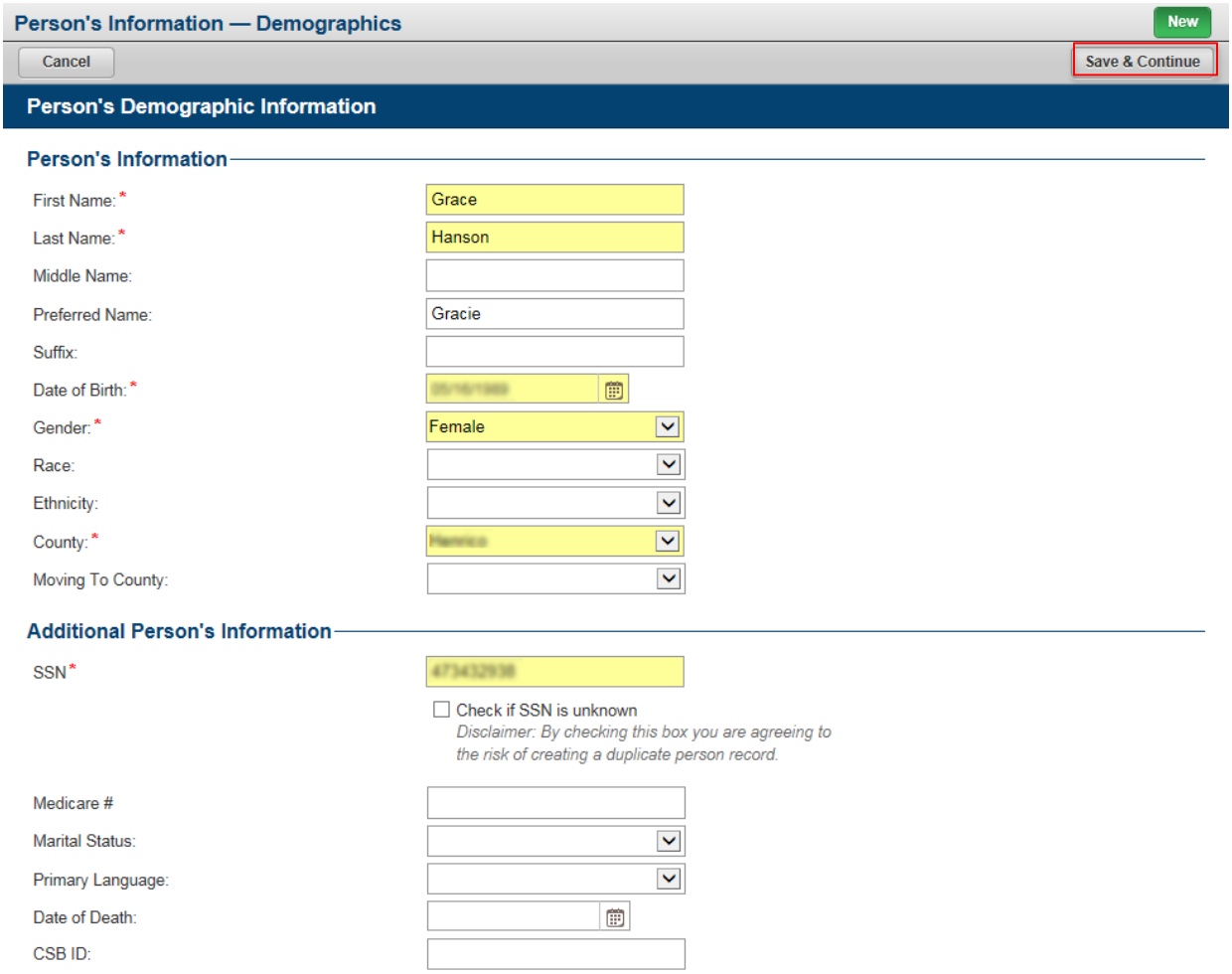
> **Note**: Search for an individual first before adding to ensure that person is not already in WaMS.

1. Click the **People** tab.
4. Type in the criteria separately in each field for the individual you are looking for (i.e., **Last Name**, **First Name** or **Social Security)**.
5. Click **Search.** If there is no match, the **Create Person Notice** box will appear indicating that a profile does not currently exist.



6. Click **OK**. *The New Person's Demographic Information page appears.*

> **Note**: The **Add Person** link on the *People* tab can also be used to add a new individual (without searching).



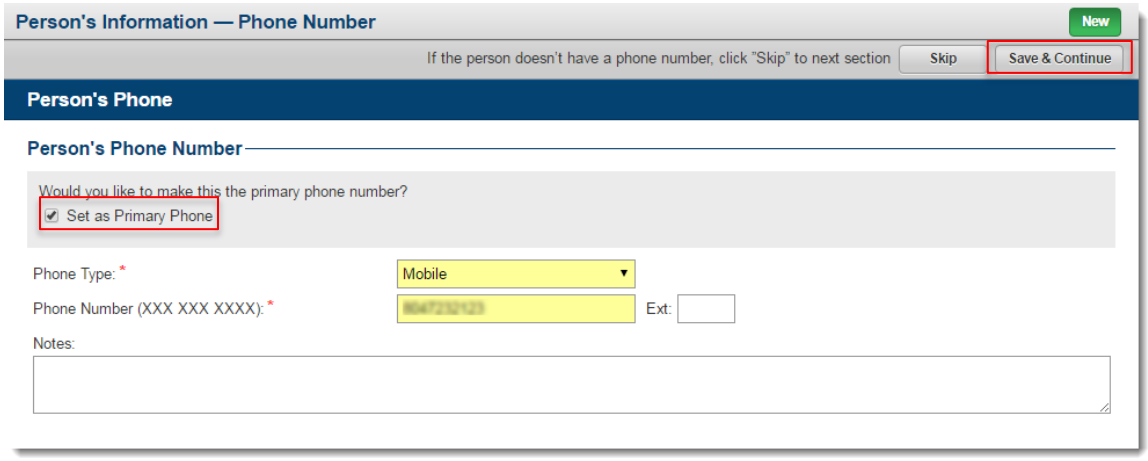
2.2.1 Add Person's Demographics Information

Complete the new person's demographic information. Fields that are *yellow* with a *red* asterisk (*) are required.

1. Complete all required fields (*First Name, Last Name, Date of Birth, Gender, County* and *SSN*).
2. Input as much optional information as possible.
3. Click **Save & Continue**.

> **Note**: If the individual SSN is not known click the checkbox to accept the risk of creating a duplicate person record.

2.2.2 Add Person's Phone



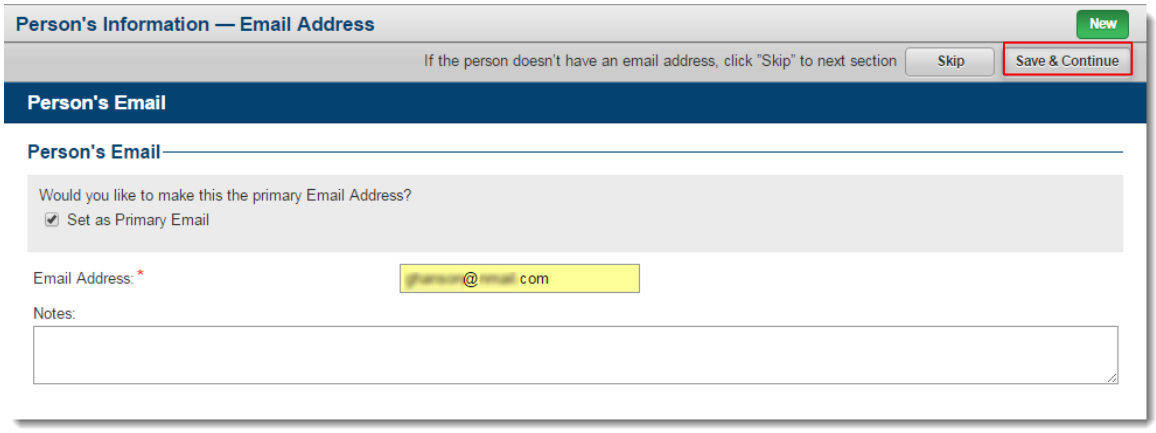
1. Complete all required fields (*Phone Type* and *Phone Number*). If the person does not have a phone number, click **Skip.**

> **Note**: Place a check in the "**Set as Primary Phone**" checkbox in order for the phone number to be visible in the *Overview* section of the person's profile

2. Add Notes if necessary.
3. Click **Save & Continue**.

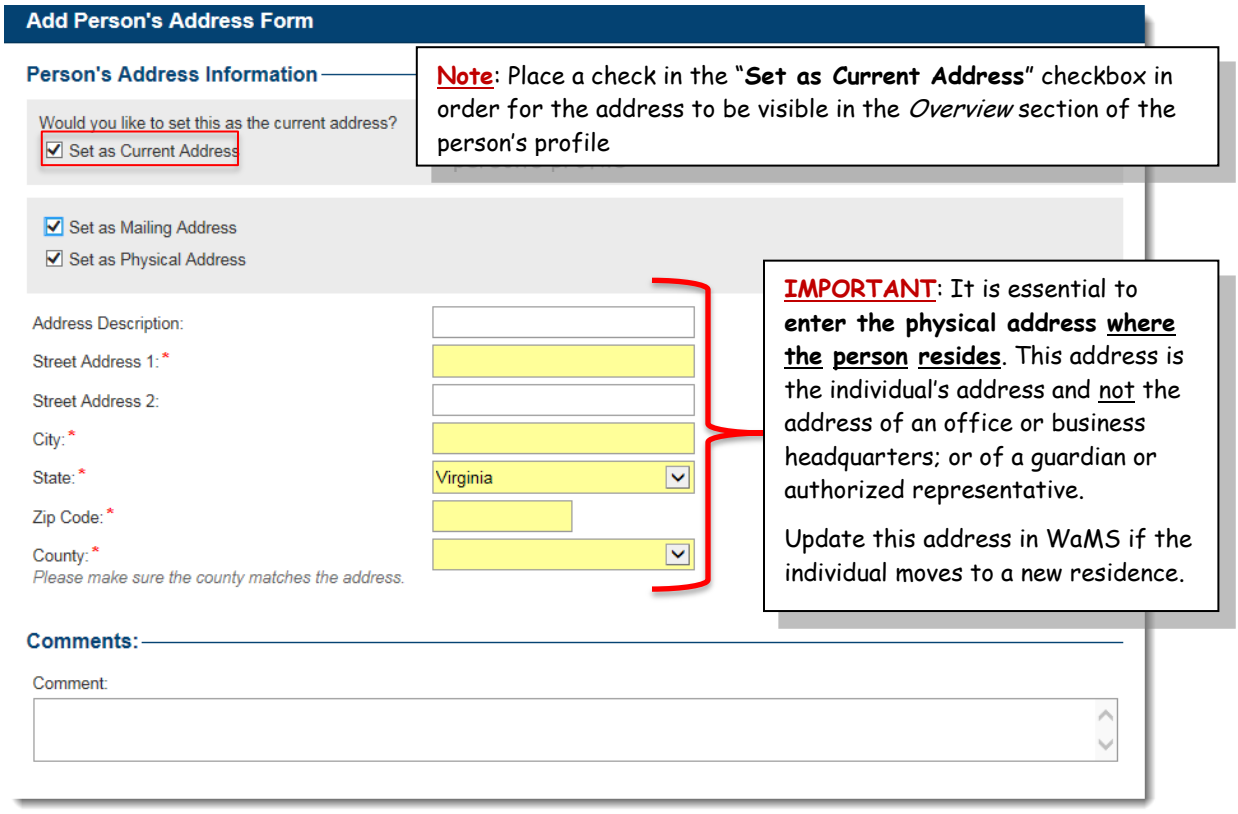
> **Note**: Additional phone number(s) may be added from the Person's Overview page. 1) Choose *Overview -> Phone # ->* 2) Click **Details**, 3: Click **Add Person's Phone Number**.

2.2.3 Add Person's Email



1. Complete all required fields (*Email Address*). If the person does not have an email, click **Skip.**
2. Add Notes if necessary.
3. Click **Save & Continue**.

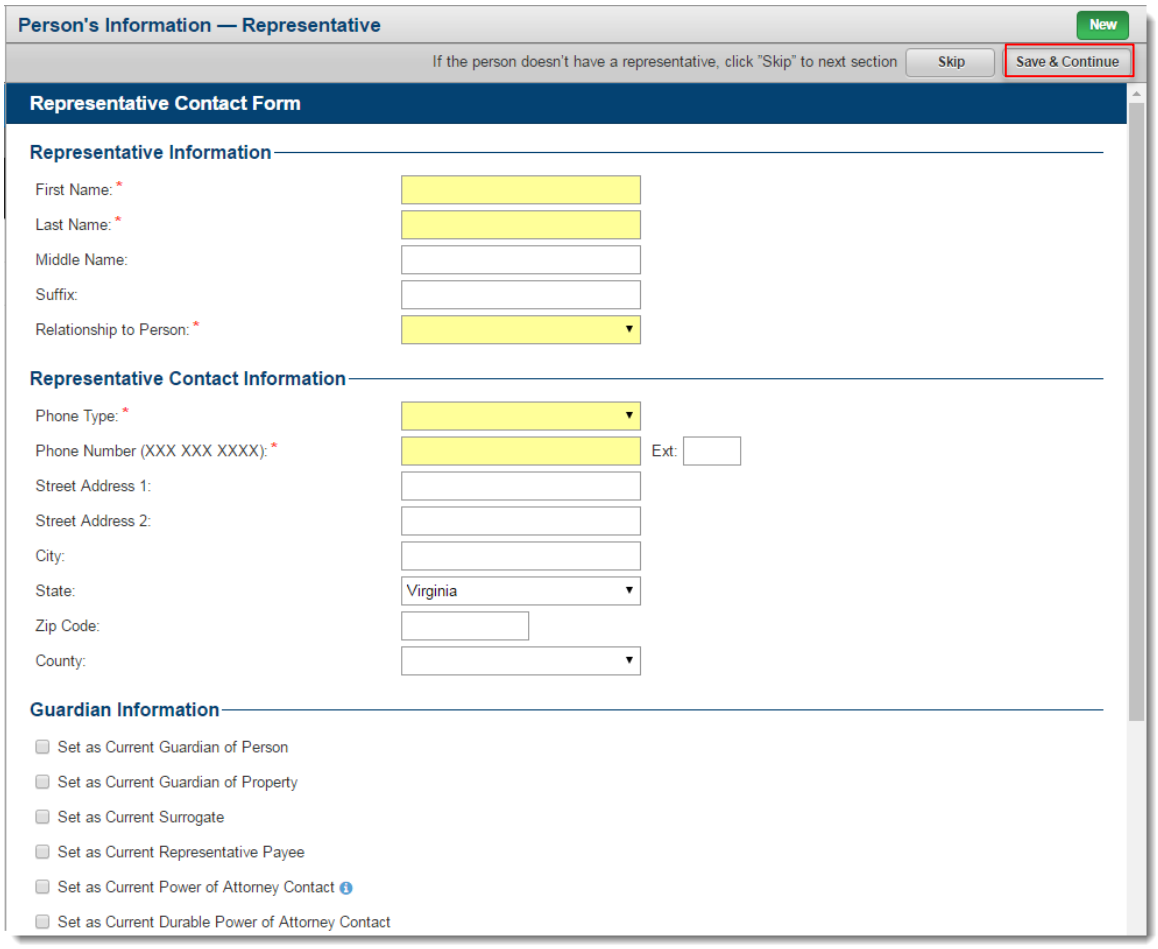
2.2.4 Add Person's Address



1. Complete all required fields (*Street Address 1, City, State, Zip Code, County*). If the person's address is unknown, click **Skip**.
2. Add **Comments** if necessary.
3. Click **Save & Continue**.

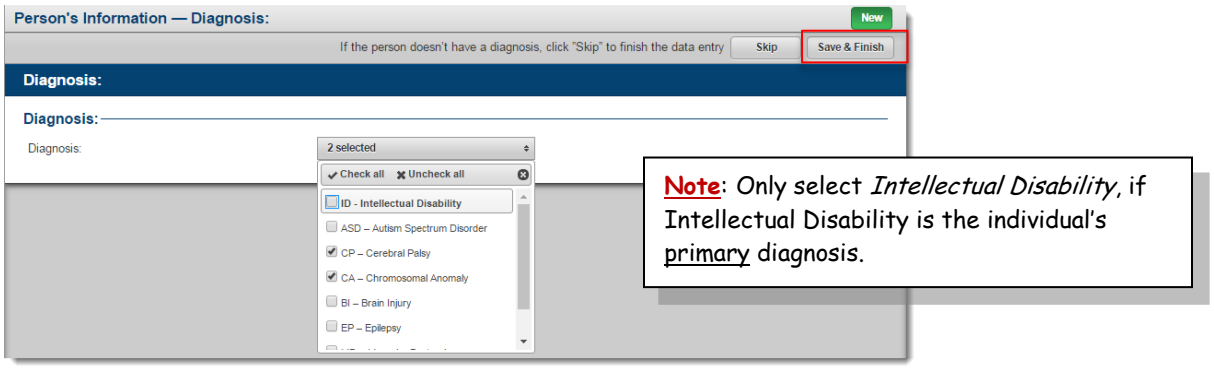
Note: Additional address(es) may be added from the Person's Overview page. 1) Choose *Overview* -> *Phone #* -> 2) Click **Details**, 3: Click **Add Person's Phone Number**.

2.2.5 Add Representative Contact



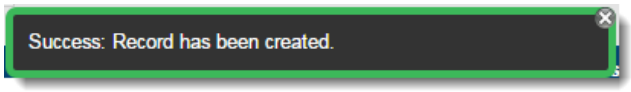
1. Complete all required fields for contact (*First Name, Last Name, Relationship to Person, Phone Type, Phone Number*). If the person does not have a known representative, click **Skip**.
2. Input as much optional information as possible.
3. Add Comments if necessary.
4. Click Save **& Continue**.

2.2.6 Add Diagnosis

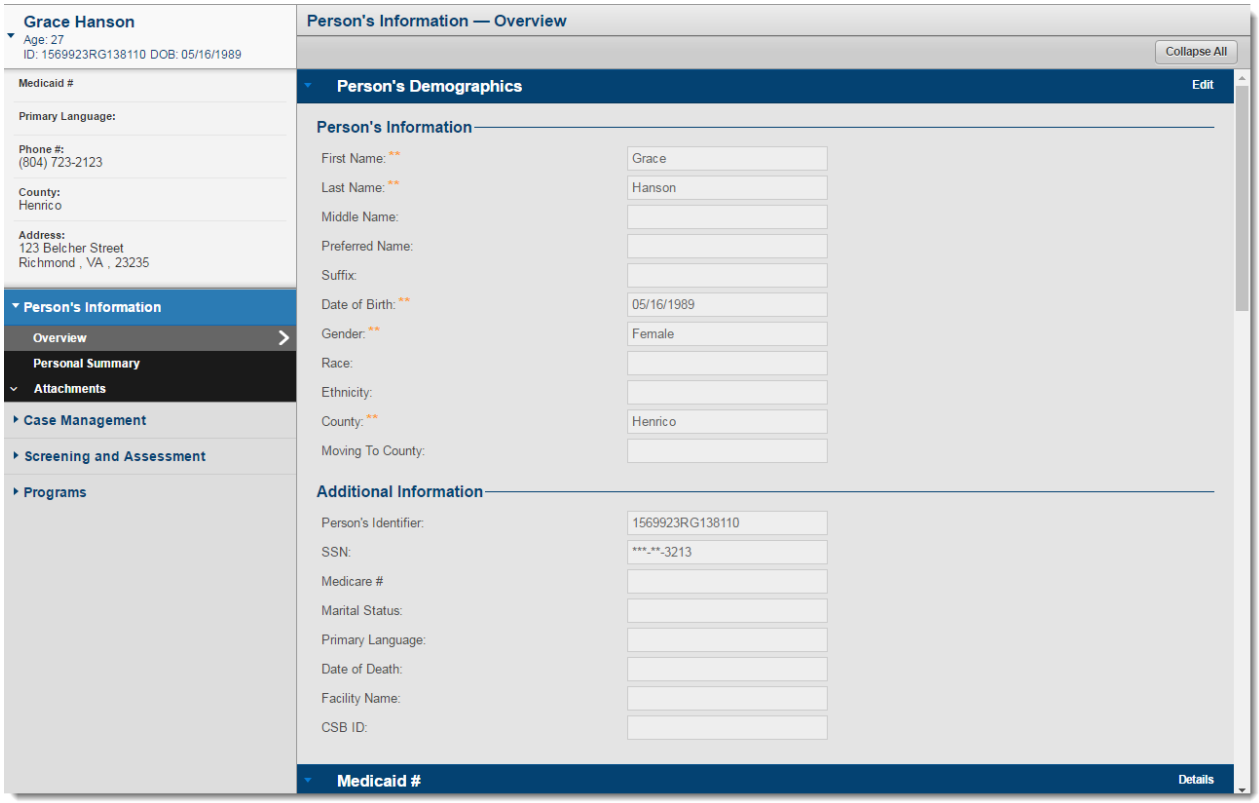


1. Click the drop down arrows to select the Diagnoses (select as many as needed).
2. Click **Save & Finish**.

   The individual has now been added to WaMS.



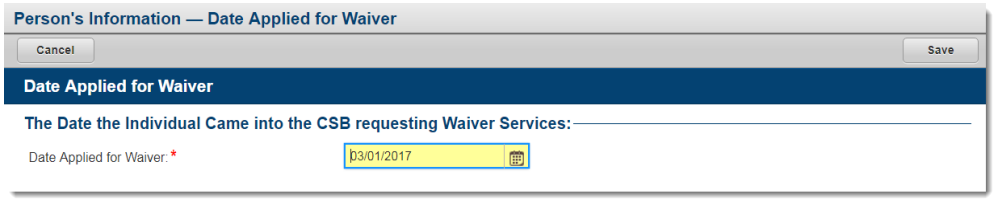
*The **Overview** page appears:*



2.2.7 Date Applied for Waiver

Add the date the individual came to the CSB to request Waiver services.

1. Scroll to the bottom of the *Overview Page*.
2. Click on **Edit**. *The Person's Information – Date Applied for Waiver window appears.*
3. Click in the *Date Applied for Waiver* field to select the appropriate date (or type it in the field).
4. Click on **Save**.

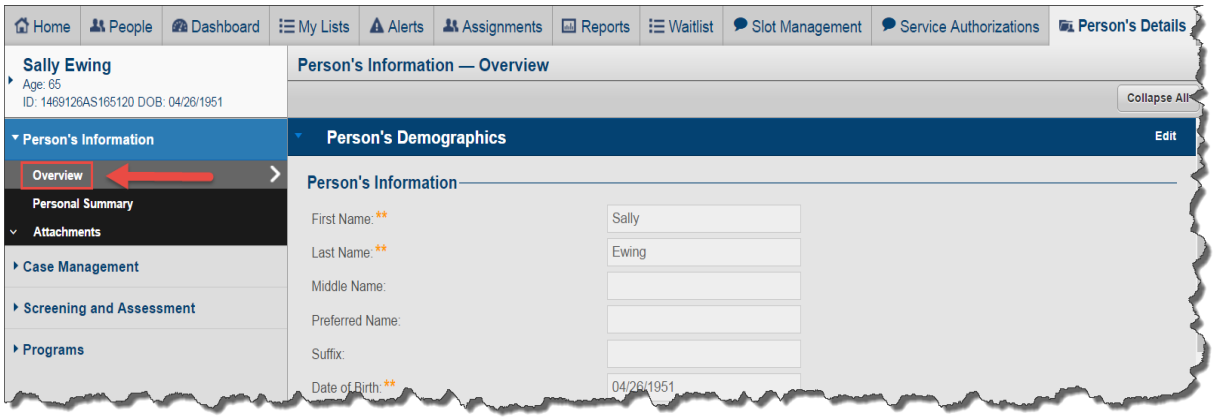


2.2.8 The Overview Page

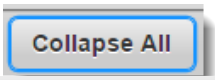
Once an individual has been added to WaMS their *Overview* page will be displayed. The *Overview* page can also be accessed by searching for an individual and clicking the *Summary* link (*Follow steps in Section 2.1: Locate an Existing Individual's Profile above*).

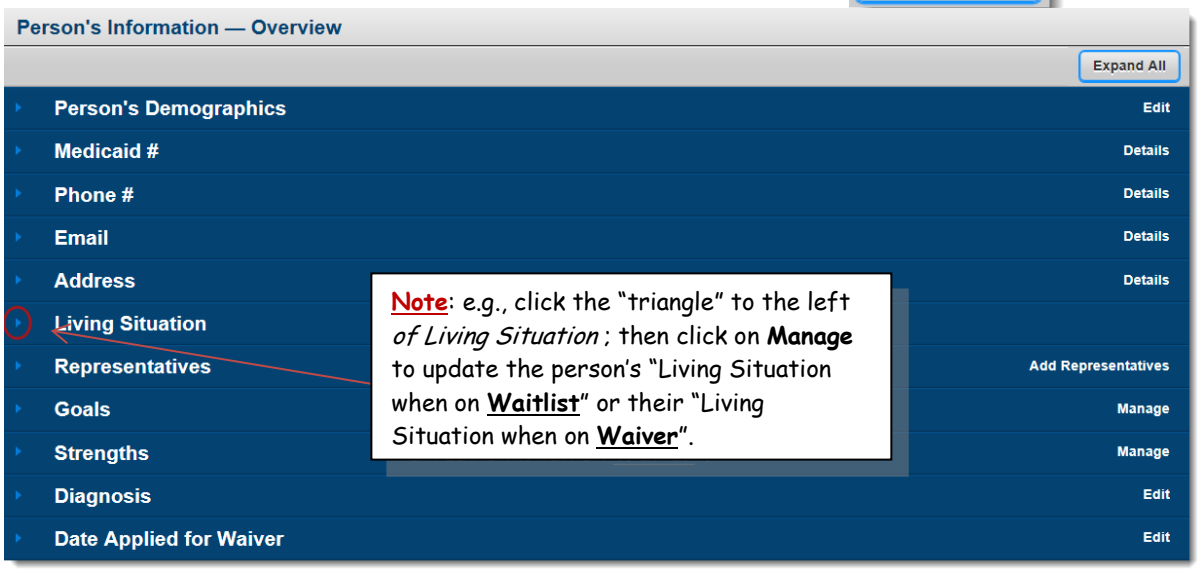
2.2.9 Update Person's Information/Overview Page

1. From the **Person's Details** tab, click on **Person's Information**, **Overview** on the *left navigation bar. The Person's Information – Overview displays.*



2. Click the Collapse **All** button to display *all* sections.





   a. Click **Edit, Details, Manage** and/or **Add Representatives** to update the *Person's information* as necessary.

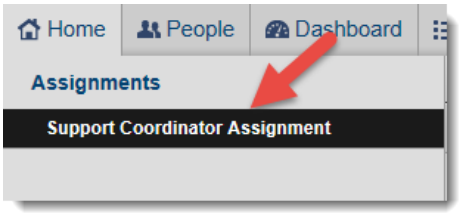
3 Support Coordinator Assignment

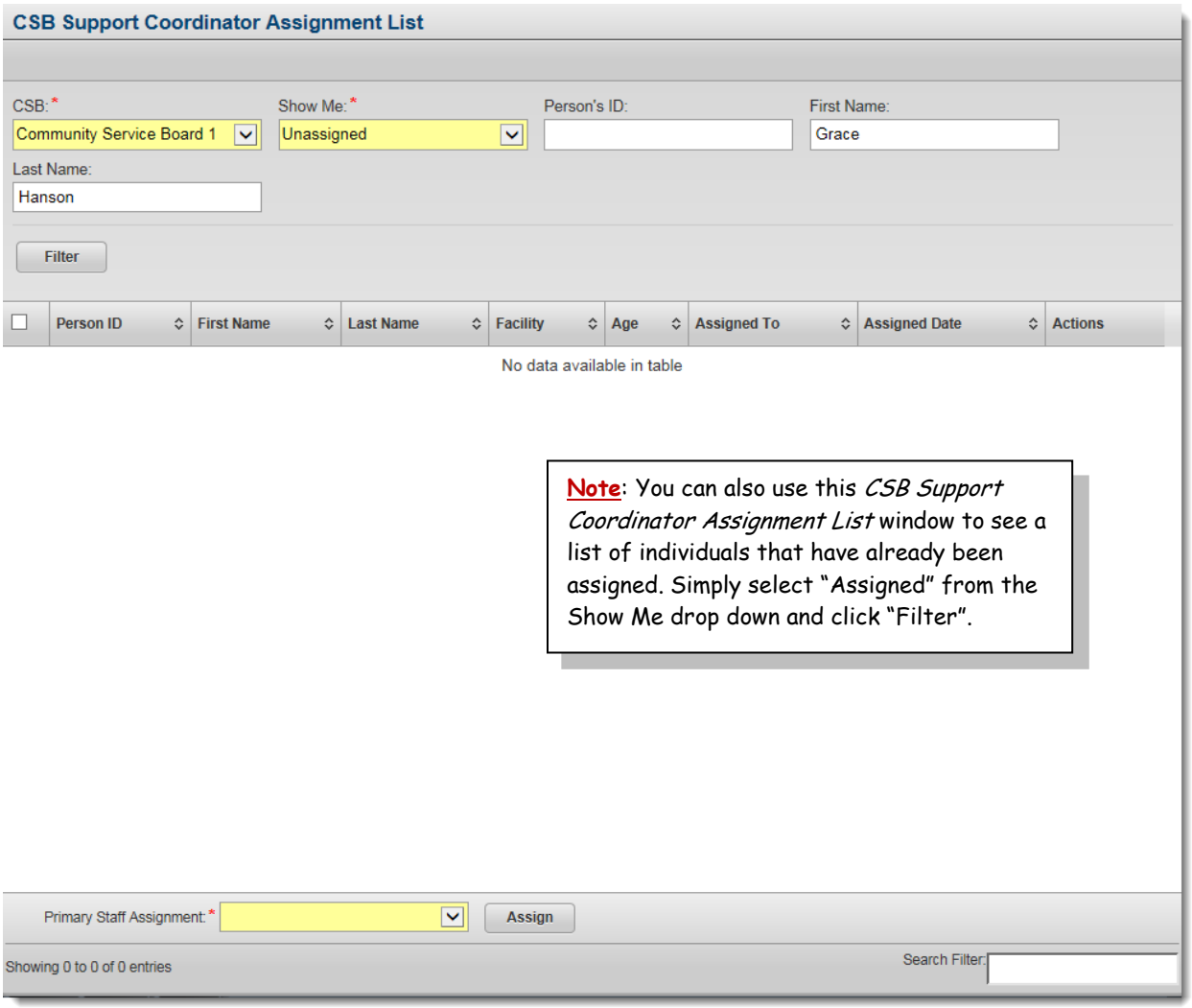
When an individual's profile is created, the individual added to WaMS is automatically assigned to the creating CSB Organization Unit. The **Assignments** tab allows authorized users to assign or reassign staff in their agency to an individual.

3.1 Assign Support Coordinator to an Individual

1. Click the **Assignments** tab.
2. Click on **Support Coordinator Assignment** (located on the left navigation bar).

   The CSB Support Coordinator Assignment List window appears.



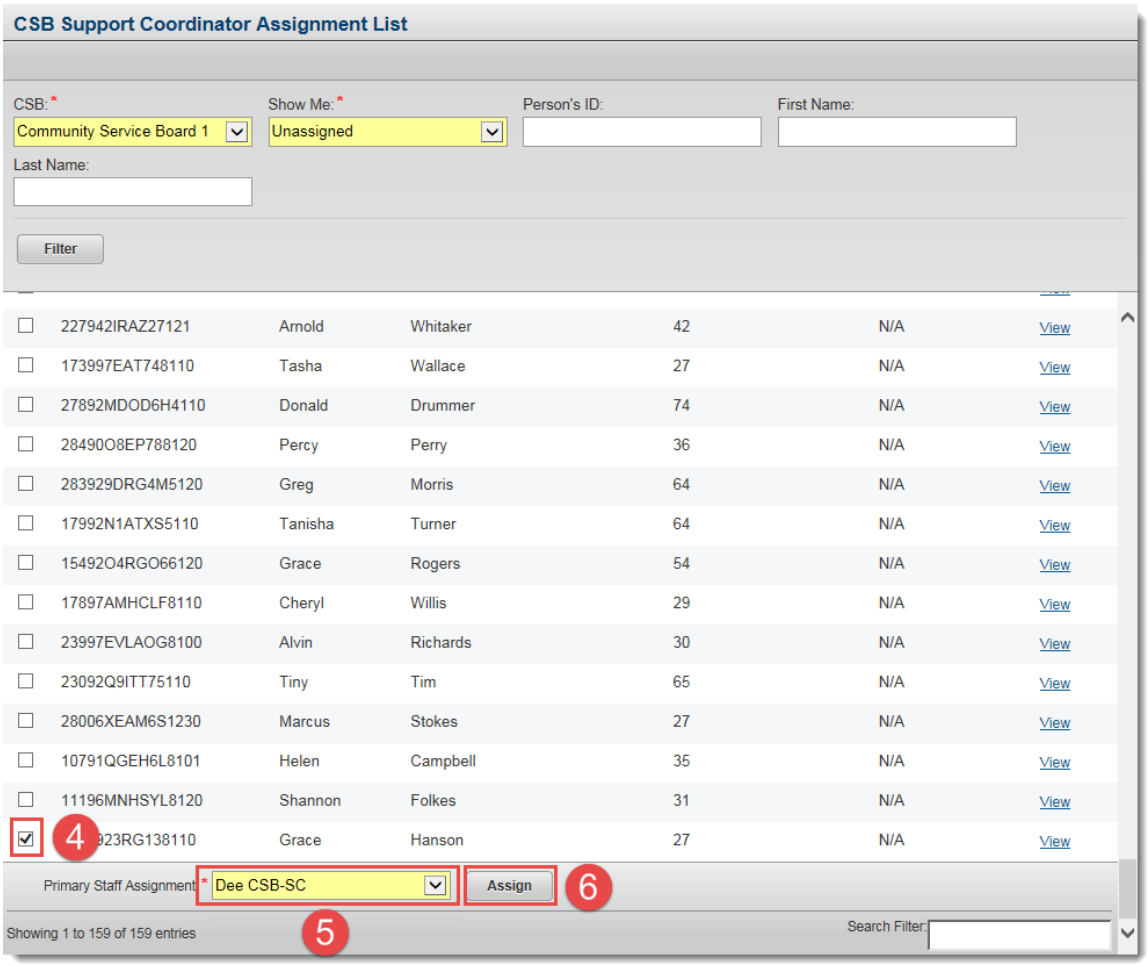


Note: You can also use this *CSB Support Coordinator Assignment List* window to see a list of individuals that have already been assigned. Simply select "Assigned" from the Show Me drop down and click "Filter".

3. Click the **Show Me** drop down list and select **Unassigned**.
4. Click on **Filter**.

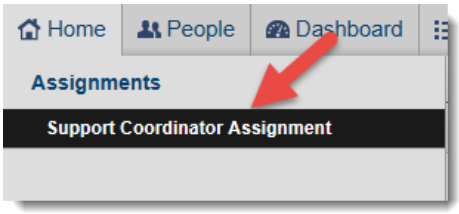
A list of all individuals in your Organization Unit (OU) without an assigned Support Coordinator will appear.

> **Note**: If you are looking for a specific individual, type their ID in the *Person's ID* field, and/or their name in the *First Name* and *Last Name* fields.



5. Click the **check box(es)** next to the individuals' name(s) you wish to assign to a Support Coordinator.
6. Click the **drop down arrow** for the **Primary Staff Assignment** field to select the appropriate Support Coordinator.
7. Click **Assign**. *The newly assigned Support Coordinator will receive an Alert* (shown below).

3.2 Reassign Individual to Different Support Coordinator (Same CSB)



1. Click the **Assignments** tab.
2. Click **Support Coordinator Assignment** (located on the left navigation bar). *The CSB Support Coordinator Assignment List window appears.*
3. Click the **Show Me** drop down list and select **Assigned**.
4. Click on **Filter**. *A list of all individuals Assigned to Organization Unit will appear.*
    a. To filter the list for certain Support Coordinator(s) click the **Staff** drop down list and select the name of the Support Coordinator that the individual(s) is currently assigned to and click on **Filter**.

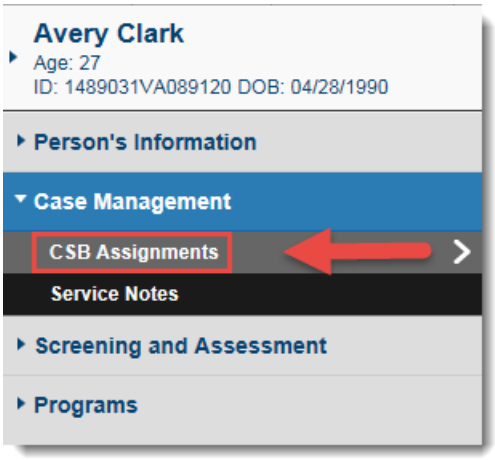
Note: If you are looking for a specific individual, type their ID in the *Person's ID* field, and/or their name in the *First Name* and *Last Name* fields.

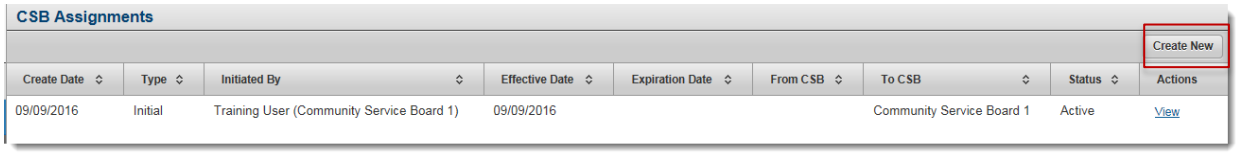
5. Click the **check box(es)** next to the individuals' name(s) you wish to reassign to a different Support Coordinator.
6. Click the **drop down arrow** for the **Primary Staff Assignment** field to select the *new* Support Coordinator to be assigned.
7. Click **Assign**.

3.3 Transfer Individual to a Different CSB

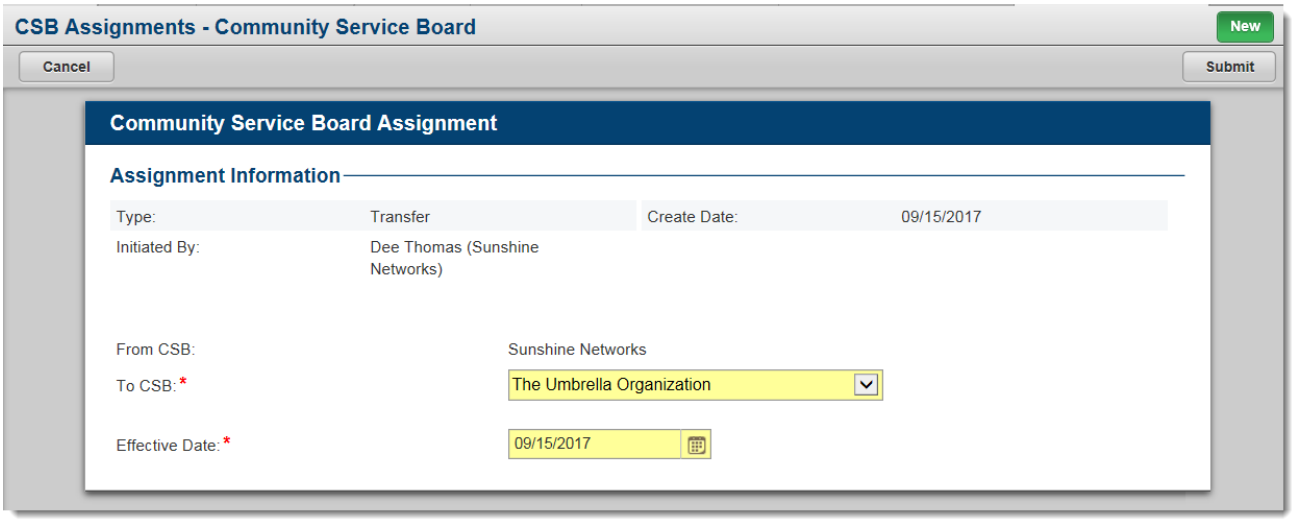
When an individual transfers to another area, the transferring CSB should transfer the individual in WaMS to the newly assigned CSB. This should be completed once the transfer date has been established and the new CSB is ready to accept the case. The transferring CSB's Support Coordinator is responsible for transferring the individual in WaMS.

1. Open the profile for the individual to be transferred to a new CSB. (See steps in ***Section 2.1: Locate an Existing Individual's Profile*** *above*).
2. Click on **Case Management**, **CSB Assignments**. *The CSB Assignment window opens.*





3. Click on **Create New**. *The Community Service Board Assignment dialog box appears.*



4. Click the **To CSB** dropdown arrow to select the CSB the individual should be transferred to.
5. Select the **Effective Date** calendar button to select the appropriate date for the transfer.
6. Click on **Submit**.

Note: The assigned Support Coordinator is automatically "unassigned" by the system when a CSB transfer occurs. A new Support Coordinator will have to be reassigned. Follow steps in Section 3.2 above.

Note: The Transfer will be in "Pending Status" if a future effective date is selected and will be unavailable to the receiving CSB until the effect date occurs.

4 The VIDES Survey

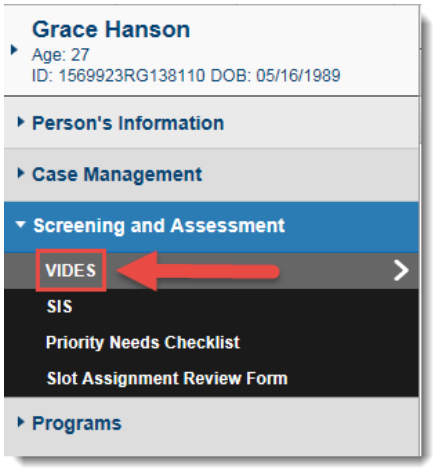
The *Virginia Individual Developmental Disability Eligibility Survey* (**VIDES)** details the process for determining the eligibility and *Level of Care* for infants under age of 3, children aged from 3 to 18, and adults over the age of 18. The **VIDES** must be created and submitted in order to add an individual to the *Waitlist*. The **VIDES** is located under the *Screening and Assessments* section.

> Note: The ***Waiver Application Date*** must be added in the *Overview* section before the VIDES can be completed.

4.1 Create a New VIDES

1. **Search** for the individual. (See steps in ***Section 2.1: Locate an Existing Individual's Profile*** *above*).

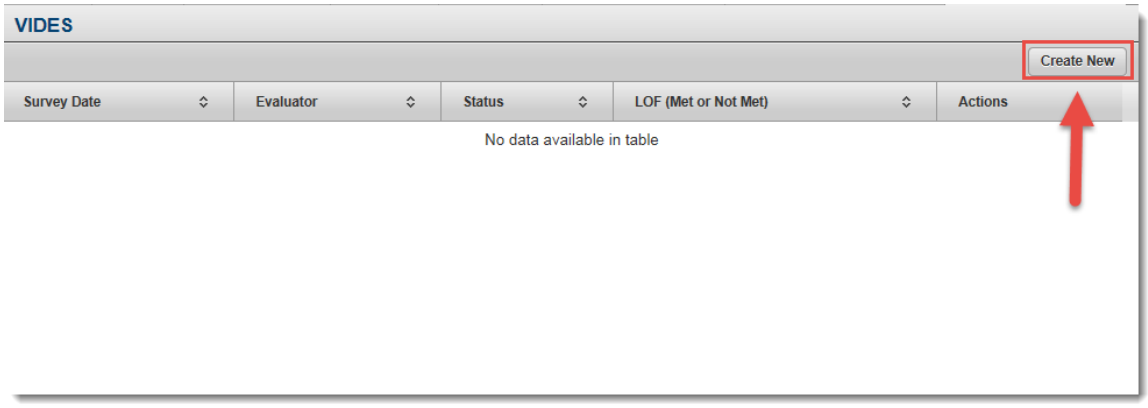
   From the **Screening and Assessments** section on the left navigation bar, click on **VIDES**.



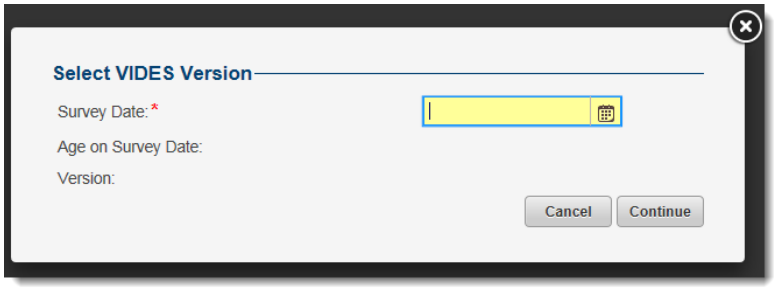
   The VIDES window appears on the right.

4.1.1 Start VIDES Questionnaire

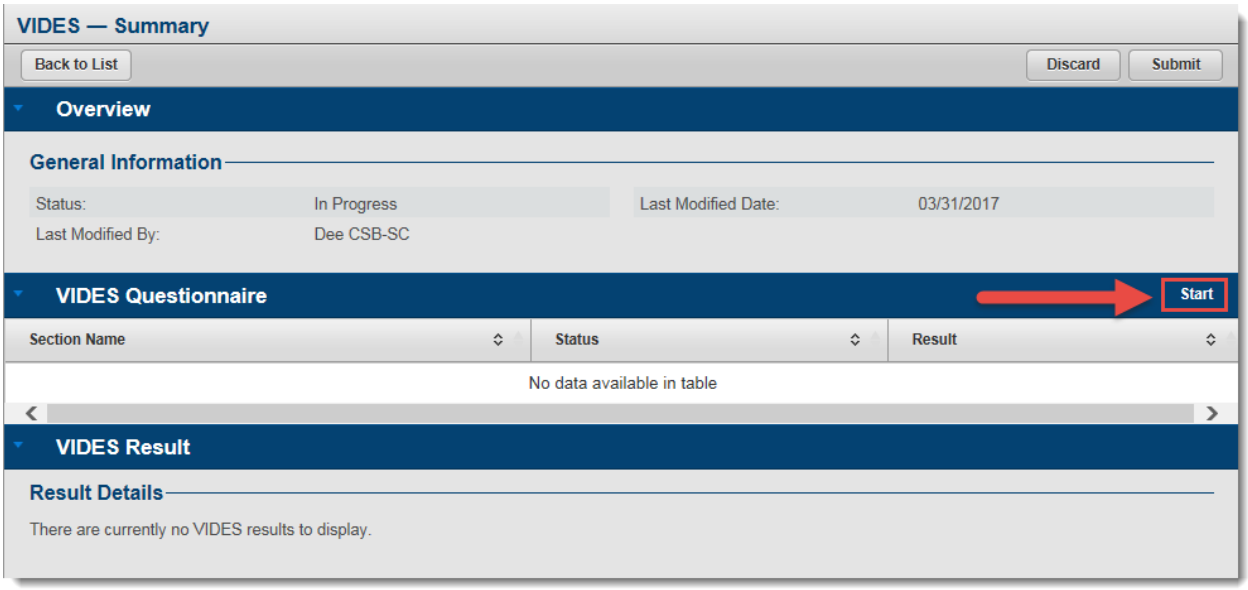
1. Click **Create New**.



The Select VIDES Version dialog box appears.



2. Click the **Calendar** button to select the date for the *Survey Date,* then click **Continue**. *The VIDES Summary window appears.*



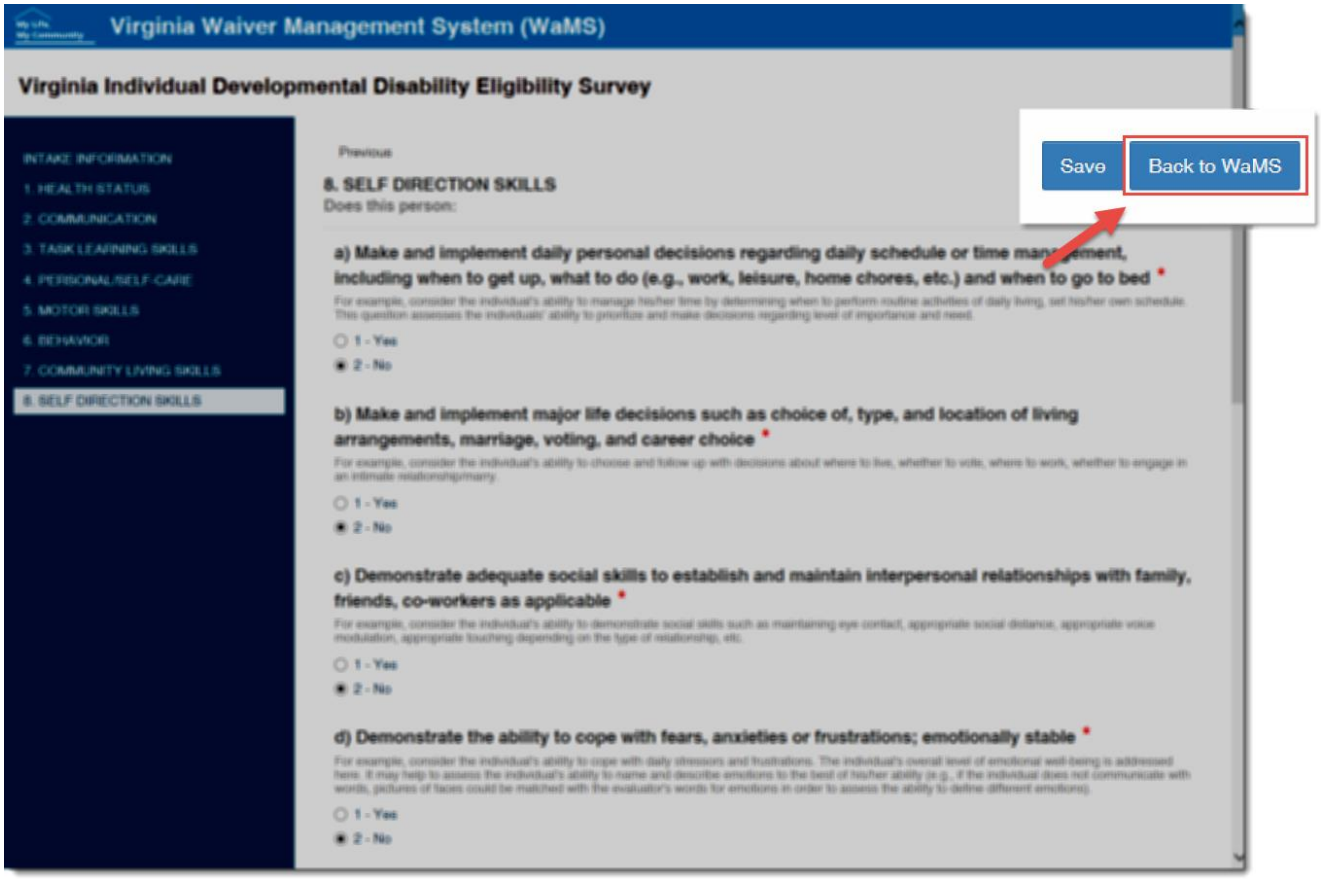
3. Click on **Start** in the *VIDES Questionnaire* section. The *Virginia Individual Developmental Disability Eligibility Survey* form opens in a new browser window outside of WaMS in Dynamic Forms.

4.1.2 Complete VIDES Questionnaire

The correct version of the VIDES (*Adult, Child* or *Infant*) is automatically selected and includes the individual's First and Last Name, Date of Birth, Age on Assessment Date, Survey Date and Evaluator.

1. Click on **Next**.
2. Complete all sections of the VIDES, selecting **Next** to go to each section of the form and adding notes as appropriate.
3. Click **Save** at the end of the last section.

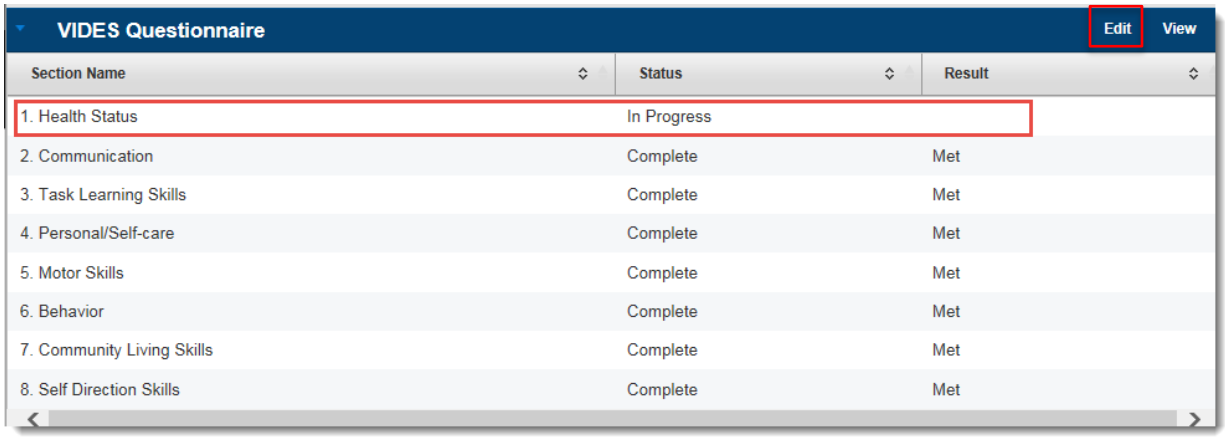
4. Click **Back to WaMS** to return to the WaMS environment.



Note: Any unanswered question(s) will result in an incomplete survey.

4.2 Edit or View VIDES

If any of the questions in the VIDES remain unanswered the status will show as *In Progress* and you must *Edit* to continue.



Section Name	Status	Result
1. Health Status	In Progress	
2. Communication	Complete	Met
3. Task Learning Skills	Complete	Met
4. Personal/Self-care	Complete	Met
5. Motor Skills	Complete	Met
6. Behavior	Complete	Met
7. Community Living Skills	Complete	Met
8. Self Direction Skills	Complete	Met

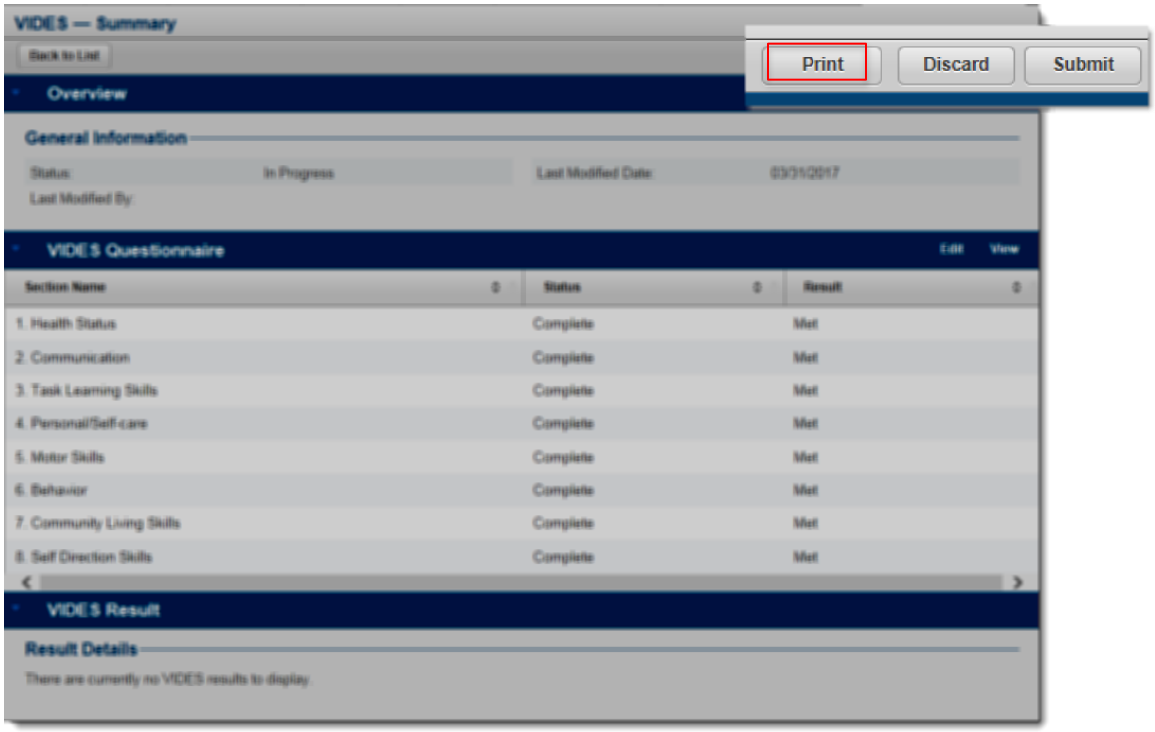
1. If necessary, access **VIDES** under *Screening and Assessment* and click **Summary** to open the **VIDES Questionnaire** page.
2. Click **Edit** in the **VIDES Questionnaire** to make changes or click **View** to review the **VIDES** without making changes.
3. Make updates as necessary.
4. Click **Save**.
5. Click **Back to WaMS**.

4.3 Print VIDES

The **Print** button becomes available for the VIDES once the form is *Complete*.

4.3.1 Print Completed VIDES Questionnaire

1. From the **VIDES Summary** window, click the **Print** button.



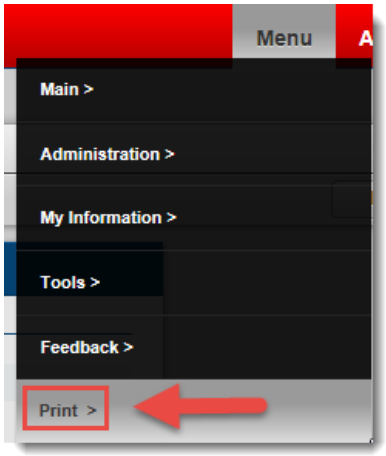
A PDF version of the VIDES Survey form opens in a new window.

2. **Print** (*Control +P, right-click and click Print, or click on the printer icon*) or **download** to *save* the PDF document.

4.3.2 Print VIDES Summary

To print a paper copy of the *VIDES Summary*, use the **Print** option under the **Menu**.

1. From the **VIDES Summary** window, click on **Menu, Print**.



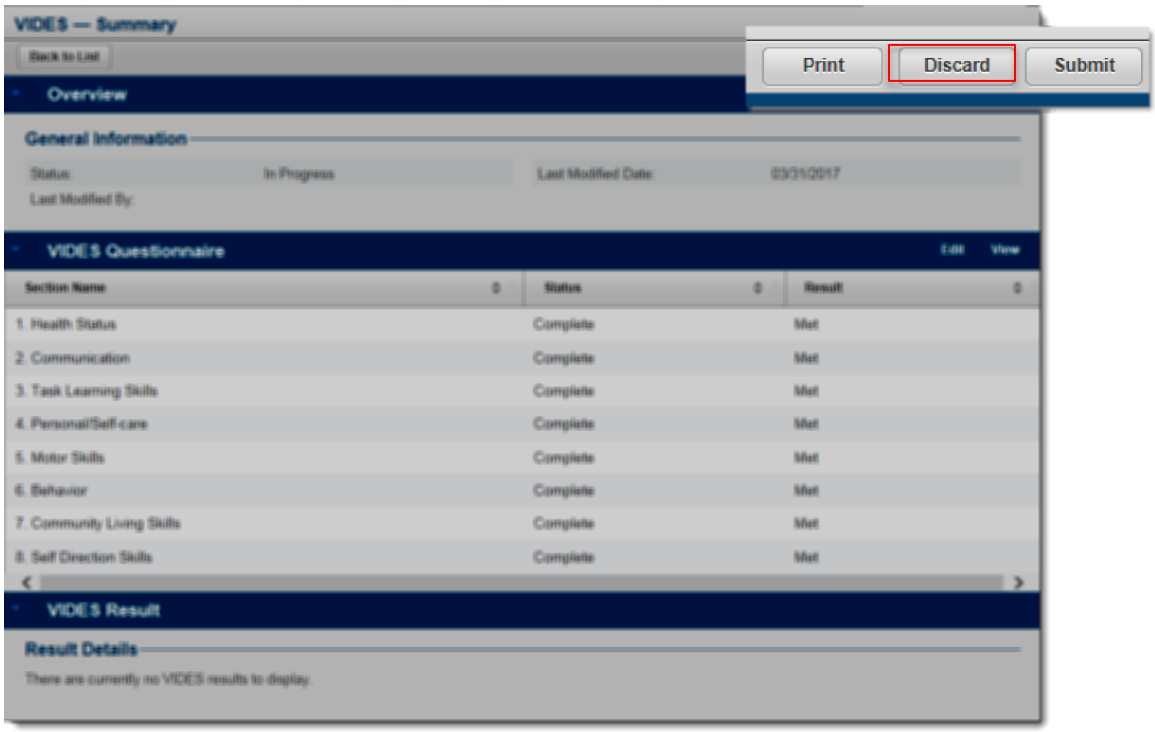
A PDF version of the VIDES Summary page opens in a new window.

2. **Print** (*Control +P, right-click and click Print,* or *click on the printer icon*) or **download** to *save* the PDF document.

4.4 Discard VIDES

If it is necessary, the VIDES can be discarded *before* it is submitted. To discard the VIDES:

1. From the **VIDES Summary** window, click the **Discard** button.



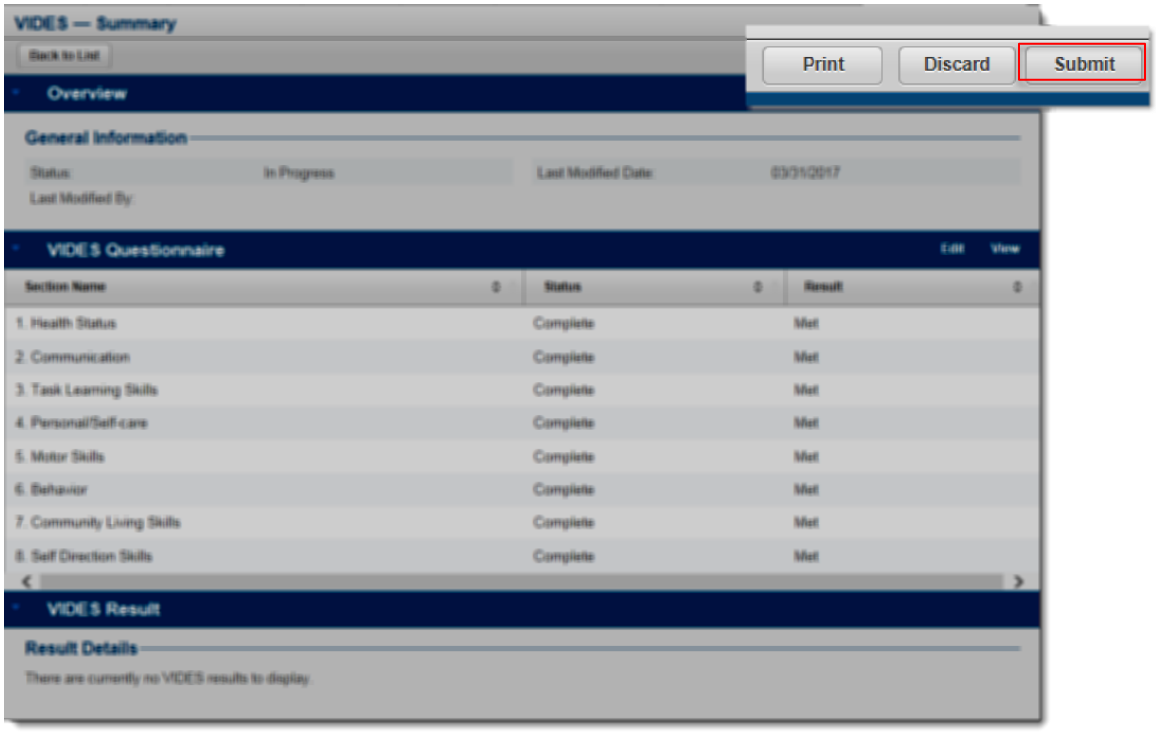
A **discarded** VIDES Questionnaire responses may be viewed or printed by selecting *Screening and Assessments, VIDES*.

1. Click the **Summary** link. *The VIDES Summary window opens.*
2. Click **View** *The discarded VIDES opens in a new browser window.*

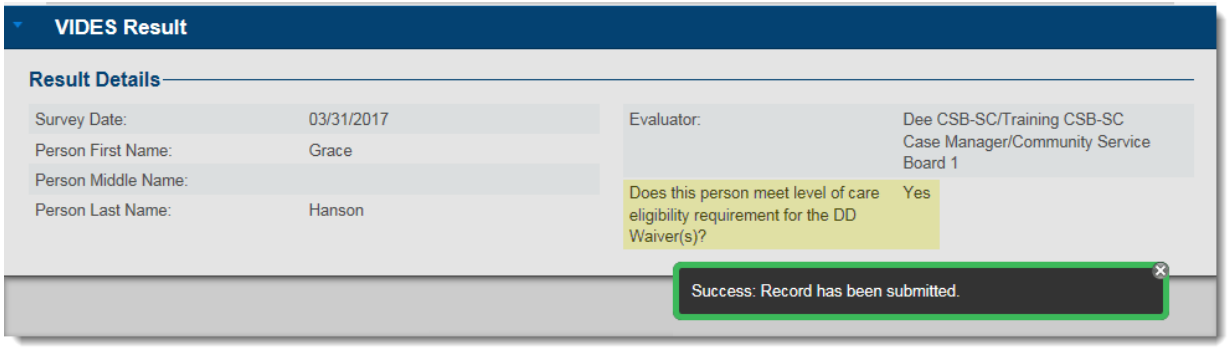
4.5 Submit VIDES

> **Note**: The VIDES is NOT complete until it is submitted!

1. From the **VIDES Summary** window, click the **Submit** button.



The "Success Record has been submitted" message appear and the VIDES results displays.



Points to Remember
• Children of different ages have different question requirements. Their questions will not go in alphabetical order. There may be missing alphabet designations. This is normal.
• VIDES results for each category are visible prior to submission; the results of each section (Met or Not Met) will be displayed once the status of the section is changed to complete.
• The VIDES Questionnaire will reflect the met/not met result for each category in the questionnaire, VIDES Results are not available until the VIDES is submitted in WaMS.
• If an individual has a completed VIDES it will display in the Personal Summary, Eligibility Information, section
• CSBs can create and edit the VIDES; however Providers can only view the VIDES

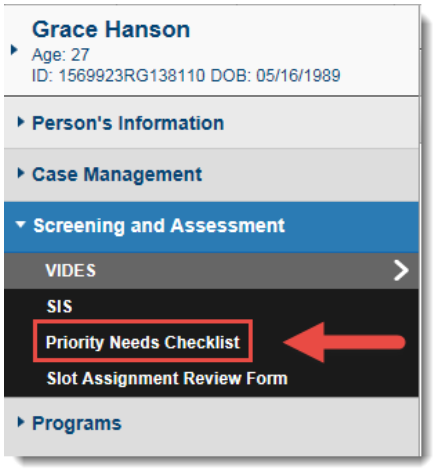
5 The Priority Needs Checklist

The **Priority Needs Checklist** must be completed and submitted in order to add an individual to the *Waitlist*. The checklist identifies the reason an individual falls into priority category (one, two or three) and is completed after the VIDES has been submitted. The **Priority Needs Checklist** is located under the *Screening and Assessments* section.

5.1 Create Priority Needs Checklist

1. **Search** for the individual. (See steps in ***Section 2.1: Locate an Existing Individual's Profile*** *above*).

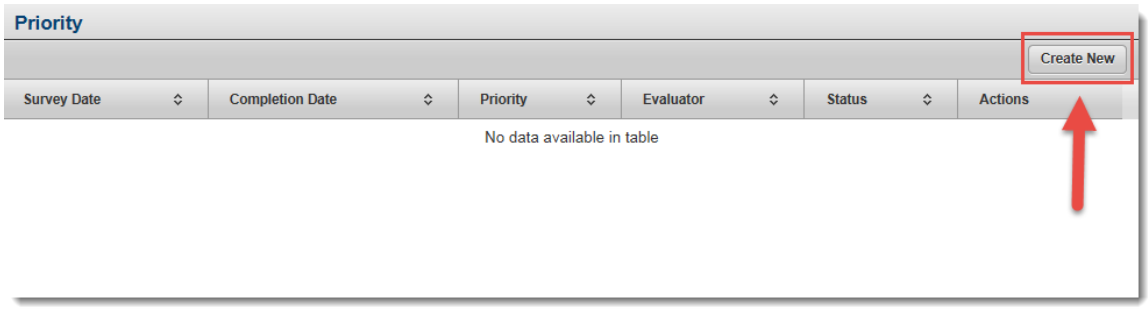
   From the **Screening and Assessments** section on the left navigation bar, click on **Priority Needs Checklist**



   The Priority window appears on the right.

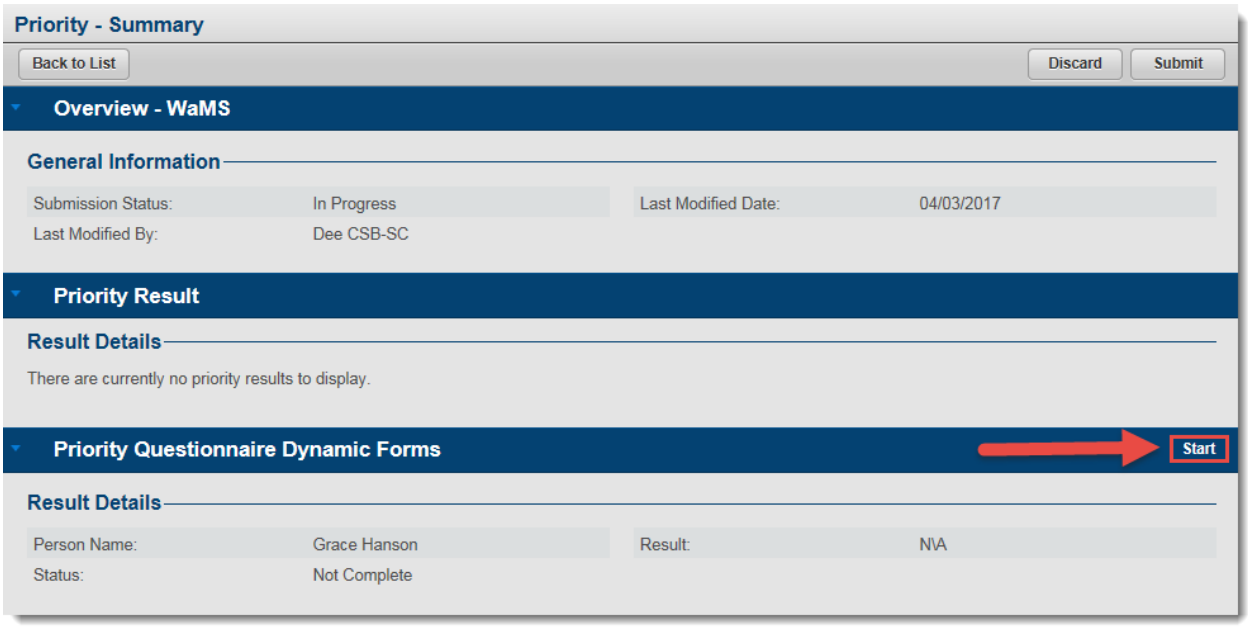
5.1.1 Start Priority Needs Checklist

1. Click **Create New**.



The Priority Survey Date dialog box appears. The survey defaults to the current date and may not be changed.

2. Click **Continue**. *The Priority - Summary window appears.*

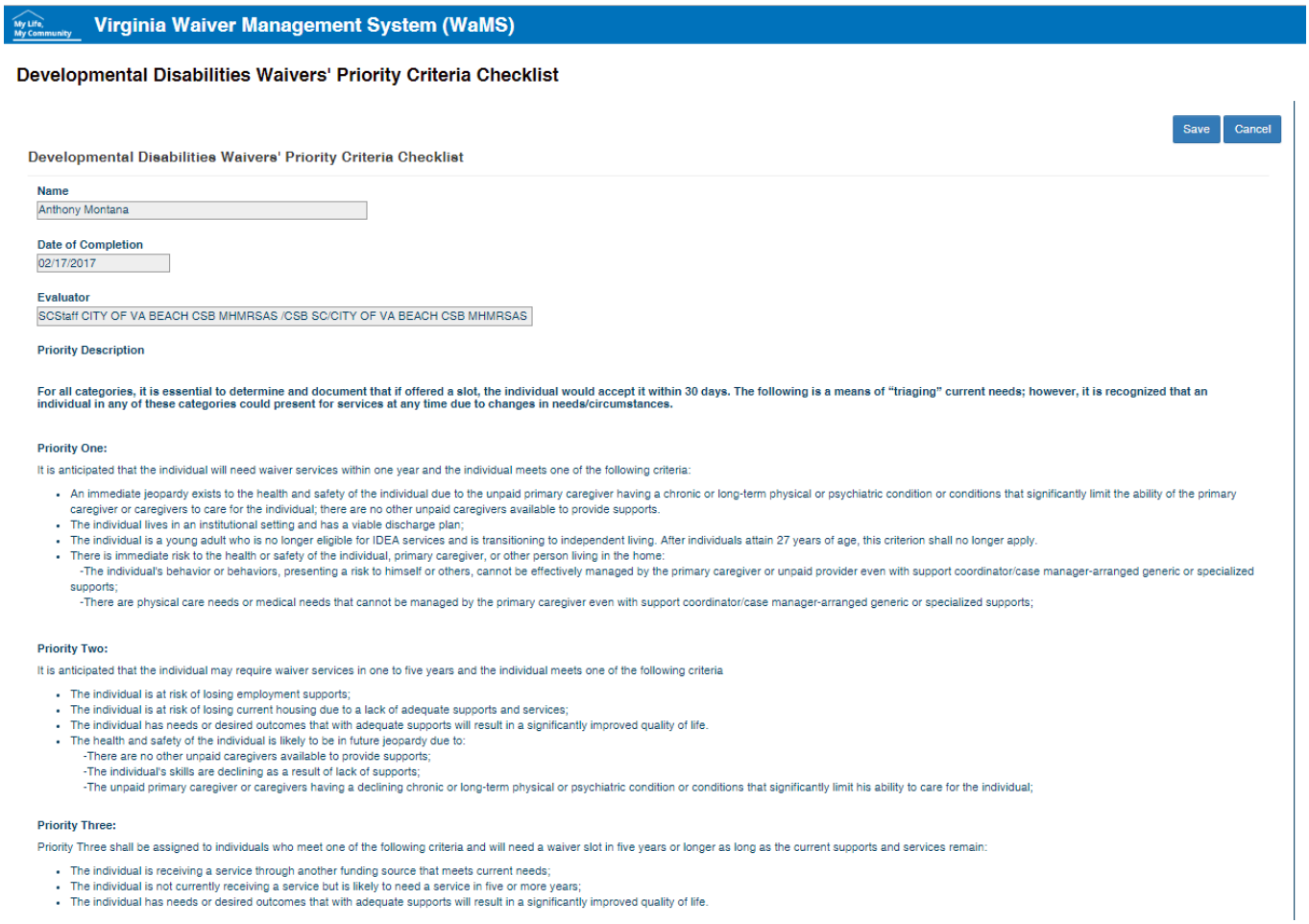


3. Click on **Start** in the *Priority Questionnaire Dynamic Forms* section. The *Developmental Disabilities Waivers' Priority Criteria Checklist* form opens in a new browser window outside of WaMS in Dynamic Forms.

5.2 Complete the Developmental Disabilities Waivers' Priority Criteria Checklist

The top portion (individual's name, completion date and the name of the Evaluator) is automatically filled-in.

> **Note**: For all priorities, it is essential to determine and document that if an individual is offered a slot, the individual will accept it within 30 days.



Virginia Waiver Management System (WaMS)

Developmental Disabilities Waivers' Priority Criteria Checklist

Save Cancel

Developmental Disabilities Waivers' Priority Criteria Checklist

Name
Anthony Montana

Date of Completion
02/17/2017

Evaluator
SCStaff CITY OF VA BEACH CSB MHMRSAS /CSB SC/CITY OF VA BEACH CSB MHMRSAS

Priority Description

For all categories, it is essential to determine and document that if offered a slot, the individual would accept it within 30 days. The following is a means of "triaging" current needs; however, it is recognized that an individual in any of these categories could present for services at any time due to changes in needs/circumstances.

Priority One:

It is anticipated that the individual will need waiver services within one year and the individual meets one of the following criteria:

- An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.
- The individual lives in an institutional setting and has a viable discharge plan;
- The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.
- There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home:
  -The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports;
  -There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports;

Priority Two:

It is anticipated that the individual may require waiver services in one to five years and the individual meets one of the following criteria

- The individual is at risk of losing employment supports;
- The individual is at risk of losing current housing due to a lack of adequate supports and services;
- The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.
- The health and safety of the individual is likely to be in future jeopardy due to:
  -There are no other unpaid caregivers available to provide supports;
  -The individual's skills are declining as a result of lack of supports;
  -The unpaid primary caregiver or caregivers having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limit his ability to care for the individual;

Priority Three:

Priority Three shall be assigned to individuals who meet one of the following criteria and will need a waiver slot in five years or longer as long as the current supports and services remain:

- The individual is receiving a service through another funding source that meets current needs;
- The individual is not currently receiving a service but is likely to need a service in five or more years;
- The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

4. Scroll down the questionnaire form and choose the appropriate **Priority Status** (*One, Two or Three)*:

PRIORITY ONE

It is anticipated that the individual will need waiver services within one year and the individual meets <u>one</u> of the following criteria:

☐ An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.

☐ The individual lives in an institutional setting and has a viable discharge plan;

☐ The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.

☐ There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home

<u>Note</u>: When selecting the last option "*There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home"*, there are additional conditions (select all that are appropriate)

☐ The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports;

☐ There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports

PRIORITY TWO

It is anticipated that the individual may require waiver services in one to five years and the individual meets one of the following criteria

☐ The individual is at risk of losing employment supports;

☐ The individual is at risk of losing current housing due to a lack of adequate supports and services;

☐ The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

☐ The health and safety of the individual is likely to be in future jeopardy

Note: When selecting the last option "*The health and safety of the individual is*, there are additional conditions. (select all that are appropriate)

☐ There are no other unpaid caregivers available to provide supports;

☐ The individual's skills are declining as a result of lack of supports;

☐ The unpaid primary caregiver or caregivers having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limit his ability to care for the individual;

PRIORITY THREE

Priority Three shall be assigned to individuals who meet one of the following criteria and will need a waiver slot in five years or longer as long as the current supports and services remain:

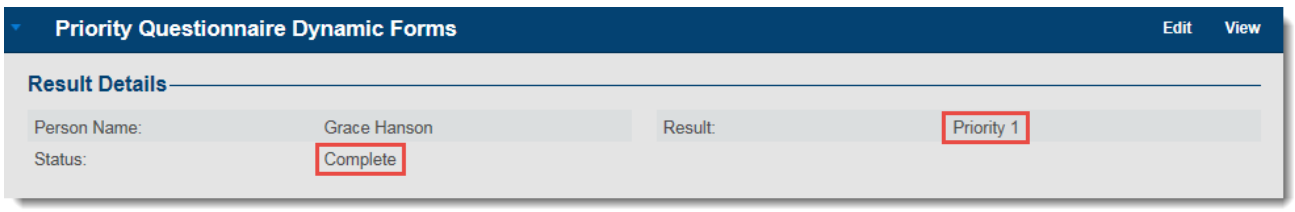
☐ The individual is receiving a service through another funding source that meets current needs;

☐ The individual is not currently receiving a service but is likely to need a service in five or more years;

☐ The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

5. Click on Save.
6. Click on **Back to WaMS**.

   *The Status for the form shows as **Complete** with the **Priority** selected as the Result.*

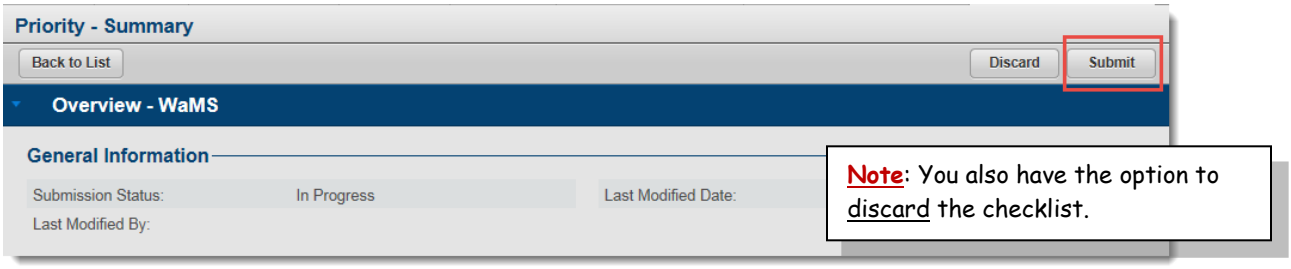


7. Select **Edit** to modify or **View** to see/review the checklist. A new checklist should be completed if the individual's priority level changes.

5.3 Submit Priority Needs Checklist

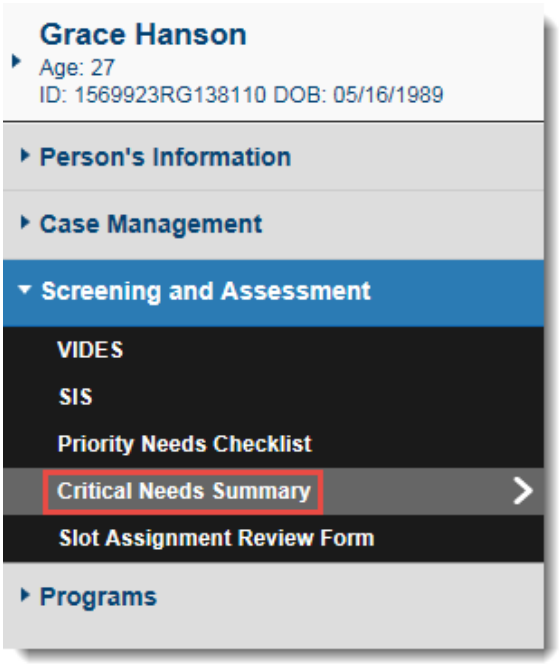
Note: The Priority Needs Checklist is NOT complete until it is submitted!

1. Click **Submit** in the *Priority – Summary* window.



*When Priority One is selected, the **Critical Needs Summary** option appears in the Screening and Assessment section.*

*The **Critical Needs Summary** (CNS) must be completed for anyone with **Priority One** status.*



5.4 Update Priority Needs Checklist

In order to change the priority of an individual must submit a new *Priority Needs Checklist* and *Critical Needs Summary* forms. See steps in **Section 7.2.3** (*Update information for Individual on the Waitlist*).

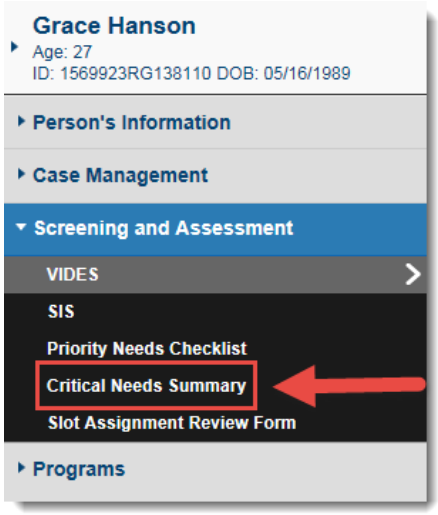
6 Critical Needs Summary

Individuals who are designated with a *Priority One* status must also have a **Critical Needs Summary** (CNS) completed. This is a required step in placing an individual on the Waitlist. The **Critical Needs Summary** option will appear under the *Screening and Assessments* section *after* the **Priority Needs Checklist** has been completed and submitted.

6.1 Create Critical Needs Summary

1. **Search** for the individual. (See steps in ***Section 2.1: Locate an Existing Individual's Profile*** *above*).

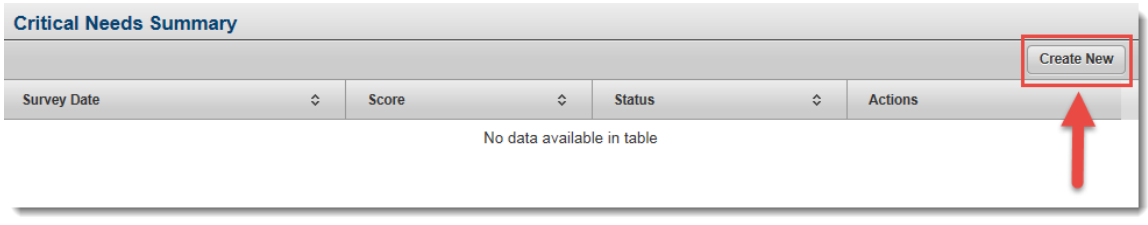
   From the **Screening and Assessments** section on the left navigation bar, click on **Critical Needs Summary**



   The Critical Needs Summary window appears on the right.

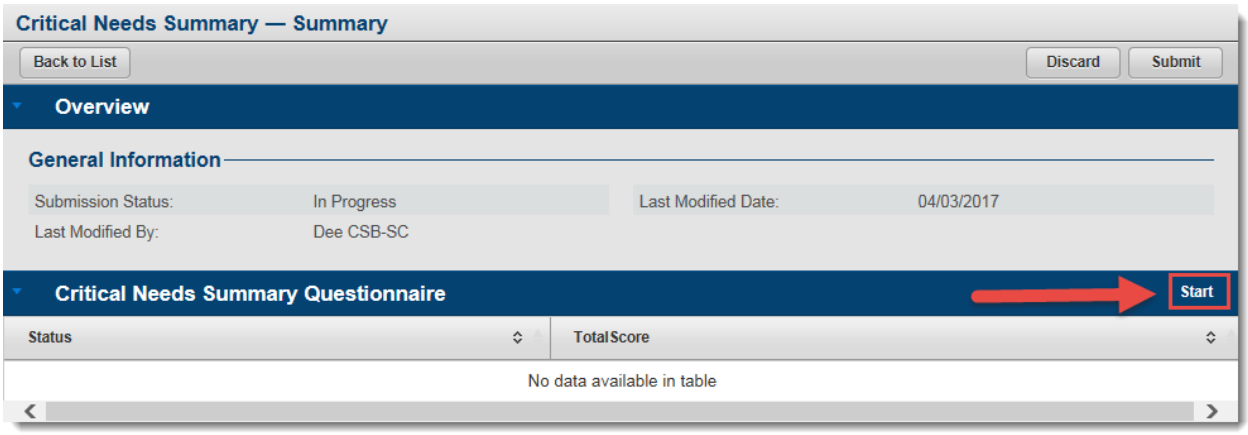
6.1.1 Start Critical Needs Summary

1. Click **Create New**.



   The Critical Need Summary Survey Date dialog box appears. The survey defaults to the current date and may not be changed.

2. Click **Continue**. *The Critical Needs Summary - Summary window appears.*



3. Click on **Start** in the *Critical Needs Summary Questionnaire* section. The *Critical Needs Summary* form opens in a new browser window outside of WaMS in Dynamics Forms.

6.2 Complete Critical Needs Summary

The top portion (*CSB name, Individual's name* and *Medicaid Number* and *if the individual is an adult*) is automatically filled-in.

Points to Remember
• The numbers next to each radio button are a score. Zero (0) indicates the statement does not apply to the individual.
• The Medicaid field is blank if not yet added to the *Person's Information Overview*.
• If the Medicaid number is added to the *Person's Information Overview* after the Critical Needs Summary has been started, the summary may be discarded and a new Critical Needs Summary created. NOTE: The discard function is only available while the Critical Needs Summary submission status is "in progress." If "completed," create a new Critical Needs Summary.
• When the WSAC meeting is convened and a slot is available for assignment, the waitlist is sorted by Critical Needs Summary score (highest to lowest). The appropriate number of individuals (based on number of slots available) is pulled to the "review pool" list to be considered for a slot.
• An individual being considered for a slot assignment (i. e., in the review pool) must have a Slot Assignment Review Form completed by the CSB for the WSAC to review.

1. Scroll down the questionnaire form and choose the appropriate scores for the individual.

2. Click on **Save** then click on **Back to WaMs** (top right).

6.3 Submit Critical Needs Summary

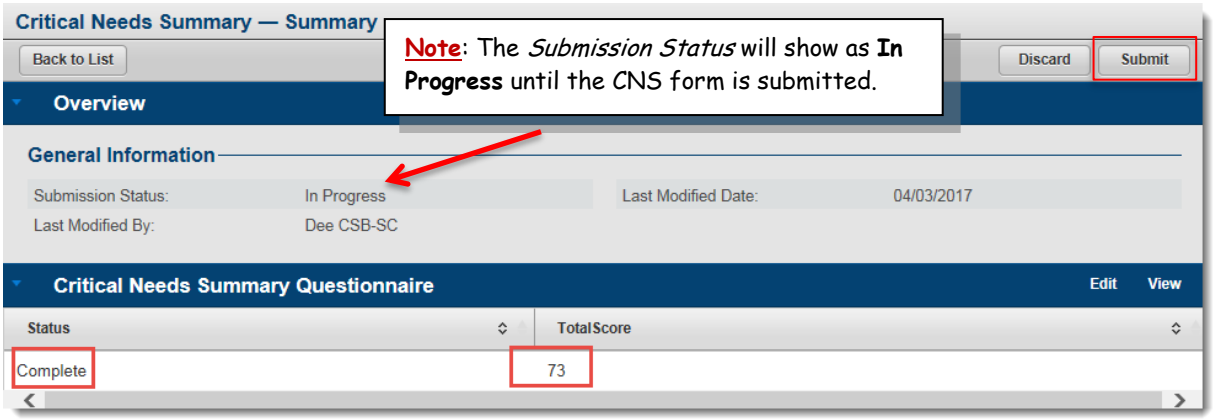
6.3.1 Edit Critical Needs Summary

If necessary, the Critical Needs Summary can be edited if the submission status is *In Progress*. Select **Edit** to modify or **View** to see/review the Critical Needs Summary.

6.3.2 Submit Critical Needs Summary

Note: The Critical Needs Summary is not complete until it is submitted!

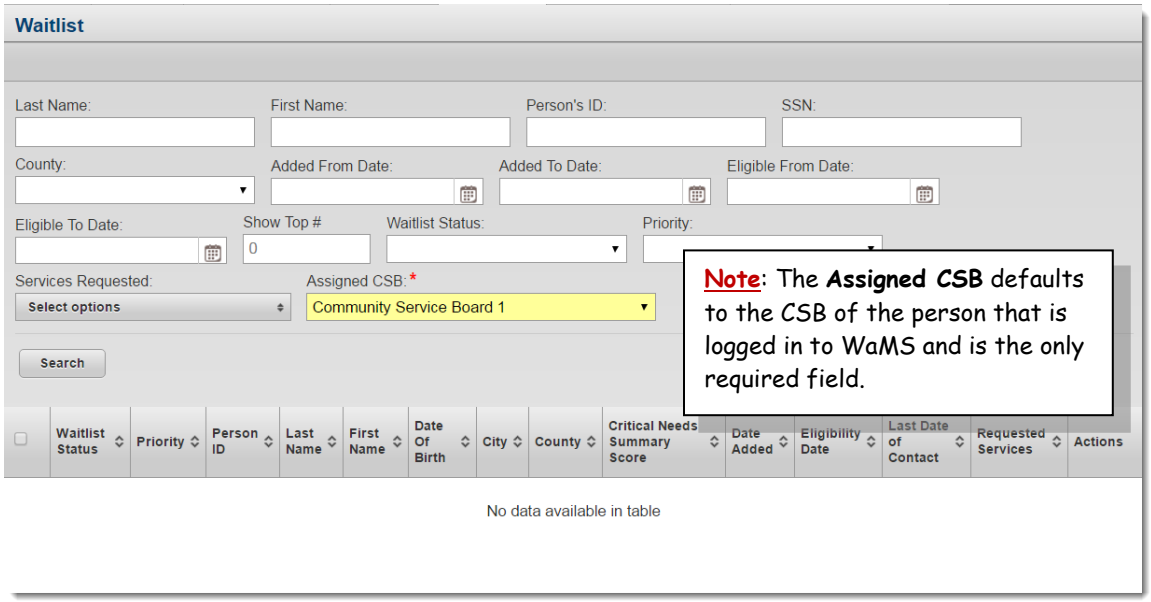
1. The *Status* shows as **Complete** with the **Total Score** displayed. Click **Submit** in the *Priority – Summary* window.
2. Click **Submit**. *The Submission status changes to "Submitted" and the form can no longer be edited.*



7 The Waitlist

7.1 The Waitlist Tab

The **Waitlist** tab displays individuals who meet criteria for the Developmental Disabilities (DD) Waiver but have not yet been assigned a slot. CSBs are only able to view persons assigned to their CSB.



7.1.1 Search for Individuals on the Waitlist

To find all individuals on the Waitlist in the organization or a specific individual do the following:

1. Click on the **Waitlist** tab from the top navigation bar.
2. Input as much or as little search criteria as needed (*the more search criteria input, the narrower the results*).
3. Click **Search**. *The search results appear.*

7.1.2 Search for Individuals by Waitlist Status

To find all individuals in the organization based on their waitlist status:

1. Click on the **Waitlist** tab from the top navigation bar.
2. Click the **Waitlist Status** down arrow to select one of the following statuses:
   - Active
   - Inactive
   - On Wave
   - Slot Assigned
3. Click **Search**. *The search results appear.*

7.2 Add Individual to Waitlist

An individual can be added to the **Waitlist** only after the following items are completed:

- ✓ VIDES
- ✓ A diagnosis has been entered (*Follow steps in Section 2.2.6: Person's Information Overview above*)
- ✓ Priority Needs Checklist
- ✓ Critical Needs Summary (for Priority One only)

An individual may be added to the Waitlist one of two ways:

1. In the *People* tab search results; or
2. From the *Person's Information* page

7.2.1 Add to Waitlist from the People Tab Search Results

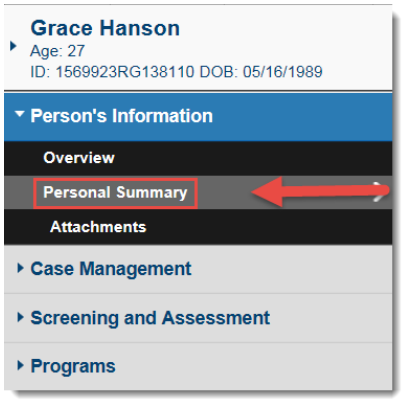
To add an individual to the Waitlist from the *People* tab search results:

1. Search for the individual. (*Follow steps in Section 2.1: Locate an Existing Individual's Profile above*).
2. From the results list, under *Actions*, click **Add to Waitlist.**

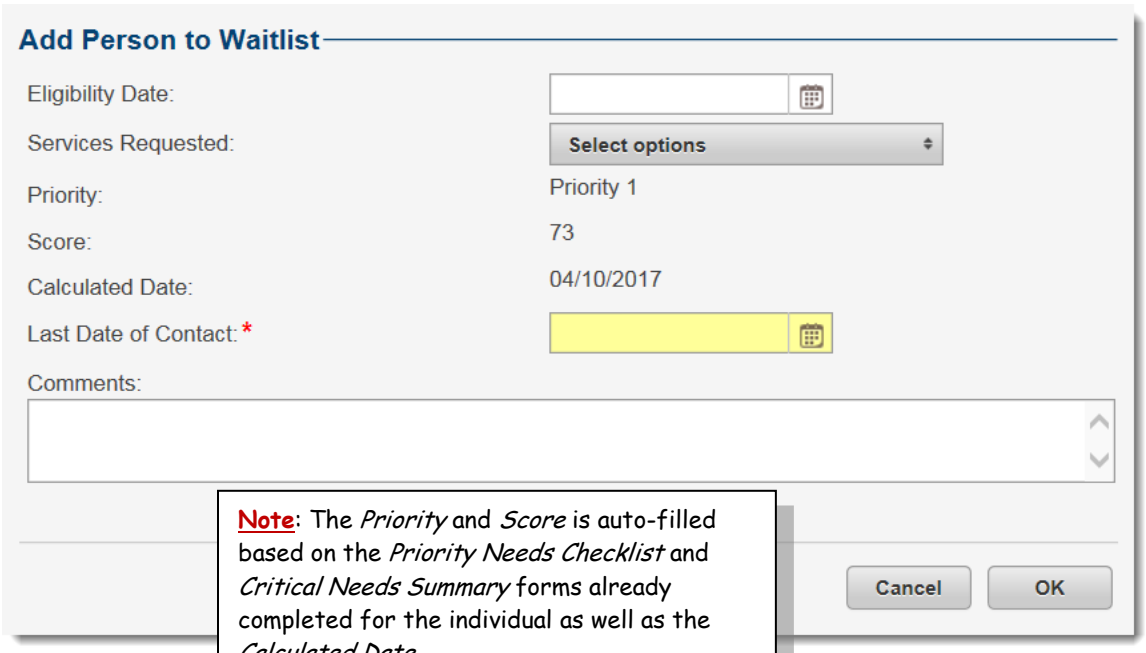
7.2.2 Add to Waitlist from the Person's Information Page

To add an individual to the Waitlist from the *Person's Information* page:

1. While in an individual's record, click **Person's Information**, **Personal Summary** from the left navigation menu. *The Personal Summary window appears.*
2. Scroll down to the *Waitlist/Slot Information* section.
3. Click **Add to Program Waitlist**.



The Add Person to Waitlist dialog box appears.



Note: The *Priority* and *Score* is auto-filled based on the *Priority Needs Checklist* and *Critical Needs Summary* forms already completed for the individual as well as the *Calculated Date*.

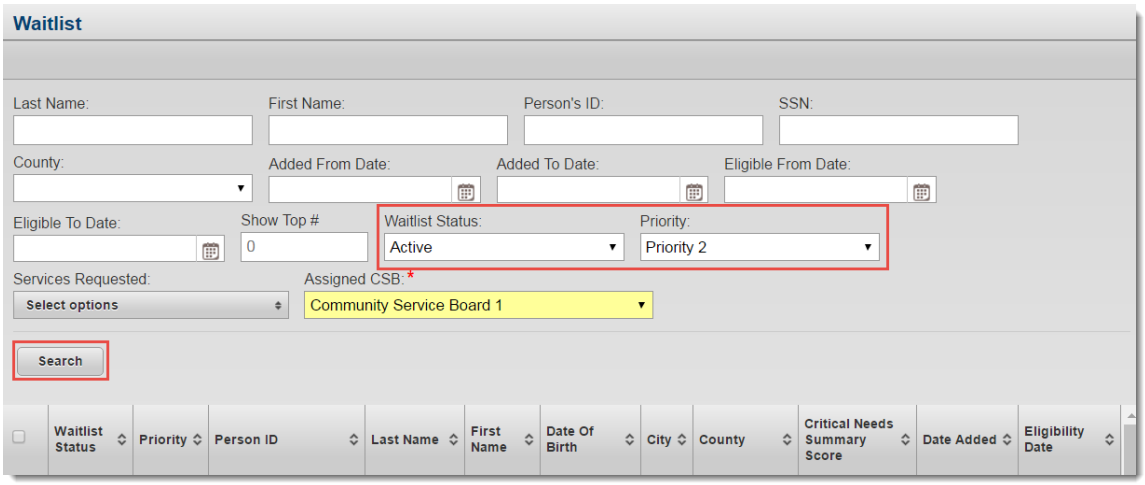
4. Add the **Eligibility Date** (if known).
5. Click the **Select options** arrows for the *Services Requested* to select each service required.
6. Click the Calendar to add **Last Date of Contact**.
7. Add any additional information in the **Comments** field.
8. Click **OK**. *The person is now added to the Waitlist.*

7.2.3 Update Information for Individual on the Waitlist

Update *requested services*, *priority status*, *critical needs score* and *date of last contact* using the **Waitlist** tab.

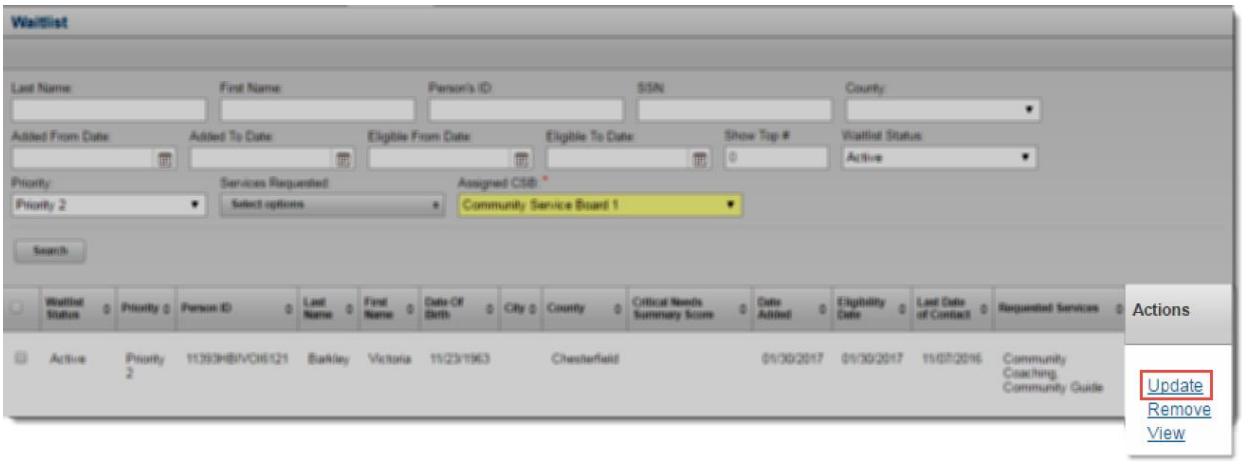
Note: The individual must be **Active** in order to update their information.

1. Click on the **Waitlist** tab from the top navigation bar.
2. Add the search criteria for the indivual to be updated from the Waitlist (i.e., Last Name, First Name, Person's ID, SSN, etc.) in the appropriate fields.
3. Click the Waitlist Status down arrow to select Active.
4. Click the Priority drop down arrow to select Priority 1, Priority 2, or Priority 3 if necessary.
5. Click **Search**.

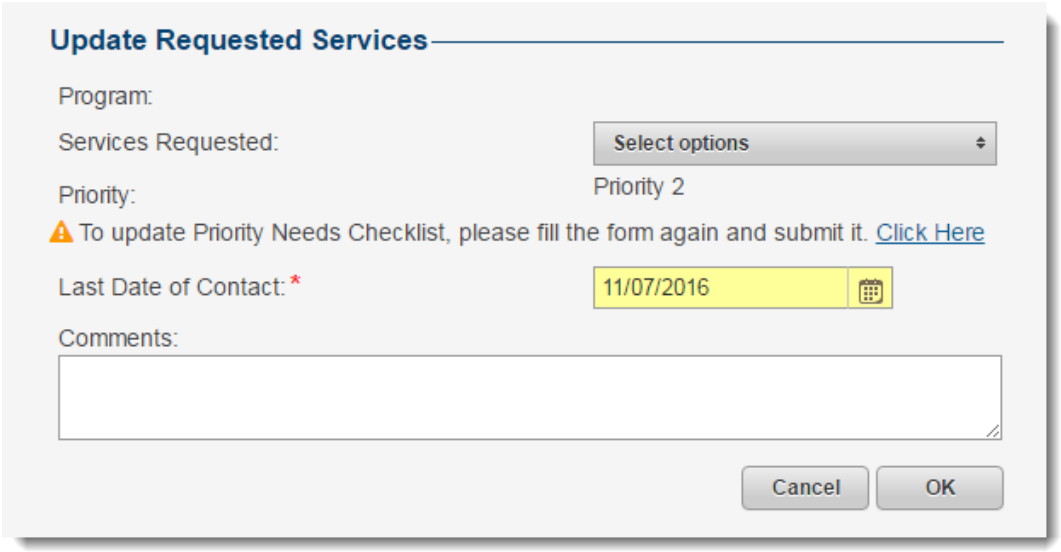


The search results appear.

6. Click **Update** link under *Actions* for the appropriate individual.



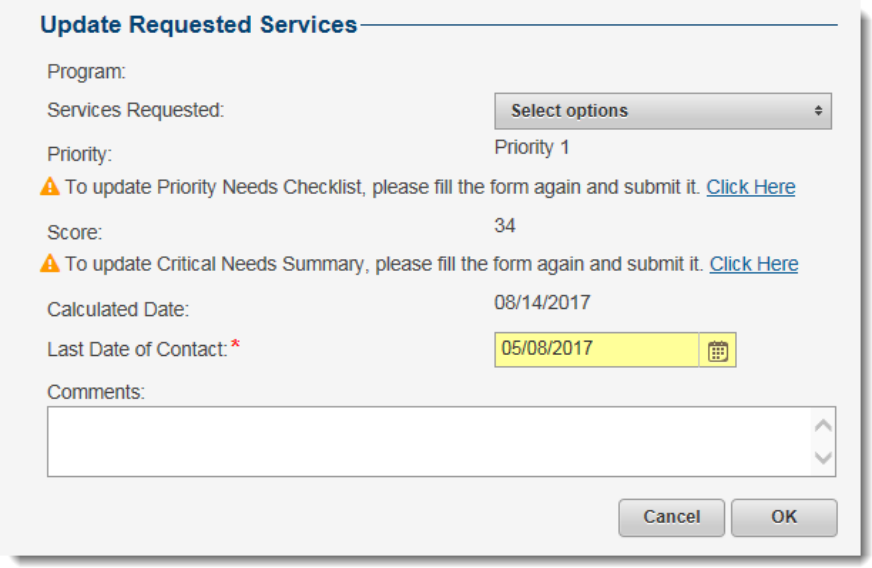
The Update Requested Services dialog box appears.



7. Click the **Select options** arrows to change the Services Requested.
    a. Disregard this field if no changes need to be made to the services requested
    b. Previously selected services are not identified in the dropdown
    c. Any new selection over writes all previous selections
8. To update the *Priority*, the **Priority Needs Checklist** form must be created and submitted. Click the **Click Here** link to go to the **Priority Needs Checklist**.
    a. Follow steps in *Section 5.1.1: Create Priority Needs Checklist above*.
    b. If the person is being assigned a *Priority One* Status, a *Critical Needs Summary* form must be submitted *before* the person's record will reflect *Priority One* status.

> **Note**: You can also select the **Critical Needs Summary** under the *Screening and Assessments* on the left navigation bar.

The Waitlist is updated once the new **Priority Needs Checklist** is submitted



Follow steps in Section 6.1.1: Create Critical Needs Summary above.

9. To update the **Last Date of Contact** click the **Calendar** and select the appropriate date.
10. Add any additional information in the **Comments** field.

    Click **OK**.

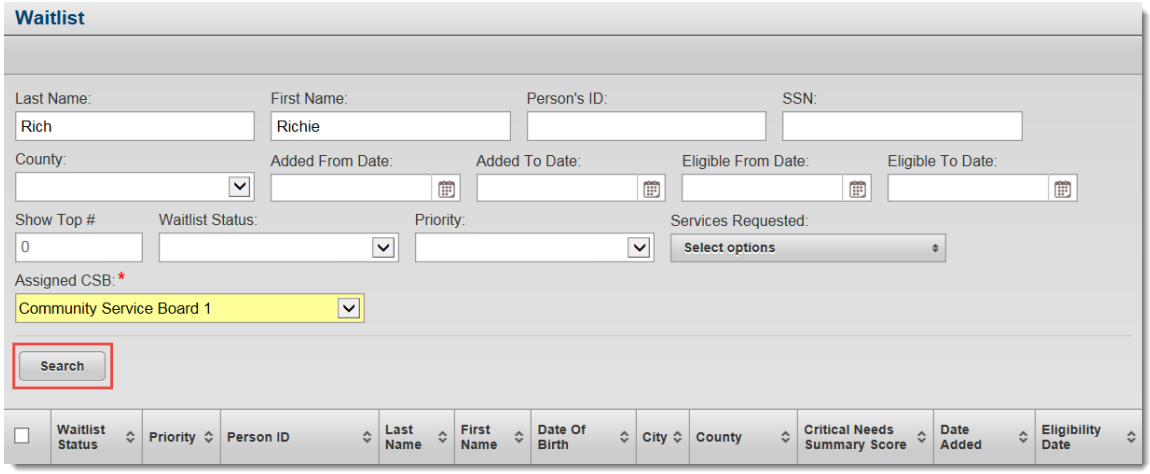
    The Waitlist information is automatically updated anytime a new Priority Needs Checklist and / or Critical Needs Summary is created and submitted.

7.2.4 Remove Individuals from the Waitlist

The Waitlist status must be *Active* for a person to be removed from the Waitlist.

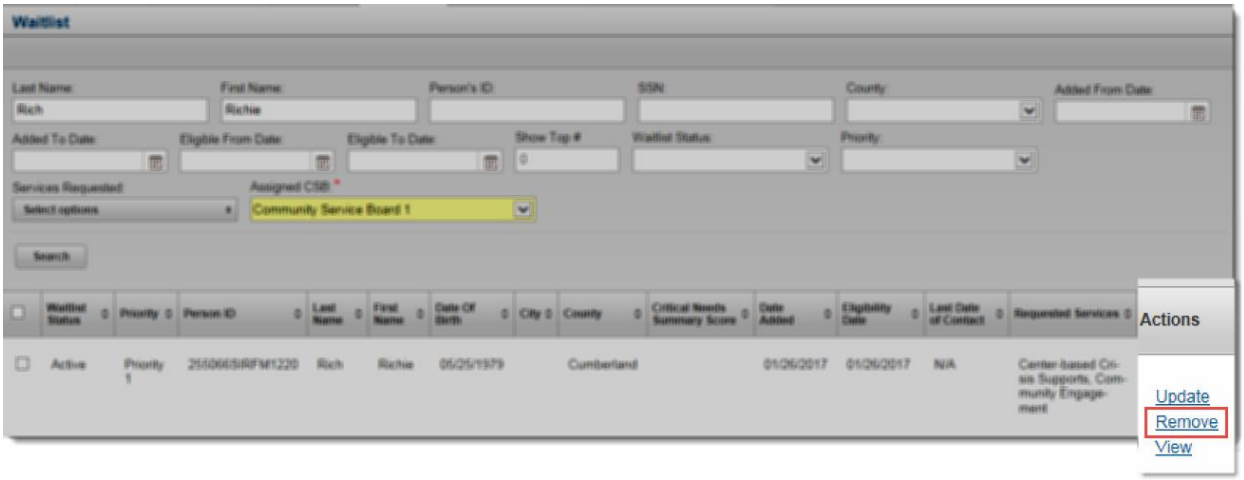
1. Click on the **Waitlist** tab from the top navigation bar.

2. Add the search criteria for the indivual to be removed from the Waitlist (i.e., *Last Name, First Name, Person's ID, SSN*, etc.) in the appropriate fields.
3. Click **Search**. *The search results appear.*

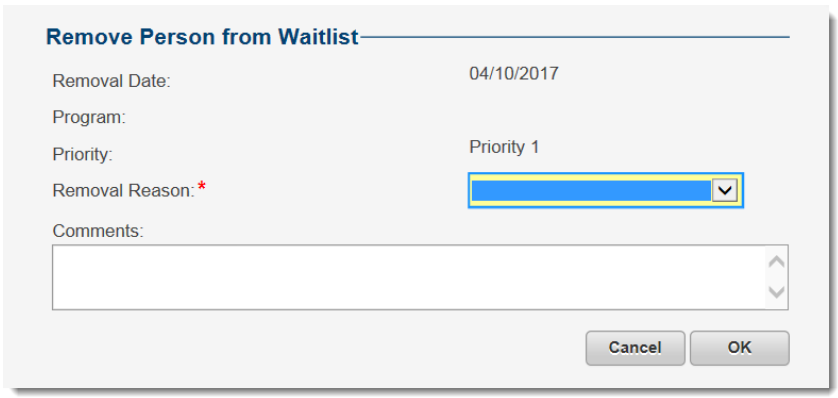


The search results list appears.

4. Click **Remove** link under *Actions* for the appropriate individual.



The Remove Person from Waitlist dialog box appears.



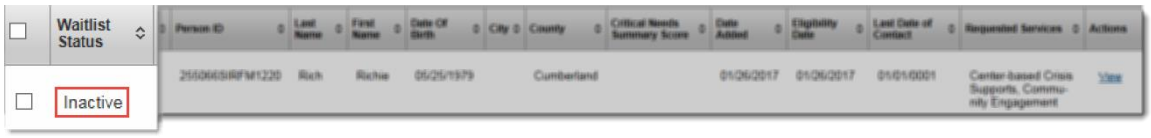
5. Click the **Removal Reason** drop down arrow to select the appropriate reason to remove the individual from the Waitlist.

   Reasons for Removal

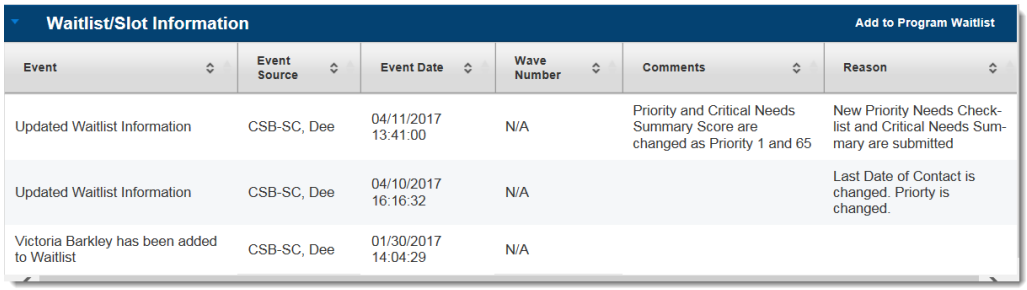
   - Declined
   - Not Eligible
   - Death
   - Moved
   - Did not Respond
   - Unable To Contact
   - Admitted to NF
   - Admitted to ICF/IID
   - Admitted to Other Waiver
   - Other

6. Add additional information in the Comments field if needed.
7. Click **OK.**

   The individual is removed from the Waitlist and Waitlist Status displays as "Inactive".



Changes to the Waitlist are reflected in the individual's **Person's Information**, **Personal Summary**, **Waitlist/Slot Information** section:



8 Slot Assignment Review Form

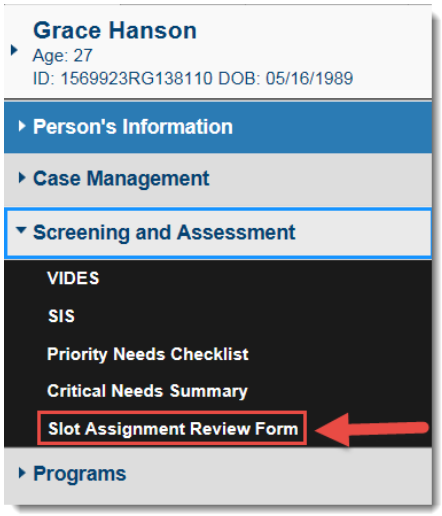
The CSB must complete a **Slot Assignment Review Form** (**SARF**) for an individual assigned with a *Priority One* status and included in the group of people being reviewed by the *Waiver Slot Assignment Committee* (WSAC). The form must be completed before the WSAC meeting. *See the WSAC Process Map (Attachment A).* The **Slot Assignment Review Form** is located under the *Screening and Assessments* section.

Note: **The SARF** is required for individuals who will be reviewed by the WSAC Committee.

8.1 Complete Slot Assignment Review Form

1. **Search** for the individual. (*Follow steps in Section 2.1: Locate an Existing Individual's Profile above*).
2. From the **Screening and Assessments** section on the left navigation bar, click on **Slot Assignment Review Form**.

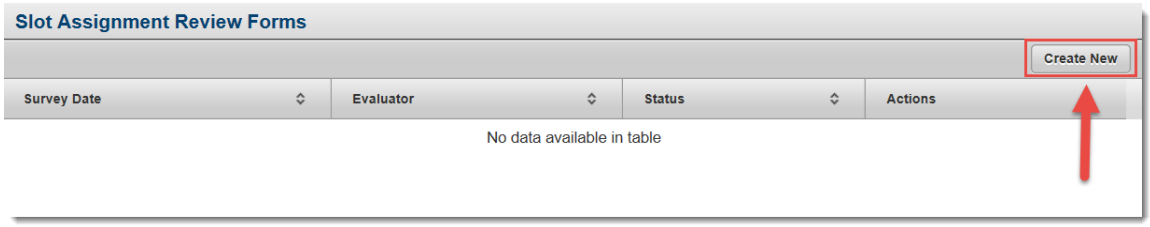
Note: Using the "WaMS version" of **SARF** is optional. A **Slot Assignment Review Form** template in MS Word or in an Electronic Health Records (EHR) system can be used in lieu of the form in WaMS. When using a form outside of WaMS it must be identical to the form in WaMS.



The Slot Assignment Review Forms window appears on the right.

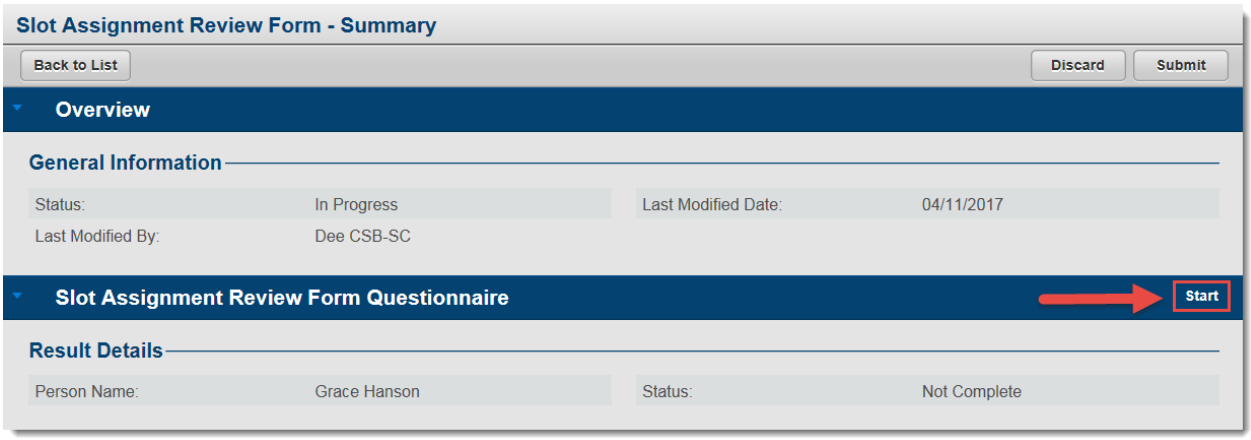
8.1.1 Start Slot Assignment Review Form

1. Click **Create New**.



The Slot Assignment Review Form Survey Date dialog box appears. The survey defaults to the current date and may not be changed.

2. Click **Continue**. *The Slot Assignment Review Form - Summary window appears.*



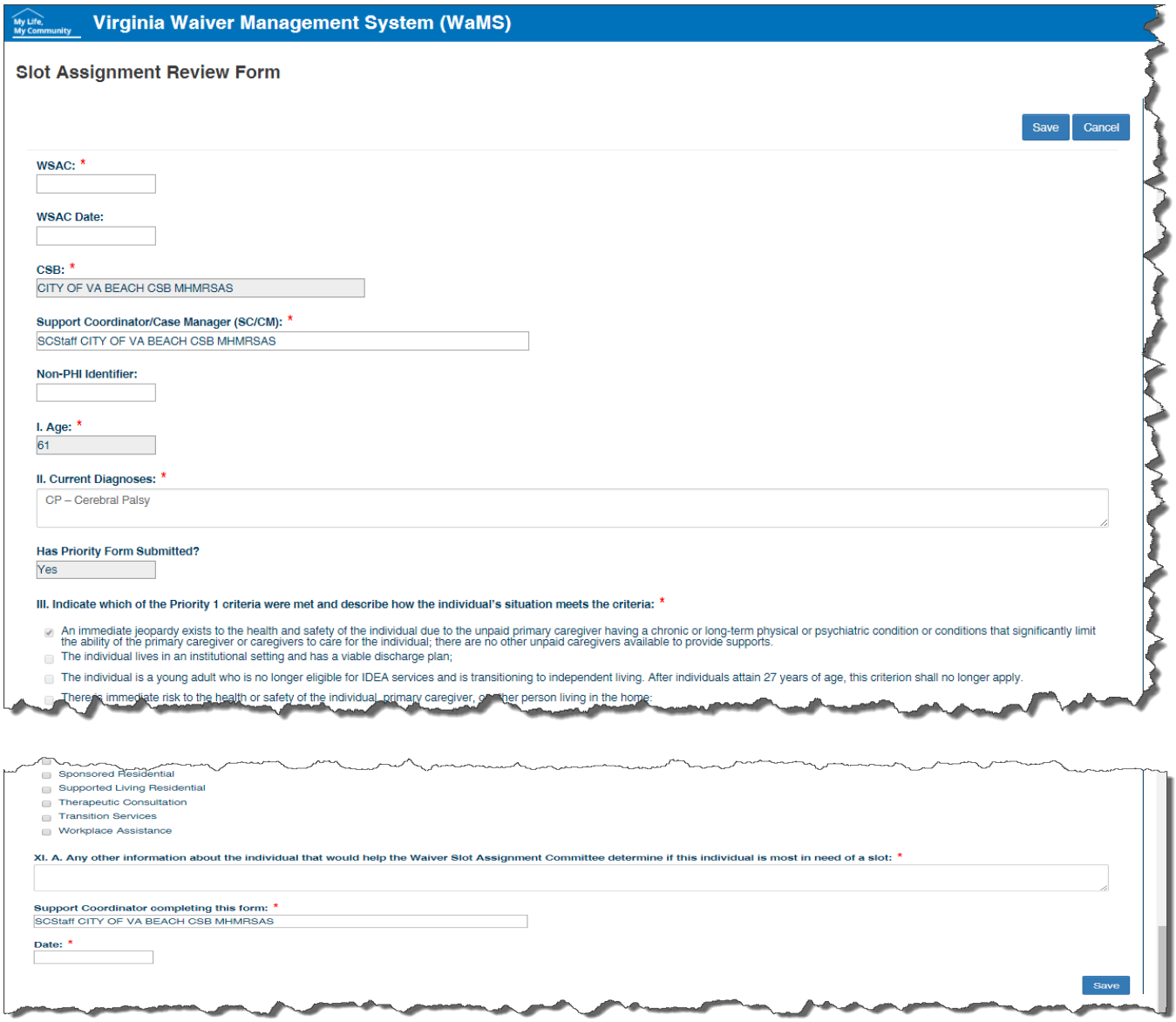
3. Click on **Start** in the *Slot Assignment Review Form Questionnaire* section. The *Slot Assignment Review Form* opens in a new browser window outside of WaMS in Dynamic Forms.

8.2 Slot Assignment Review Form (Dynamic Form)

1. In the top portion of the form, identify the **WSAC** committee/group name (e.g. City of VA Beach WSAC) or a combined WSAC covering more than one CSB (e.g. Arlington/Alexandria WSAC) and **WSAC Date**.

   The *CSB* name, *Support Coordinator/Case Manager* name, Individual's *age* and *current diagnosis*, and if *Priority* has been submitted, is automatically filled-in.

2. Scroll to complete the review form. *Be sure to add the Date at the bottom of the form.*



3. Click on **Save**.
4. Click on **Back to WaMS** (located at the top right portion of the window).

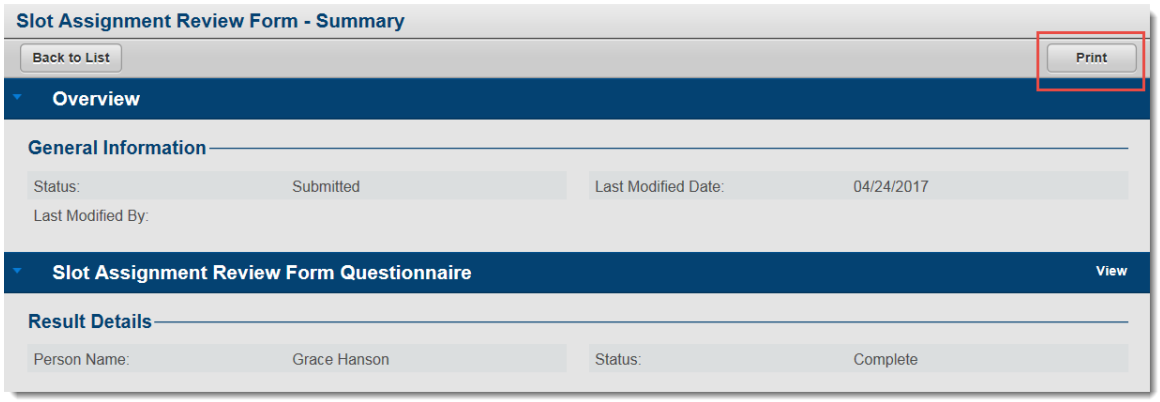
   *The Status shows as **Complete**. You will not be able to submit the form if the status shows as "Not Complete".*
5. Select **Edit** to modify or **View** to see/review the **Slot Assignment Review Form Questionnaire**.
6. Click **Submit**.

   The Slot Assignment Review Form is now ready to provide to the WSAC for their review during their session. Slots will be assigned based on the results of the WSAC session.

8.3 Print the Slot Assignment Review Form (Dynamic Form)

The **Print** button becomes available for the SARF once the form is *Complete* and has been *Submitted*.

1. From the *Slot Assignment Review - Summary* window, click on the **Print** button.



A PDF version of the Slot Assignment Review Form opens in a new window.

2. **Print** (*Control +P, right-click and click Print, or click on the printer icon*) or **download** to *save* the SARF as a PDF document.

9 Enrollment Status

When a slot has been assigned by DBHDS, the **Enrollment Status** for that an individual is **Projected Enrollment Status**. To initiate services, the individual's status must be changed to **Active**.

> **Note**: Prior to moving an individual from *Projected* to *Active* status the following must be completed:
>
> - Add a New Individual (See: 2.2)
> - Diagnosis(es) required to add to Waitlist
> - Medicaid Number added
> - VIDES submitted and Level of Functioning (LOF) for DD Waiver Met (See: 4.1)
> - Priority Needs Checklist submitted (See: 5.1)
> - Critical Needs Summary submitted (See: 6.1)
> - Individual added to Waitlist
> - (See:7.2)
> - Slot Assignment Review Form (See: 8.1)
> - Slot has been assigned by DBHDS.

9.1 Move from Projected to Active Status

There are several ways to locate an individual to move them from *Projected* to *Active* status.

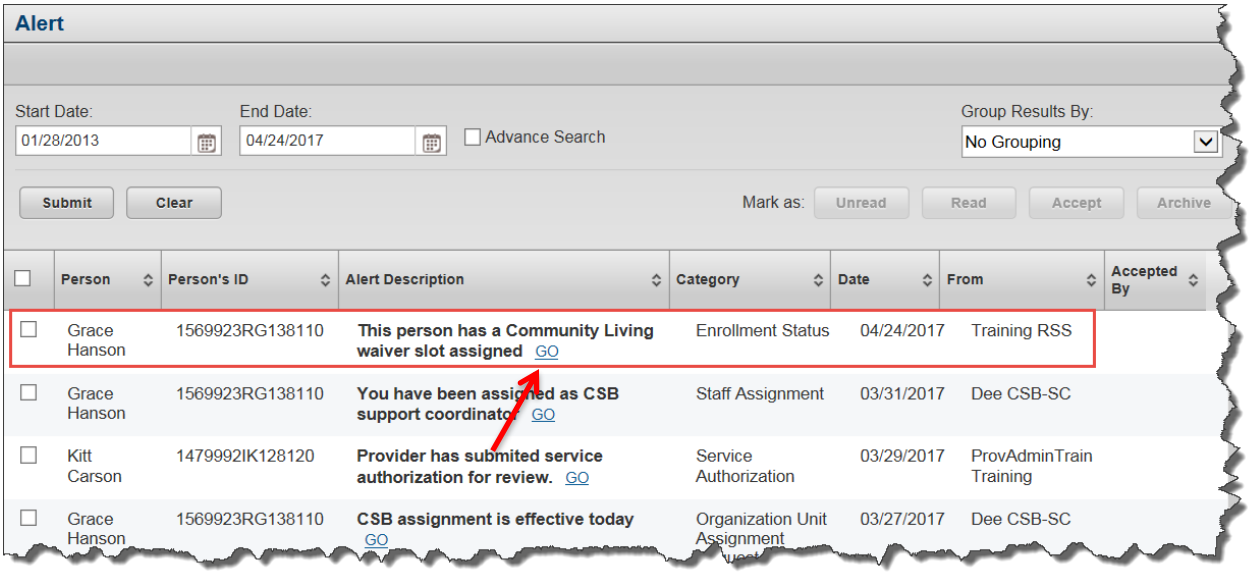
9.1.1 Locate the Individual

9.1.1.1 Via Search

1. **Search** for the individual. (*Follow steps in Section 2.1: Locate an Existing Individual's Profile above*).
2. Click on the **Summary** link. *The individual's Personal Summary page appears.*

9.1.1.2 Via Alerts

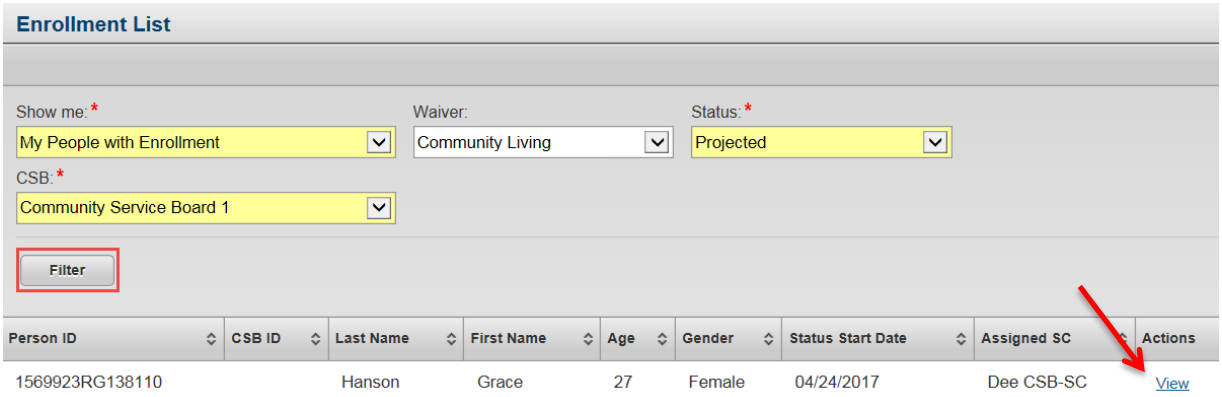
1. Click **Alerts** tab from the *top* navigation bar. *The list of alerts will appear.*



2. Click **GO**. *The individual's Personal Summary page appears.*

9.1.1.3 Via My List

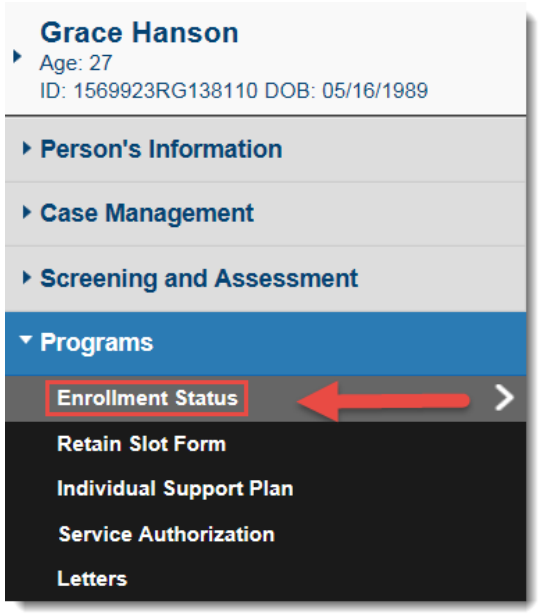
1. Click **My List** tab from the *top* navigation bar.
2. Click on **Enrollment Status** on the *left* navigation bar.
3. Ensure that:
    a. **My People with Enrollment** is selected for *Show me*
    b. **Projected** is selected for Status
    c. **Your CSB** is listed for CSB.
        i. The appropriate **Waiver** (*Community Living, Family and Individual Supports* or *Building Independence*) can also be selected if necessary.
4. Click **Filter**. *All individuals with Slots Assigned (Projected status) for the organization that have been assigned to you will appear.*

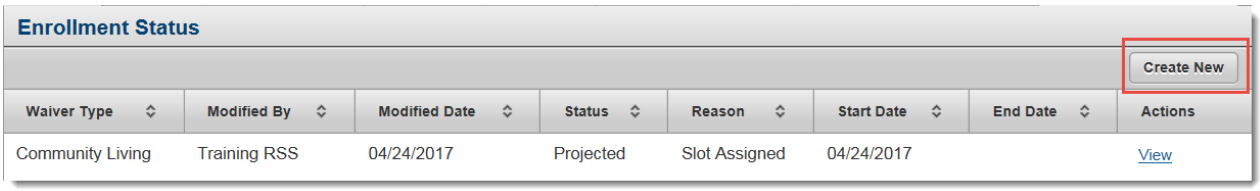


5. Click **View** for the appropriate individual in the list. *The individual's Personal Summary page appears.*

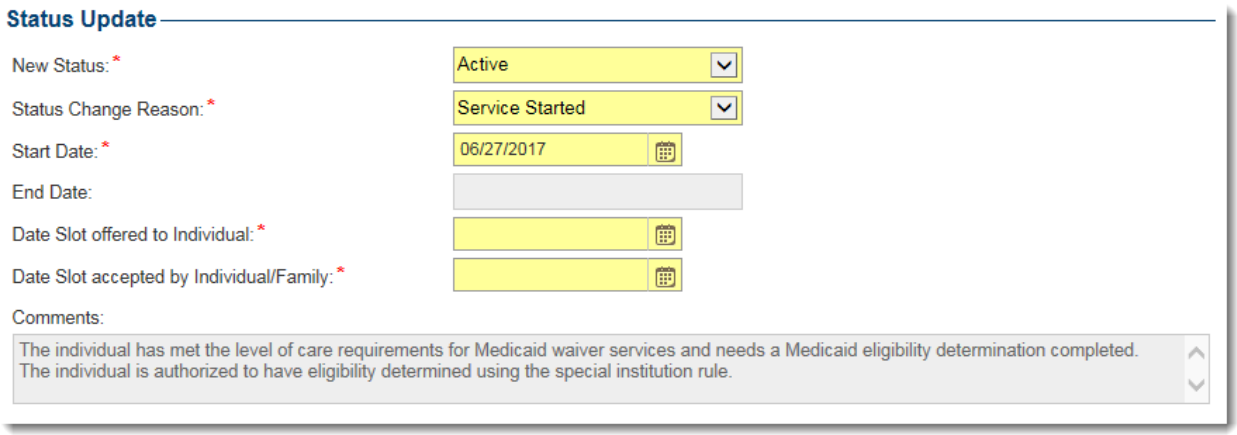
9.1.2 Create New Enrollment Status (Active)

1. Click on **Programs, Enrollment Status**. *The Enrollment Status window appears.*





2. Click on **Create New.** *The Select Waiver dialog box appears.*
3. Click on **Continue**. *The Enrollment Status dialog box appears.*

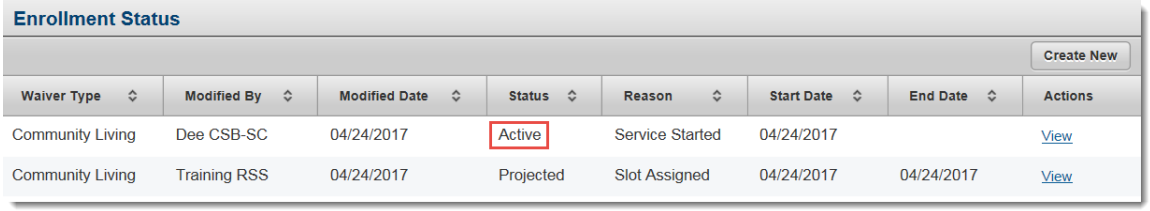


4. Ensure that:
   a. **Active** is selected for *New Status.*
   b. **Service Started** is selected for *Status Change Reason*.
5. Select the appropriate **Start Date**.
6. Select the **Date Slot offered to Individual**.
7. Select the **Date Slot Accepted by Individual/Family**.
   The **Level of Care** (LOC) statement is included in the **Comments** field.

Level of Care (LOC) Statement
The individual has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. The individual is authorized to have eligibility determined using the special institution rules.

Note: The *LOC statement* is automatically included in the *Comments* field by default. **The LOC statement cannot be amended in any way.**

8. Click **Save**. *The Enrollment Status window appears showing a new line with the status as "Active".*



- To print the Level of Care (LOC) statement which must accompany the *DMAS-225 form*, click **View** to open the *Enrollment Status* window and click on **Menu**, **Print** to print the screen (*see Section 15.6, Screen Print*).

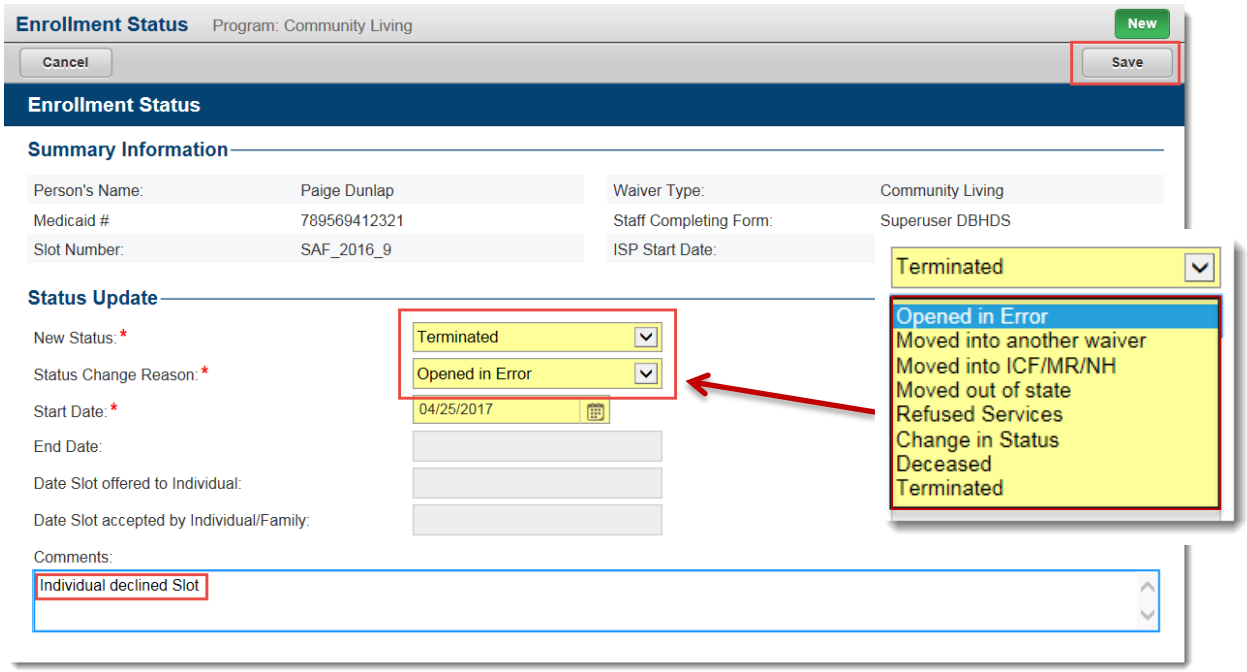
> **Note**: A Service Authorization must be submitted to DBHDS for approval within 30 days of Active Enrollment or a Retain Slot Form should be initiated.

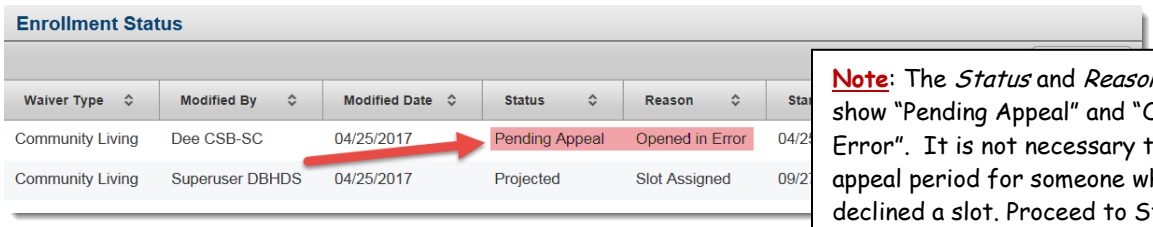
9.2 Release Slot

When an individual has been offered a slot but has decided to "decline" the slot, the assigned slot must be released. It is a two-step process to release a slot. Follow the steps below:

Step 1

1. Locate the individual using one of the steps above in sections **9.1.1.1** (*Search*), **9.1.1.2** (*Alerts*); or **9.1.1.3** (*My List*) above.
2. Click on **Create New**. *The Select Waiver dialog box appears and the waiver type is pre-populated.*
3. Click on **Continue**. *The Enrollment Status dialog box appears.*
4. Select **Terminated** for *New Status*.
5. Select the **Status Change Reason**:
6. Add information in the Comments field (i.e., "**Individual declined Slot**").
7. Click on **Save**.

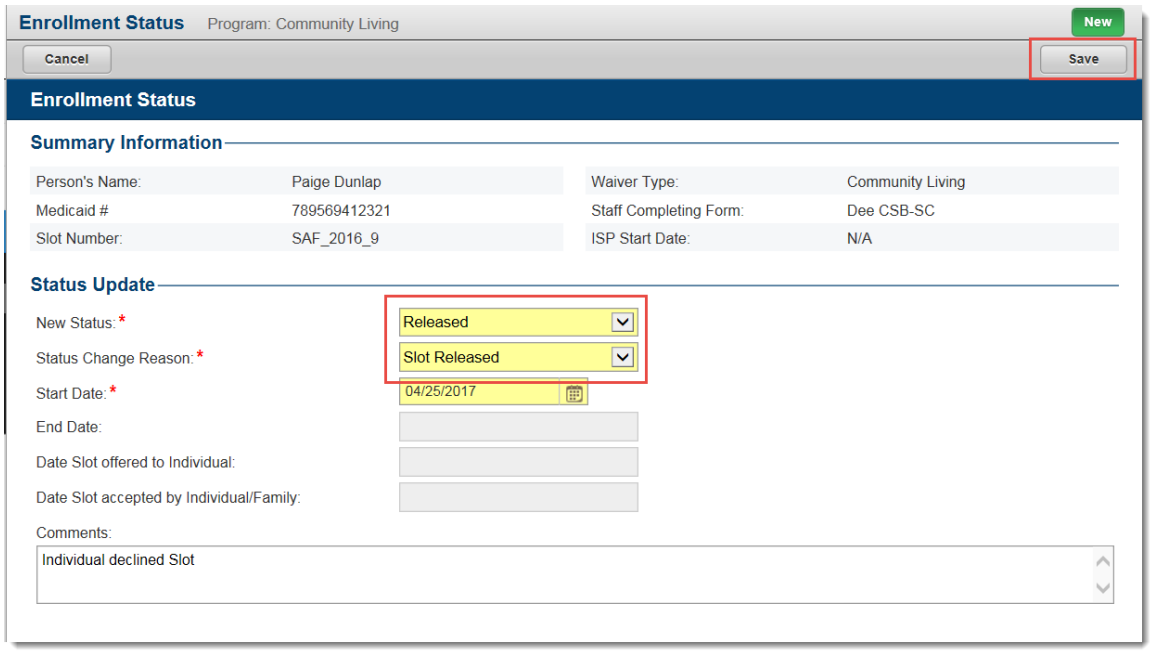




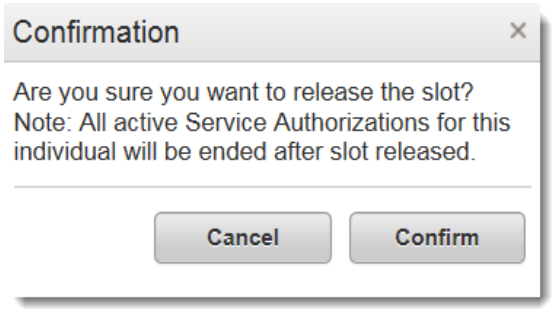
Note: The *Status* and *Reason* lines show "Pending Appeal" and "Opened in Error". It is not necessary to wait an appeal period for someone who has declined a slot. Proceed to Step 2 below to release the slot:

Step 2

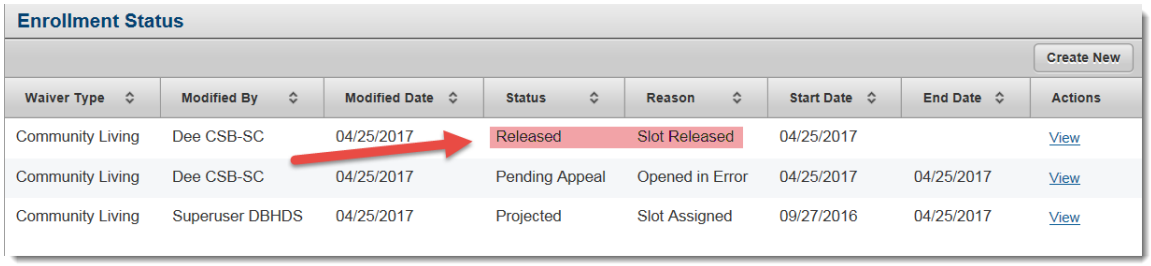
1. Click on **Create New**. *The Select Waiver dialog box appears and the waiver type is pre-populated.*
2. Click on **Continue**. *The Enrollment Status dialog box appears.*
3. Ensure that:
   a. **Released** is selected for *New Status*.
   b. **Slot Released** is selected for Status Change Reason



4. Click on **Save**. *The save Confirmation dialog box appears.*



5. Click on **Confirm**.



The Slot is now released.

9.3 Hold Status

There are several reasons to place an individual in *Hold* Status including:

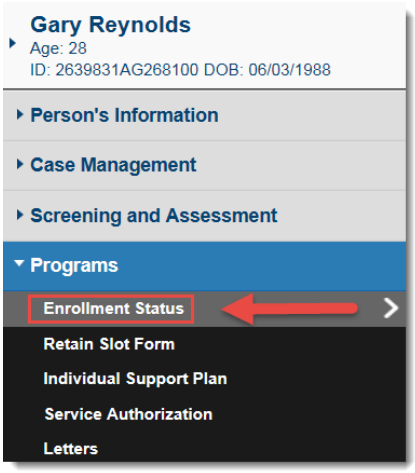
- ICF/IID Admission
- Incarceration
- Rehab hospital
- Loss of Medicaid Eligibility
- No waiver services for 30 uninterrupted days

9.3.1.1 Via My List

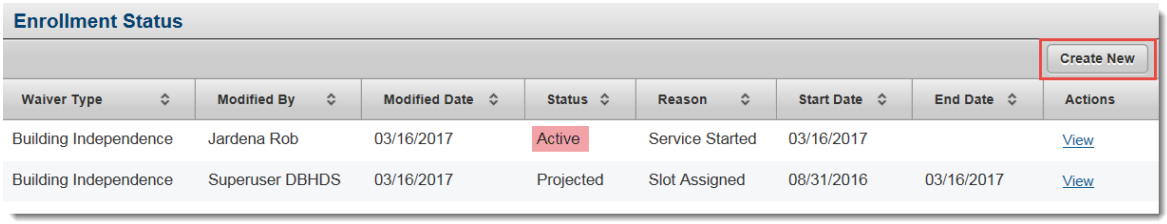
1. Click **My List** tab from the *top navigation bar*.
2. Click on **Enrollment Status** on *the left navigation bar*.
3. Ensure that:
    a. **My People with Enrollment** is selected for *Show me*
    b. Select **Active** for the *Status.*
    c. Your CSB is listed for CSB.
        i. The appropriate Waiver (Community Living, Family and Individual Supports or Building Independence) can also be selected if necessary.
4. Click **Filter**. All individuals with Slots Assigned (Active status) for the organization that have been assigned to you will appear.
5. Click on **View** for the appropriate individual to place in *Hold* status. *The individual's Personal Summary page appears.*

9.3.2 Create New Enrollment Status (Hold)

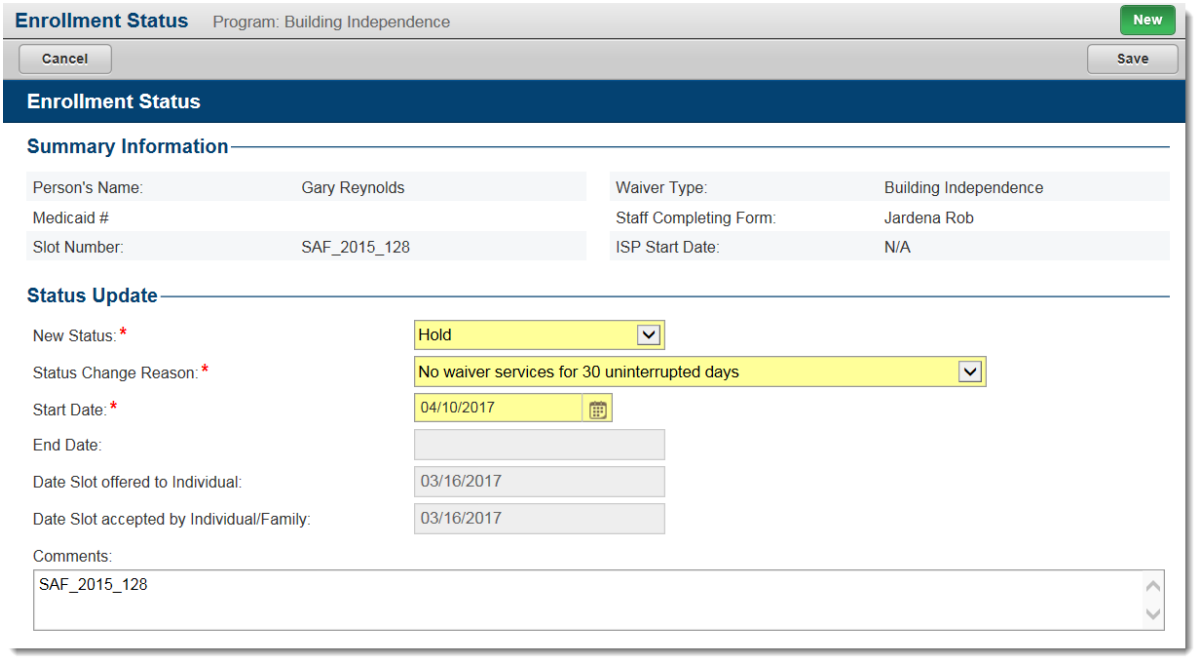
1. Click on **Programs, Enrollment Status**. *The Enrollment Status window appears displaying the "Active" individuals.*



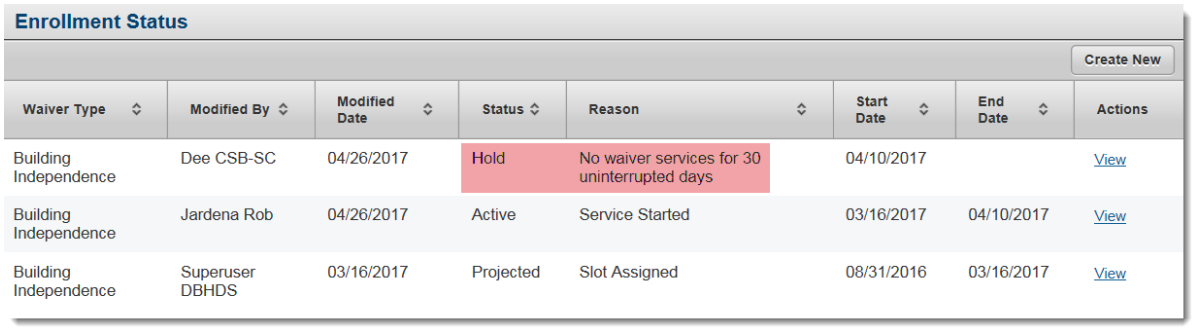
2. Click on **Create New.** *The Select Waiver dialog box appears.*



3. Click on **Continue**. *The Enrollment Status dialog box appears.*
4. Click the **New Status** drop down arrow and select **Hold**.
5. Click the **Status Change Reason** drop down arrow and select the appropriate *hold* reason.
6. Type information in the *Comments* field, if necessary.
7. Click on **Save**.



The individual status is now on hold. The **Retain Slot Form** must be completed after 30 days of interrupted services (see section **10.1: Complete Retain Slot Form**).



9.4 Additional Enrollment Status Results

The table below identifies the available new status selections that can be made based on the *Enrollment Status* of the individual.

Enrollment Status - List	**Enrollment Status – Status Update**		**Enrollment Status - List**
Status Field	**New Status Field**	**Status Change Reason Field**	**Status Field**
Status of Enrollment at beginning of process	*What the status can be changed to based on current status*	*Reason for the new status*	*Updated Current Status of Enrollment*
Projected Projected	Active	Service Started	Active
	Terminated Terminated	Opened in Error	Pending Appeal
		Moved into another waiver	Pending Appeal
		Moved into ICF/MR/NH	Pending Appeal
		Moved out of state	Pending Appeal
		Refused Services	Pending Appeal
		Change in Status	Pending Appeal
		Deceased	Released
		Terminated	Pending Appeal
Active	Hold	ICF/IID Admission	Hold
		Incarceration	Hold
		Rehab hospital	Hold
		Loss of Medicaid Eligibility	Hold
		No waiver services for 30 uninterrupted days	Hold

Enrollment Status - List	Enrollment Status – Status Update		Enrollment Status - List
Status Field	**New Status Field**	**Status Change Reason Field**	**Status Field**
Status of Enrollment at beginning of process	*What the status can be changed to based on current status*	*Reason for the new status*	*Updated Current Status of Enrollment*
	Terminated	Opened in Error	Pending Appeal
		Moved into another waiver	Pending Appeal
		Moved into ICF/MR/NH	Pending Appeal
		Moved out of state	Pending Appeal
		Refused Services	Pending Appeal
		Change in Status	Pending Appeal
		Deceased	Released
		Terminated	Pending Appeal
Hold	Active	Service Resumed	Active
Terminated (Note: Does not apply to "Deceased" Status Change Reason)	Active	Appeal Approved	Active
	Released	Slot Released	Released

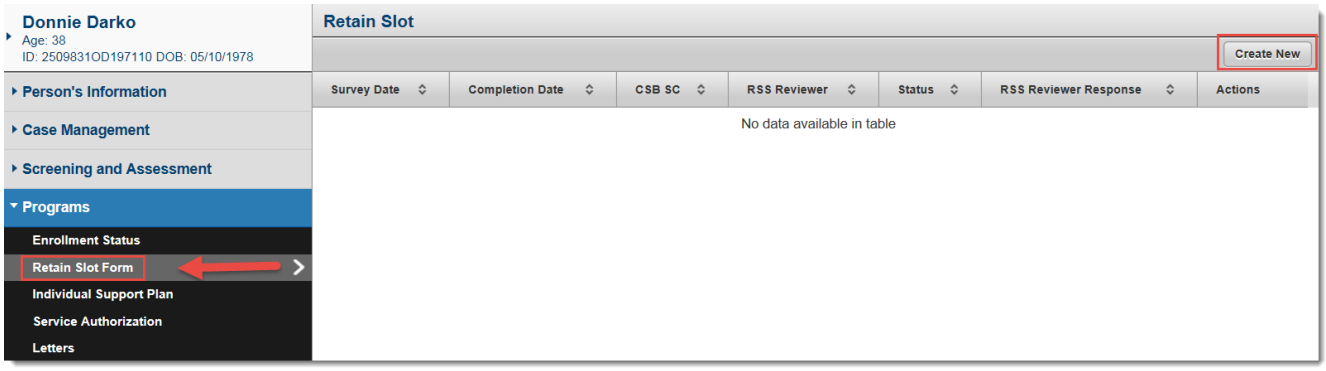
10 Retain Slot Form

When services for an individual are delayed in starting, or if services are interrupted for any reason, the CSB must request that the slot be held for that individual. The Support Coordinator should complete the **Retain Slot Form**.

10.1 Complete Retain Slot Form

10.1.1 Locate the Individual

1. Locate the individual using one of the steps above in sections 9.1.1.1(Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.
2. From the **Programs** section on the *left navigation bar*, click on **Retain Slot Form**. *The Retain Slot appears on the right.*
3. Click on **Create New** and click **Continue** to select the current date for the *Survey Date.*

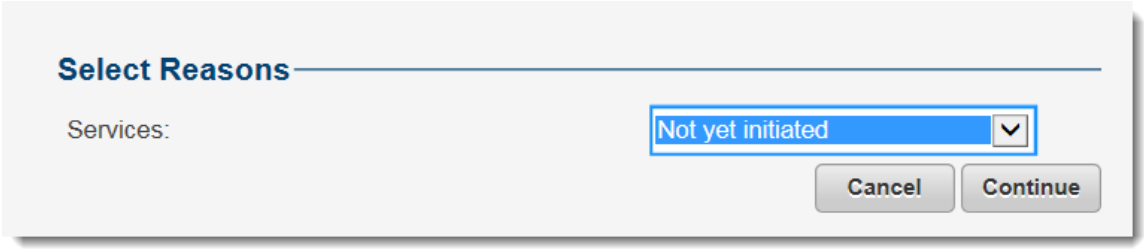


The Retain Slot Form – Summary window appears.

10.1.2 Start the Retain Slot Form

1. Click on **Start** to open the **Retain Slot Form**.

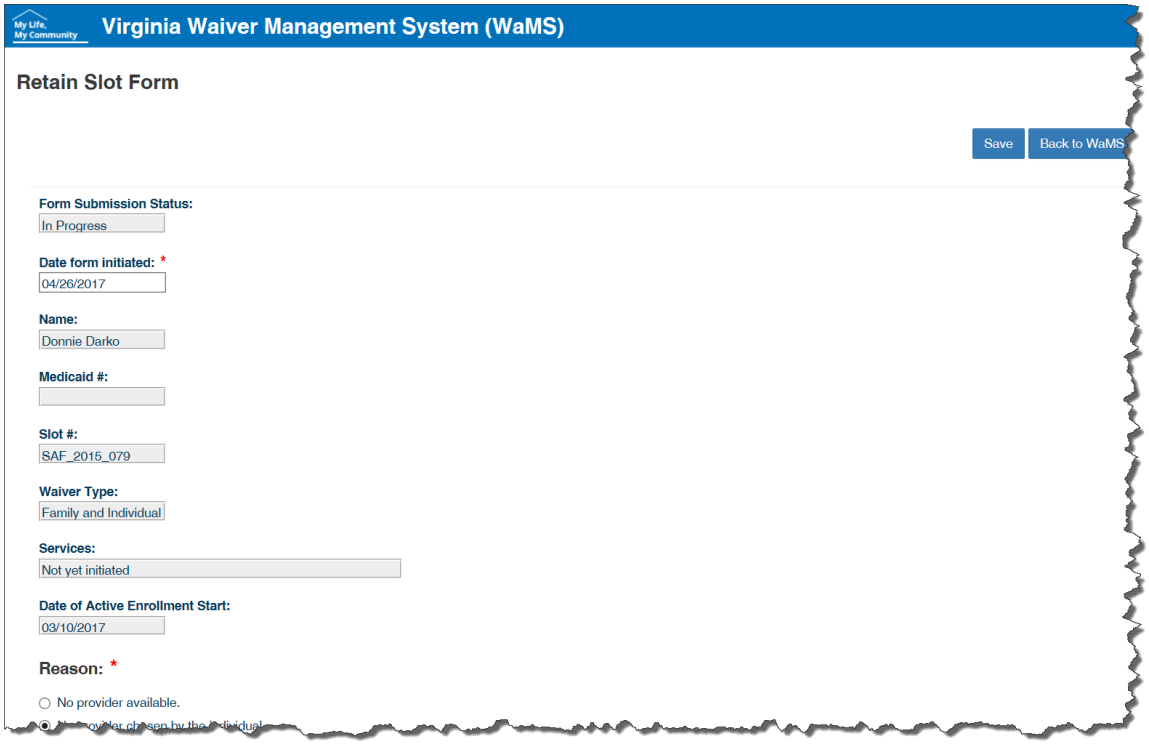
*The **Select Reasons** box appears.*



2. Click the **Services** down arrow to select the appropriate reason to hold the slot (**Not yet initiated** or **Services Interrupted**).
3. Click **Continue**. *The Retain Slot dynamic form opens in a new window outside of WaMS.*

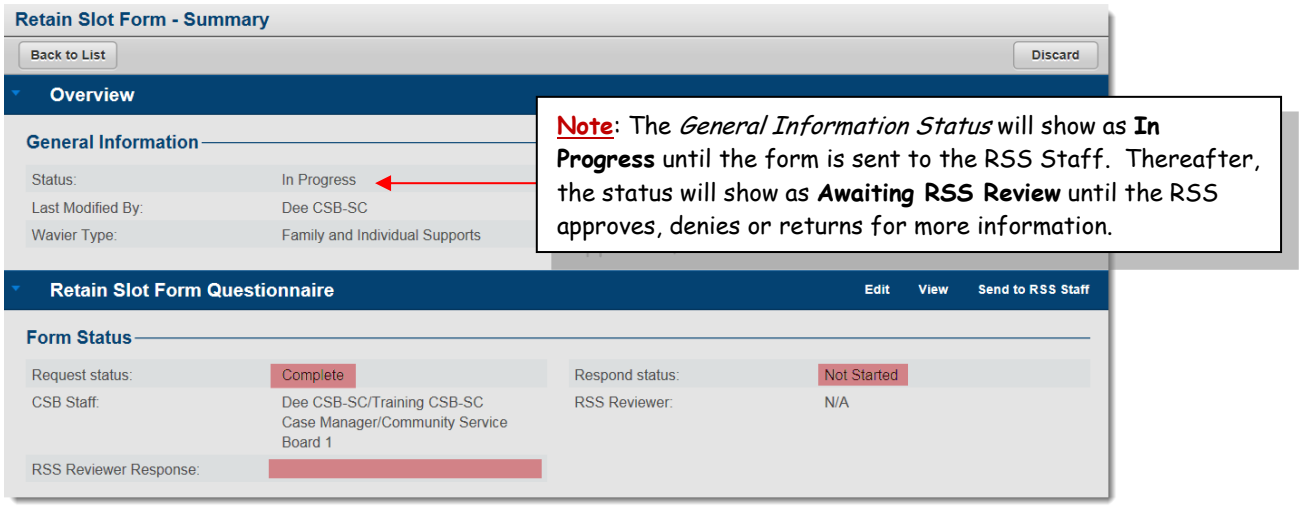
10.1.3 Create the Retain Slot Form

Required fields are denoted by a red asterisk (*).



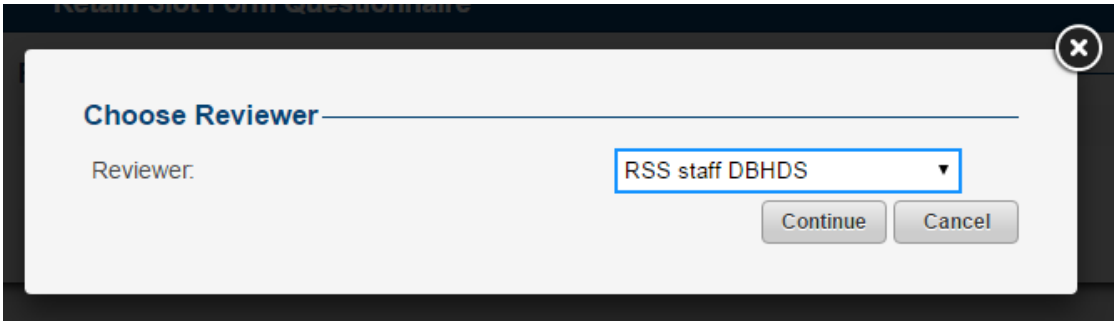
1. Select the **Reason**.
2. **Explain the situation and actions taken**.
3. Add the **Date of Anticipated Service Start**
4. Add the **Telephone Number**.
5. Add the **Date of Submission By Support Coordinator**
6. Click on **Save** then click on **Back to WaMs** (top right).

*The Retain Slot Summary form appears. The **Request Status** shows as **Complete**; the **Respond Status** shows as **Not Started** and the **RSS Reviewer Response** is blank.*



10.1.4 Send Retain Slot to RSS Staff for Review

1. Click **Send to RSS Staff**. *The Choose Review box appears*



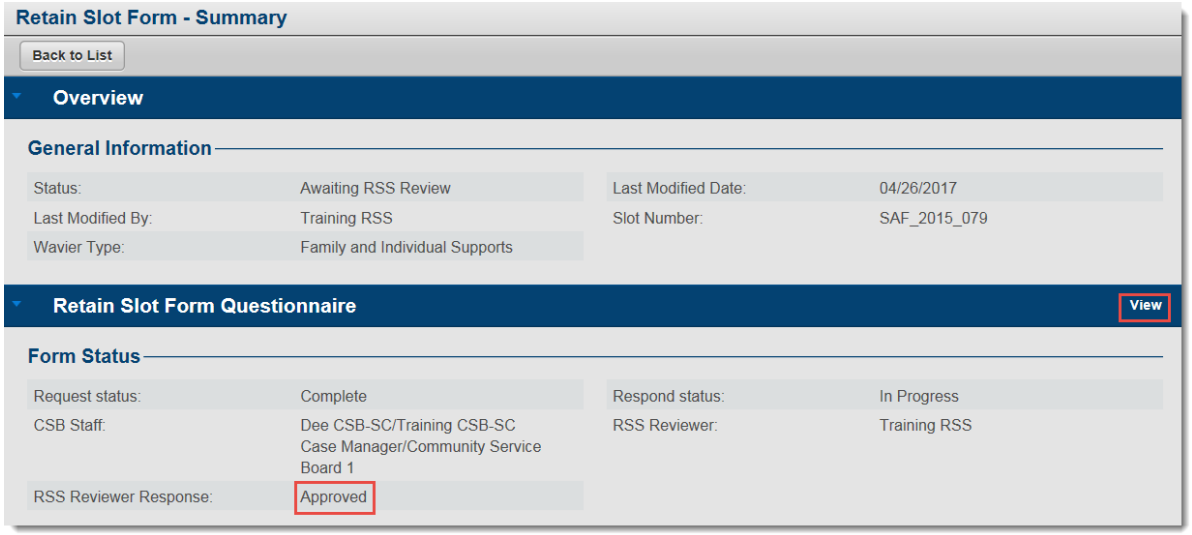
2. Click the **Reviewer** down arrow to select the appropriate *RSS staff* member to send the *Retain Slot Form* to.
3. Click **Continue**. *The General Information status changes to Awaiting RSS Review*.

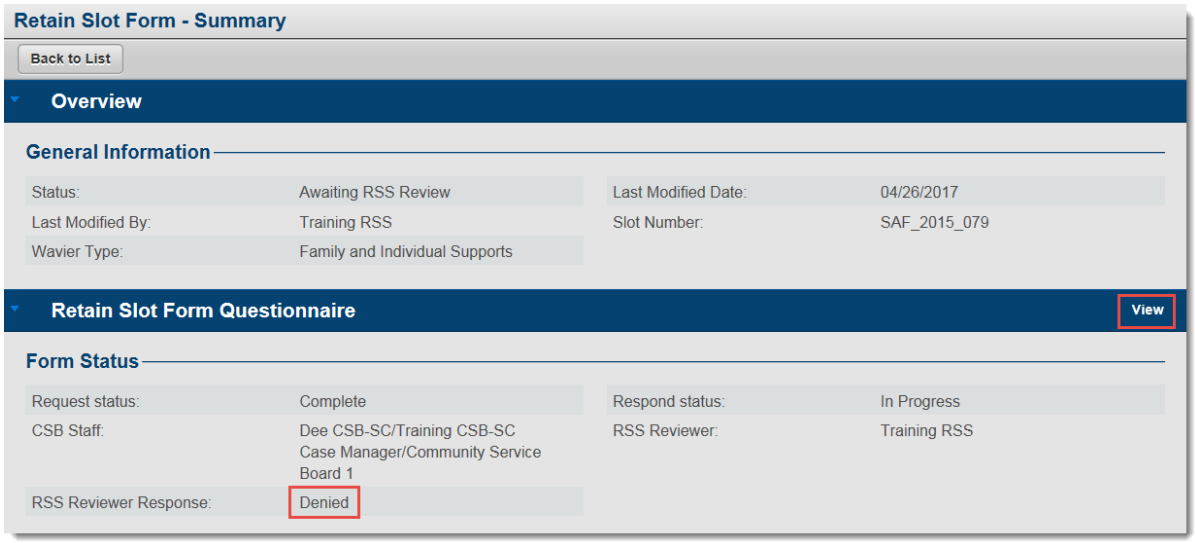
   The RSS can approve, deny or request additional information.

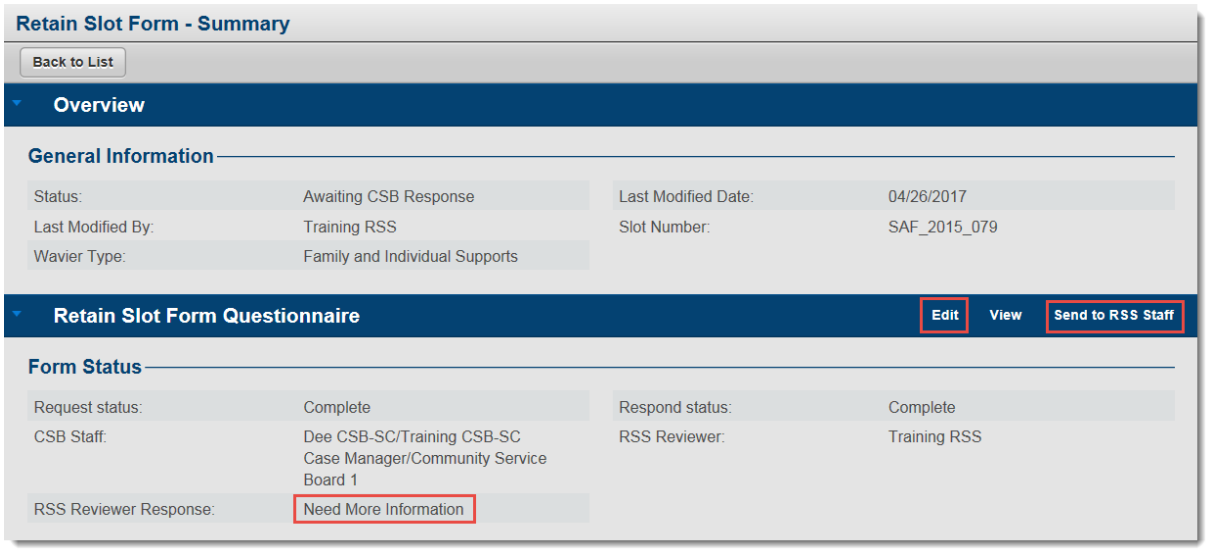
   - **APPROVED**: The slot may remain with the current individual for another 30 days.
   - **DENIED**: The request to retain the slot for an individual is denied. Send appeal rights notification and take steps to release the slot.
   - **MORE INFORMATION IS NEEDED**: The RSS may request additional information in order to approve the request to retain the slot.

Once the RSS Staff reviews and submits *the Retain Slot Form*, their response will appear in the *Form Status: RSS Reviewer Response* field.

- If the RSS Staff **Approves** or **Denies** the **Retain Slot Form** the CSB will be able to **View** the form to see any comments added by the RSS Staff.







If the RSS Staff **Needs More information**, the **Edit** option will be available.

- Click **Edit**, make appropriate changes, then Save the form and **Return to WaMS**.
- Choose **Send to RSS Staff** for approval.

11 Individual Support Plan

The Individual Support Plan (ISP) section in WaMS is used to enter information and attach documents necessary to determine services needed for an individual as well as the providers involved in providing services to the individual. To create an ISP in WaMS an individual must have an assigned slot. Additionally, the **Diagnosis** and **Living Situation** (***When On Waiver)*** in the Person's Information / Overview section must be completed.

The *Support Coordinator* is responsible for *Parts I through IV* of the ISP. The *Provider* is responsible for adding *Part V* and must have the *ISP Approver* role assigned in WaMS.

> **IMPORTANT: The following methods for both the CSB and the Provider(s) should be used for working with the ISP PRIOR to the CSB implementing the data exchange process with their electronic health records (EHR) system.**

CSB:

- Create new ISPs and Add Providers in the ISP section in WaMS
- Upload plan documents (Parts I-IV) in the ISP Attachments section:
  - Naming convention recommendation:

    [first initial][last name] Part I-IV [effective date] (e.g., GSmithPartI-IV100117.pdf)
- Use Form Notes to communicate with Providers

PROVIDER:

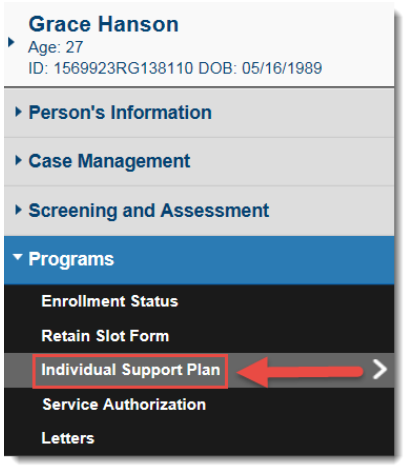
- Upload Plan for Supports (Part V) in the ISP Attachments section:
  - Naming convention recommendation:

    [first initial][last name] Part V [effective date (e.g., GSmithPartV100117.pdf)
- Use Form Notes to communicate with CSBs

11.1 Create New ISP

1. Locate the individual using one of the steps above in sections 9.1.1.1 (Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.

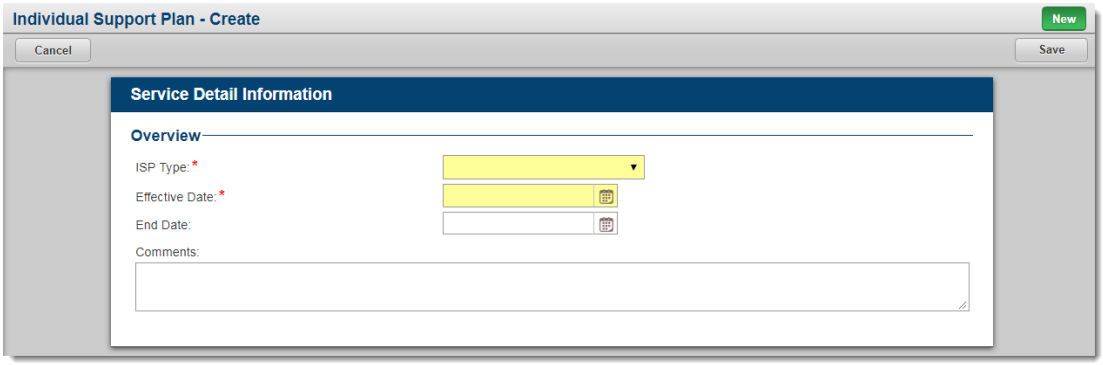
2. From the **Programs** section on the *left navigation bar*, click on **Individual Support Plan**.



The Individual Support Plan –List appears on the right.

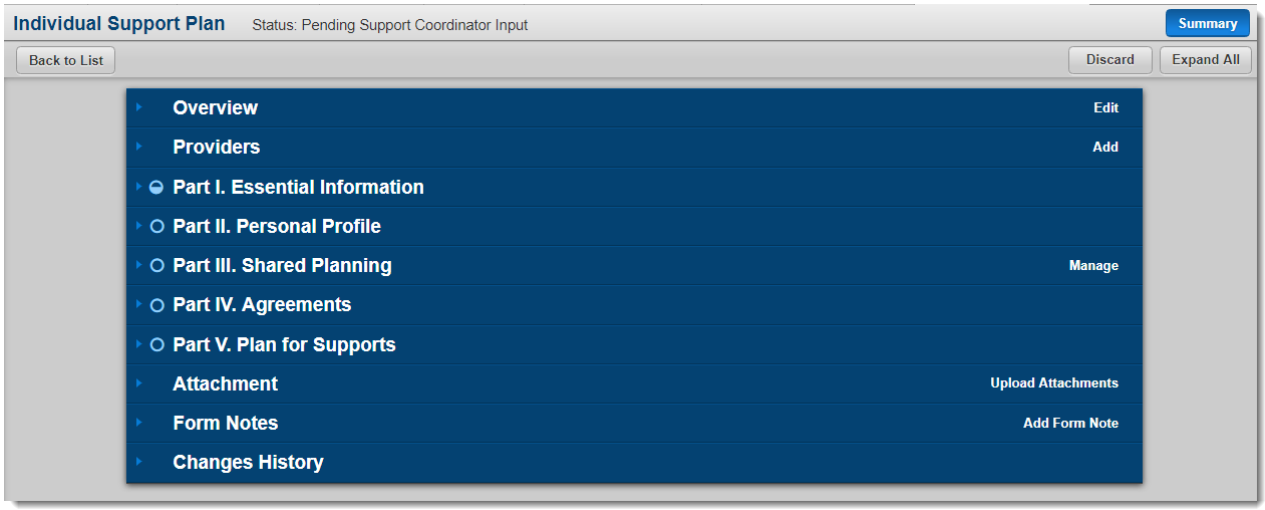
3. Click on **Create New**.
4. Confirm *Waiver* type from the *Select Waiver* drop down list.

5. Click on **Continue**. *The ISP Service Detail Information dialog box appears.*



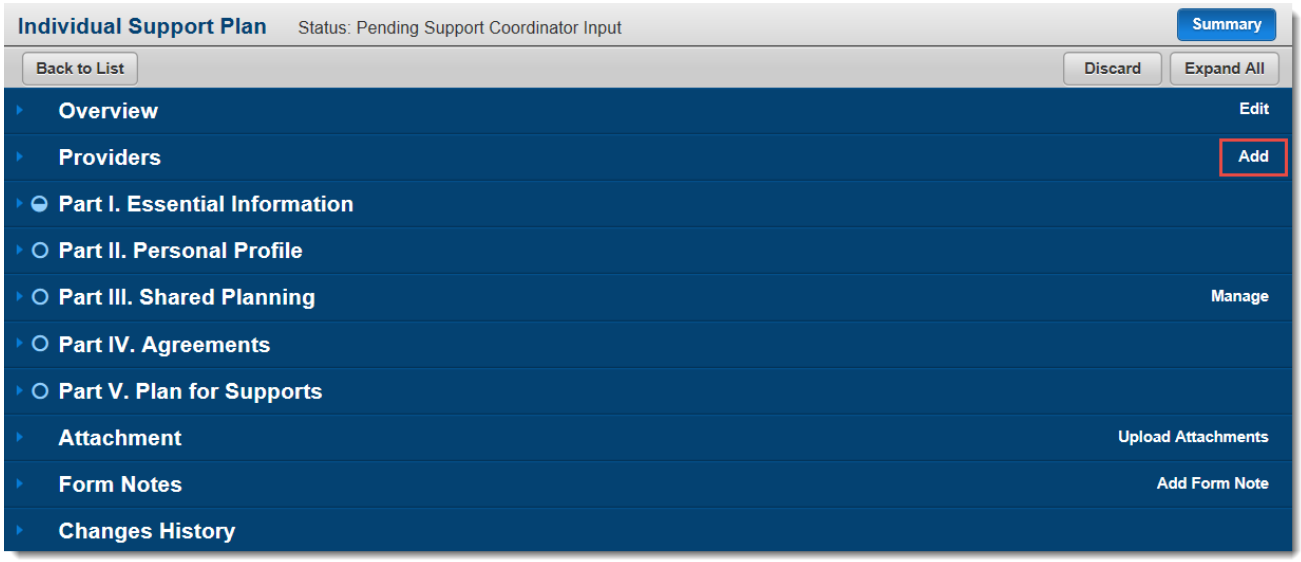
6. Click the *ISP Type* drop down arrow to select **Enrollment - new – ISP or initial**; or **Annual ISP – recertification** (use this option for every year following the initial ISP).
7. Click the **Effective Date** drop down arrow to select the ISP start date.
8. Add additional information as necessary in the **Comments** field.
9. Click on **Save**. The *Individual Support Plan – Summary* window appears and the ISP status is ***Pending Support Coordinator Input***.

Note: The default *End Date* is automatically calculated and inserted as one year from the Plan start date. This date can be changed at any time (for instance, if the Plan Year needs to end sooner, the end date can be changed to an earlier date). **End dates cannot be extended beyond one year**.

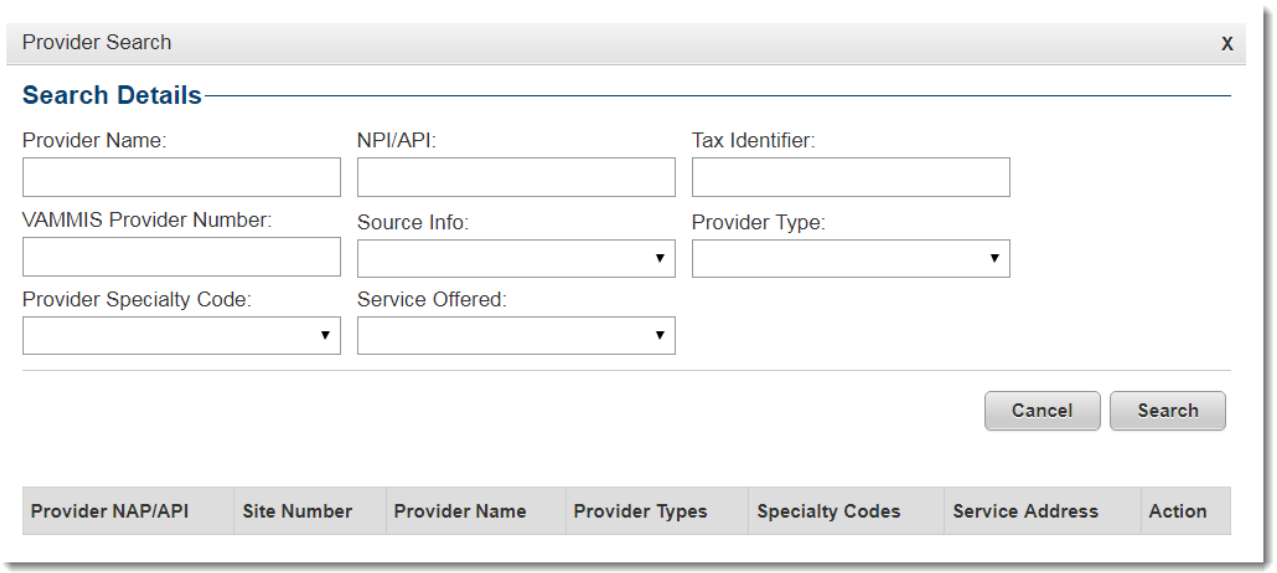


11.2 Add Provider

In order for Providers to have access to the ISP, upload attachments (*i.e., Part V, Plan for Supports*) and add Form Notes, the CSB must **Add** the Provider(s) who will be providing DD Waiver services to the individual.

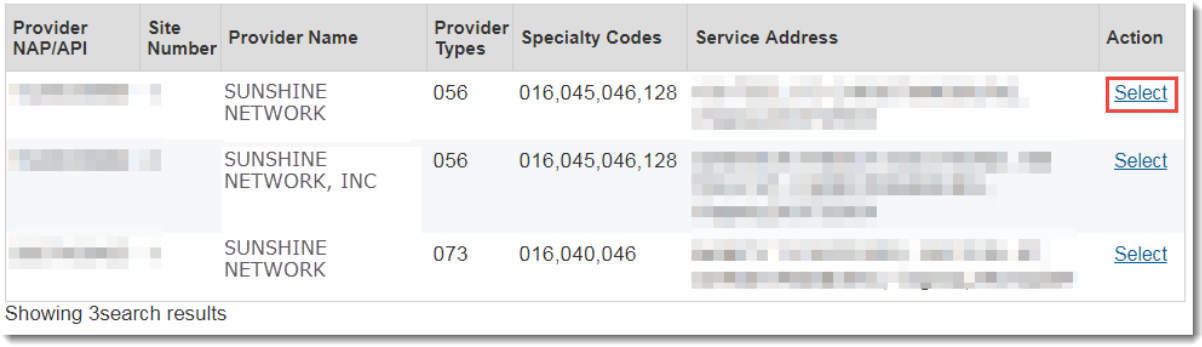


1. Click on **Add** from the *Providers* section. *The Provider Search dialog box appears.*



2. Input as much or as little search criteria as needed (*the more search criteria input, the narrower the results*).
3. Click **Search**. *The search results appear.*

4. Click **Select** to choose the appropriate Provider to be added to the ISP.

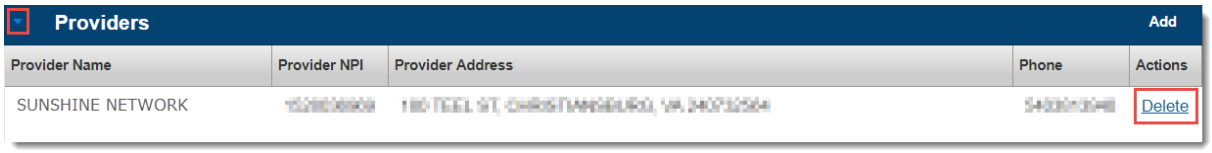


Provider NAP/API	Site Number	Provider Name	Provider Types	Specialty Codes	Service Address	Action
		SUNSHINE NETWORK	056	016,045,046,128		Select
		SUNSHINE NETWORK, INC	056	016,045,046,128		Select
		SUNSHINE NETWORK	073	016,040,046		Select

Showing 3search results

The ISP Main page reappears.

5. Click the **triangle** in the top left corner (next to Providers) to see all added providers.



Providers — Add

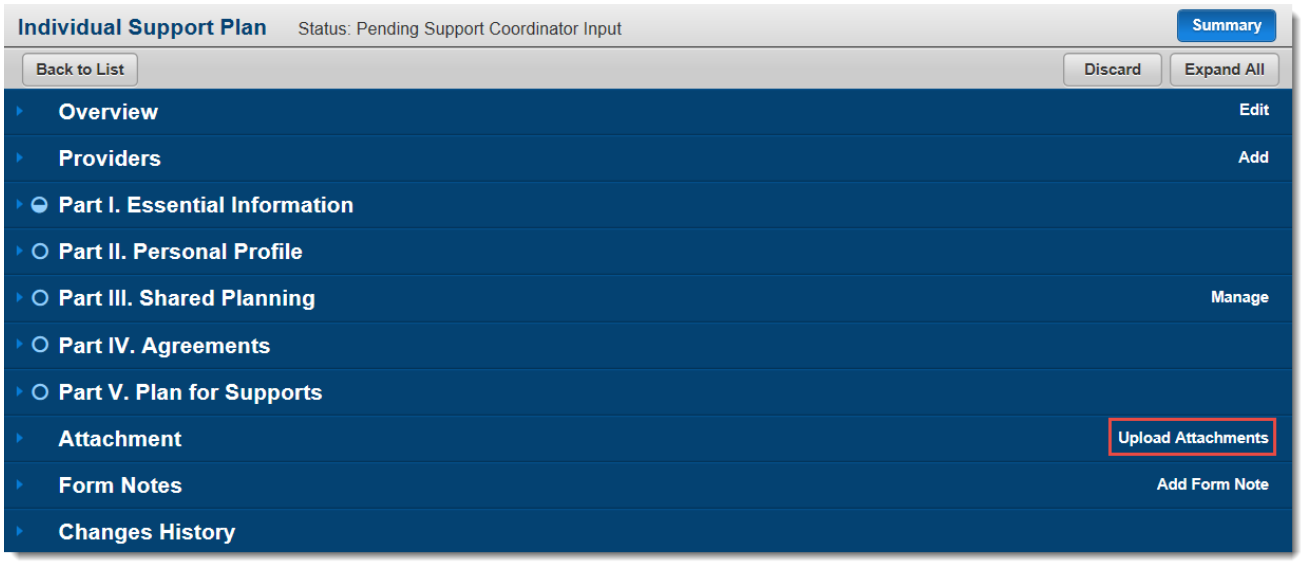
Provider Name	Provider NPI	Provider Address	Phone	Actions
SUNSHINE NETWORK				Delete

6. Click on **Delete** under *Actions* to remove an added provider.
7. Repeat steps 1 through 4 above to add additional providers.

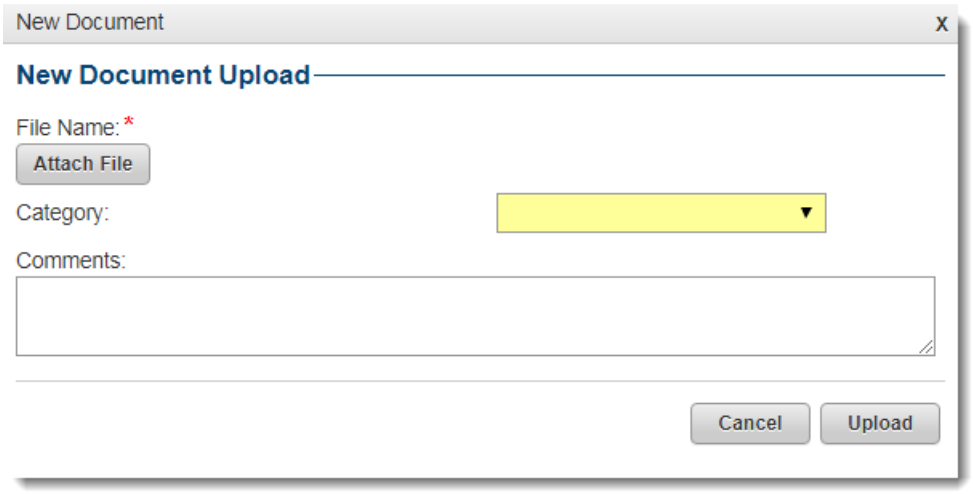
Note: Providers will lose access to an individual's details once the ISP end date has passed. They will also lose access if they are deleted from the ISP.

11.3 Upload Attachments to ISP

Attachments should be uploaded to an ISP in progress for the categories related to the plan such as, *Assisted Technology Plan, Environmental Modification, Nurse Plan, Therapeutic Consultation* and *Other*:



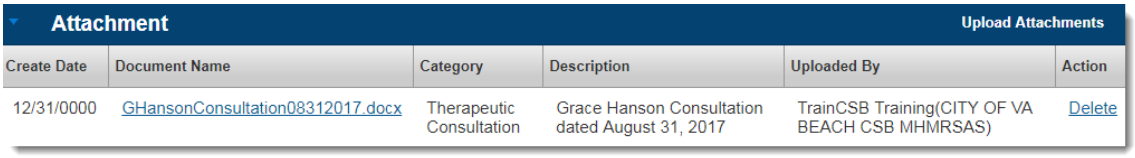
1. Click on **Upload Attachments** from the ISP *Attachment* section. *The New Document Upload dialog box appears.*



2. Click **Attach File** and browse to locate the attachment to upload.
3. Select the file to upload and click Open. *The file is attached and the file name appears above the Attach File button.*
4. Click the **Category** down arrow to select the appropriate category for the attachment.
5. Type a description for the attachment in the **Comments** field.
6. Click on **Upload**. *The file is attached and available in the Attachment section.*
7. Repeat steps 1 through 6 above to add additional attachments.
    a. Click the triangle next to *Attachments* to expand the category and click on the *Document Name* to download ad ded attachment(s).
    b. Click the triangle next to *Attachments* to expand the category to <u>delete</u> attachment(s).

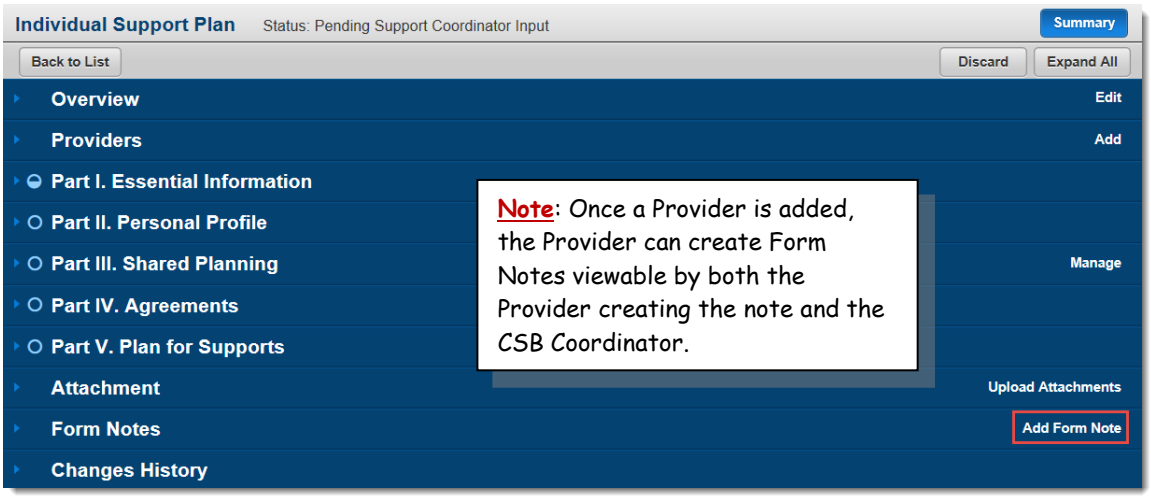
Assisted Technology Plan
Environmental Modification
Nurse Plan
Therapeutic Consultation
Other

Note: Attachments can only be deleted by the person who uploaded it.

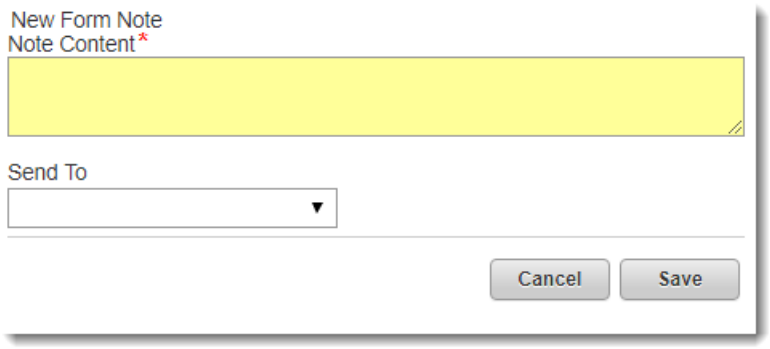


11.4 Add Form Note to ISP In Progress

Use *Form Notes* to communicate with Providers about the ISP.



1. Click on **Add Form Note** from the *Form Notes* section. *The Individual Support Plan New Form Note dialog box appears.*



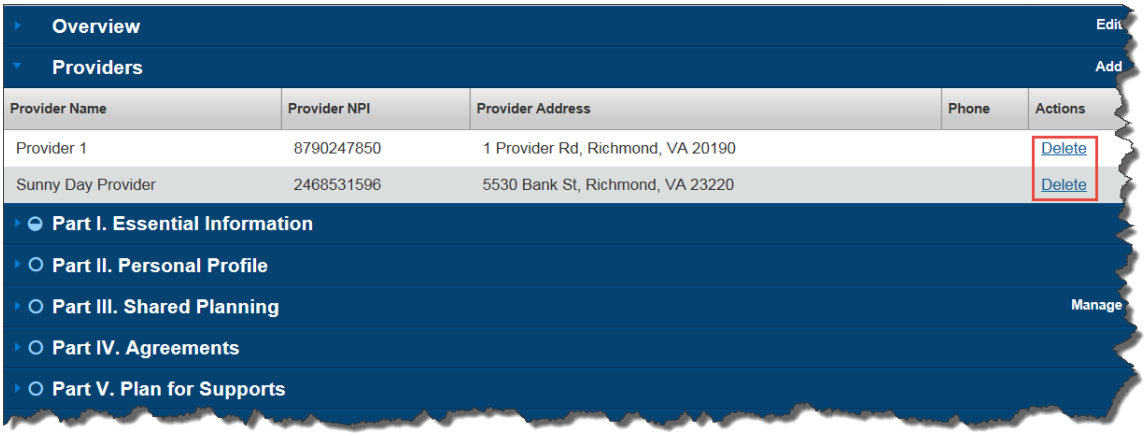
2. Enter the communication in the **Note Content** field.
3. To send the *Form Note* to a specific Provider, click the **Send to** down arrow to select the Provider who should see the note.
4. Click on **Save**. *The provider selected in the "Send To" list will receive an Alert that there is a note attached to the ISP.*

Note: To send the note to ALL Providers added for the individual, leave the "Send To" drop down box empty. As long as no specific provider is selected, ALL added Providers will be notified via an alert and will be able to view the Form Note.

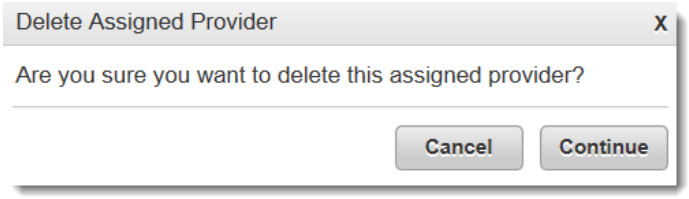
11.5 Remove Provider

Providers can be removed from the current year's ISP. Once a provider is removed, they will not have access to the ISP.

1. Click on the **Providers** heading. *The section will expand to display all added providers.*



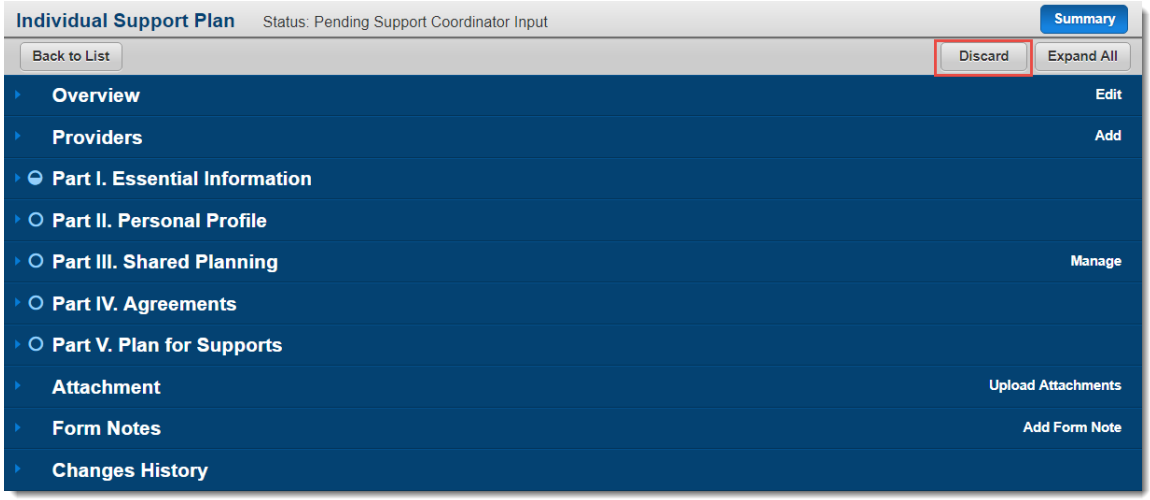
2. Under *Actions*, click on the **Delete** for the provider that should be removed from the ISP. *The Delete Assigned Provider box appears.*



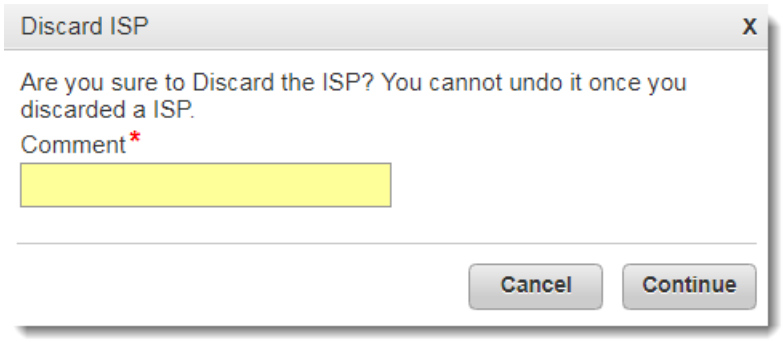
3. Click on **Continue**. The selected provider will be removed from the ISP.

11.6 Discard ISP

1. If necessary, select **Programs**, **Individual Support Plan** on the *left navigation bar* and click on **Summary** to open the ISP.



2. Click on **Discard**. *The Discard ISP box appears.*



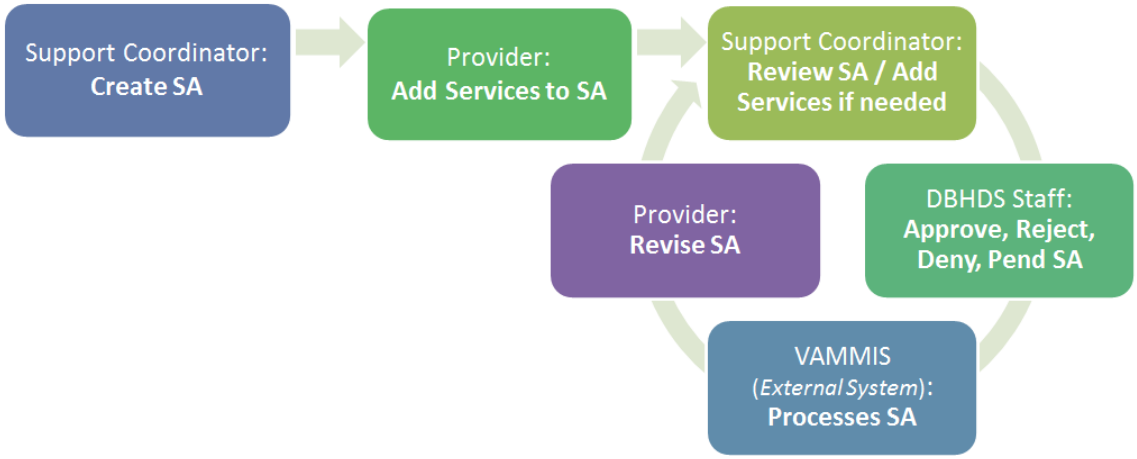
Note: Discard an ISP if it is opened in error. When an ISP is discarded, it will remain in the ISP list; however, it can no longer be edited!

3. Add a comment to the **Comment** field.
4. Click on **Continue**. *The ISP status will update to show as "Discarded".*

ISP Points to Remember
• An ISP can only be created when a person has an assigned slot
• During the time period that attachments for *Parts I-V* are being uploaded (i.e., Pre-EHR), the status for the ISP will remain in *Pending Support Coordinator Input* and will remain *Open* (in not complete status)
• The ISP process in this User Guide only applies until the CSB transitions to an automated data transfer of information from their EHR into WaMS OR a decision by the CSB to complete Parts I-IV directly into WaMS.

12 Service Authorizations

The overall process for requesting a Service Authorization (SA) is shown in the graphic below. The *Support Coordinator* begins the process by creating the SA.

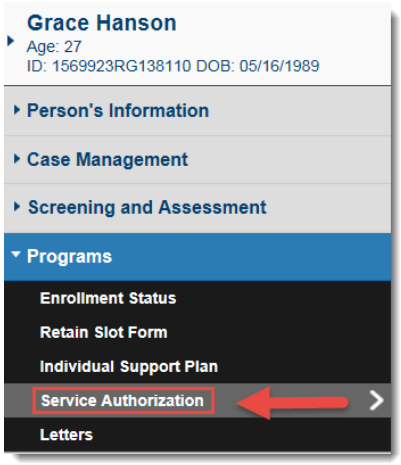


To create an SA the following must occur:

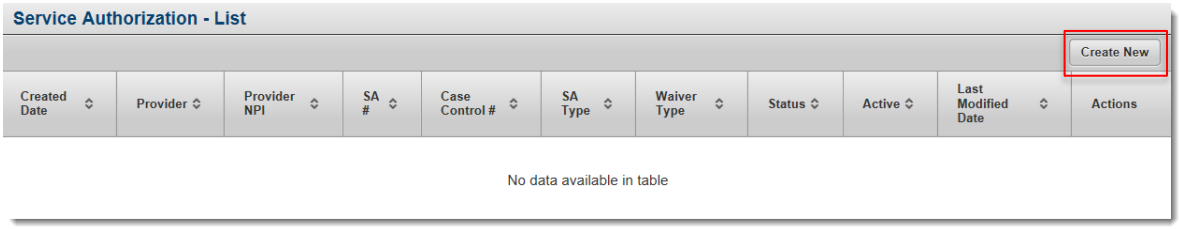
- Profile created (*See section 2.2 Add New Individual to WaMS*)
- VIDES submitted and LOF for DD Waiver Met (*See section 4.1: Create New VIDES*)
- Add Individual to the Waitlist (*See section 7.2: Add Individual to Waitlist)*
- Slot has been assigned by DBHDS
- Individual has an Active Enrollment Status (current or future) (*See section 9.1: Move from Projected to Active Status)*

12.1 Create Service Authorization

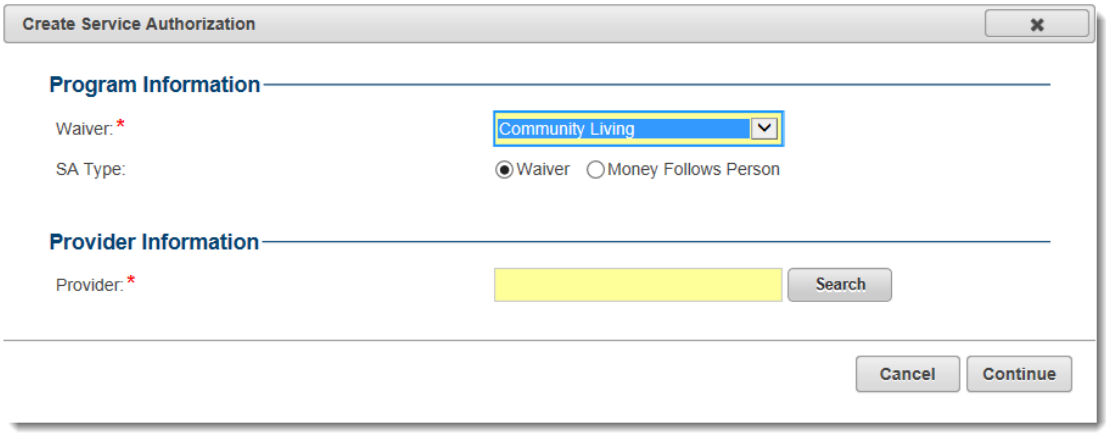
1. Locate the individual using one of the steps above in sections 9.1.1.1(Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.
2. From the **Programs** section on the *left navigation bar*, click on **Service Authorization**.



3. *The Service Authorization – List appears on the right.*

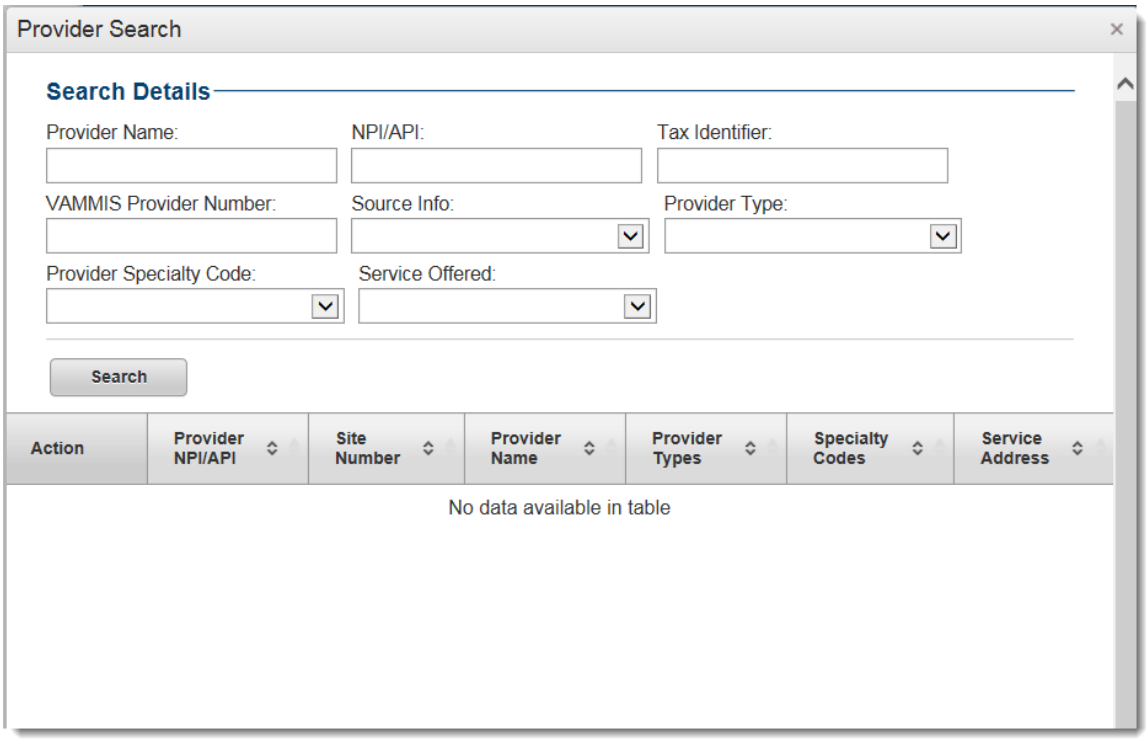


4. Click on **Create New**.
5. Confirm *Waiver* type from the *Select Waiver* drop down list.



12.1.1 Add Provider to Service Authorization

1. Click on **Search** to add the *Provider*. *The Provider Search dialog box appears.*



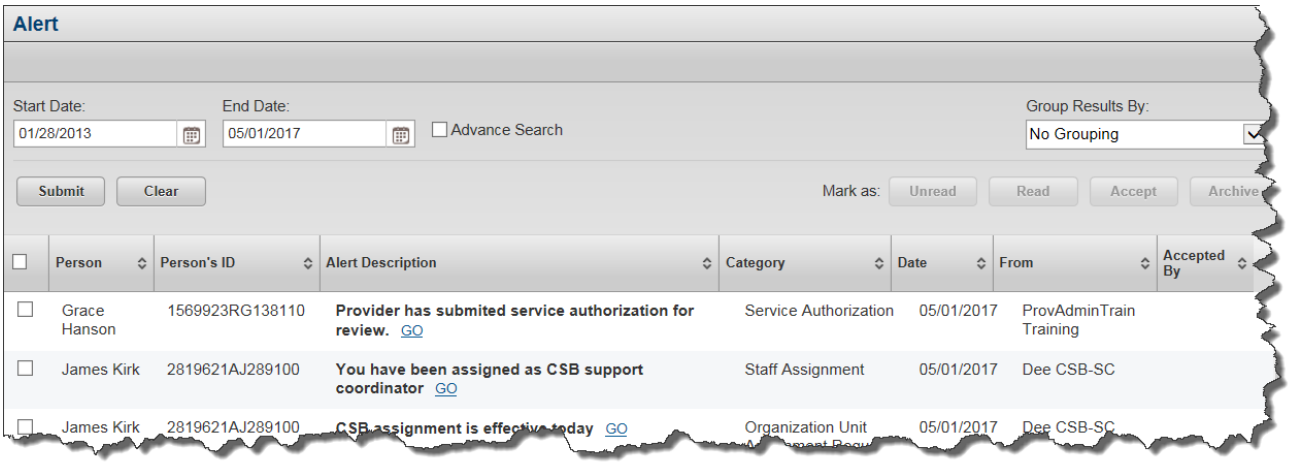
2. Input as much or as little search criteria as needed (*the more search criteria input, the narrower the results*).
3. Click **Search**. *The search results appear.*
4. Click **Select** to choose the appropriate Provider to be added to the SA.
5. Click on **Continue**. *The status shows as "Pending Provider Input". The Provider selected can now add services to the SA.*

12.2 Review Services

After the Provider has added service lines and submitted the SA back to the Support Coordinator, the Support Coordinator must review the SA. All service lines must be reviewed by the Support Coordinator before it can be submitted to DBHDS for review by the Service Authorization Consultants (a.k.a. PA Staff).

Note: Support Coordinators cannot add service lines before the provider has done so; however, service lines can be added, if necessary, during the review process.

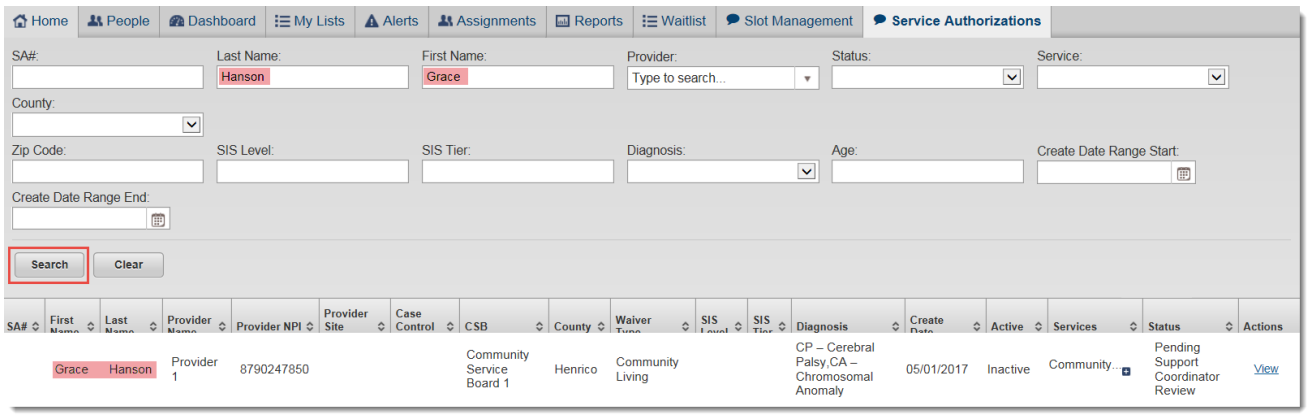
1. Locate the individual's SA using one of the steps above in sections 9.1.1.1(Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.



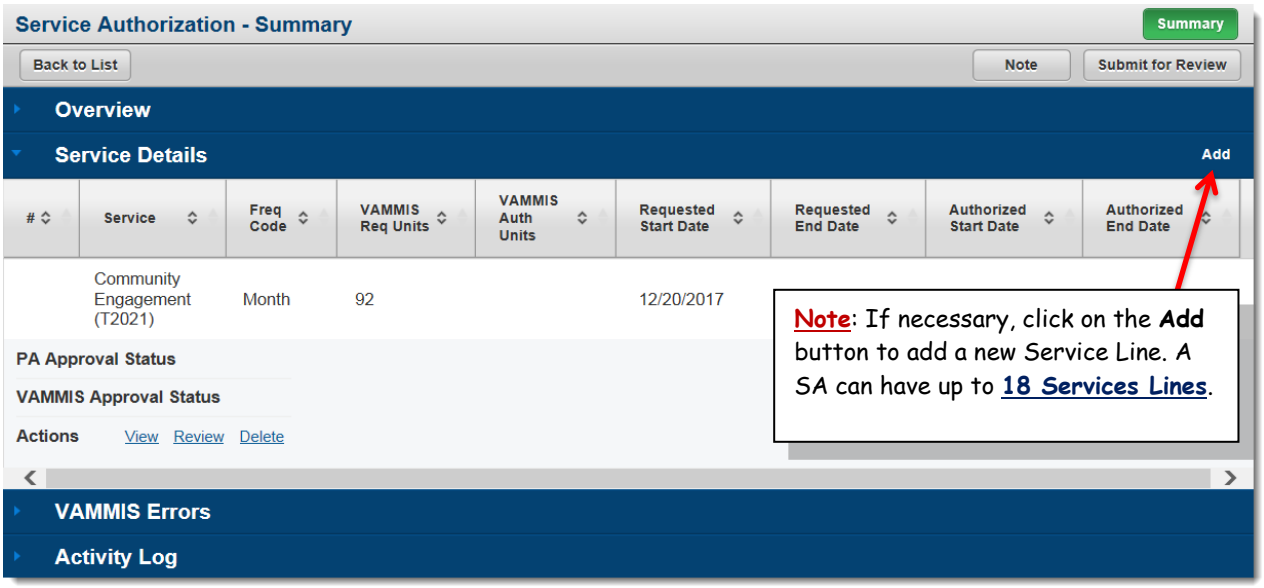
OR

2. Click on the **Service Authorization** tab.
7. Type in the criteria for the individual you are looking for (i.e., **Last Name**, and **First Name)**.
8. Click **Search**. *The search results will display a list of individuals which meet the search criteria.*

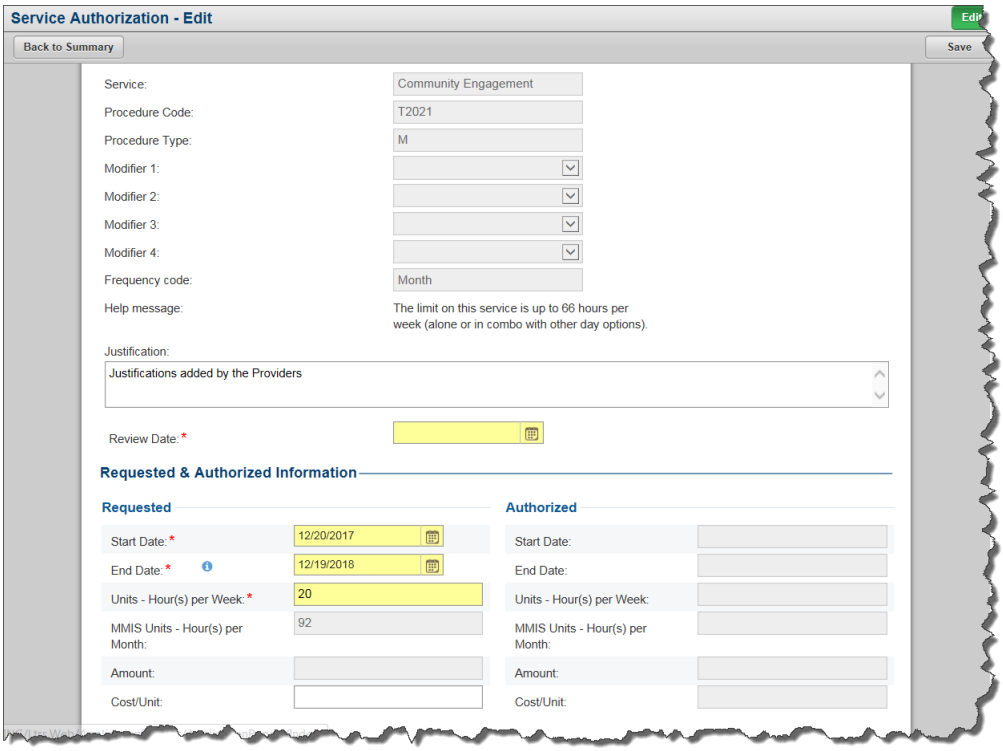
Note: Input as much information as you know in each field to retrieve the most accurate search.



9. Click on **View** link under *Actions* to open the SA. *The Service Authorization – Summary appears.*



10. Under the *Service Details* section, click on **Review**. *The Service Authorization - Edit window opens.*



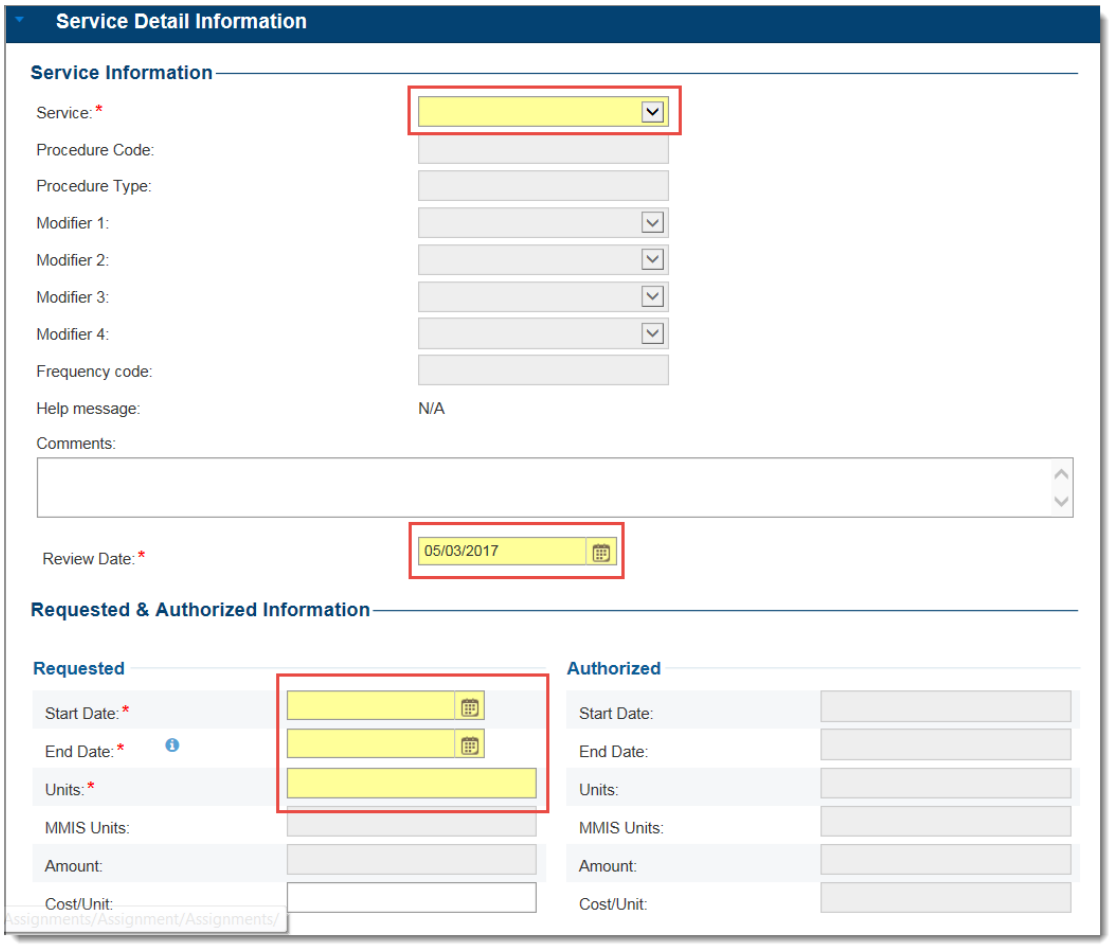
11. The *Justification* information for the service is added in the **Justification** field by the Provider. Make edits/adjustments to the justification area as necessary.
12. Modify the **Start Date**, **End Date**, **Units – Hour(s) per Week** fields if necessary, in the *Requested* section.
13. Click the **Calendar** icon for the *Review Date* to select the SA is being reviewed.
14. Click on **Save**.

12.3 Add Service Line

Support Coordinators can add service lines to an SA *after* the provider has added service lines and submitted the SA to the Support Coordinator. All service lines must be reviewed by the Support Coordinator before it can be submitted for review to the Service Authorization Consultants (a.k.a. PA Staff).

Note: Support Coordinators cannot add service lines before the provider has done so; however, they can be added, if necessary, during the review process.

1. Under the *Service Authorization – Summary* window, click on **Add**.



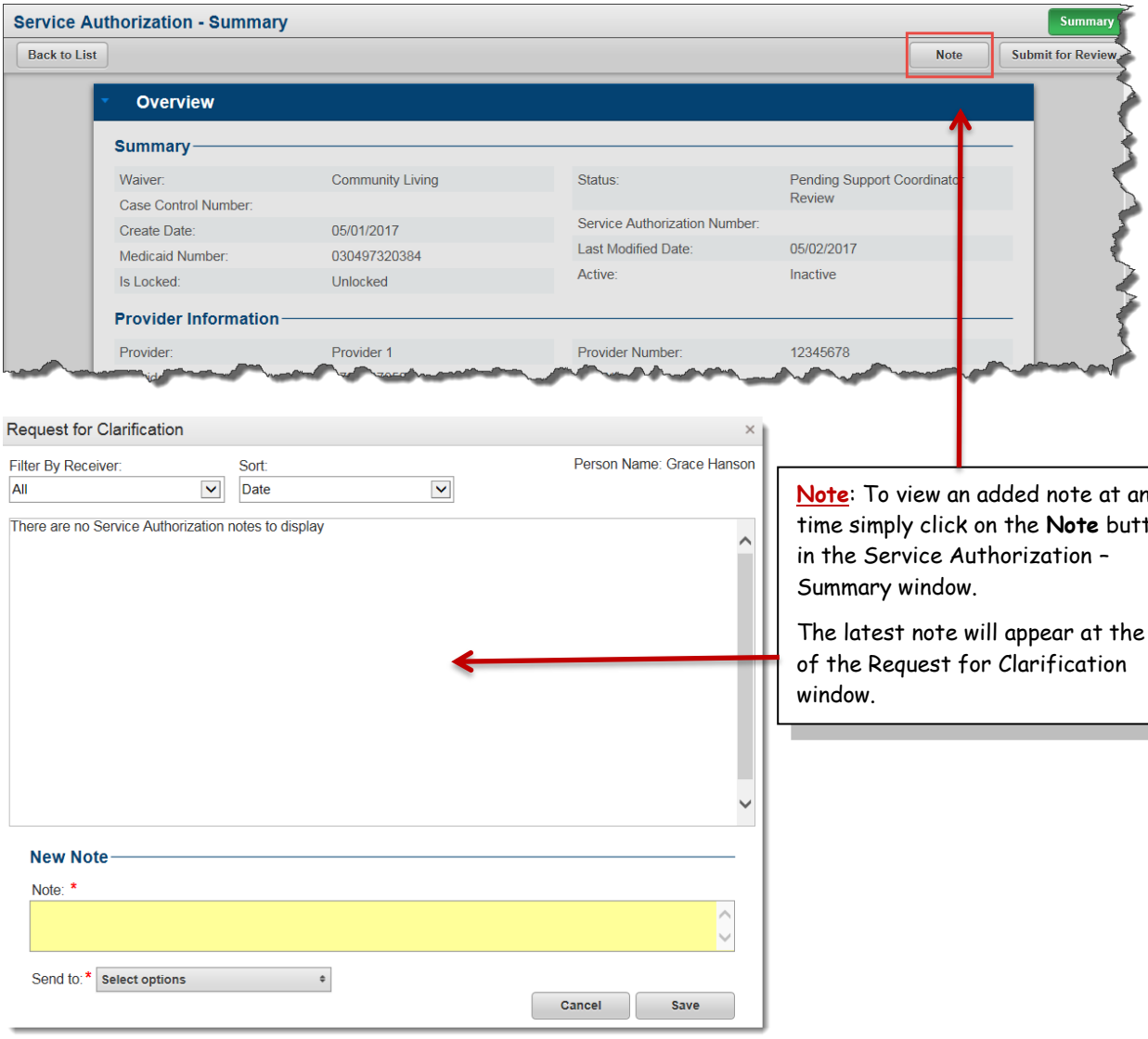
2. Under the *Service Information* and *Requested & Authorized Information* sections:
    a. Add *Comments* to provide information regarding the specific service for the PA Staff (*Service Authorization Consultants)*.
    b. The *Review Date* defaults to the current date.
    c. Select the *Service* drop down to choose the specific service,
    d. Click the *Calendar* icons to add the *Start* and *End Dates*.
    e. Add the number of *Units/Hours* for the service.
    f. Click on *Save*.

An SA can have a total of 18 service lines. After 18 lines have been added to a single, the system will automatically create a new SA with a new SA number.

12.4 Add Notes

Use *Notes* to communicate information regarding the SA to the Providers and DBHDS staff. The notes can be entered or viewed at any time. An *alert* will be sent to the selected organization(s) that a note has been added to the SA.

1. Click on **Note**. *The Request for Clarification note box appears.*



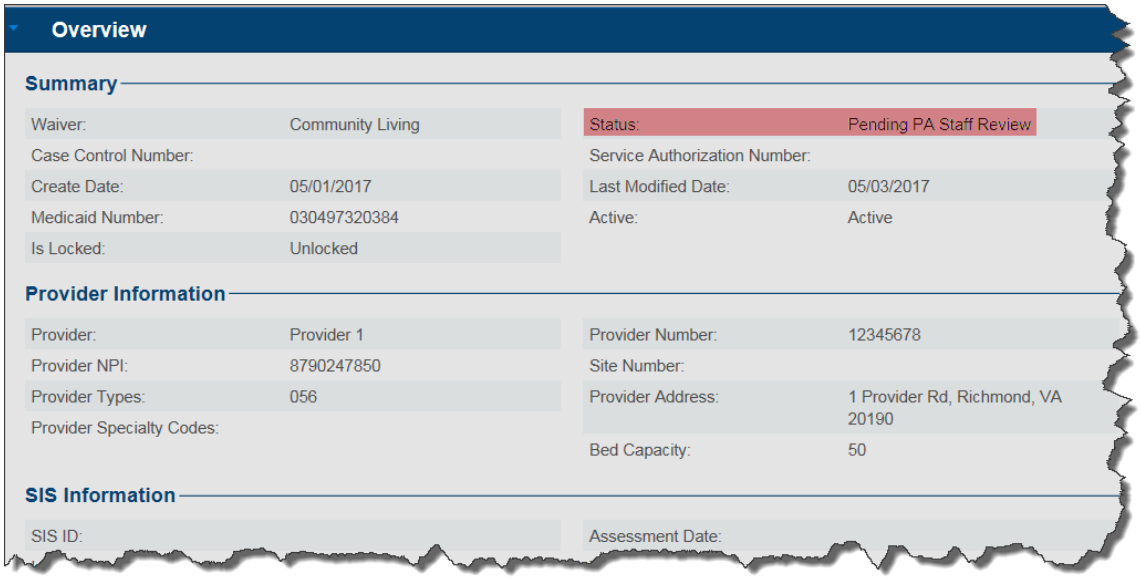
2. Click in the **Note** field to add the note.
3. Click the **Send to**: select arrows and select the appropriate organization(s) to send the note to (DBHDS or Provider).
4. Click on **Save**. *The Note is added to the Request for Clarification note box.*

12.5 Submit to PA Staff (Service Authorization Consultants)

Once all services have been added and reviewed, the *Support Coordinator* submits the SA to the *Service Authorization Consultants* for their review.

1. From the *Service Authorization – Summary* window, click on **Submit**. *The "Are you sure you want to submit for review?" dialog box appears.*

2. Click on **Continue**. *The SA is now in Pending PA Staff review status.*



Note: Once the SA is submitted for review, the SA can only be viewed. New service lines cannot be added and it cannot be deleted by the Provider or CSB; however, Notes can be viewed/entered at any time by clicking the "Note" button.

12.6 Revise SA

The SA can be revised by the Support Coordinator *or* the proposed Provider when the following conditions have been met:

- SA has the status of VAMMIS Approval Complete
- SA has at least one active service
- User has the Provider Admin user role

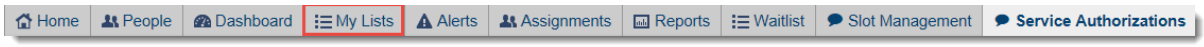
The Support Coordinator will need to create a *new* SA when:

- It is the first SA for the provider for an individual
- All services have ended/expired on all existing SAs for that provider
- A particular service (or group of services) is provided under a different provider number/NPI for the same provider

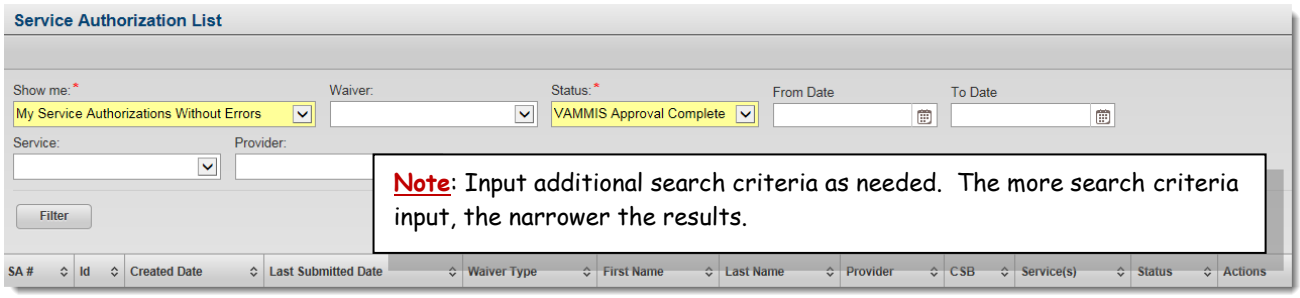
12.6.1 Locate the SA to be Revised

12.6.1.1 Using My Lists Tab

1. Click on the **My Lists** tab. *The My Lists window appears (displaying the Individual Support Plan and Service Authorization options on the left).*



2. Click on **Service Authorizations**. *The Service Authorizations List window appears.*
3. Click the **Status** down arrow to change to **VAMMIS Approval Complete**.



4. Click on **Filter**. *The search results appear. Select the specific Service Authorization that needs to be revised.*

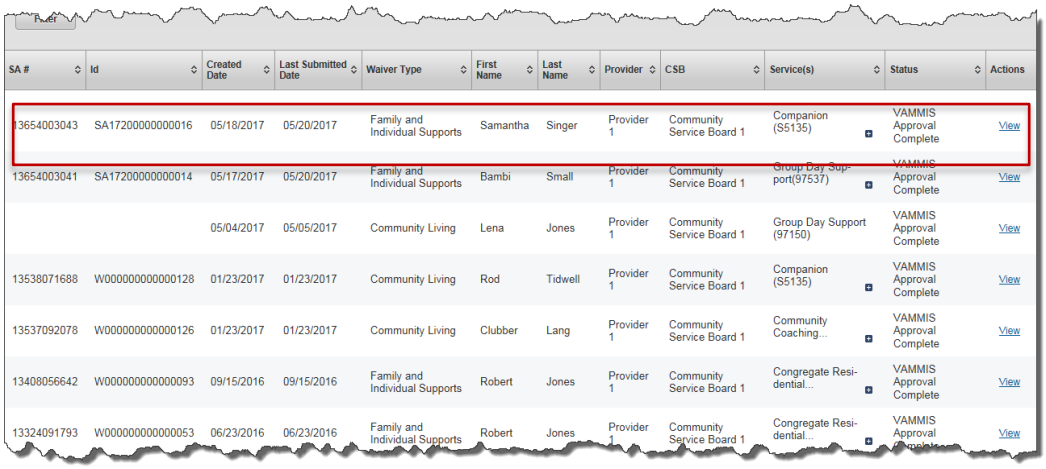
Note: You may need to scroll to find the appropriate SA.

OR

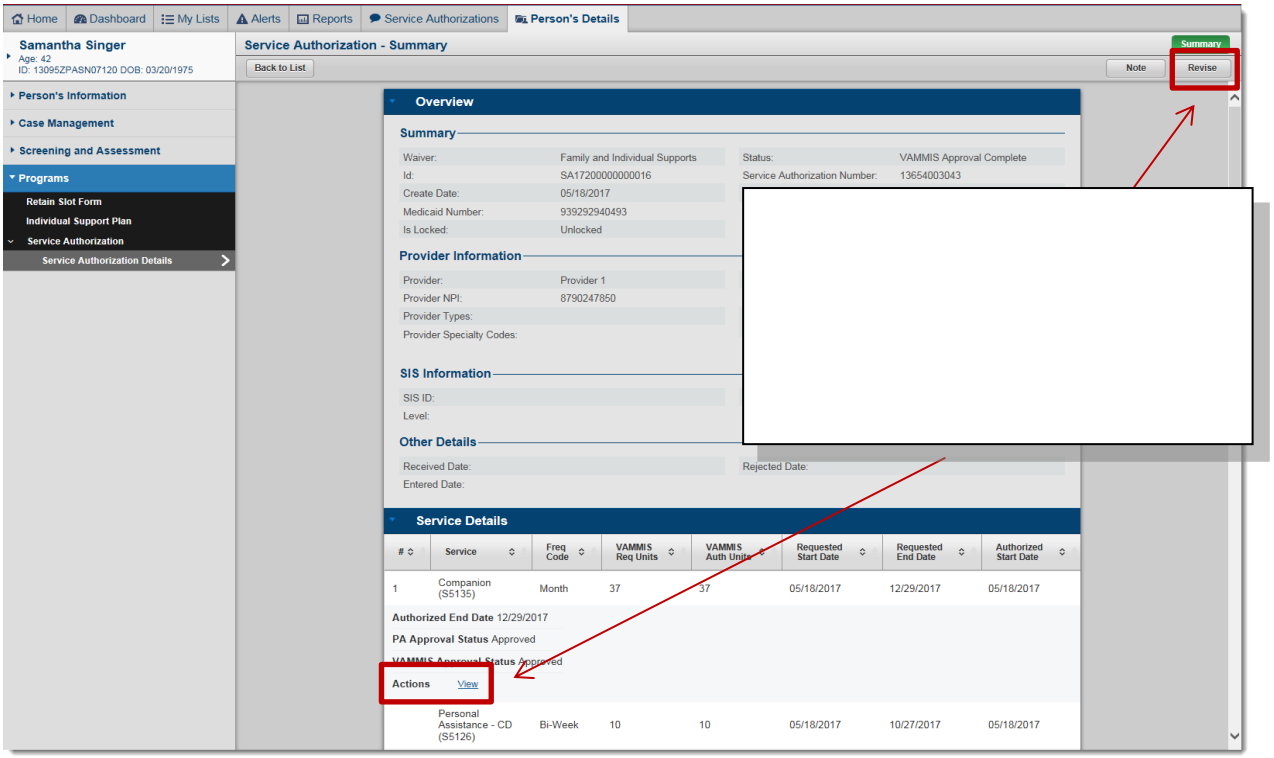
12.6.1.2 Using Service Authorizations Tab

The *Service Authorizations* tab can also be used to locate the SA. By using the SA tab, the individual's name is used to search without needing to know the status.

Follow the steps 2 through 5 in Section 12.2 above to search using the SA tab. The results will show all SAs associated with that individual.



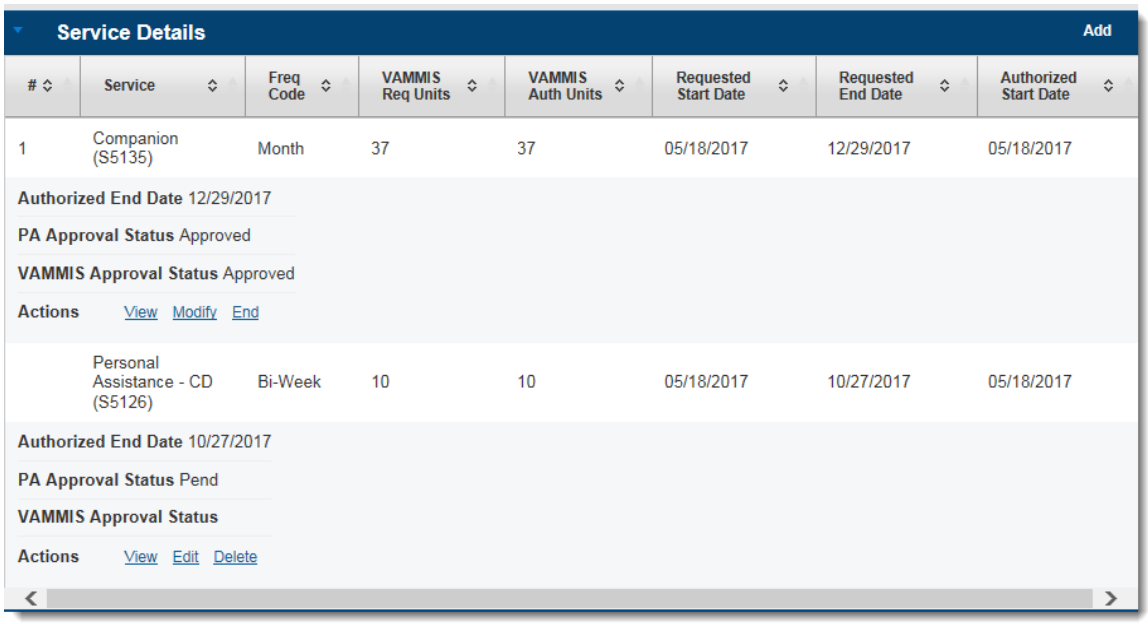
1. Click on **View** (*under Actions*) for the individual's SA that needs to be revised. *The Service Authorization – Summary window appears.*



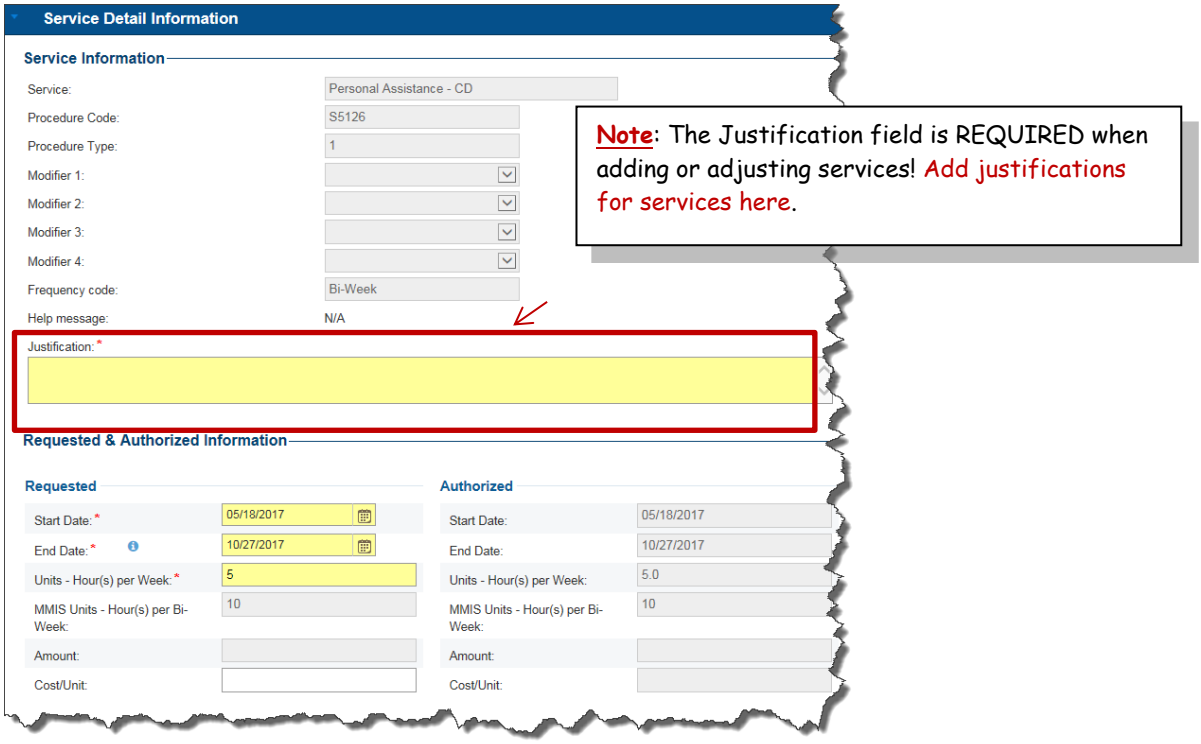
12.6.2 Revise the SA

1. Click on the **Revise** button. *The **Are you sure you want to revise?** prompt appears.*

2. Click on **Continue**. *The SA status changes to **Pending Provider Input** and can now be revised.*



- If the SA has been approved the *Modify* and *End* options are available for the service.
- If the SA has been pended, the *Edit* and *Delete* option are available for the service.
- If a New service is needed, the *Add* option is available.



The revised SA should be re-submitted to PA Staff for approval

13 Letters

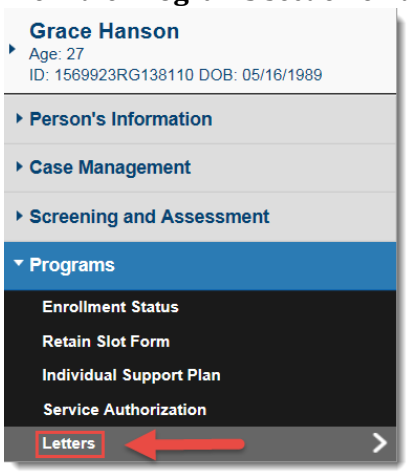
CSBs have the ability to create and print waiver letters for individuals directly from WaMS. Letters are located under **Programs**. There are two types of letters (*Slot Assignment* and *Notification of Right to Appeal*) that can be created for each Waiver type (Community Living, Family and Individual Supports and Building Independence).

The Slot Assignment Letter

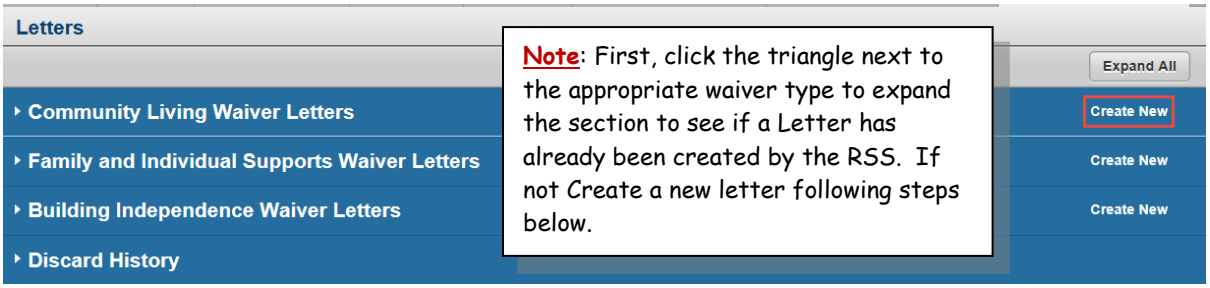
The Regional Support Specialists (RSS) at DBHDS usually create the Slot Assignment letter for Support Coordinator to print and provide to the individual; however, the CSB also has the ability to create the Slot Assignment Letter.

13.1 Create New Letters

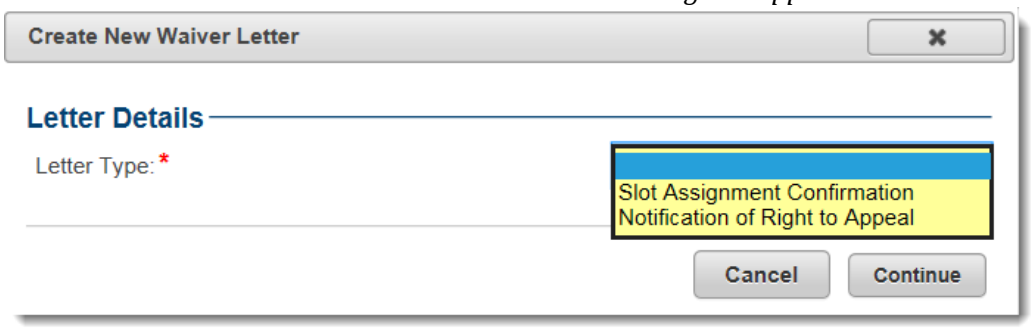
1. Locate the individual using one of the steps above in sections 9.1.1.1(Search), 9.1.1.2 (Alerts); or 9.1.1.3 (My List) above.
2. From the **Programs** section on the *left navigation bar*, click on **Letters**.



The Letters window appears on the right.

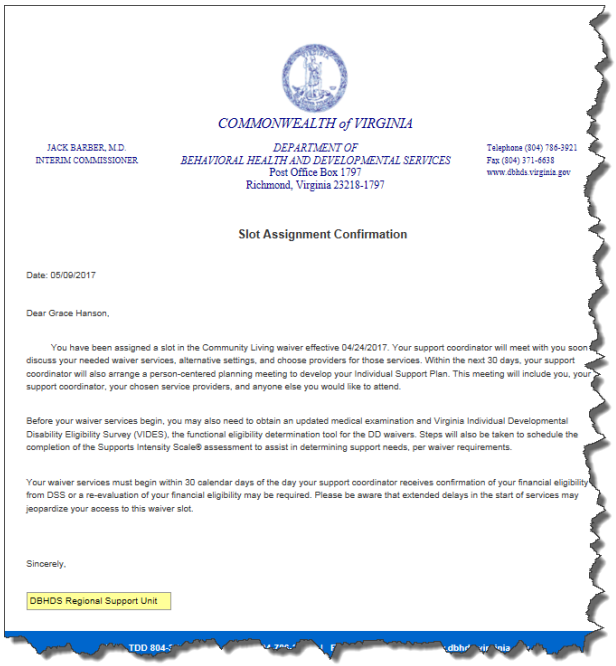


3. Click **Create New**. *The Create New Waiver Letters dialog box appears.*



4. Select the appropriate **Letter Type**.
   - *Slot Assignment Confirmation* Letter
     i. Informs the individual that they have been assigned a slot, and what to expect within the first 30 days, beginning with a call from their support coordinator.
     ii. Prints on DBHDS letterhead and signed by an RSS.
   - *Notification of Right to Appeal* Letter
     i. Titled *Notice of Action* once created
     ii. Used when there is a change to the individual's status for receipt of benefits.
     iii. Has four selections for the reason for the letter. More than one may be selected.
     iv. Signed by the CSB.
5. Click on **Continue**. *The Waiver Letter – Slot Confirmation window appears.*

Slot Assignment Confirmation Letter



COMMONWEALTH of VIRGINIA

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INTERIM COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

Slot Assignment Confirmation

Date: 05/09/2017

Dear Grace Hanson,

You have been assigned a slot in the Community Living waiver effective 04/24/2017. Your support coordinator will meet with you soon to discuss your needed waiver services, alternative settings, and choose providers for those services. Within the next 30 days, your support coordinator will also arrange a person-centered planning meeting to develop your Individual Support Plan. This meeting will include you, your support coordinator, your chosen service providers, and anyone else you would like to attend.

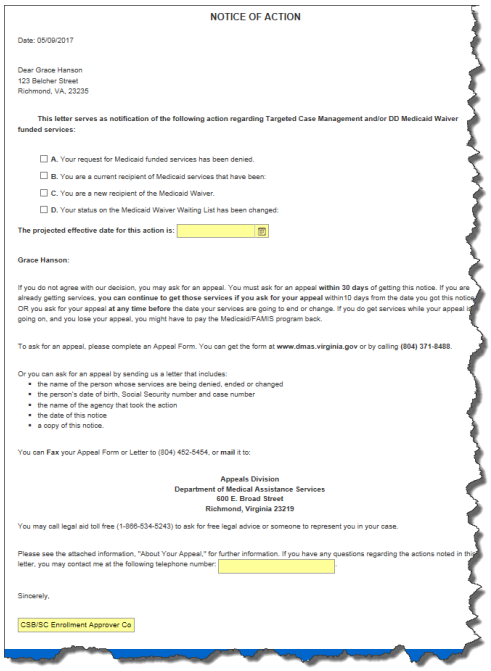
Before your waiver services begin, you may also need to obtain an updated medical examination and Virginia Individual Developmental Disability Eligibility Survey (VIDES), the functional eligibility determination tool for the DD waivers. Steps will also be taken to schedule the completion of the Supports Intensity Scale® assessment to assist in determining support needs, per waiver requirements.

Your waiver services must begin within 30 calendar days of the day your support coordinator receives confirmation of your financial eligibility from DSS or a re-evaluation of your financial eligibility may be required. Please be aware that extended delays in the start of services may jeopardize your access to this waiver slot.

Sincerely,

DBHDS Regional Support Unit

Notification of Action Letter



NOTICE OF ACTION

Date: 05/09/2017

Dear Grace Hanson
123 Belcher Street
Richmond, VA, 23235

This letter serves as notification of the following action regarding Targeted Case Management and/or DD Medicaid Waiver funded services:

- ☐ A. Your request for Medicaid funded services has been denied.
- ☐ B. You are a current recipient of Medicaid services that have been:
- ☐ C. You are a new recipient of the Medicaid Waiver.
- ☐ D. Your status on the Medicaid Waiver Waiting List has been changed:

The projected effective date for this action is:

Grace Hanson:

If you do not agree with our decision, you may ask for an appeal. You must ask for an appeal **within 30 days** of getting this notice. If you are already getting services, **you can continue to get those services if you ask for your appeal** within10 days from the date you got this notice OR you ask for your appeal **at any time before** the date your services are going to end or change. If you do get services while your appeal is going on, and you lose your appeal, you might have to pay the Medicaid/FAMIS program back.

To ask for an appeal, please complete an Appeal Form. You can get the form at **www.dmas.virginia.gov** or by calling **(804) 371-8488**.

Or you can ask for an appeal by sending us a letter that includes:

- the name of the person whose services are being denied, ended or changed
- the person's date of birth, Social Security number and case number
- the name of the agency that took the action
- the date of this notice
- a copy of this notice.

You can **Fax** your Appeal Form or Letter to (804) 452-5454, or **mail** it to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219

You may call legal aid toll free (1-866-534-5243) to ask for free legal advice or someone to represent you in your case.

Please see the attached information, "About Your Appeal," for further information. If you have any questions regarding the actions noted in this letter, you may contact me at the following telephone number:

Sincerely,

CSB/SC Enrollment Approver Co

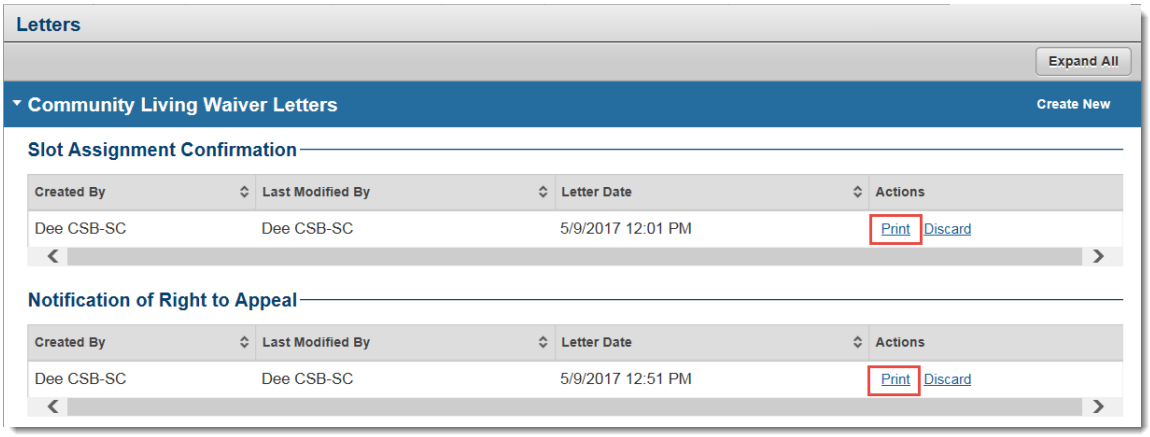
- For *Notice of Action* letter: Identify the purpose of the letter by clicking on the A, B, C and/or D check box(es), projected effective date and contact phone number.
    i. Square radio buttons – one or more selections may be selected
    ii. Circular radio buttons – only one selection may be chosen
- If desired, scroll to the bottom of the letter, below "Sincerely," click in the yellow field to type in name/title other than the default.

6. Click on **Submit**. The letter is saved in the appropriate waiver type section.

13.2 Print Letters

Once a letter is submitted, it is stored in WaMS and can be printed.

1. Access the appropriate letter(s) *(see number 2above*).
2. Click the down arrow next to the letter waiver type to be printed. *The Waiver type section expands.*
3. Click **Print** under *Actions*.

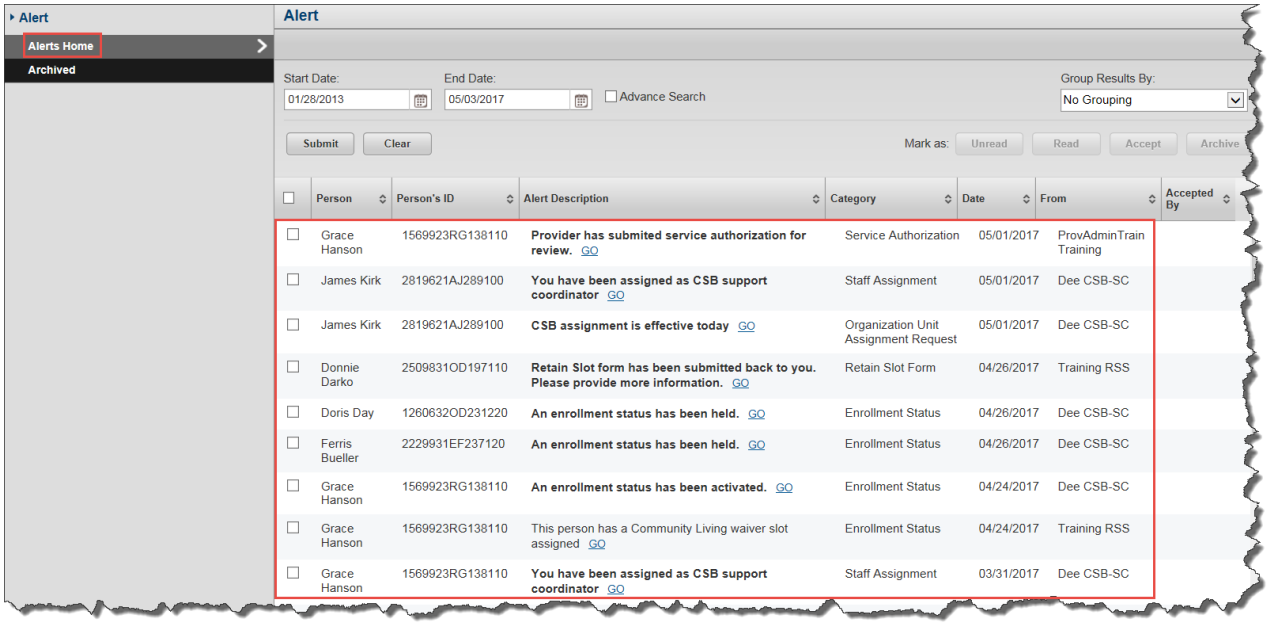


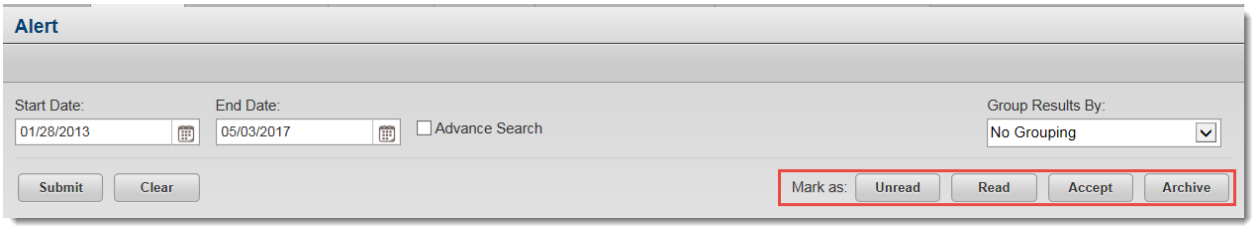
14 Miscellaneous

14.1 Alerts

Alerts inform the recipient that some type of action is required or has been completed. Alerts are specific to the user's role and assignments to specific tasks. Use Alerts to view and accept notifications from others. The list displays at most 500 records.

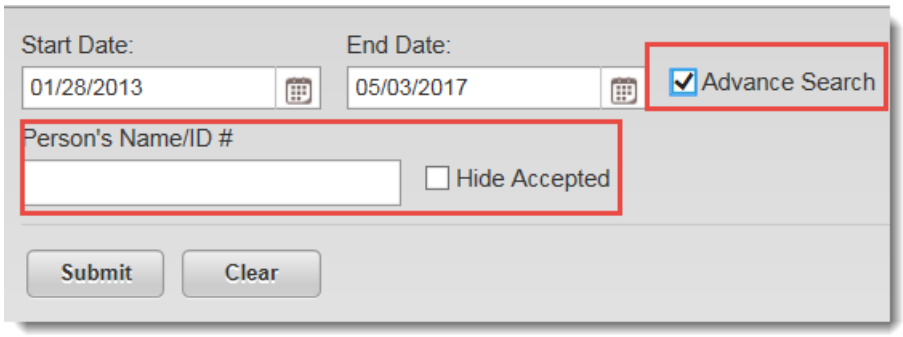
1. Click on the **Alerts** tab to display all current alerts.





2. Select the **Start** and **End** dates to narrow or broaden the search results.
3. Click the **check box** to the left of an individual's name to enable the *Mark as:* actions, then click on one of the actions:
    a. Unread – mark read items as *unread* to identify them as follow-up items. *Note*: *Unread and Read buttons will not be enabled at the same time*
    b. Read – mark unread items as read to identify completed actions or. *Note*: *Unread and Read buttons will not be enabled at the same time*
    c. Accept –Login name shows in the *Accepted By* column. This is a useful tool to easily identify what actions have been completed on the alert
    d. Archive – Move the selected alert to *Archived* (left menu item) to mark the alert as:

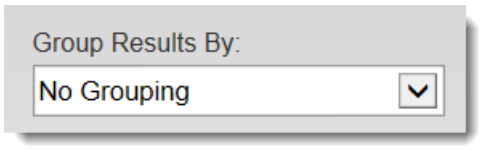
4. Click on **Archived** on the left nave bar to display all alerts that were marked as *Archive*.
5. Click on **Advance Search** check box to input the **Person's name or ID #.**



14.1.1 Grouping Alerts

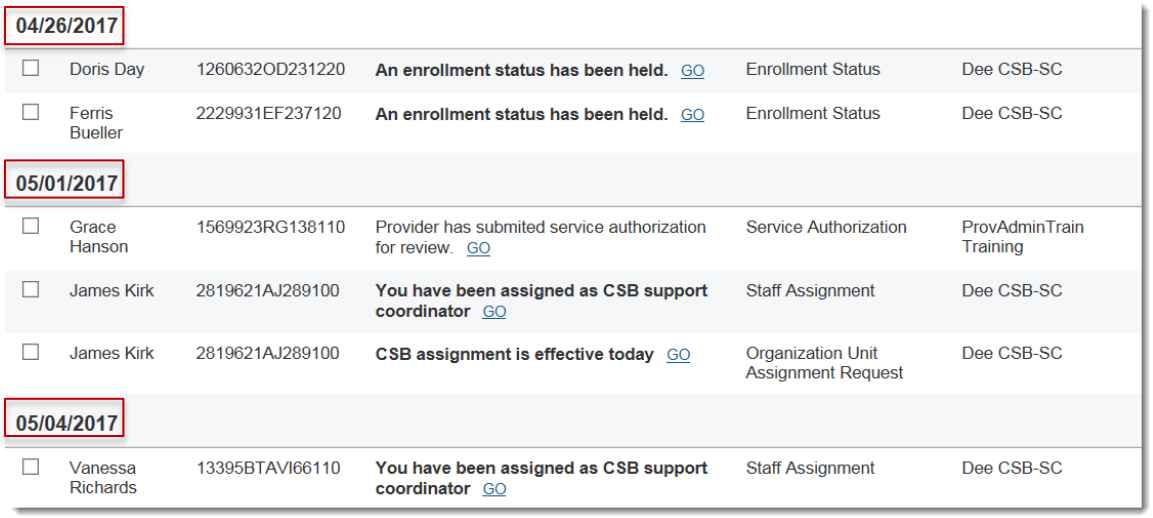
To easily sort and locate alerts, group them by a *Person's Name*, *Date* or *Category*.

1. Click on the **Group Results By:** down arrow.



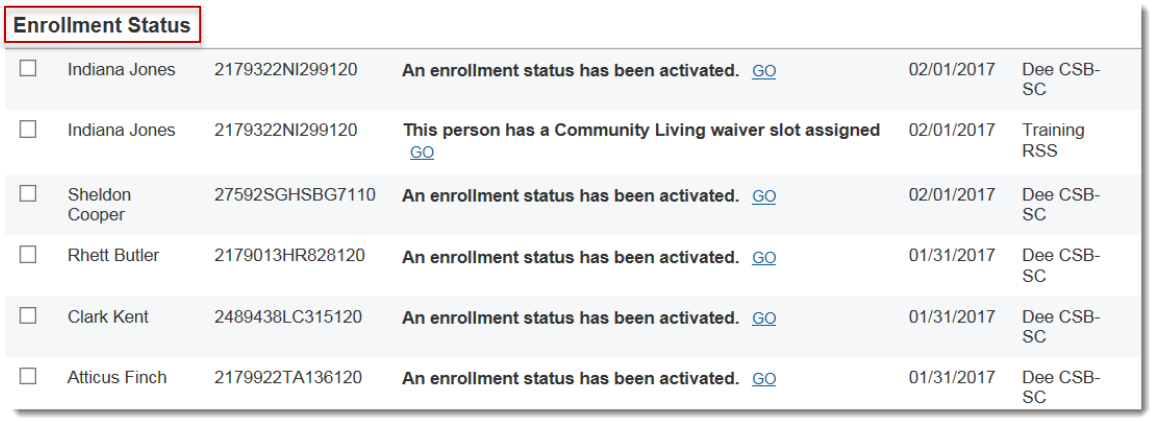
   a. Select **Person's Name** to group all alerts received for an individual together.

b. Select **Date** to group alerts by all individuals based on date the alert is received.



04/26/2017						
☐	Doris Day	1260632OD231220	**An enrollment status has been held.** GO	Enrollment Status		Dee CSB-SC
☐	Ferris Bueller	2229931EF237120	**An enrollment status has been held.** GO	Enrollment Status		Dee CSB-SC
05/01/2017						
☐	Grace Hanson	1569923RG138110	Provider has submited service authorization for review. GO	Service Authorization		ProvAdminTrain Training
☐	James Kirk	2819621AJ289100	**You have been assigned as CSB support coordinator** GO	Staff Assignment		Dee CSB-SC
☐	James Kirk	2819621AJ289100	**CSB assignment is effective today** GO	Organization Unit Assignment Request		Dee CSB-SC
05/04/2017						
☐	Vanessa Richards	13395BTAVI66110	**You have been assigned as CSB support coordinator** GO	Staff Assignment		Dee CSB-SC

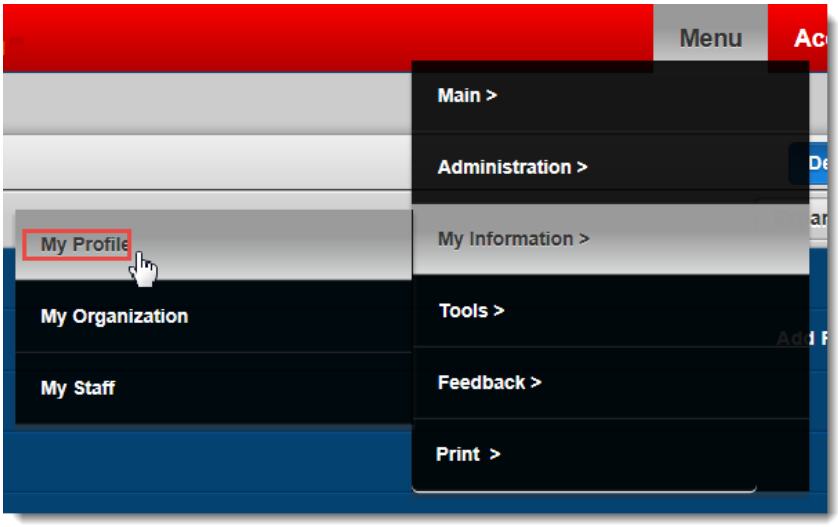
c. Select **Category** to group alerts by a category (i.e., *Staff Assignment, Enrollment Status, Service Authorization, Individual Support Plan, Organization Unit Assignment Request*).



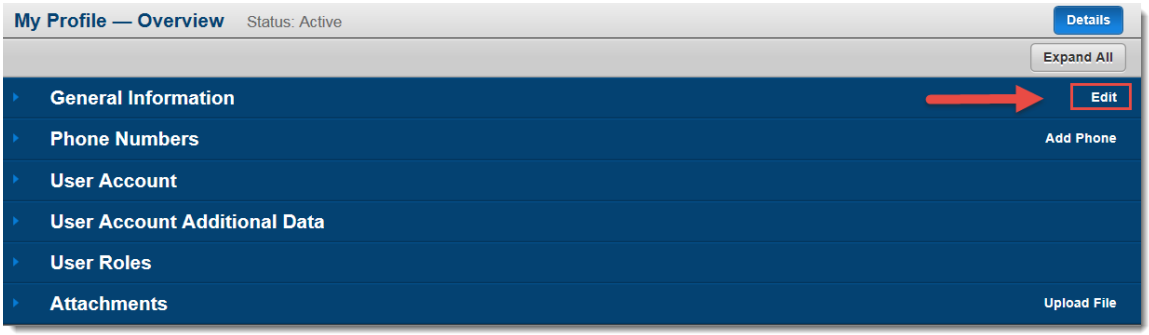
Enrollment Status					
☐	Indiana Jones	2179322NI299120	**An enrollment status has been activated.** GO	02/01/2017	Dee CSB-SC
☐	Indiana Jones	2179322NI299120	**This person has a Community Living waiver slot assigned** GO	02/01/2017	Training RSS
☐	Sheldon Cooper	27592SGHSBG7110	**An enrollment status has been activated.** GO	02/01/2017	Dee CSB-SC
☐	Rhett Butler	2179013HR828120	**An enrollment status has been activated.** GO	01/31/2017	Dee CSB-SC
☐	Clark Kent	2489438LC315120	**An enrollment status has been activated.** GO	01/31/2017	Dee CSB-SC
☐	Atticus Finch	2179922TA136120	**An enrollment status has been activated.** GO	01/31/2017	Dee CSB-SC

14.1.2 Alert Email Settings

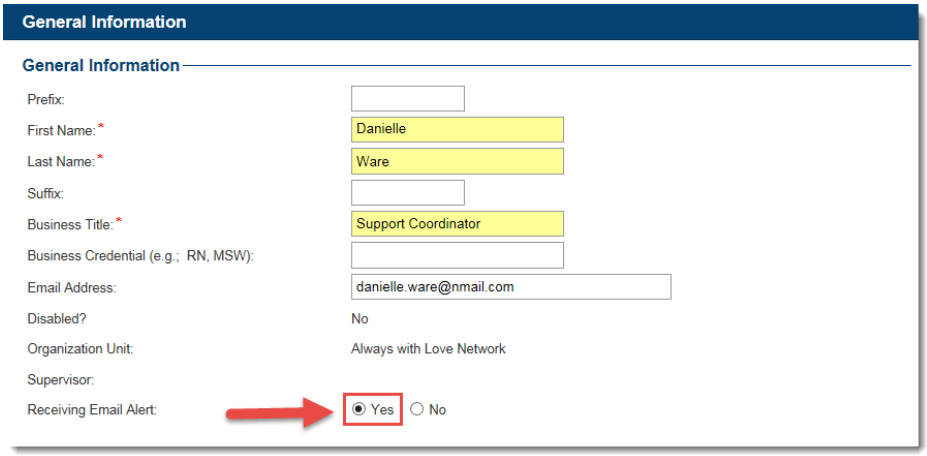
Update your user profile to be notified via email when an alert is sent in WaMS.



1. Click on **Menu**, **My Information**, **My Profile**. *The My Profile — Overview window appears*
2. Click on **Edit** for the *General Information* section.



3. Click on **Yes** radio button for the *Receiving Email Alert* section.



4. Click on **Save**.
5. Click on **Menu**, **Main**, **Home** to return to the WaMs main *Home* page.

14.1.3 Alert Categories (and text received)

Category	Alert Text
Enrollment Status	An enrollment status has been held.
	An enrollment status has been terminated.
	An enrollment status has been activated.
	This person has a {*program Name*} waiver slot assigned
	An enrollment status has been held.
	No additional extension to Retain the Slot are available. Please contact RSS.
	A Retain Slot Request must be submitted and the person placed on Hold status if the individual wishes to retain this slot.
	It has been 150 days since assignment to active enrollment status. Slot should be reassigned.
	It has been 120 days since assignment to active enrollment status and no SA has been submitted.
Individual Support Plan	The Individual Support Plan has been assigned to you
	A form note has been created
	A Form Note has been created
	The Individual Support Plan has been completed
	Individual Support Plan for this person is due on {*Due Date*}
	Attachment has been added to Individual Support Plan

Category	Alert Text
	Attachment has been removed from Individual Support Plan
	Attachment has been added to Individual Support Plan
	Attachment has been removed from Individual Support Plan
	The Individual Support Plan has been assigned to you
	Access to ISP has been revoked
Organization Unit Assignment Request	CSB assignment is effective today
	CSB assignment has been deactivated
	CSB assignment has been created effective {*Effective Date*}
	CSB transfer has been initiated. The current assignment will expire on {E*ffective Date*}
Retain Slot Form	Retain Slot Form has been submitted to you. Please review the form.
	Retain Slot form has been submitted back to you. Please provide more information.
Service Authorization	There is an error related to a Service Authorization.
	The Status Code for Service Authorization has been updated.
	The Status Code for Service Authorization has been updated.
	A new service authorization has been created.
	A service authorization has been deleted.

Category	Alert Text
	A person's slot has been released.
	Provider has submitted service authorization for review.
	A service authorization has been submitted to PA staff for review.
	A new service authorization has been submitted for review.
	A new note has been added to the Service Authorization record
	A new note has been added to the Service Authorization record
	A new note has been added to the Service Authorization record
	A service authorization has been sent back to provider.
	A service line has been removed from service authorization
	A service line has been removed from service authorization
	A service authorization has been sent back to Pending Support Coordinator Review.
SIS	Tier has changed from {*Previous Tier*} to {*Tier*} effective {*Assessment Date*}.
	Tier has changed from {*Previous Tier*} to {*Tier*} effective {*Assessment Date*}.
	Tier has added as {*Tier*} effective {*Assessment Date*}.
	Tier has added as {*Tier*} effective {*Assessment Date*}.

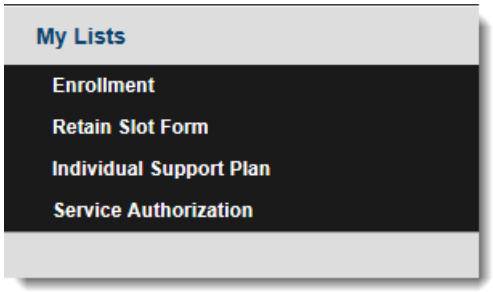
Category	Alert Text
Slot Assignment	Slot "{*Slot Number*}" has been released. This slot must be reassigned to another individual within 90 days of release.
Slot Deletion	Slot "{*Slot Number*}" has been deleted.
Staff Assignment	You have been assigned as CSB support coordinator
	You're no longer the assigned CSB support coordinator for this person

14.2 My Lists Tab

The *My Lists* tab allows for easy access to lists of individuals by of *Enrollment, Retain Slot*, *Individual Support Plan* and *Service Authorization*.

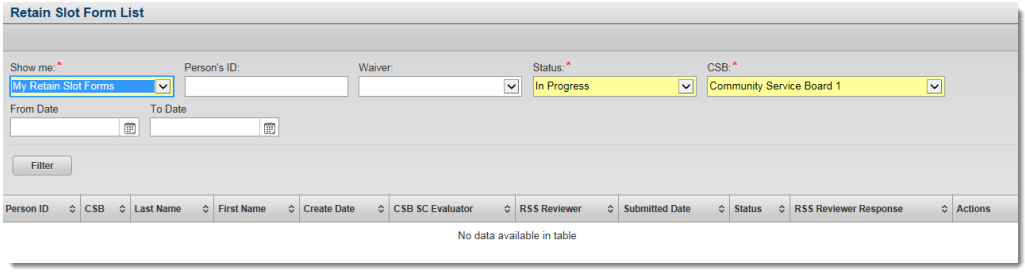
Note: CSBs are only able to view their own Organizational Unit ("OU").

1. Click on the **My Lists** tab. *The **My List** options appear on the left.*



14.2.1 Enrollment

1. Click on Enrollment.



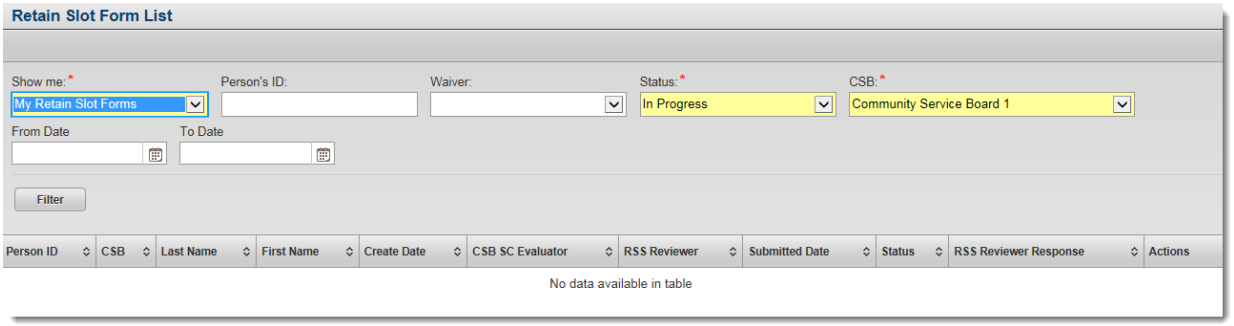
2. Complete required fields:
    a. **Show Me**
        i. My people with enrollment (those assigned to who is logged in)
        ii. People with Enrollment (everyone in the CSB)

b. **Status**
    i. Projected
    ii. Active
    iii. Hold
    iv. Released
    v. Pending Appeal
c. **CSB** (will default to the CSB of the person logged in)

14.2.2 Retain Slot

Access a list of assigned individuals with Retained Slots.

1. Click on **Retain Slot**.

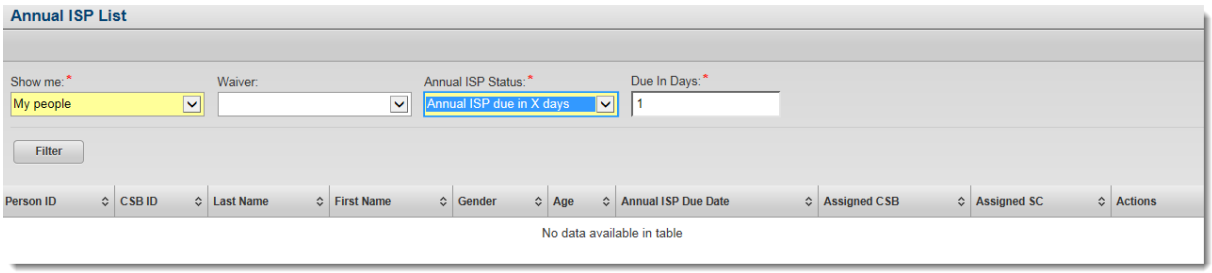


2. Complete required fields:
    a. **Show Me**
        i. My Retain Slot Forms (those assigned to who is logged in)
        ii. All Retain Slot Forms (everyone in the CSB)
    b. **Status**
        i. In Progress
        ii. Awaiting RSS Review
        iii. Awaiting CSB Response
        iv. Complete
        v. Discarded
    c. **CSB** (will default to the CSB of the person logged in)

14.2.3 Individual Support Plan

Access a list of assigned individuals with an Annual ISP status of Overdue or due in a given number of days

1. Click on **Individual Support Plan**.



2. Complete required fields:
    a. **Show Me**
        i. My people (those assigned to who is logged in)
        ii. All People (everyone in the CSB)
    b. **Annual ISP Status**
        i. Annual ISP overdue
        ii. Annual ISP due in X days
        iii. A required *Due in Days* field displays if Annual ISP due in X days is selected for you to add the specific number of days due

14.2.4 Service Authorizations

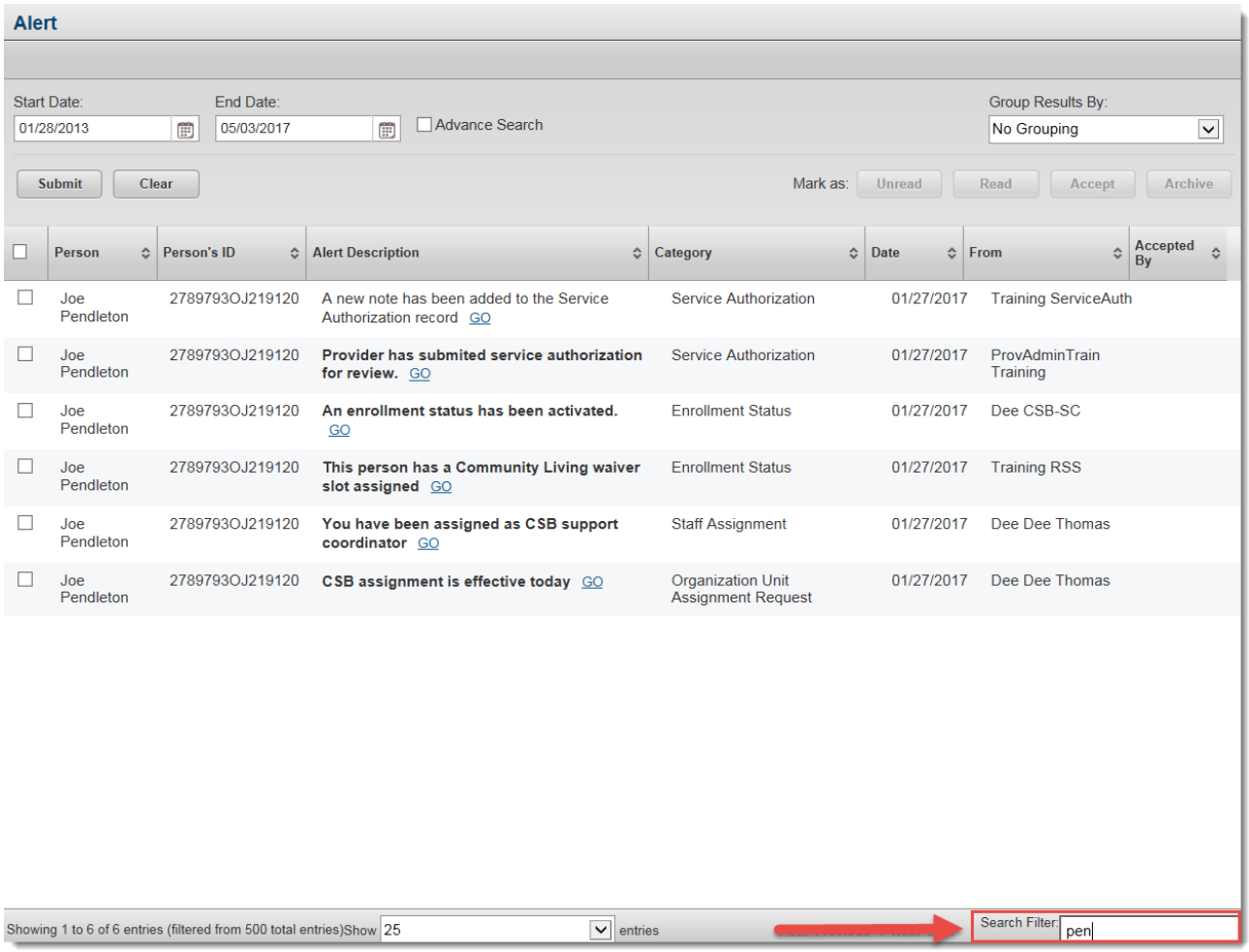
Access a list of assigned individuals with a Service Authorization based on status.

1. Complete required fields:
    a. **Show Me**
        i. My Service Authorizations without Errors (those assigned to the Support Coordinator)
        ii. My Service Authorizations with Errors (those assigned to the Support Coordinator)
        iii. All Service Authorizations without Errors (everyone in the CSB)
        iv. All Service Authorizations with Errors (everyone in the CSB)
    b. **Status**
        i. Pending Provider Input
        ii. Pending Support Coordinator Review
        iii. Pending PA Staff Review
        iv. Pending VAMMIS Approval
        v. VAMMIS Approval Complete
        vi. Waiver Slot Released
        vii. SA Terminated

14.3 Search Filter

When looking for a specific individual in the *My List* or *Alerts* or other tabs simply start typing their *first* or *last* name (or other column information known) in the *Search Filter* field (located in bottom right-hand corner) of each tab. The list will be filtered to display information that matches the criteria typed.

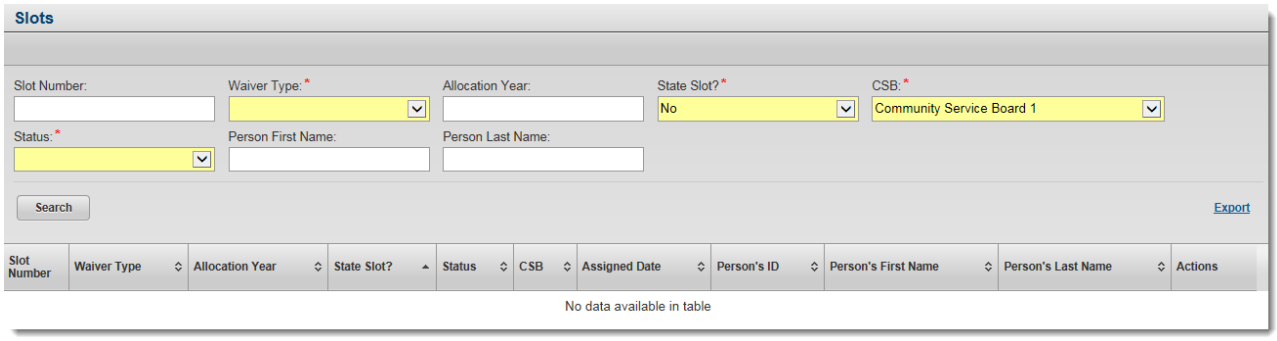
Begin typing the search criteria (i.e., first or last name) in the **Search Filter** field. *The list is filtered to display only the information that matches the criteria you type.*



14.4 Slot Management Tab

Use the **Slot Management** tab to view assigned slots by Waiver. The slot for a specific individual can be viewed by inputting their *first* and/or *last* name into the search criteria.

1. Click on the **Slot Management** tab. *The Slots window appears.*



2. Complete required fields using the drop-downs
    a. Waiver Type
        i. Community Living
        ii. Family and Individual Supports
        iii. Building Independence
    b. State Slot
        i. Defaults to No
    c. CSB
        i. Defaults to the CSB
    d. Status
        i. Available
        ii. Assigned
        iii. Assigned to Wave
3. Add known optional information to narrow the search
4. Click on **Search**.

Note: The search will not yield results if there is a conflict in search criteria. Example: Person is not in the identified Waiver Type.

14.5 Search by Slot Number

1. Click on the **Slot Management** tab. *The Slots window appears*.
2. Add the Slot Number in the Slot Number field. *The required fields (Waiver Type, State Slot? and Status) are no longer required fields.*
3. Click **Search**.

14.6 Export Slot Information

1. Click on the **Slot Management** tab. *The Slots window appears*.
2. Complete required fields using the drop-downs
    a. Waiver Type
        i. Community Living
        ii. Family and Individual Supports
        iii. Building Independence
    b. State Slot
        i. Defaults to No
    c. CSB
        i. Defaults to the CSB
    d. Status
        i. Available
        ii. Assigned
        iii. Assigned to Wave

3. Add known optional information to narrow the search
4. Click on **Search**.
5. Click the **Export** link (above the *Actions* column).

6. Click to **Open** or **Save** the .xls file (or **Cancel** the export).
    a. Click on the Excel file at bottom of desktop; or
    b. Open from the *Save* location

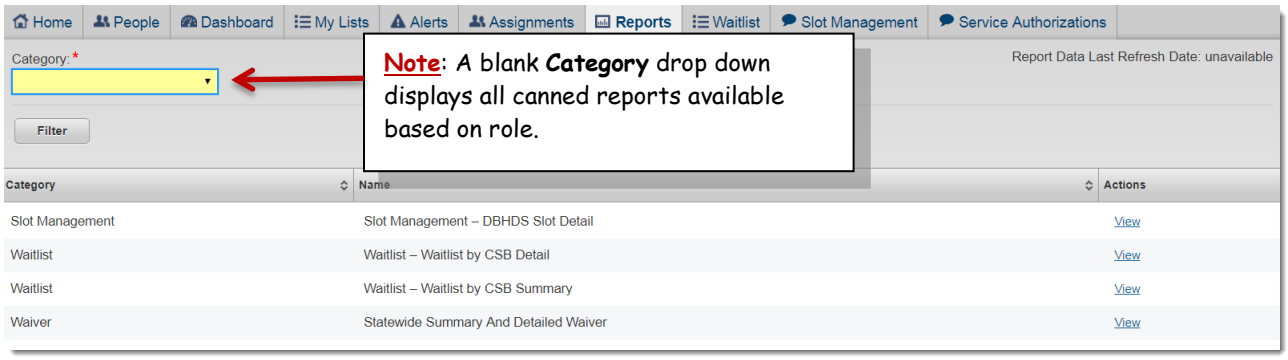
14.7 Reports Tab (Canned Reports)

There are several canned **Reports** available by default under the Reports tab. These reports are based on a predefined Business Intelligence model ~ WaMSBIModel.

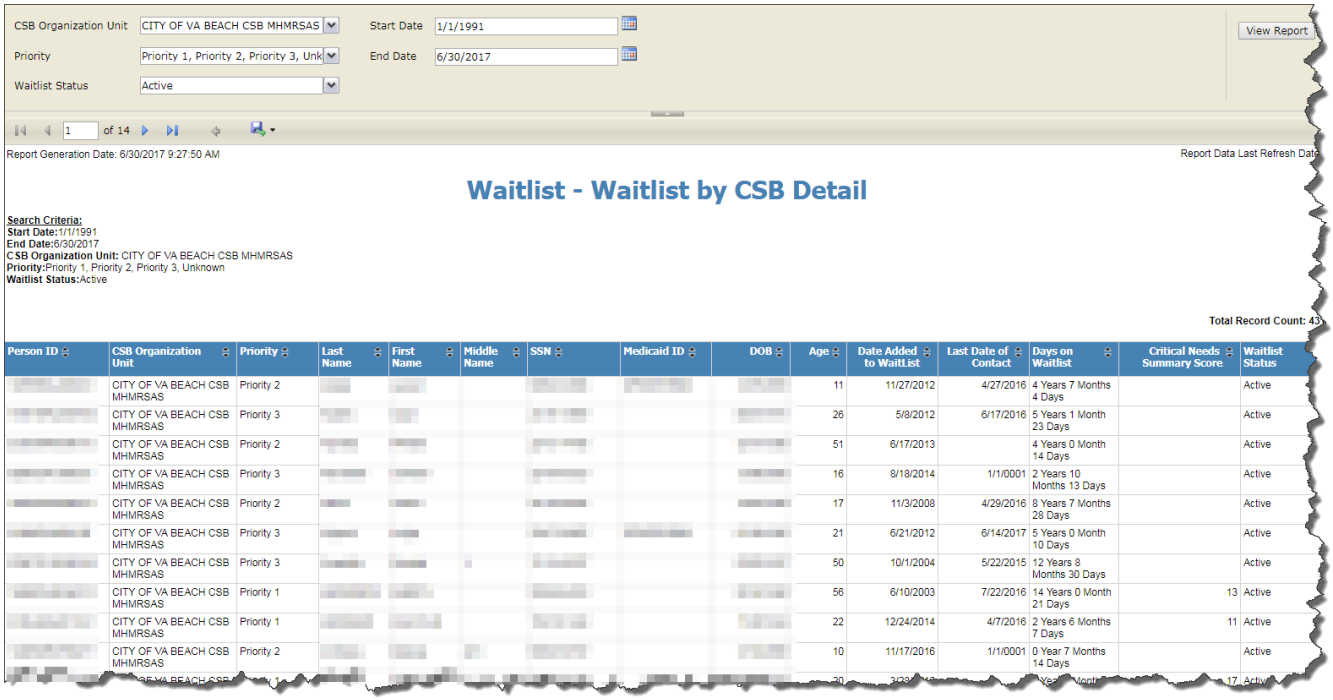
The reports available are based on the role of the person logged in to WaMS. CSB Administrators have access to generate reports for their OU.

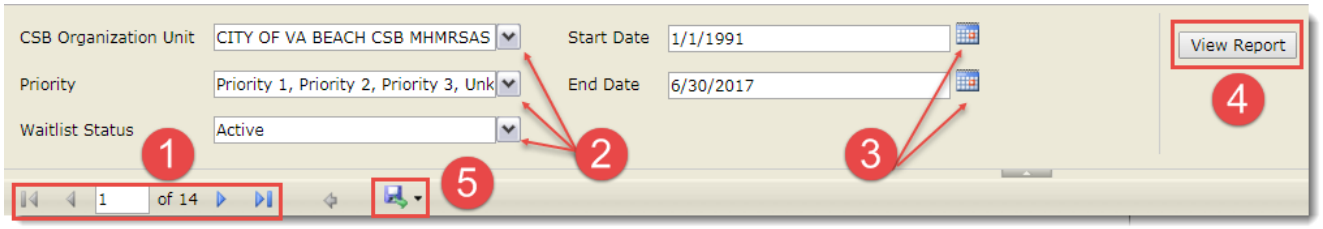
14.7.1 Generate Reports

1. Click on the **Reports** tab. The reports categories available appear by default (for instance:
    a. Slot Management
    b. Waitlist (detail or summary)
    c. Waiver



2. Click on **View** to open the appropriate report. *The report opens in a separate tab in the browser.*





1. Click **Next Page**, **Last Page** or **Previous Page**, **First Page** buttons to go to additional pages in the report (these buttons are available when there is more than one page in the report).
2. Click the drop down arrows to narrow search parameters.
3. Click the **Calendar** icons to select the Start and End dates for the report.
4. Click **View Report** when parameters of numbers 2 or 3 above are selected or modified to refresh the report.
5. Click the **Export drop down menu** to save the report as:
    c. Word
    d. Excel
    e. PowerPoint
    f. PDF
    g. TIFF file
    h. MHTML (web archive)
    i. CSV (comma delimited)

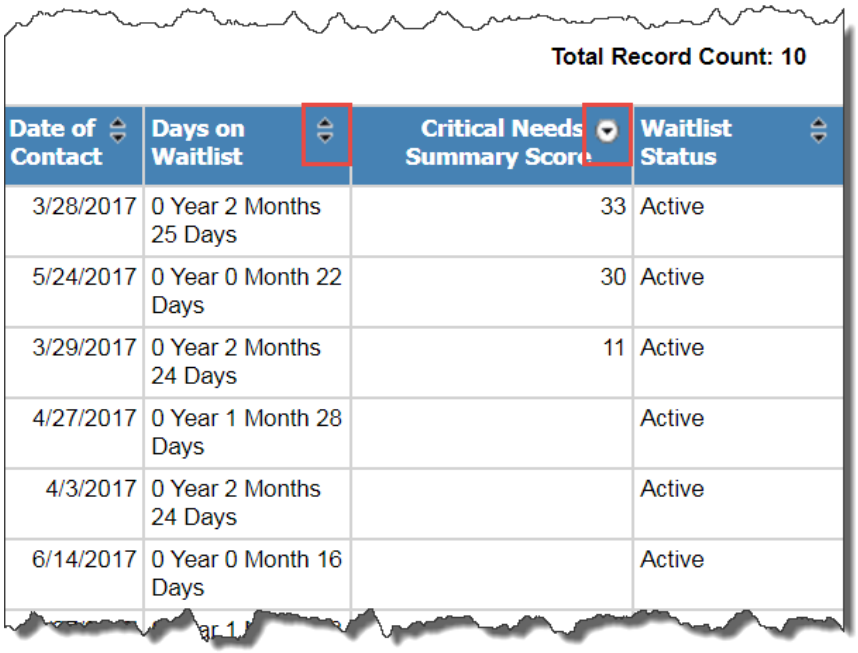
j. XML file with report data

k. Data Feed

14.7.2 Filter Reports

1. Click the **Up** and **Down** arrows next to the column name to filter the data on that column.

   *The **Up** and **Down** arrows will change to a single white up or down arrow once the filter is selected.*



Total Record Count: 10

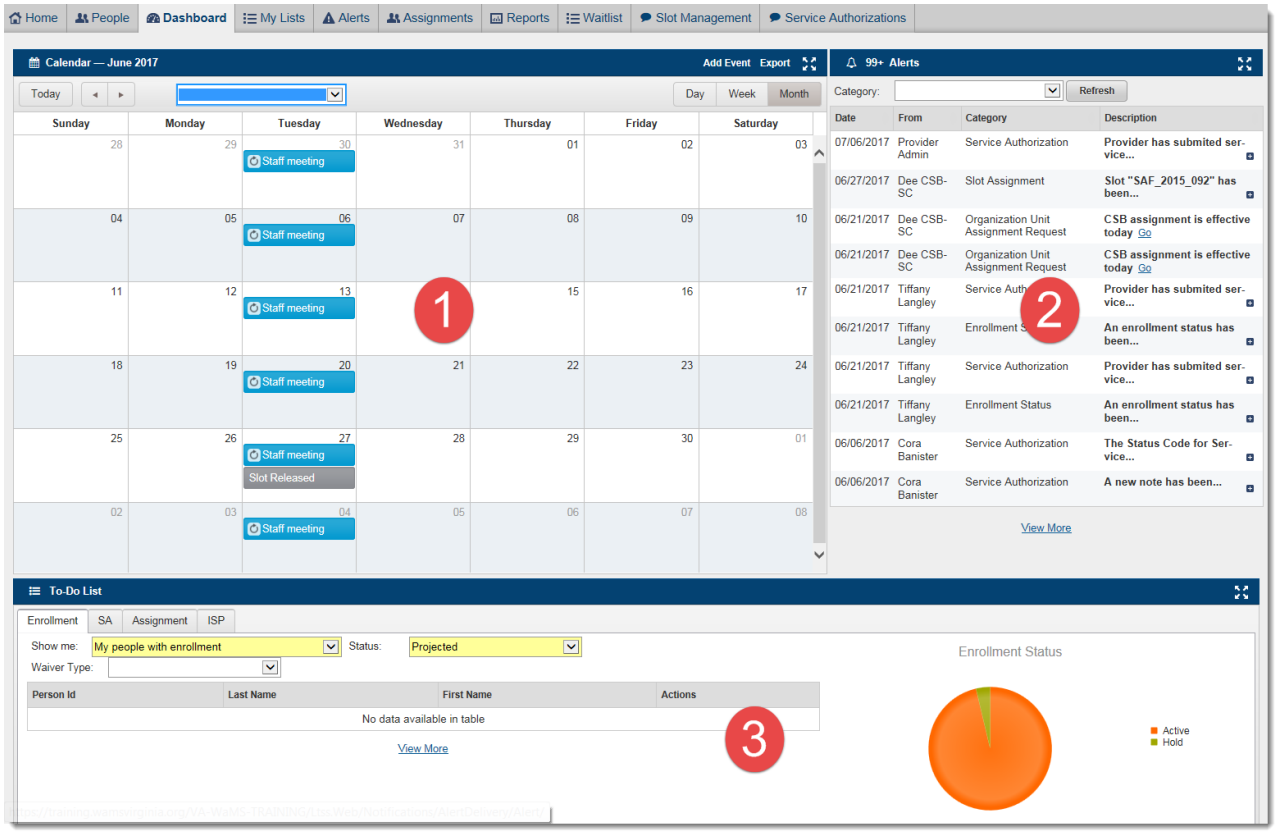
Date of Contact	Days on Waitlist	Critical Needs Summary Score	Waitlist Status
3/28/2017	0 Year 2 Months 25 Days	33	Active
5/24/2017	0 Year 0 Month 22 Days	30	Active
3/29/2017	0 Year 2 Months 24 Days	11	Active
4/27/2017	0 Year 1 Month 28 Days		Active
4/3/2017	0 Year 2 Months 24 Days		Active
6/14/2017	0 Year 0 Month 16 Days		Active

14.8 Dashboard

The Dashboard represents a snapshot of activities required and is based on the login role.

1. Click on the **Dashboard** tab. *The three sections of the Dashboard appear (1) Calendar, (2) Alerts, and (3) To Do List).*

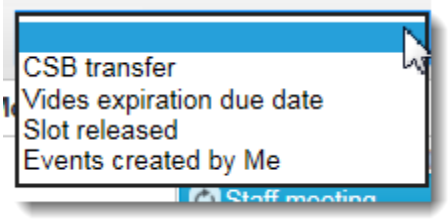
2. Click the **Expand** buttons to open each section in its own window.



14.8.1 Dashboard Calendar

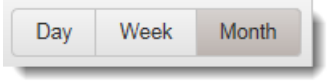
The dashboard calendar provides system generated reminders and manually added events

a. Click the calendar drop down arrow to filter view by specific events



b. Click the **Previous** and **Next** arrows next to "*Today*" to change the calendar month.

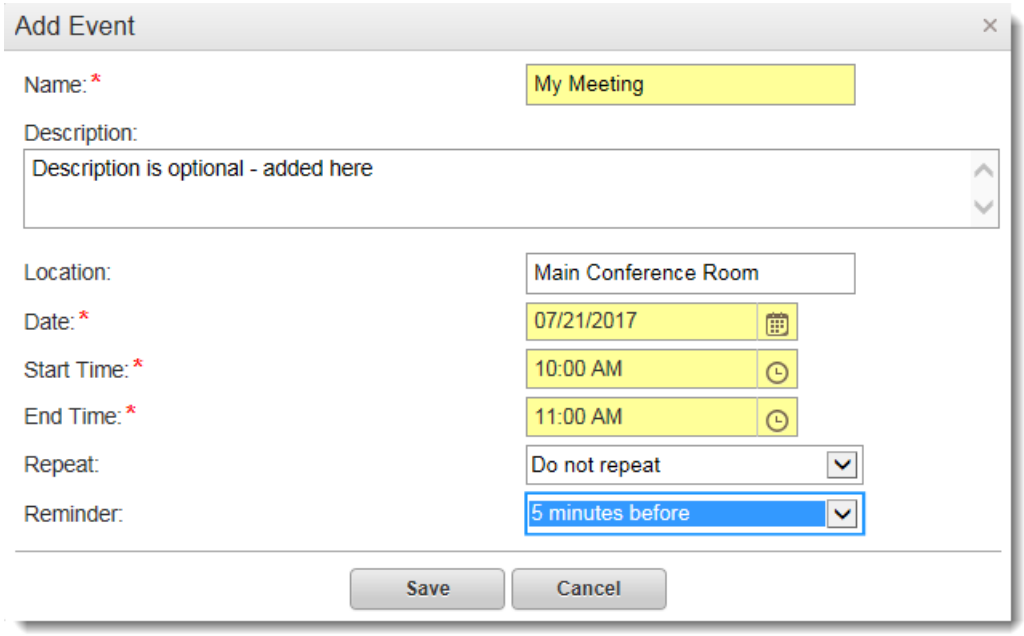
c. Click on the **Day**, **Week** or **Month** for the desired view.



14.8.1.1 Add Event

Meetings or reminders are added to the calendar manually as a one-time or recurring (repeating) event. Click **Add Event** in the Calendar title bar 

1. Input required information into the *Add Event* window
    a. Name of the event/reminder
    b. Date
    c. Start and End Times
2. Input optional information.
    a. Description or details about the event
    b. Repeat – Identify if or how often the event reoccurs. Recurring options are daily, weekly, monthly or yearly basis if applicable
    c. Reminder – Identify if or when a reminder should be generated
3. Click on **Save.** *The meeting appears in the calendar. Manually added events display in a different color from the system generated events.*

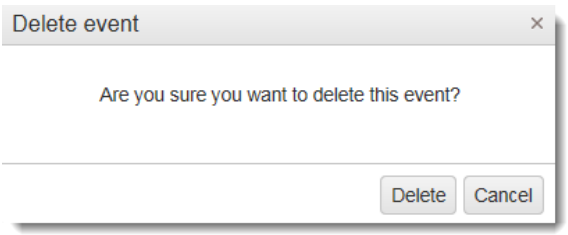


14.8.1.2 Edit a Manually Added Event

1. Double-click on the added event. *The Edit/View Event window appears.*
2. Make appropriate changes.
3. Click on **Save.**

14.8.1.3 Delete a Manually Added Event

1. Place the Mouse Pointer over event. *An X appears to the right of the Event Name.*
2. Click the **X**. *The Delete Event dialog box appears asking "Are you sure you want to*



delete this event".

3. Click on the **Delete** button**.** *The Event is removed from the calendar.*

14.8.2 Dashboard Alerts

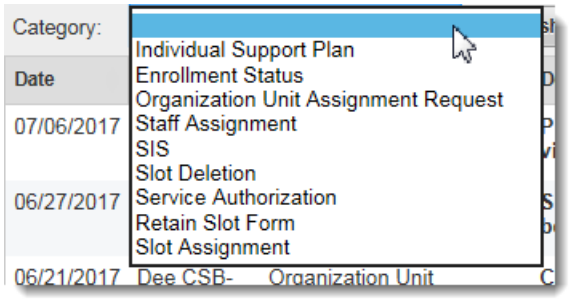
The Dashboard **Alerts** display the last 10 unread alerts in the dashboard sorted by date.

d. The dashboard reflects the number of alerts in the **Alerts** tab is in the upper left corner of the Dashboard Alerts title bar

e. If the number of alerts is below 99 the number displayed will decrease as each alert is clicked on

f. Alerts over 99 will display as **+99** and will remain at that number until there are 99 or less Alerts.

1. Click on the **Category** drop-down arrow to display a specific category *(i.e., alerts related only to Enrollment Status*)



2. Click on the category to be viewed.
3. Click the **+** in the description column to expand the alert and display the **Go** link.
4. Click on **Go** to go directly to the Individual's record. *The record will be opened in a new browser window.*

14.8.2.1 Refresh Alerts

Easily remove viewed and acted upon Alerts from the Dashboard and see newly added Alerts

1. Click on the **Refresh** button*. Acted on and viewed alerts will be removed from the list. Any new alerts will be added*.

14.8.3 Dashboard To Do List

The **To Do List** provides a snapshot of *Enrollment Status*, *SA (Service Authorization)*, *Assignments* and *ISP (Individual Support Plan).* Each has a graphic that provides a visual of pending and completed actions.

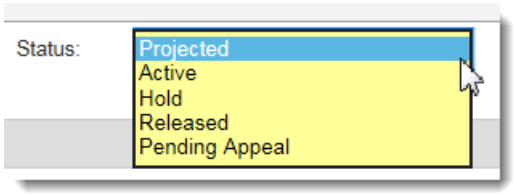
14.8.3.1 Enrollment Status

View the most recent *Enrollment Status* for assigned individual or those in the CSB by status.

1. Click on the **Enrollment** tab so it is the active tab (displays in white).
2. Click the **Show Me** down arrow to select:

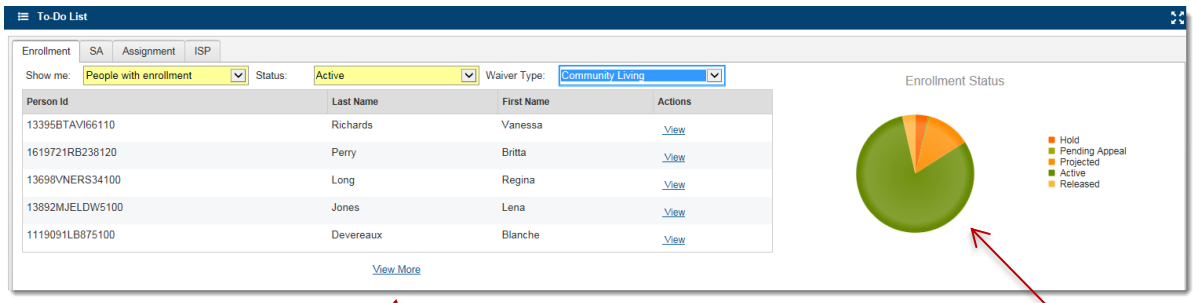
a. My people with enrollment: individuals assigned to the support coordinator
b. People **with Enrollment:** individuals in the CSB

3. Click the **Status** down arrow to select the appropriate status to display
   a. Projected
   b. Active
   c. Hold
   d. Released
   e. Pending Appeal



4. If necessary, click the **Waiver Type** down arrow to select the appropriate waiver to display
   a. Community Living
   b. Family and Individual Supports
   c. Building Independence

   Results automatically display as each selection is made.



5. Click on **View** to access the specific record in the Person's Details tab.

Note: To view the full *Enrollment Status* list for individuals click on the **View More** link. The **My List** tab opens in a new window.

Note: The pie chart is a visual representation of data based on the filter selections made. The pie chart changes based on the *Show Me*, *Status* and *Waiver type* selections. Hovering over pie chart displays the status and percentage representation of related data.

14.8.3.2 SA (Service Authorization)

View the most recent Service Authorizations by status.

1. Click on the **SA** tab so it is the active tab (displays in white).
2. Click the **Show Me** down arrow to select
   a. My Service Authorizations with error
   b. My Service Authorizations without error

c. All Service Authorizations with error
d. All Service Authorizations without error

3. Click the **Status** down arrow to select the appropriate status to display:
    a. Pending provider input
    b. Pending support coordinator review
    c. Pending PA staff review
    d. Pending VAMMIS approval
    e. VAMMIS approval complete
    f. Waiver slot released
    g. SA terminated
4. If necessary, click the **Waiver Type** down arrow to select the appropriate waiver to display
    a. Community Living
    b. Family and Individual Supports
    c. Building Independence

    Results automatically display as each selection is made.
5. Click on **View** to access the specific record in the Person's Details tab.

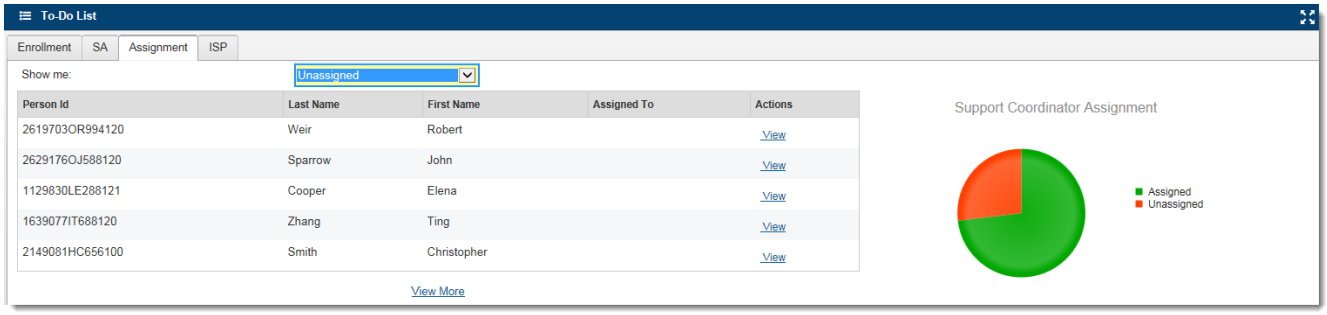
To view the full *SA* list for individuals click on the **View More** link. The *My List* tab opens in a new window.

14.8.3.3 Assignment

View recent assignments of individuals to the Support Coordinator or individuals in the CSB who have not yet been assigned to a Support Coordinator.

1. Click on the **Assignment** tab so it is the active tab (displays in white).
2. Click the **Show Me** down arrow to select
    a. Unassigned
    b. Assigned

    Results automatically display as each selection is made.
3. Click on **View** to access the specific record in the Person's Details tab.

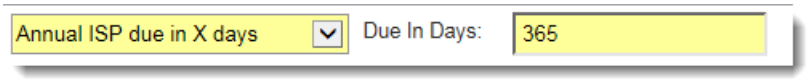


To view the full *Assignment* list for individuals click on the **View More** link. The *Assignments* tab opens in a new window.

14.8.3.4 ISP (Individual Support Plan)

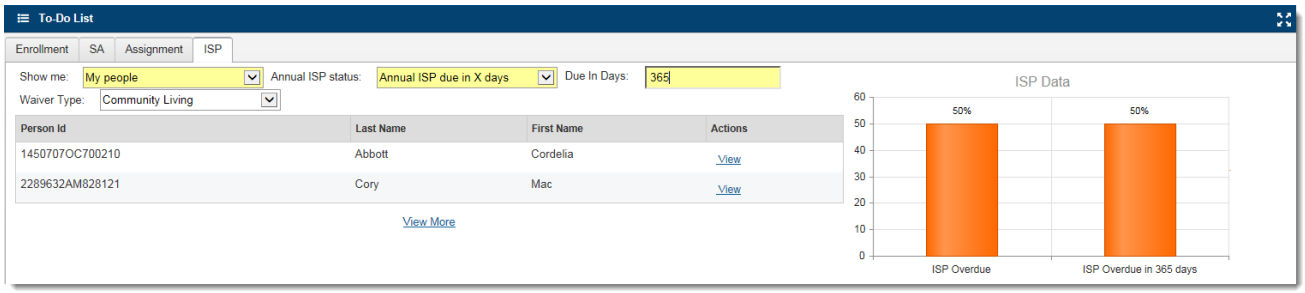
View the most recent ISP status based on selections in the *Show Me* and *Annual ISP* Status fields.

1. Click on the **ISP** tab so it is the active tab (displays in white).
2. Click the **Show Me** down arrow to select
    a. My people
    b. All people (in the CSB)
3. Click the **Status** down arrow to select the appropriate status to display:
    a. Annual ISP overdue
    b. Annual ISP due in X days
        - Add a number in the **Due in Days** field (i.e., 365 to see due in 1 year)



4. If necessary, click the **Waiver Type** down arrow to select the appropriate waiver to display
    a. Community Living
    b. Family and Individual Supports
    c. Building Independence

    Results automatically display as each selection is made.
5. Click on **View** to access the specific record in the Person's Details tab.



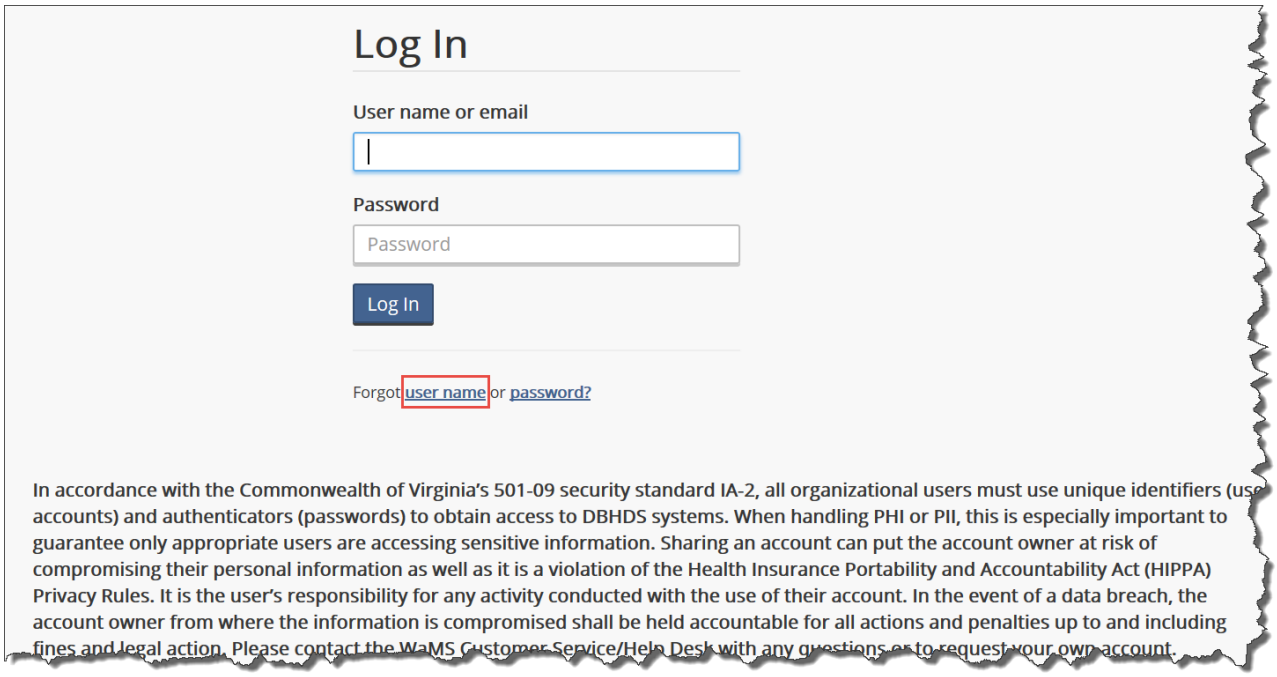
To view the full *ISP* list for individuals click on the **View More** link. The *My List* tab opens in a new window.

14.9 Forgot User Name or Password

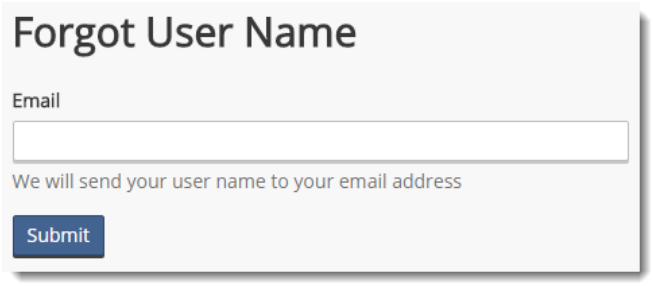
If the *User Name* has been forgotten, the system can send it to the email address that is associated with WaMS. If the *Password* has been forgotten, it can easily be reset by email.

14.9.1 Receive Forgotten User Name

1. At the WaMS **Log In** screen, click **user name**.



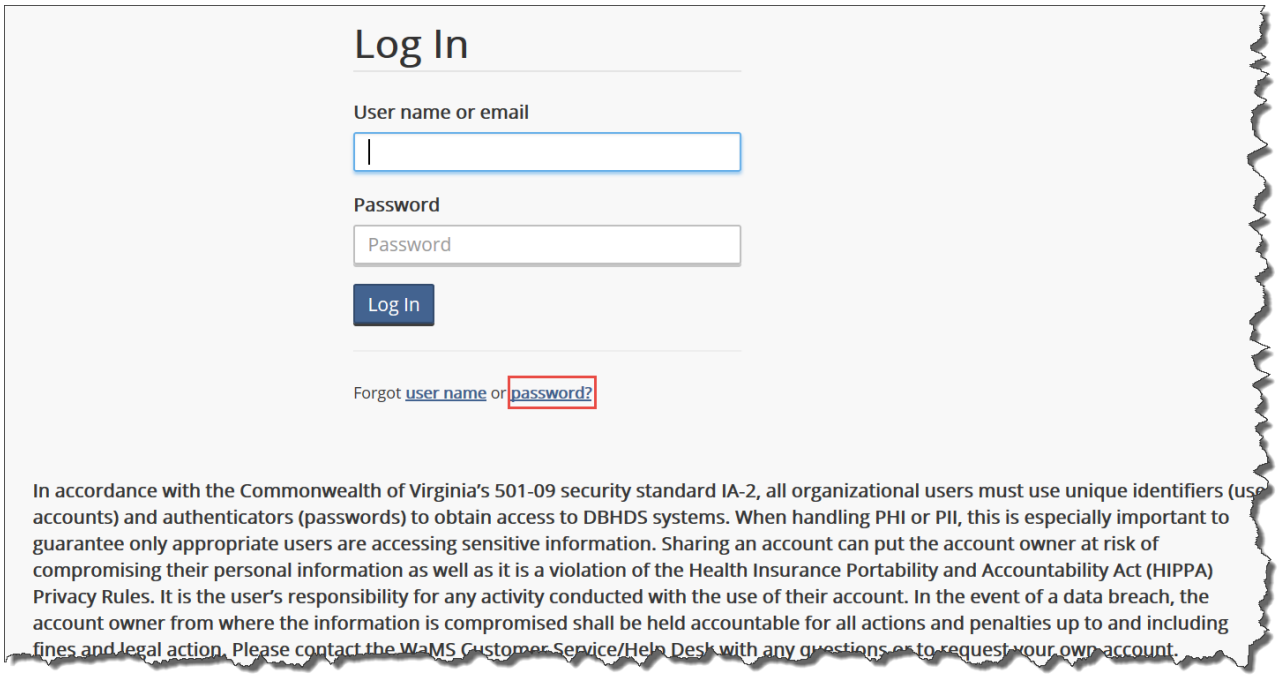
The Forgot User Name window opens.



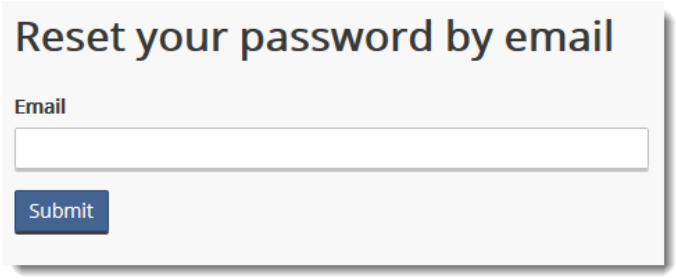
2. Enter the email address associated with the WaMS login.
3. Click on **Submit**.

14.9.2 Reset Password

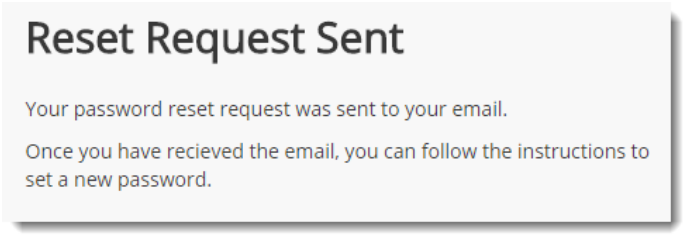
1. At the WaMS **Log In** screen, click **password?**.



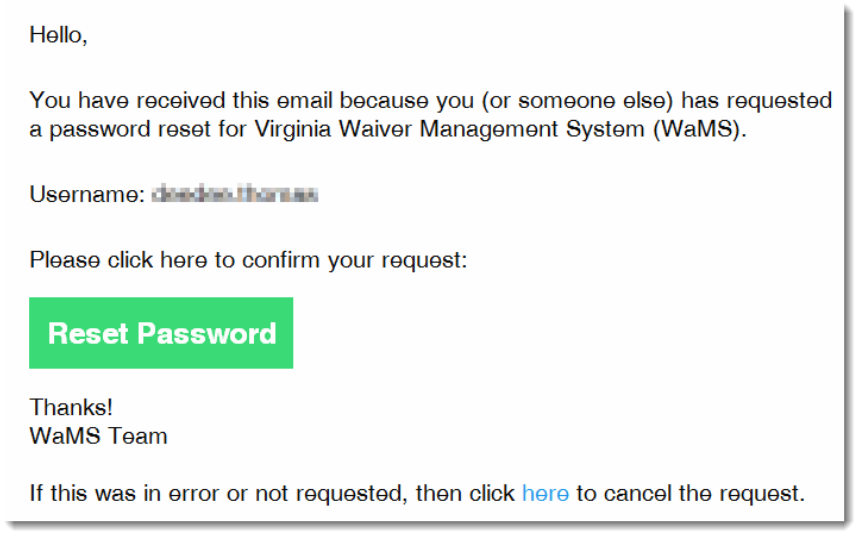
The Reset your password by email window opens.



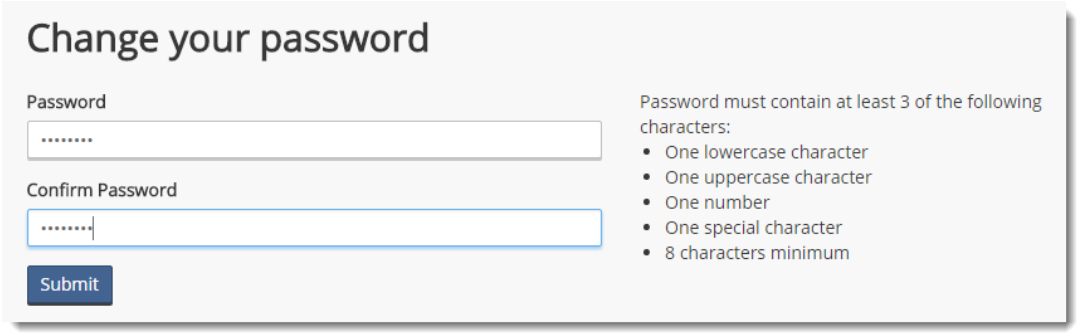
2. Enter the **email address** associated with the WaMS login.
3. Click on **Submit**. *The Reset Request Sent box appears.*



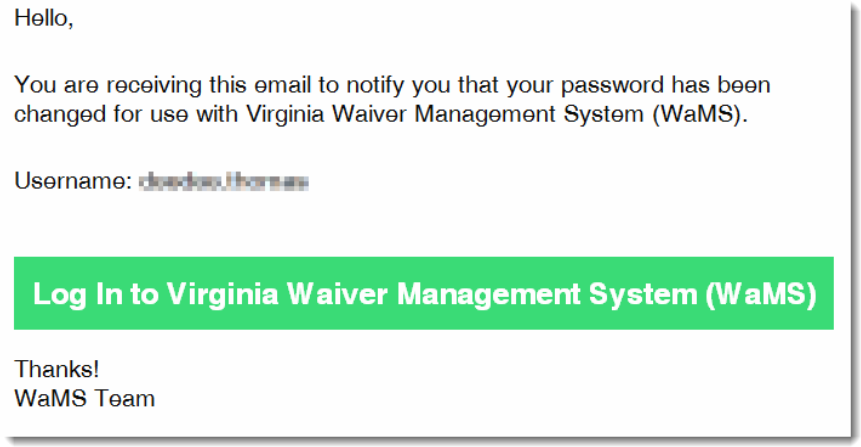
4. Click on the **Reset Password** link in the email to return to WaMS and create a new password.



5. In the *Change your password* window, type in a new **Password**, retype the new password in the **Confirm Password** field, and then click on **Submit**. (*note password parameters below*).

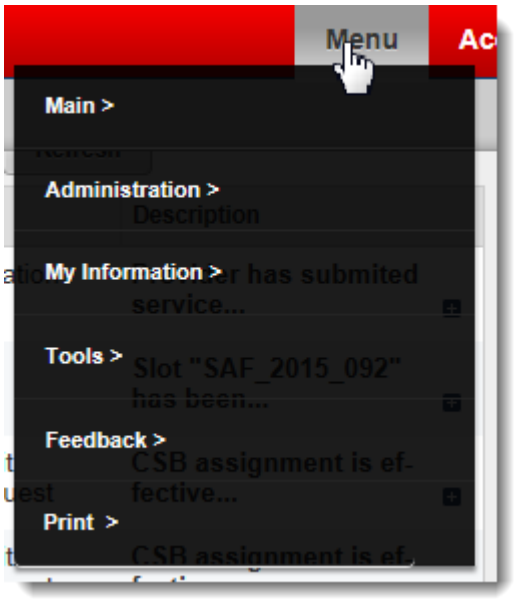


A confirmation email will be sent confirming that your password has been changed.



15 WaMS Menu Options

Menu options are available based on the organization and role of the user logged in.



15.1 Main

The **Main** submenu provides an alternative way to access the top-level navigation tabs.

To return to the WaMS *Home* page, click on **Main / Home**.

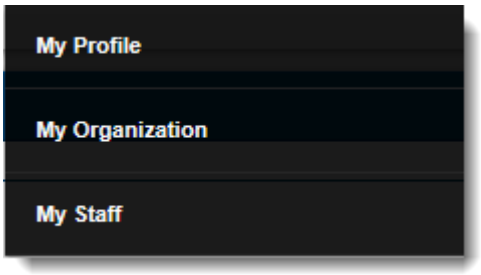
15.2 Administration / User Directory

Search for and obtain email and telephone information for other users of WaMS.

1. Click on **Menu**, **Administration**, **User Directory**. *The User Directory tab opens.*
2. Enter information into the **Organization Unit** and/or **Staff Name** fields.
3. Click on **Search**.

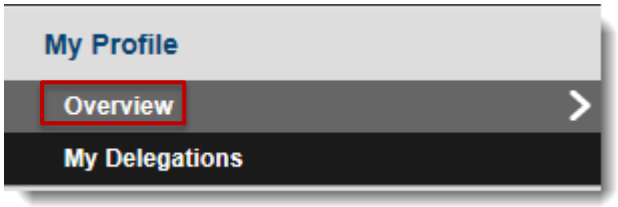
15.3 My Information

The **My Information** submenu includes *My Profile*, *My Organization* and *My Staff* options.



15.3.1 My Profile, Overview

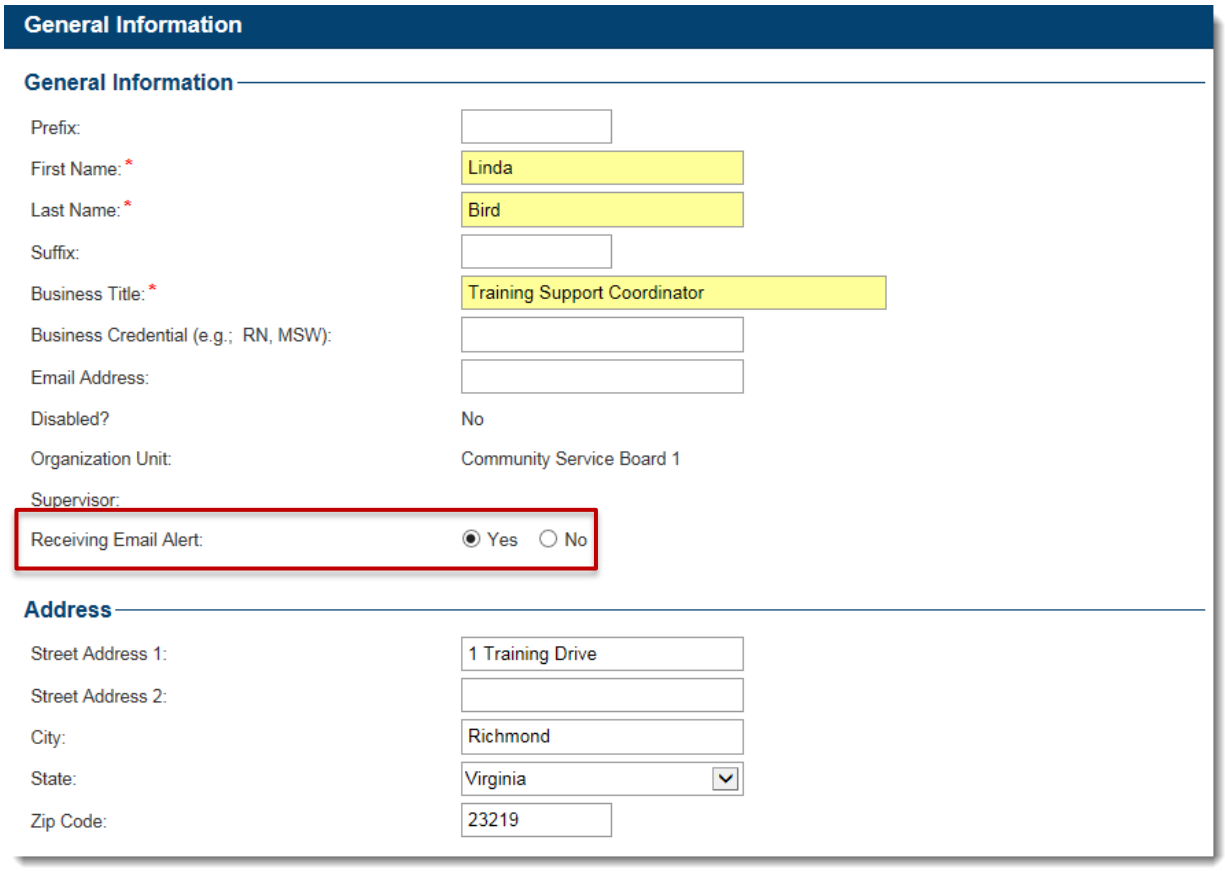
Use the **My Profile, Overview** submenu view and edit certain user and login information such as name, title, email address, phone number and address assigned to the account. This is also where to view the specific *Role (s)* assigned to the user account.



15.3.1.1 Receive Email Alerts

To receive emails when *Alerts* are received in addition to being notified in WaMS, edit the *General Information* under *My Profile*:

1. Click on **Menu**, **My Information, My Profile**. *The My Profile - Overview tab opens.*
2. Click on the *General Information* **Edit** button. *The My Profile — General Information window opens.*



3. Click on the **Yes** radio button for *Receiving Email Alert* to select it.
4. Click on **Save**.

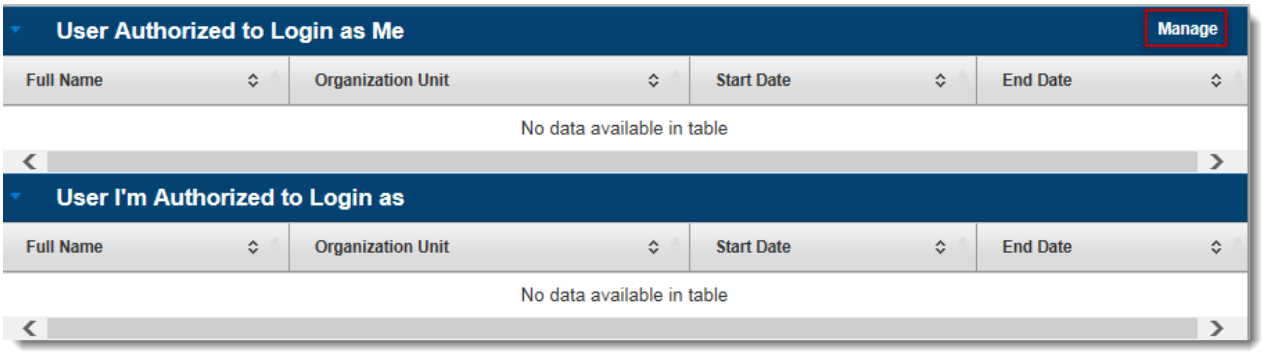
Each time an Alert is received, an email will also be sent to the email address listed in the My Profile section.

15.3.2 My Profile, My Delegations

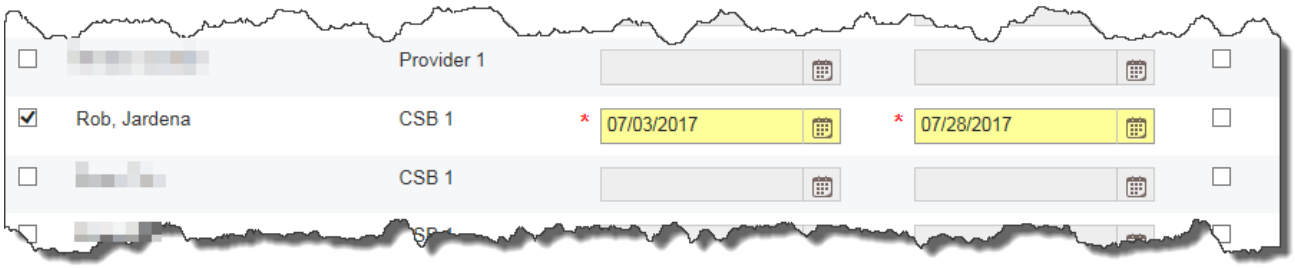
Use **My Profile, My Delegations** to set up delegate access to WaMS. This allows a person you designate to work in WaMS on your behalf. The delegate logs on as the user they are completing the authorization for.

15.3.2.1 Assign Delegate

1. Click on **Menu**, **My Information, My Profile**. *The My Profile - Overview tab opens.*
2. Click on **My Delegations.** *The My Profile — My Delegation window opens.*

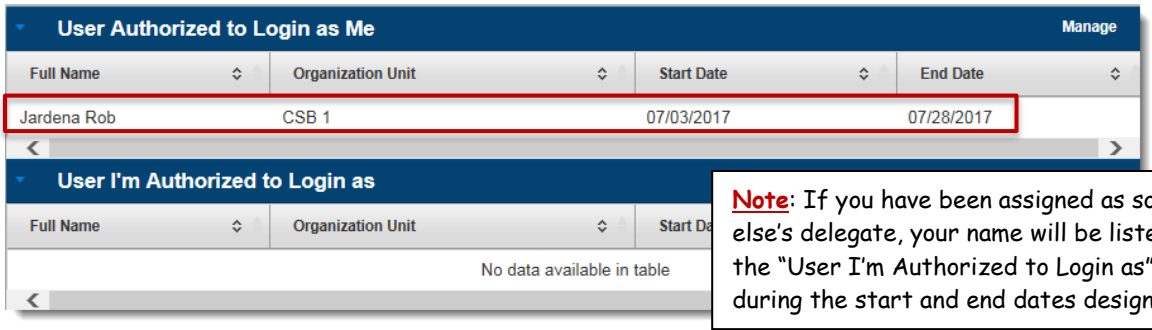


3. Click on **Manage**. *The My Delegation — User(s) Authorized to Login as Me window opens displaying all users in the Organization Unit.*
4. Click the **checkbox** next to each desired user(s) to be set as a delegate. *The start and end date fields become required.*
5. Enter the **Start Date** and **End Date** of the delegation.



6. Click on **Save**. *The delegate(s) name appears in the "User Authorized to Login as Me" section along with the start and end dates.*

Note: The delegate will no longer be able to login as that user after the end date. The End Date should be the day after the last day permission is needed.

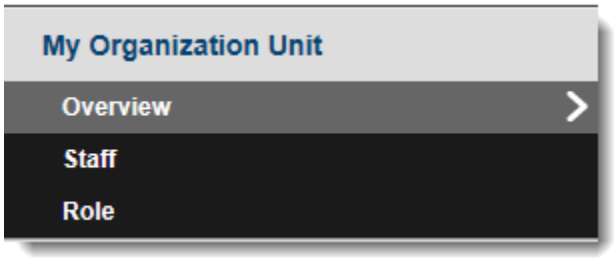


Note: If you have been assigned as someone else's delegate, your name will be listed under the "User I'm Authorized to Login as" section during the start and end dates designated..

15.3.2.2 Remove Delegate (Deactivate)

1. Click on **Manage** in the *My Delegation — User(s) Authorized to Login as Me* window.
2. Locate your delegate's name, then click the **checkbox** next to delegates name to remove the check. *The start date and end date will also be removed.*
3. Click on **Save**. *The delegate(s) name is removed from the "User Authorized to Login as Me" section along with the start and end dates and will no longer be able to login as your delegate.*

15.3.3 My Organization Unit



15.3.3.1 Overview

Use to see and edit certain attributes of the organization, including organization name, point of contact, address, Service Areas and Telephone numbers.

15.3.3.2 Staff

Use to search for existing staff and create new staff members. (See **Section 16 – Add New Staff Members**) for step-by-step instructions for adding new staff members.

15.3.3.3 Role

Use to view roles available to the organization and to see view and edit permissions allowed for a role.

15.3.4 My Staff

Opens the *Staff Search — Overview* window to allow for locating existing staff and creating new staff in the organization. (See **Section 16 – Add New Staff Members**) for step-by-step instructions for adding new staff members

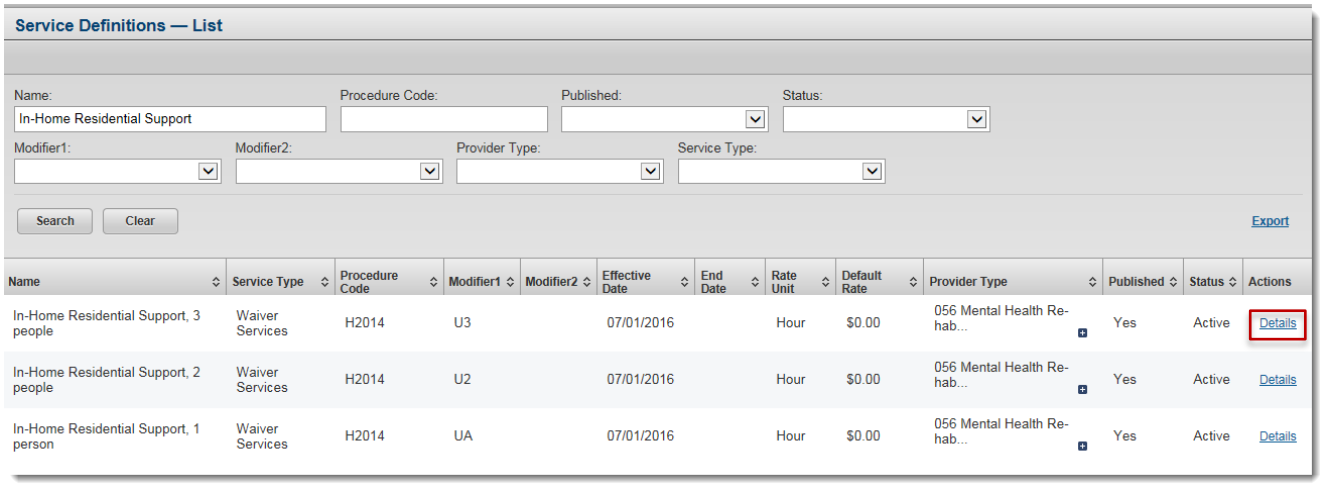
15.4 Tools

Use **Tools** to access **Service Definitions**. Service Definitions describe the parameters of all services.

15.4.1 Service Definitions

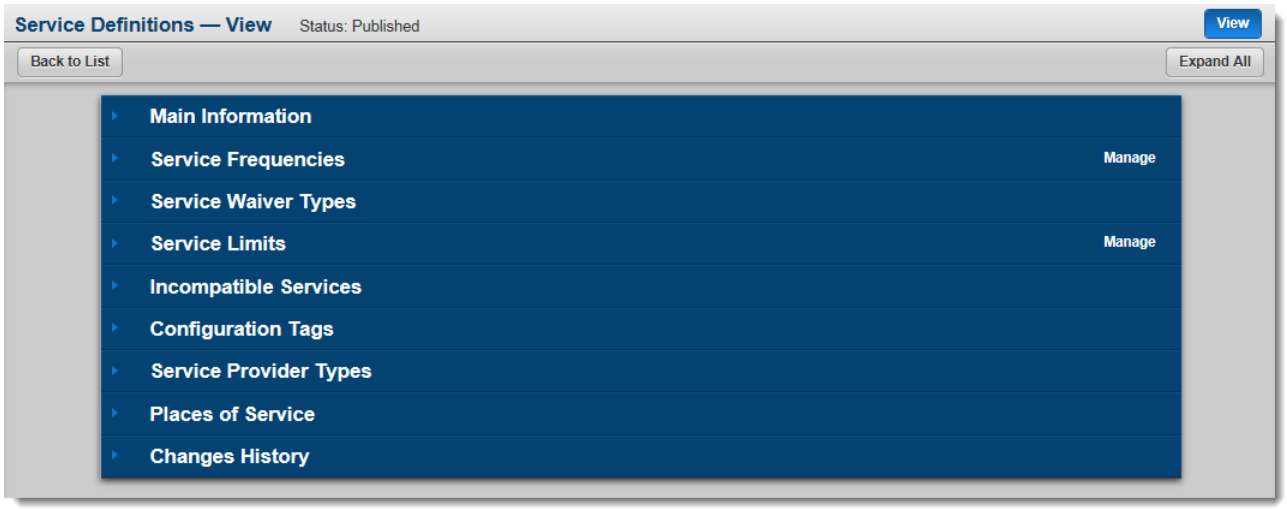
1. Click on **Menu, Tools, Service Definitions.** *The Service Definitions — List window appears.*
2. Type in the search criteria:
    - Name
    - Procedure Code
    - Published
    - Status
    - Modifier 1
    - Modifier 2
    - Provider Type
    - Service Type
3. Click on **Search**.

> Note: Click the **Clear** button to clear search fields and begin a new search.

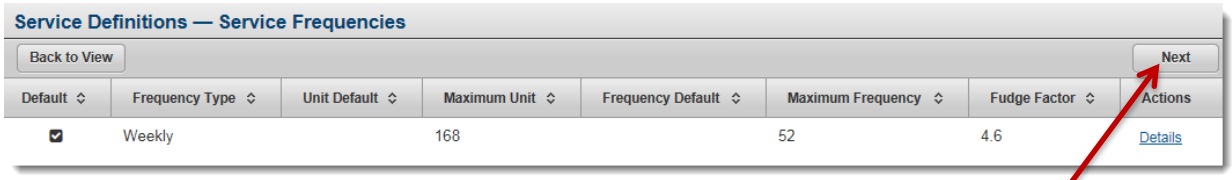


15.4.1.1 View Service Definition Details

1. Click **Details** under the *Actions* column. *The Service Definition – View window opens.*

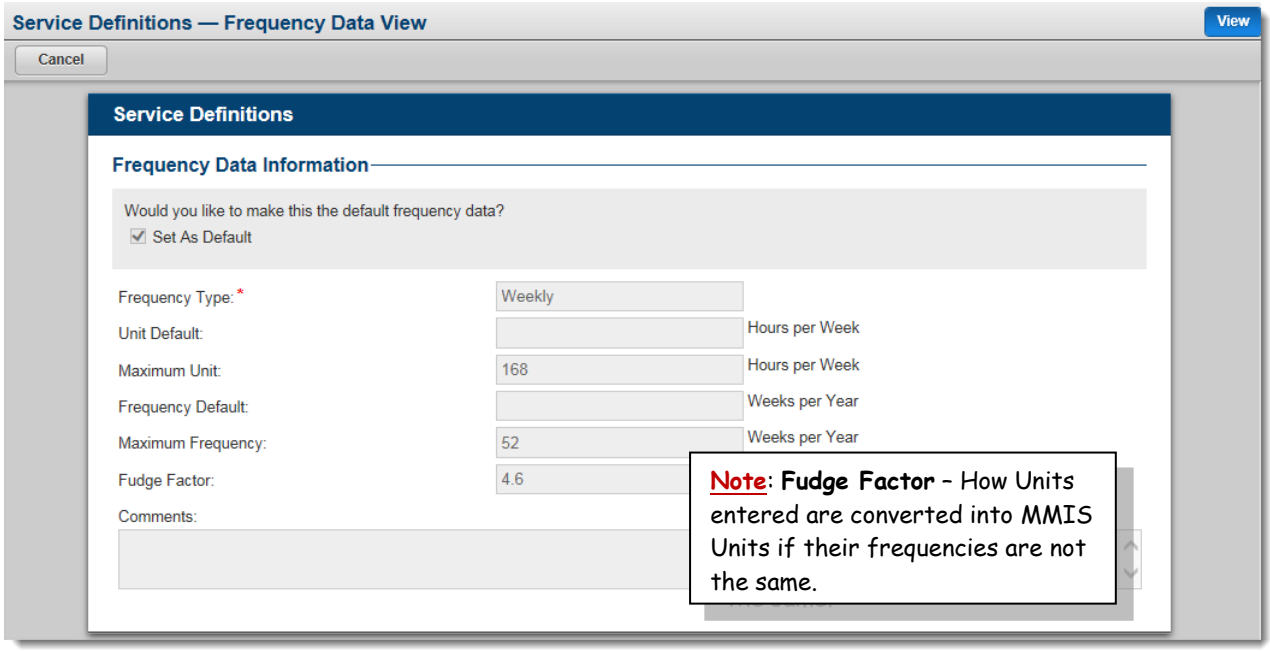


2. Click **Manage** for the category name to view additional details.



3. Click **Details** under the *Actions. The Service Definitions — Frequency Data View window opens with additional information.*

Note: The **Next** button is not active. The following message is received when the **Next** button is clicked: "**Error: Access denied. Reason: No permission. You're not authorized to access.**"

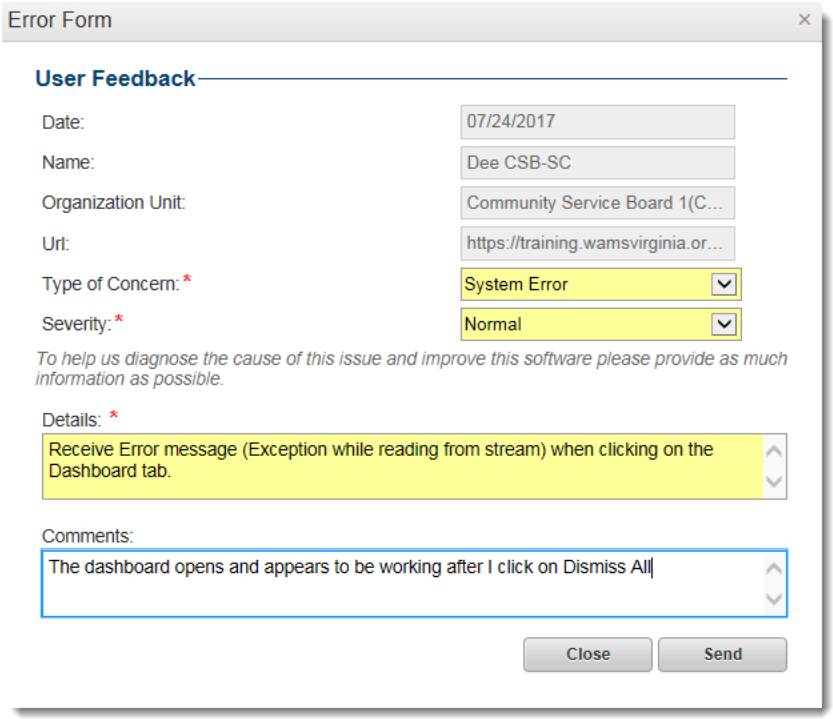


15.5 Feedback

Use the **Feedback** option to send feedback to the WaMS Help Desk. Create new feedback and send to the WaMS Help Desk or view a list previously submitted.

15.5.1 Submit Feedback to WaMS Helpdesk

1. Click on **Menu**, **Feedback**, **Create**. *The Error Form appears.*



2. Complete the required fields:
   - **Type of Concern**: System Error, Question/Comment, Unknown
   - **Severity**: Normal, Urgent
   - **Details**: Free form comments field to address the concern
3. Add additional comments if necessary in the **Comments** field.
4. Click on **Send**.

15.5.2 View List of Previously Submitted Feedback

1. Click on **Menu**, **Feedback**, **List**.

2. Click the **Status** drop down arrow to select submissions that are *Pending*, *In Progress* or *Resolved*.
3. If necessary, select the **Severity** (*Normal* or *Urgent*) and/or **Waiver Type** (*Community Living, Family and Individual Supports or Building Independence*) to narrow the search.
4. Click on **Search**. *The submitted List appears.*

   *To perform another search, click on **Clear** to remove the search results and repeat steps 2 – 4 above.*

15.5.2.1 Add a Note to the Submitted Feedback Form

1. From the *List* search results (*by performing Steps 1-4 in **Section 15.5.2** above*), click on **View** under *Actions*. *The Status window opens.*

2. Scroll to the bottom of the *Status* window to display the **Notes** section.

3. Click on **Add**. *The Error Note field appears.*
4. Add additional information for the error in the *Error Note* field.
5. Click on **Save**. Added information appears in the *Notes* field.

Note: Use the Notes field to add notes to the feedback or review notes added by the WaMS Help Desk.

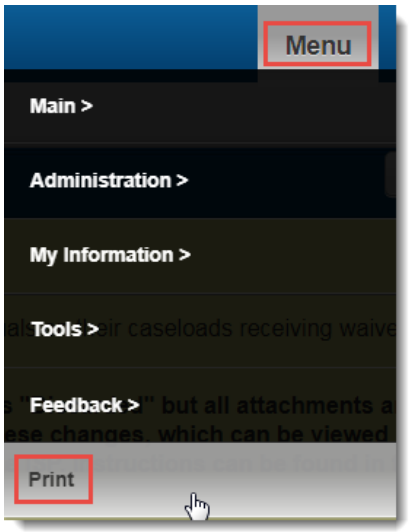
15.5.2.2 Export Submitted Feedback Form

1. Click **Export To CSV** to create an Excel file of the feedback list.

15.6 Print (Print the Screen)

When the **Print** option is selected, a PDF version of any page in WaMS is created for printing or saving (downloading).

1. From any WaMS page, click on **Menu**, **Print**. *A PDF version of the page opens in a new window.*
2. **Print** (*Control +P* or *click on the printer icon*) or **download** to save the PDF document.

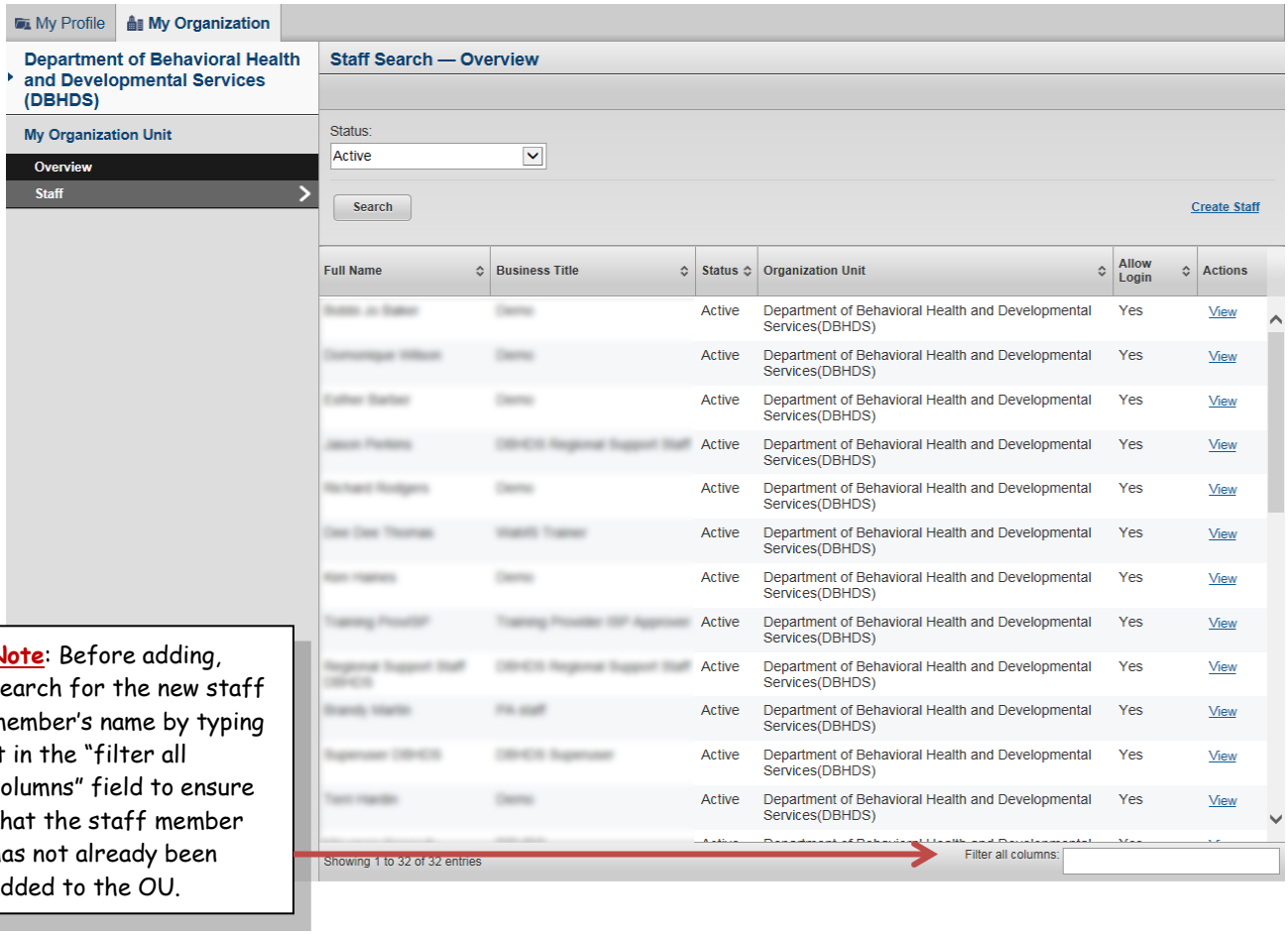


16 Add New Staff Members

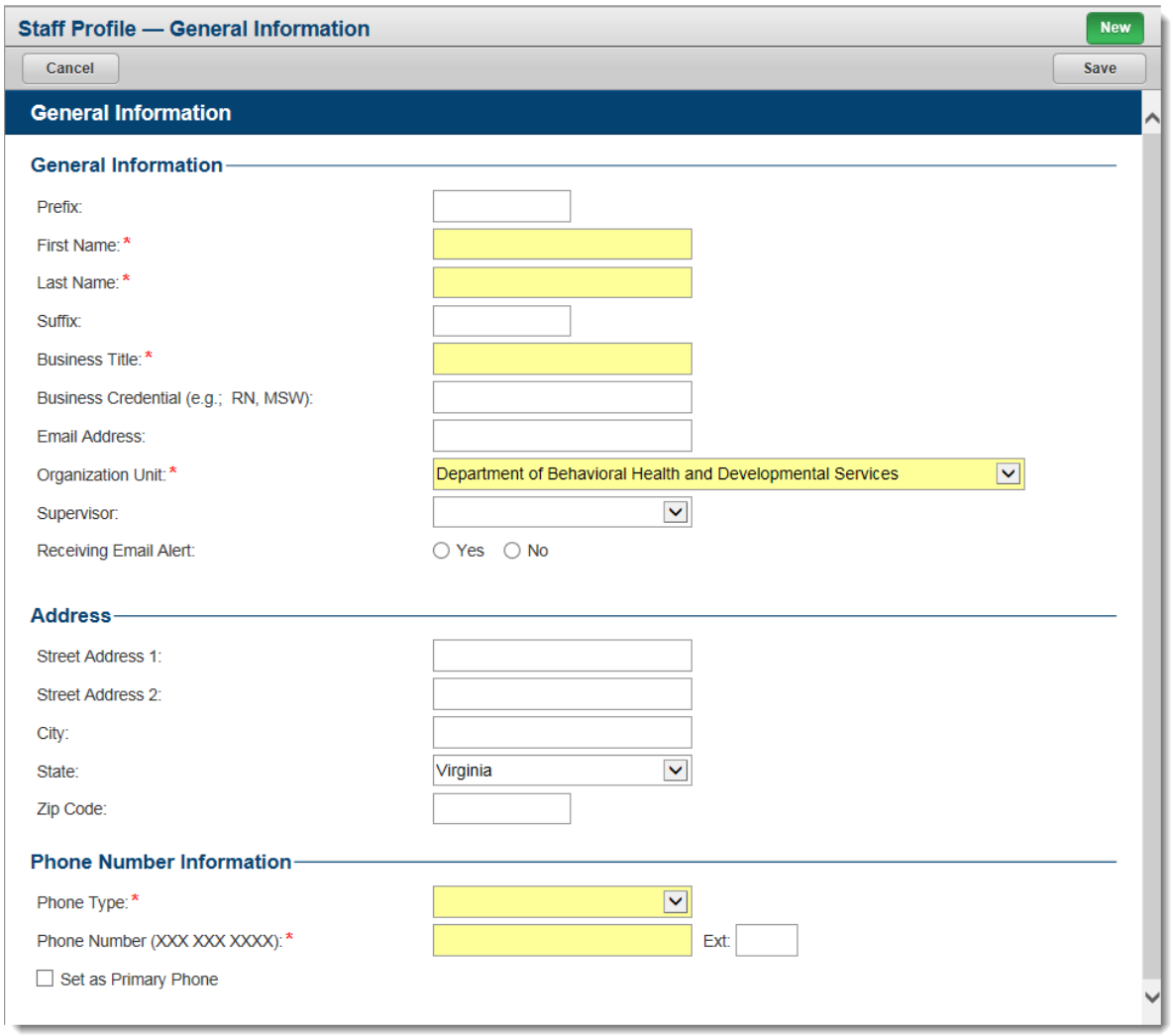
A new Staff Member profile should be created for each person who should access to WaMS. 1) Add the New Staff Member to WaMS; and 2) add the member's Role. Once the new member has been added, they will need to confirm and create a password in order to log in to WaMS.

16.1 Complete Staff Profile – General Information

1. Click on **Menu**, **My Information**, **My Staff**. *The Staff Search — Overview window appears on the My Organization tab:*



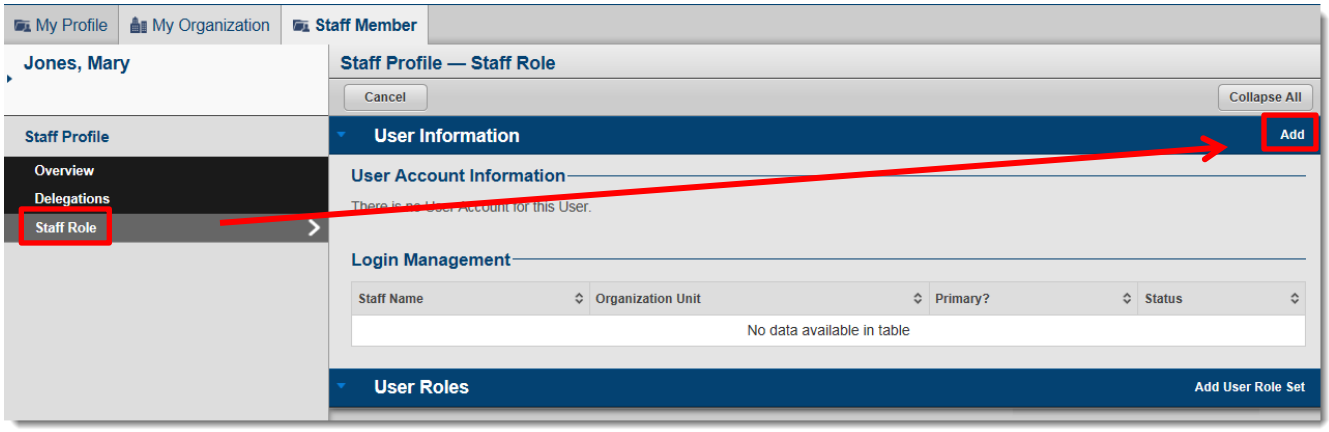
2. Click **Create Staff**. *The Staff Profile — General Information window appears.*
3. Complete the fields for the new staff member's *General Information*.
    a. **Required Fields**: (denoted by yellow field with red asterisk): First Name, Last Name, Business Title, Organization Unit, Phone Type and Phone Number.
    b. **Optional Fields**: Prefix, Suffix, Business Credential (e.g., RN, MSW), Email Address, Supervisor, Address, Phone Ext.



4. Click **Save**. *The New Staff Member has been added to the OU. You will receive a Success: Record has been created message.*

16.1.1 Add User Information

1. From the left navigation, click **Staff Role**. *The Staff Profile — Staff Role window appears.*

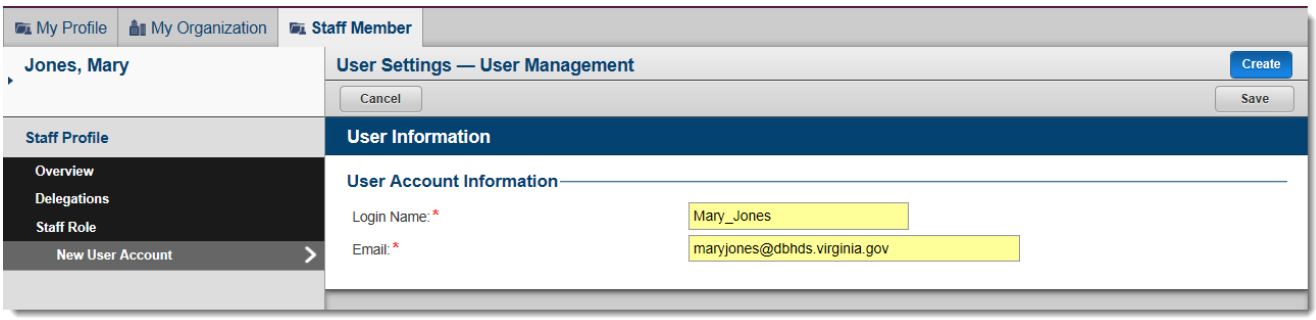


2. Click **Add**. *The User Settings — User Management window appears.*
3. Type in login information for the new staff member (login name and email address) in the appropriate fields.

*An email is sent to the new staff member at the email address provided letting them know that their account has been created. The new user must confirm their email address by clicking on **Confirm Account Creation**. They will then be provided with an opportunity to set their WaMS login password. Once the password has been set, the new user can log into WaMS.*

Note: The *New User Account* email address must be an accurate work email in order to receive the New Staff Log-on email.

Forwarding the link to a new staff member will not provide WaMS access.

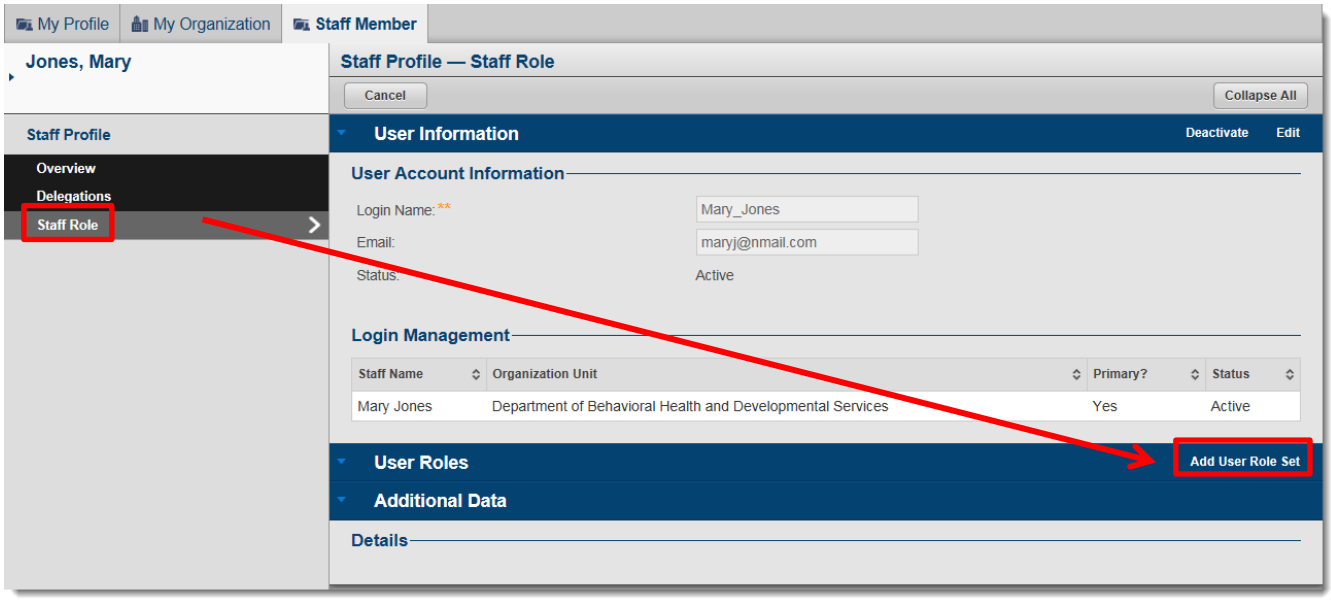


4. Click **Save**.

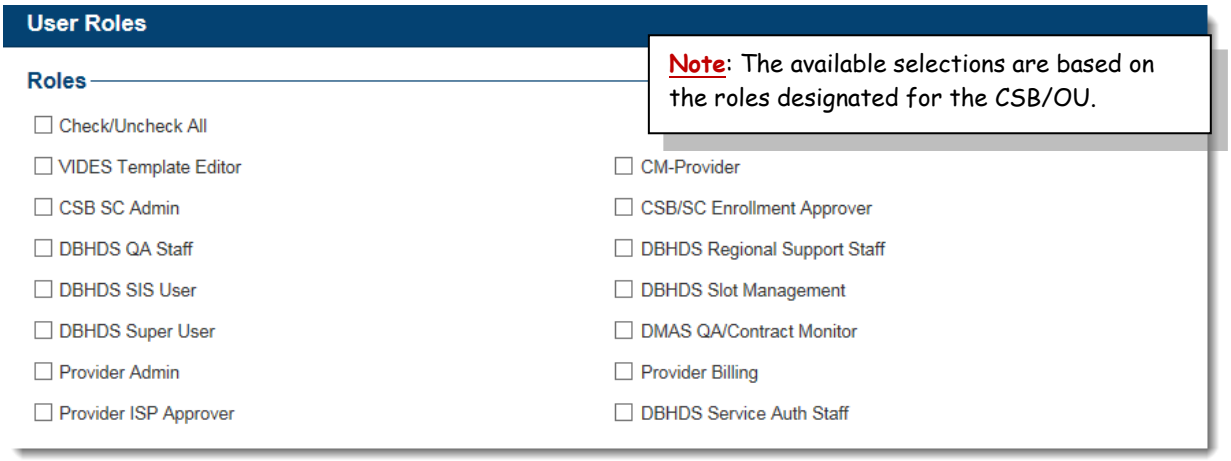
16.2 Add Role for New Staff Member

1. Make sure **Staff Role** is selected from the left navigation.

2. Click **Add User Role Set**. *The User Settings — User Roles window appears.*



3. Select the appropriate role(s) for the new staff member.



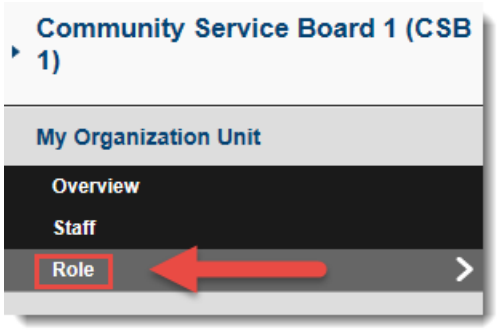
4. Click **Save**. *The New Staff Member's role has been added to the OU. You will receive a Success: Record has been created message.*

After a new staff member's account has been created, the new user must confirm their email address from their email account by clicking on *Confirm Account Creation*. They will receive an email to set their WaMS login password. After the password has been set, the new staff member will be able to log into WaMS.

Note: WaMS will send two emails: 1) the account has been verified; and 2) the password has been changed.

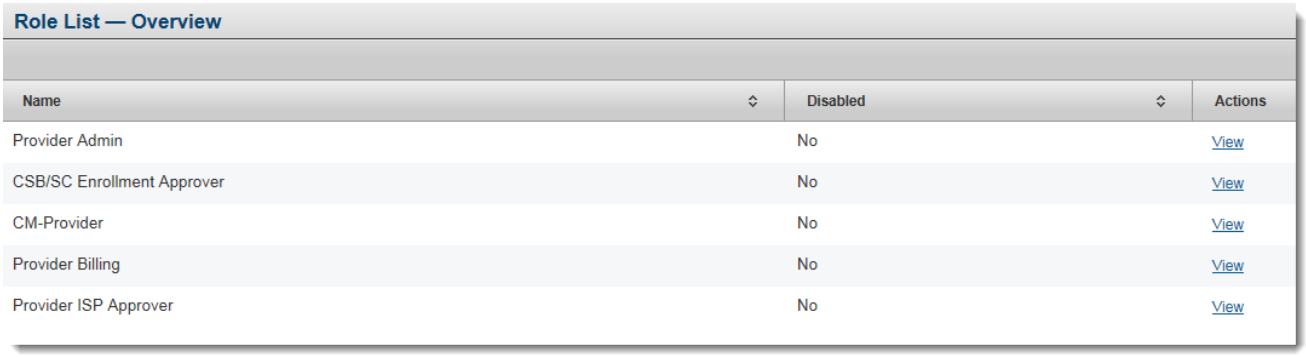
17 CSB Role Permissions

To see the list of roles and permissions available in WaMS for the organization:

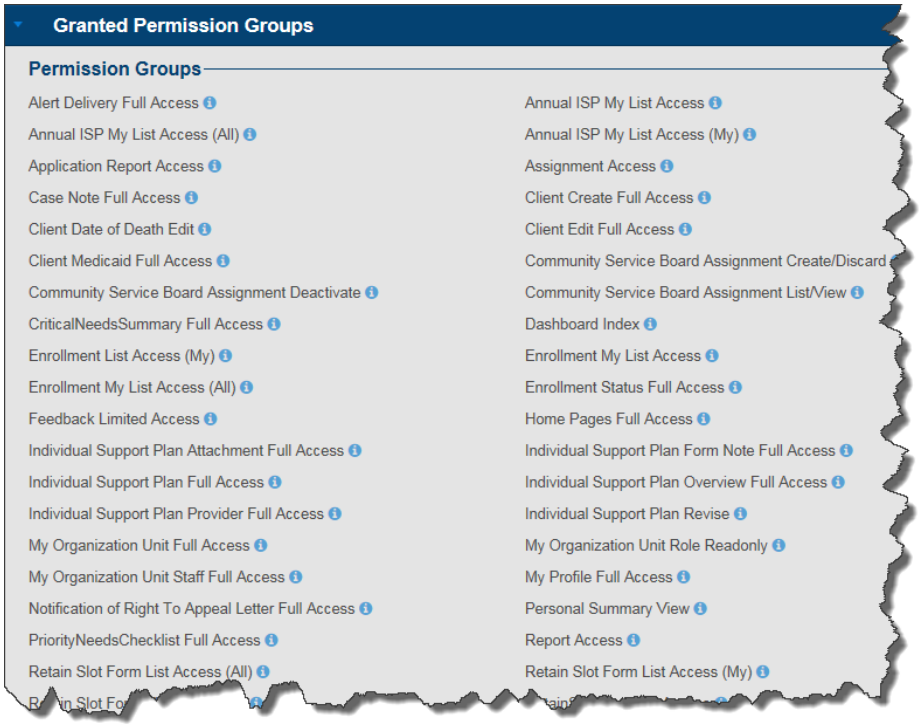


1. Click on **Menu**, **My Information**, **My Organization**.
2. Click on **Role.**

   The Role List — Overview window for the organization opens.



3. Click on **View** for a specific role. *The Role details appear displaying permissions available for that role.*



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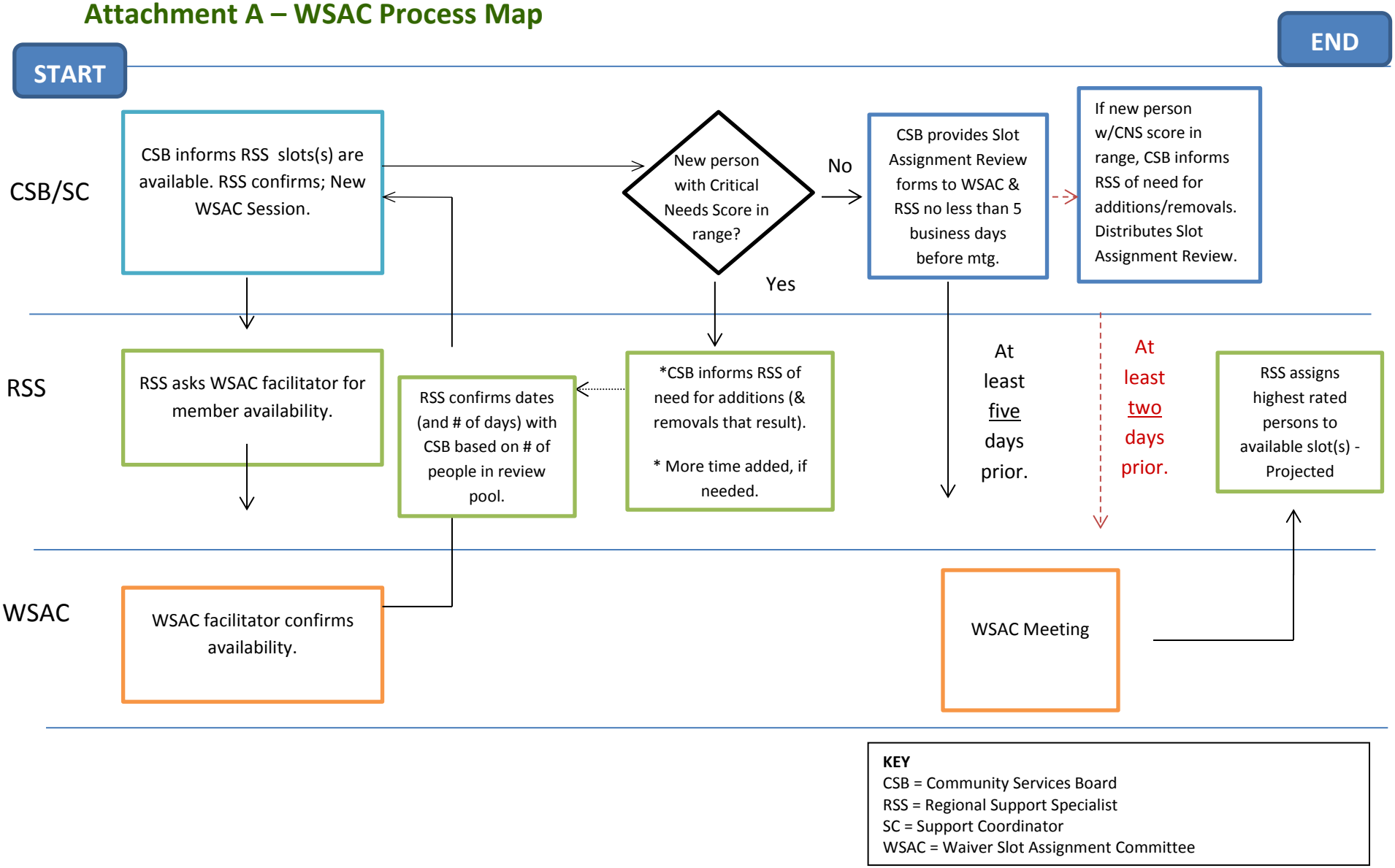
Attachment A – WSAC Process Map



KEY
CSB = Community Services Board
RSS = Regional Support Specialist
SC = Support Coordinator
WSAC = Waiver Slot Assignment Committee

DD Waivers: "When to Submit What"

Situation	WaMS/Service Authorization Actions Needed	Additional Actions Needed
Bold italics below indicate actions in WaMS.		
WAITING LIST		
Add individual to the DD Waivers' Wait List	***This process occurs in WaMS.*** • ***Please reference: Job Aid – CSB Detailed Workflow ++*** • ***Please reference: Job Aid – Priority Needs Checklist*** • ***If Priority 1, please reference Job Aid – Critical Needs Summary.*** • ***Please reference: Job Aid - Letters***	***Send Notice of Action Letter to individual/family when adding the person to the DD Waiver Wait List.*** ***If Priority 1, complete Slot Assignment Review Form in WaMS.*** • May use agency's electronic health record template if information is identical to WaMS.
Changing Priority Status on Wait List	***This process occurs in WaMS.*** • ***Please reference: Job Aid – Priority Needs Checklist*** • ***Please reference: Job Aid – Letters***	***Complete Critical Needs Summary as required in WaMS (if Priority 1).*** ***Send Notice of Action Letter to individual/family when moving the person from:*** • Priority 1 to Priority 2 or 3 • Priority 2 to Priority 3 .
Removing individual from Wait List	***This process occurs in WaMS.*** • ***Please reference: Job Aid – Letters***	***Send Notice of Action Letter to individual/family. Remove the person from the wait list <u>following</u> expiration of appeal rights.***
*++All Job Aids may be located on WaMS Home Page → **Training Manuals, Webinars, and FAQs***		
ENROLLMENT		
Individual has been placed in projected enrollment status by DBHDS.	***Change the individual's enrollment status from "Projected" to "Active."*** • Level of Care (LOC) statement is automatically inserted in notes section when status is changed.	***Print the enrollment screen containing the LOC eligibility statement and submit to local DSS along with the DMAS-225.*** ***Send Notice of Action Letter to individual/family for waiver enrollment.*** • DMAS-225 may be located at: www.dmas.virginia.gov.
Services not initiated within 30 days of active enrollment.	***Complete Retain Slot Request in WaMS and submit to the appropriate Regional Support Staff.*** • DBHDS may approve initial retain slot request and up to four extensions for a total of no more than 150 days.	***Send Notice of Action Letter to individual/family if DBHDS staff denies request to retain slot.***

Service Authorization – Requires a SAR (Service Authorization Request) to be submitted in Virginia WaMS (Waiver Management System). Each DD waiver service has specific requirements/supporting documentation (attached in the ISP section of WaMS) which must be included with the SAR in order to justify the request. ++		
Initial request for authorization of Waiver services for individual newly enrolled.	• ***Date of VIDES must be no more than 6 months prior to active waiver enrollment.*** • ***The date and results of current Physical Evaluation and Psychological Evaluation or Developmental Evaluation in ISP overview section of WaMS.*** • ***Submit SAR(s) in WaMS for individual services to include a concise narrative of the individual and their assessed need for the service.***	
Request for continued service authorization.	• ***Submit SAR(s) in WaMS - ADD requests to the existing SA instead of "creating new." It is helpful if all of the authorizations are on the same SA record for the same NPI number instead of creating new SAs (there are 18 lines for dates of service on each SA record).*** • ***Concise description of the individual's assessed need for the service.***	
Request for new service authorization.	• ***Submit SAR(s) in WaMS - ADD requests to an existing SA instead of "creating new." It is helpful if all of the authorizations are on the same SA record for the same NPI number instead of creating new SAs (there are 18 lines on each SA record).*** • ***Concise description of the individual's assessed need for the service.***	
Decreasing/increasing a service or ending a service.	• ***Ending SAR with explanation documented in comments or notes.*** • ***Decreasing/increasing – select revise on the service authorization detail line on the SAR record in WaMS and adjust the end and start dates relative to the start date of the requested decrease/increase.*** • ***Concise description of the individual's assessed need for the service.***	***Send Notice of Action Letter to individual/family for decreasing or ending a service.***
Changing the provider of a service without a decrease in services.	• ***End current provider in WaMS with explanation in comments or notes.*** • ***Submit new provider's SAR.***	

++ WaMS reflects the status of the SA request in the review process ("Pending Provider Input," "Pending Support Coordinator Review," "Pending PA Staff Review," "Pending VAMMIS Approval," and "VAMMIS Approval Complete.")

++Service Authorization Consultants have ten business days (from date of submission) to take action on all requests in WaMS.

INTERRUPTION / EXTENSION / RESTART OF SERVICES		
Individual does not receive any DD Waiver services for 30 consecutive days.	***Change enrollment status from "Active" to "Hold."*** ***Complete Retain Slot Request in WaMS and submit to the appropriate Regional Support Staff.*** • ***Resubmit Retain Slot Request in WaMS every 30 days until services are re-initiated.***	Submit DMAS-225 with date and reason for interruption noted to local DSS.
Temporary loss of Medicaid eligibility	***Change enrollment status from "Active to Hold".*** ***Complete Retain Slot Request in WaMS and submit to the appropriate Regional Support Staff.*** • ***Resubmit Retain Slot Request every 30 days until eligibility is re-established.***	Notify all providers.
Temporary stay in ICF-IID, Nursing Facility, or Rehab Hospital.	***Change enrollment status from "Active to Hold".*** ***Complete Retain Slot Request in WaMS and submit to the appropriate Regional Support Staff.*** • ***Resubmit Retain Slot Request every 30 days until individual is discharged.***	Submit DMAS-225 with date and status noted to local DSS.
Restart services following interruption	***Change enrollment status from "Hold" to "Active."***	Submit DMAS-225 with date and status noted to local DSS.
DISCHARGE FROM WAIVER		
Termination of **all** DD Waiver services (except for **'Deceased'**)	***Change enrollment status from "Active/Hold" to "Terminated."*** • ***Please reference: Job Aid – Letters*** • ***Please remember to select the correct reason for termination.*** ***Following the expiration of appeal rights, change enrollment status from "Terminated" to "Released."***	***Send Notice of Action Letter to individual/family when terminating waiver services.*** • Send DMAS-225 with date and discharge reason noted to local DSS.

Termination of **all** DD Waiver services for a ***deceased*** individual.	• ***Send Notice of Action Letter to individual/family.*** • ***Do not change the person's enrollment status in WaMS until the 30 day appeal period has expired.*** • ***Upon expiration of appeal rights, change enrollment status in WaMS from "Active/Hold to Terminated."*** • ***Select termination reason "Deceased". This immediately releases the slot in WaMS.***	***Send Notice of Action Letter to individual/family when all waiver services are being terminated.*** • Send DMAS-225 with date and discharge reason noted to local DSS.
TRANSFER OF SUPPORT COORDINATION		
Transfer of support coordination for an individual in DD Waiver/on DD Waiver waitlist.	***CSB of origin assigns individual to the receiving CSB.*** • ***Please reference: WaMS Case Management Navigation Manual (Page 30)*** • ***Please reference: VA Support Coordination/Case Management Transfer Procedures for Persons with a Developmental Disability***	Each CSB submits DMAS-225 to local DSS with address and SC/CM change noted. CSB of origin reassigns SIS Assessment(s) to receiving CSB via SIS Online.

SERVICE AUTHORIZATION GUIDANCE

Each DD waiver service has specific requirements which must be included with the Service Authorization (SA) request in order to justify the request. Specific minimum SUPPORTING DOCUMENTATION FOR SA, per service, includes but is not limited to:

WAIVERS – BUILDING INDEPENDENCE (BI), FAMILY & INDIVIDUAL SUPPORTS (FIS) & COMMUNITY LIVING (CL)			
SERVICES	**WAIVER**	**MINIMUM DOCUMENTATION**	**WHAT YOU SHOULD KNOW, BUT NOT REQUIRED DOCUMENTATION FOR SUBMISSION**
Assistive Technology (AT)	BI, FIS, CL	• Requests for AT must include in the ISP a description of the individual and (1) the individual's need for equipment for remedial or direct medical benefit in the individual's primary home, primary vehicle, community activity setting, or day program to specifically improve the individual's personal functioning; and (2) the items being requested to include (a) specialized medical equipment, ancillary equipment, and supplies necessary for life support; (b) durable or nondurable medical equipment and supplies that are not otherwise available through the State Plan for Medical Assistance; (c) adaptive devices, appliances, and controls which enable an individual to be independent in areas of personal care and ADLs; and (d) equipment and devices which enable an individual to communicate more effectively. • Documentation within the current ISP of at least one other waiver service. • Documentation that the item(s) is not covered in the State Plan for Medical Assistance under Durable Medical Equipment. • Documentation that the AT has been recommended and determined appropriate by an independent professional consultant.	• A DME denial letter may be requested. • Maximum expenditure is $5,000.00 per calendar year. • The AT independent professional consultant shall not be the AT provider, and the AT provider shall not be the individual's parent or spouse. • Item(s) must be cost effective, not for purposes of convenience of the caregiver or restraint of the individual and no additional provider mark-ups shall be permitted.

		• Request must include an itemized invoice/ estimate from the chosen provider/vendor. • Drawings, images or pictures of the requested AT item(s) are recommended and/or may be requested by SA Consultant.	
Center Based Crisis Support Services	BI, FIS, CL	• Clear documentation of at least one of following: history of psychiatric hospitalization(s), incarceration, or terminated residential/day placement, behavior(s) has significantly jeopardized placement. • Specific documentation of at least one of following: current reduction in psychiatric, adaptive or behavioral functioning, current increase in emotional distress, present need for ongoing intervention in order to maintain stability, currently causing harm to self or others. • Documentation of current risk of psychiatric hospitalization or risk of emergency ICF/IID placement or immediate risk of loss of community service or currently causing harm to self or others. • Documentation of the date of the face-to-face assessment by a QDDP to determine need for service. • Number of days service is being requested. • Requests for Center-based Crisis Support services must delineate in the ISP which of the following allowable activities will be provided: (i) face-to-face assessments and stabilization techniques by professionals; (ii) medication management and monitoring; (iii) behavior assessment and positive behavior support; (iv) intensive care coordination with other agencies or providers to maintain the individual's community placement; (v) training family members/caregivers and service providers in positive behavior supports; (vi) skill building related to the behavior creating the crisis such as self-care/ADLs, independent living skills, self-	• Center based crisis support providers shall be licensed by DBHDS as providers of group home residential services and either emergency services or residential crisis stabilization services. • Center based crisis supports shall be provided by a Licensed Mental Health Professional (LMHP), LMHP-supervisee, LMHP-resident LMHP-RP, certified pre-screener, QDDP, or DSP under the supervision of one of the professionals listed above. • Center based crisis supports shall be limited to six months per ISP year and shall be authorized in increments of up to a maximum of 30 days with each authorization. • Requests may be for planned admissions for individuals who need temporary, therapeutic interventions outside of their home setting to maintain stability or emergency admissions for individuals who are experiencing an identified behavioral health need or behavior challenge that is preventing them from reaching stability within their home settings. • Service authorization requests may be submitted up to 72 hours after assessment/reassessment by a QDDP. • Center based crisis supports shall not be provided or billed concurrently during the provision group home, sponsored residential, supported living, agency directed or consumer directed services.

		esteem, appropriate self-expression, coping skills, and medication compliance; and (vii) supervising the individual in crisis to ensure his safety and that of other persons in the environment.	
Community Based Crisis Support Services	BI, FIS, CL	• Clear documentation of at least one of following: history of psychiatric hospitalization(s), incarceration, or terminated residential/day placement, behavior(s) has significantly jeopardized placement. • Specific documentation that the individual is experiencing at least one of following: marked reduction in psychiatric, adaptive or behavioral functioning, current increase in extreme emotional distress, a present need for ongoing intervention in order to maintain stability, or currently causing harm to self or others. • Documentation of the date of the face-to-face assessment by a QDDP to determine need for service. • Documentation of current risk of psychiatric hospitalization or risk of emergency ICF/IID placement or immediate risk of loss of community service or currently causing harm to self or others. • ISP must include the support activities to be provided using (i) coaching; (ii) teaching; (iii) modeling; (iv) role-playing; (v) problem solving; or (vi) direct assistance. • Requests for Community-based Crisis Support services must delineate in the ISP which of the following allowable activities will be provided: (i) psychiatric, neuropsychiatric psychological, and behavioral assessments and stabilization techniques; (ii) medication management and monitoring; (iii) behavior assessment and positive behavior support; (iv) intensive care coordination with agencies or providers to maintain the individual's community placement; (v)	• Community based crisis support providers shall be licensed by DBHDS as providers of emergency services outpatient crisis stabilization services, residential crisis stabilization services or non-residential crisis stabilization services. • Community based crisis support services shall be provided by an LMHP. LMHP-supervisee, LMHP-resident, LMNHP-RO, a certified pre-screener, or QDDP. • Community based crisis support is an hourly service unit and may be authorized for up to 24 hours per day if necessary in increments of no more than 15 days at a time. • The annual authorization limit is 1080. • Request for additional community based crisis support services in excess of the 1080 hour annual limit will be considered if justification of medical necessity is provided. • Service authorization requests may be submitted up to 72 hours after assessment/reassessment by a QDDP.

		family/caregiver training in positive behavioral supports to maintain the individual in the community; (vi) skill building related to the behavior creating the crisis such as self-care/ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance; and (vii) supervision to ensure the individual's safety and the safety of others in the environment. • Documentation of location of the community-based crisis supports (either the individual's home or in community settings or both). • Documentation of the date of the face-to-face assessment by a QDDP to determine the need for service. • Number of hours the service is being requested.	
Community Coaching (CC)	BI, FIS, CL	• Requests for Community Coaching must delineate in the ISP (1) that the individual requires one-to-one support to address identified barriers that prevent him/her from participating in community engagement services, including identification of those barrier(s) to participation in community engagement services; (2) the planned supports, which may include a) one-on-one skill-building and coaching to facilitate participation in community activities and opportunities such as (i) activities and public events in the community; (ii) community education, activities, and events; and (iii) use of public transportation; b) skill building and support in positive behavior, relationship building, and social skills; c) support with the individual's self-management, eating, and personal care needs in the community; (3) a schedule of daily and weekly supports.	• The unit of service is an hour. • Community coaching providers must be licensed by DBHDS as a provider of non-center based day support services.

		• Documentation that the included activities shall be sensitive to the individual's age, abilities and personal preferences. • Documentation that the service will be delivered 1:1. • Documentation shall include a weekly schedule with no more than 66 hour per week combining all other employment and day options,	
Community Engagement (CE)	BI, FIS, CL	• Requests for Community Engagement must delineate in the ISP (1) the need for ; (2) which of the following allowable activities will be provided: a) skill building, education, supports and monitoring that assist the individual with acquisition and retention of skills in the following areas: (i) activities and public events in the community; (ii) community educational activities and events; (iii) interests and activities that encourage therapeutic use of leisure time; (iv) volunteer experiences; and (vi) maintaining contact with family and friends; (b) Skill building and education in self-direction to enable the individual to achieve one or more of the following outcomes particularly through community collaborations and social connections developed by the provider (e.g., partnerships with community entities such as senior centers, arts councils, etc.): (i) development of self-advocacy skills; (ii) exercise of civil rights; (iii) acquisition of skills that promote the ability to exercise self-control and responsibility over services and supports received or needed; (iv) acquisition of skills that enable the individual to become more independent, integrated, or productive in the community; (v) development of communication skills and abilities; (vi) furthering spiritual practices; (vii) participation in cultural activities; (viii) developing skills that enhance	• The unit of service is an hour. • Community engagement providers must be licensed by DBHDS as a provider of non-center based day support services. • Community Engagement activities should enhance the individual's involvement with the community and facilitate the development of natural supports. This service is to be provided in the least restrictive and most integrated settings possible.

		career planning goals in the community; (ix) development of living skills; (x) promotion of health and wellness; (xi) development of orientation to the community, mobility, and the ability to achieve the desired destination; (xii) access to and utilization of public transportation; or (xiii) interaction with volunteers from the community in program activities; (3) a schedule of daily and weekly supports. • Documentation that, if Community Engagement includes planning community activities with the individual, this is limited to no more than 10% of the total number of authorized hours per month. • Documentation of the specific setting of the service delivery to confirm that the service is conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). • Documentation of the staff/individual ratio, as the ratio shall be no more than 1:3. • Documentation shall include a weekly schedule with no more than 66 hour per week combining all other employment and day options.	
Companion Services (Agency Directed - AD & Consumer Directed - CD)	FIS, CL	• Requests for Companion services must delineate in the ISP (1) the individual's need for nonmedical care, socialization, or general support (2) the planned activities, which may include (a) assistance with IADLs including meal preparation, laundry, and shopping, (b) light housekeeping, (c) community access and activities, (d) general supports and (e) safety supports; and (3) a schedule of daily and weekly supports. • Documentation identifying the Employer of Record (EOR) for an individual who is unable to	• The unit of service is an hour. • No regularly scheduled hands-on care or Activities of Daily Living (ADLs). • No skill building or nursing activities. • Companion Services can be used in conjunction with residential support services. • May not be provided during the same billable hours as Personal Assistance services or Respite (Consumer and/or Agency-Directed). • The Consumer-Directed Companion Assistant shall not be the individual's spouse.

		independently manage his own consumer-directed companion services. The EOR may be an adult family member/caregiver or some other person who agrees to fulfill the required duties to serve as the employer of record on behalf of the individual. • Documentation that the individual is 18 years of age or older. • Companion Services shall only be authorized to be delivered by family members living under the same roof as the individual if there is objective written documentation submitted by the support coordinator as to why there are no other providers available to render the services to the individual. • The schedule must include no more than 8 hours per day of either or a combination of CD and AD Companion services.	• Companion services cannot be provided by adult foster care providers or any other paid caregivers for an individual residing in that foster care home. • No more than two unrelated individuals who are receiving waiver services and who live in the same home shall be permitted to share the authorized work hours of the companion.
Crisis Support Services	BI, FIS, CL	• Specific documentation that the individual is experiencing at least one of following: marked reduction in psychiatric, adaptive or behavioral functioning, current increase in extreme emotional distress, a present need for ongoing intervention in order to maintain stability, or currently causing harm to self or others. • Documentation of the date of the face-to-face assessment by a QDDP to determine need for service. • Number of hours the service is being requested. • Requests for Crisis Support services must delineate in the ISP which of the following components/allowable activities will be provided: • Crisis Prevention – Documentation will indicate assessment of individual's medical, cognitive and behavioral status and predictors of self/other injurious, disruptive or destructive behaviors and the positive behavior supports to	• Crisis Support services shall be authorized or re—authorized following a documented face-to-face assessment conducted by a QDDP. • Crisis Support services shall be provided by entities licensed by DBHDS as providers of outpatient crisis stabilization services, residential crisis stabilization services or non-residential crisis stabilization services. • Crisis Support services providers shall employ or utilize QDDPs, licensed mental health professional or other qualified personnel licensed to provide clinical or behavioral interventions. • Service authorization requests may be submitted up to 72 hours after assessment/reassessment by a QDDP. • The unit of the service for **crisis prevention** is one hour and billing may occur up to 24 hours

		prevent crisis situations; training to be provided to family/caregivers to avert further crises and to maintain the individual's typical routine to the maximum extent possible. • Crisis Intervention - Documentation will indicate short-term structured strategies that will be used to prevent further escalation and maintain immediate personal safety of those involved. • Crisis Stabilization – Documentation will indicate efforts and strategies that will be used to gain a full understanding of all factors that precipitated the crisis and training to be provided to family/caregivers and other persons significant to the individual in techniques and interventions to avert future crises.	per day if necessary. Crisis prevention may be authorized for up to 60 days per ISP year. • The unit of the service for **crisis intervention** is one hour and billing may occur up to 24 hours per day if necessary. Crisis intervention may be authorized in increments of no more than 15 days at a time for up to 90 days per ISP year. • The unit of the service for **crisis stabilization** is one hour and billing may occur up to 24 hours per day if necessary. Crisis stabilization may be authorized in increments of no more than 15 days at a time for up to 60 days per ISP year. • Crisis Support services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).
Electronic Home Based Supports (EHBS)	BI, FIS, CL	• Requests for EHBS must delineate in the ISP the need for the service, how it will decrease the need for other Medicaid services, promote inclusion in the community or increase the individual's safety in the home environment, the equipment or device being requested, which may include ongoing electronic monitoring services, and how it will be used. • Documentation of the assessment for the need for this service from a technology specialist for the requested equipment, which may be (but not limited to) a registered Occupational Therapist. • Documentation that the individual is at least 18 years of age and physically able to utilize the equipment. • Documentation of the complete provider proposal with itemized quote and diagram, pictures, etc.	• EHBS is not available to individuals receiving group home, sponsored residential or supported living services. • Receipt of this service and related equipment is not tied to any other waiver or covered service. • Equipment or supplies already covered by any other Medicaid covered service may not be included in requests for this waiver service. • The annual ISP year limit for this service is $5,000.

Environmental Modifications (EM)	BI, FIS, CL	• Requests for EM must delineate in the ISP (1) a description of the individual, reason for the request with a clear statement(s) of remedial or direct medical benefit and how it will improve the individual's personal functioning; (2) a description of the EM (which may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies required by the individual, as well as modifications to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of services) and where the EM will be completed. May include Environmental Modification Maintenance. Documentation within the current ISP of at least one other waiver service. • Request must include an itemized proposal/ estimate from the chosen provider/contractor. • Drawings, images or pictures of the requested EM are recommended and/or may be requested.	• EM is not available for individuals receiving Group Home Supports, Sponsored Residential Services, or Supported Living Residential Services. • The service unit is the cost of the EM. Maximum expenditure is $5,000 per calendar year. • Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards or add square footage to the home. • Providers of EM services shall not be the spouse or parents (natural, adoptive, or foster parents) or legal guardians of the individual enrolled in the waiver. • Adaptations or improvements to the home shall not include those that are not of direct medical or remedial benefit to the individual enrolled in the waiver. • EM to vehicles shall not include: improvements that are of general utility, purchase or leasing, or regularly scheduled upkeep and maintenance. • The EM must be cost effective. • The EM is typically a permanently installed fixture.
Group Day Services	BI, FIS, CL	• Requests for Group Day services must delineate in the ISP (1) the need for skill-building or supports that promotes the individual's opportunities for being a productive and contributing member of his community and (2) planned skill building (required) and support activities in: (a) problem-solving, sensory, gross and fine motor, communication, and personal care skills (b) self, social, and environmental awareness skills (c) positive behavior, using community resources, community safety and	• The service unit is one hour. • No greater than a 1:7 staff to individual ratio. • Group Day services are provided primarily in settings other than the individual's own residence. • Group Day services shall be coordinated with the therapeutic consultation plan, as applicable.

		positive peer interactions, volunteering and educational programs in integrated settings, forming community connections or relationships; (d) supporting older adults in participating in meaningful retirement activities in their communities (i.e., clubs and hobbies); and (e) career planning and resume developing based on career goals, personal interests, and community experiences; (3) a schedule of daily and weekly supports. • Skill building must be a component of this service unless the ISP documents that the individual has a progressive condition, in which case Group Day services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. • Documentation of the weekly schedule may include staff time when required to ride with the individual to and from Group Day service, up to 25% of the total time the individual is scheduled to participate in Group Day services for the day. • Documentation of weekly schedule with no more than 66 hour per week combining Group Day with all other employment and day options.	
Group Home Residential	CL	• Requests for Group Home services must delineate in the ISP (1) the need for skill-building, as well as routine supports, general supports, and/or safety supports to enable the individual to successfully live the community; and (2) planned skill building (required) and supports related to (a) ADLs and IADLs; (b) the use of community resources (transportation, shopping, restaurant dining, and participating in social and recreational activities); (c) replacing challenging behaviors with positive, accepted behavior for home and community environments; d) health,	• The unit of service is a day. • Homes of 4 persons (or less): use the UA modifier; homes of 5 – 12 persons: use the U2 – U9 modifiers, as appropriate.

		safety, and physical condition; e) transportation; and (3) a schedule of daily and weekly supports. • Request must indicate the number of beds for which the home is licensed.	
Group Supported Employment	BI, FIS, CL	• Requests for Group Supported Employment services must delineate in the ISP (1) the individual's need for employment-related skill building and ongoing support to perform in a work setting and (2) planned skill building (required) and supports related to (a) Vocational/job-related discovery or assessment; (b) Person-centered employment planning that results in employment related outcomes; (c) Negotiation with prospective employers, with or without the individual present; (d) On-the-job training in work skills required to perform the job; (e) Ongoing evaluation, supervision, and monitoring of the individual's performance on the job but which do not include supervisory activities rendered as a normal part of the business setting; (f) Ongoing support services necessary to ensure job retention, with or without the individual present; (g) Supports to ensure the individual's health and safety; (h) Development of work-related skills essential to obtaining and retaining employment, such as the effective use of community resources and break or lunch areas and transportation systems; and (i) Staff provision of transportation between the individual's place of residence and the workplace in the absence of other transportation. • Documentation that this service is not available from DARS or IDEA for the individual enrolled in the waiver. • Documentation of the size of the group.	• The unit of service is one hour and the services can be authorized for no more than 40 hours per week per individual. Groups are limited to 2 to 8 individuals and services are provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace.

		• Documentation of weekly schedule with no more than 66 hour per week combining all other employment and day options.	
Independent Living Supports	BI	• Requests for Independent Living Supports must delineate in the ISP (1) the individual's need for skill building and assistance to secure a self-sustaining, independent living situation in the community and provide the support necessary to maintain those skills; (2) skill building (required) and supports to (a) increase community participation and inclusion in meaningful activities; (b) increase socialization skills and maintain relationships; (c) improve and maintain health, safety and fitness; (d) increase decision-making and self-determination skills; and (e) increase/maintain ADLs and IADLs; (3) a schedule of daily and weekly supports. • Documentation indicating that the individual is at least 18 years old and has no primary care giver. • Documentation to indicate living situation (roommates, own home, etc).	• The unit of service is a month or, when beginning or ceasing the service, may be a partial month. Services will be authorized for no more than 21 hours of Independent Living Supports per week. • Individuals receiving this service must be adults 18 years of age and older who live alone or with roommates in their own homes or apartments. • The supports may be provided in the individual's residence or in other community settings. • This service shall not be provided in a licensed residential setting.
Individual Supported Employment	BI, FIS, CL	• Requests for Individual Supported Employment services must delineate in the ISP (1) the individual's need for employment-related skill building and ongoing support to perform in a work setting and (2) planned skill building (required) and supports related to (a) vocational/job-related discovery or assessment; (b) person-centered employment planning that results in employment related outcomes; (c) individualized job development, with or without the individual present, that produces an appropriate job match to include job analysis or determining job tasks, or both (d) negotiation with prospective employers, with or without the individual present; (e) on-the-job training in work skills required to perform the job; (f) ongoing	• The unit of service is one hour and the services can be authorized for no more than 40 hours per week per individual. • For time-limited and service authorized periods (not to exceed 40 hours) individual supported employment may be provided in combination with day services or residential services for purposes of job discovery. • Services must be provided 1:1.

		evaluation, supervision, and monitoring of the individual's performance on the job but which do not include supervisory activities rendered as a normal part of the business setting; (g) ongoing support services necessary to ensure job retention, with or without the individual present; (h) supports to ensure the individual's health and safety; (i) development of work-related skills essential to obtaining and retaining employment, such as the effective use of community resources and break or lunch areas and transportation systems; and (j) staff provision of transportation between the individual's place of residence and the workplace in the absence of other transportation; (3) a schedule of daily and weekly supports. • Documentation that this service is not available from DARS or IDEA for the individual enrolled in the waiver. • Documentation of weekly schedule with no more than 66 hour per week combining all other employment and day options.	
In-Home Support Services	FIS, CL	• Requests for In-Home Support services must delineate in the ISP (1) the individual's need for skill-building and routine supports, general supports, and safety supports that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings; (2) planned skill building (required) and supports related to (a) personal care activities (ADLs) and IADLs; (b) the use of community resources (transportation, shopping, dining at restaurants, and participating in social and recreational activities); (c) replacing challenging behaviors with positive, accepted behaviors for home and community environments; (d) the individual's	• In-home support services are reimbursed according to the number of individuals being served. • These services shall not typically be authorized for 24 hours per day, but may be authorized for brief periods up to 24 hours when medically necessary. • Services are designed to supplement the primary care provided by the individual, family, or other unpaid caregiver and are designed to ensure the health, safety and welfare of the individual. • In-home support services shall not be covered for the individual simultaneously with the coverage of group home residential, supported living residential, or sponsored residential services.

		health and physical condition or other medical needs; (e) using community resources; (e) transportation; or (f) providing safety supports to ensure the individual's health and safety (3) a schedule of daily and weekly supports. • Documentation that the individual is living in his own home or family home. • Documentation of the number of individuals living in home and receiving the service at the same time. • Documentation of the individual's back-up plan for times when In-home Supports cannot occur as regularly scheduled.	• Individuals may have In-home Supports, personal assistance, and respite services in their ISP but shall not receive these Medicaid-reimbursed services simultaneously with In-home Supports.
Individual & Family/Caregiver Training (IFCT)	FIS	• Requests for Individual & Family/Caregiver Training services must delineate in the ISP (1) the need for training and counseling or education for the family or caregiver (to include the name & relationship of the training recipient(s) and an indication of how the training will improve their ability to care for and support the individual enrolled in the waiver), or the individual's need for educational opportunities to better understand his disability and increase his self-determination and self-advocacy; (2) the name of the conference, seminar, or individual practitioner conducting the training event; and an agenda, schedule, etc., which indicates the date(s), time(s), location(s) of the IFCT.	• Authorized hours may not exceed 80 total hours per ISP year. • Travel and room and board expenses shall not be authorized.
Personal Assistance Services (Agency Directed-AD & Consumer Directed-CD)	FIS, CL	• Requests for Personal Assistance services must delineate in the ISP (1) the individual's need for assistance with activities of daily living (a need for and provision of support with ADLs REQUIRED for authorization of this service), reminders to take medication, or other medical needs, or monitoring health status or physical condition;	• If the individual requires skill building services, those must be provided through another appropriate service. • These services do not include nursing services. • Services may not be provided to individuals receiving Sponsored Residential Services, Supported Living Residential, or Group Home

		(2) the supports required by the individual in any of the following areas: (i) ADLs; (ii) monitoring of health status or physical condition; (iii) medication and other medical needs; (iv) preparation and eating of meals; (v) housekeeping (such as bed making, cleaning, individual's laundry) activities; (vi) participation in social, recreational, and community activities; (vii) bowel/bladder care needs, range of motion activities, nonsterile technique routine wound care, and external catheters when supervised by an RN; (ix) accompanying the individual to appointments or meetings; (x) safety supports; and (xi) assistance and supports to individuals in the workplace and postsecondary educational institutions (as long as these supports should not be provided by DARS, under IDEA, as part of the employer's responsibility, or are provided under supported employment; (3) a schedule of daily and weekly supports. • Requests for Consumer-Directed PA must include documentation identifying the Employer of Record (EOR). • Documentation of a back-up plan must be submitted.	Supports. However, there is an exception to this when individuals have visits to family homes away from these settings that require staff support. • Individuals may receive a combination of Personal Assistance, Respite, and In-home Support services in their ISP, but will not be authorized to receive these services at the same time. • Services may be authorized for provision by the individual's relative or legal guardian. living under the same roof as the individual if there are no other providers available to render the services and the support coordinator can provide objective written documentation to support this option. • Services shall not be reimbursed by Medicaid when they are provided by the individual's spouse or, if the individual is a minor child, by his parent or parents (natural, adoptive, foster, or step-parent). • No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the personal assistant. • IADLs authorized must be essential to the health and welfare of the individual, rather than for the individual's family/caregiver's comfort.
Personal Emergency Response System (PERS)	BI, FIS, CL	• Requests for PERS services must delineate in the ISP (1) the individual's need to secure help in an emergency because there is no one else in the home with the individual who is competent or continuously available to call for help in an emergency; (2) the times when individual is alone and that the individual has the cognitive and physical ability to use the PERS; (3) the type of unit (i.e., PERS only, medication dispensing unit in	• The unit is the one-time cost of installation or monthly rental/monitoring fee. • Physician-ordered medication monitoring units may only be authorized for those individuals receiving PERS services. • PERS services provide support to those who have no regular caregiver for extended periods of time and who would otherwise require supervision.

		addition to PERS device), monthly monitoring service, RN medication dispensing unit refilling.	• PERS shall not be authorized for individuals who are simultaneously receiving Group Home Supports, Sponsored Residential services, or Supported Living Residential services.
Private Duty Nursing Service	FIS, CL	• Requests for Private Duty Nursing services must delineate in the ISP (1) the individual's serious medical conditions and complex health care needs that require specific nursing services that cannot be provided by non-nursing personnel; (2) nursing services to be provided: (a) monitoring of an individual's medical status; (b) administering medications or other medical treatment. • Requests for service authorization must include doctors' orders affirming the individual's need for continuous medical care, the nursing (RN or LPN) services to be provided, and number of hours requested. The completed and signed CMS 485/POC form is strongly recommended • Service authorization documentation must include the location of the services.	• The unit of service is a quarter hour. • Private duty nursing may occur concurrently with other services. • These services may be provided in the individual's residence or in the community. • Individuals enrolled in waiver services shall not be authorized to receive private duty nursing services concurrently with skilled nursing services.
Respite Services (Agency Directed - AD & Consumer Directed - CD)	FIS, CL	• Requests for Respite services must delineate in the ISP (1) the individual's need for assistance with ADLs, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition; (2) supports to be provided including (a) ADLs and IADLs; (b) monitoring health status and physical condition; (c) medication and medical needs; (d) safety supports; (e) participation in social, recreational, or community activities; (f) accompanying the individual to appointments or meetings; and (g) bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when trained and supervised by an RN.	• The unit of service is an hour. • Authorized units of service may not exceed 480 hours per state fiscal year (7/1 – 6/30) to include a combination of Consumer-Directed Respite and Agency-Directed Respite. • May not be provided to Individuals receiving Supported Living services, Sponsored Residential services or Group Home Supports. • No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the respite assistant. • This service is authorized for two years (refer to Medicaid Memo 4/3/14), but must be included in the ISP both years.

		• Documentation should identify the setting for the service. • Documentation must accompany the service authorization request identifying the family member or other unpaid, primary caregiver who resides in the same home as the individual who is the beneficiary of the respite services. • Requests for Consumer-Directed Respite must include documentation identifying the Employer of Record (EOR). • Documentation of a back-up plan must be submitted.	
Shared Living	BI, FIS, CL	• Requests for Shared Living services must delineate in the ISP (1) the individual's need for fellowship, safety supports, and limited ADL/IADL help and (2) the supports to be provided by the Shared Living roommate that have been determined by the individual and roommate, which may include fellowship, safety supports, and limited ADL/IADL help. • Documentation accompanying the service authorization request must include a copy of the lease/mortgage verifying that supports are provided in the individual's own home or leased residence and the monthly rent or mortgage amount. • Accompanying documentation must also include the name and relationship of the roommate to the individual as well as the name of the DBHDS-licensed provider agency responsible for oversight.	• The unit of service shall be a month or may be a partial month for months in which the service begins or ends. • The individual must be 18 years or older. • ADLs and/or IADLs (help with meal preparation, light housework, reminders to take medications, routine prompting or intermittent direct assistance with ADLs) may be provided but may not exceed 20% of the roommate's time. • The roommate may not be the parent (biological, adoptive, foster, or step-parent), legal guardian, or spouse of the individual. • The individual shall be receiving at least one other waiver service in order to be approved for Shared Living. • Shared living services will not be authorized for individuals who are simultaneously receiving group home residential, sponsored residential services, or supported living residential services.
Skilled Nursing Services	FIS, CL	• Requests for Skilled Nursing services must delineate in the ISP (1) that the individual has serious medical conditions and complex health care needs that do not meet home health criteria but require specific skilled nursing services that	• The unit of service is a quarter-hour. • This service shall be authorized to provide part-time or intermittent care.

		cannot be provided by non-nursing personnel, and (2) the supports required by the individual in any of the following areas: (a) administering medications and other medical treatment, (b) Monitoring an individual's medical status, (c) provision of consultation, assistance to direct support staff, and nurse delegation, and (d) training of family and other caregivers regarding the individual's medical needs/procedures. • Documentation must include doctor orders which indicate the medical necessity of the service and the number of hours to be provided by a registered nurse and/or licensed practical nurse.	• Short-term, acute, and limited-in-nature skilled nursing needs are to be met through State Plan for Medical Assistance home health services. • This service may be provided concurrently with other services except for personal assistance services or private duty nursing services. • Waiver Skilled Nursing shall not be authorized or covered if the necessary service is available under EPSDT for an individual who is under the age of 21 years old (after 2/28/17). • Foster care providers shall not be the skilled nursing providers for the same individuals for whom they provide foster care.
Sponsored Residential	CL	• Requests for Sponsored Residential services must delineate in the ISP (1) the individual's need to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings and (2) the supports required by the individual in any of the following areas: (a) personal care activities, (such as ADLs), communication and IADLs; (b) the use of community resources; (c) replacing challenging behaviors with positive, accepted behaviors; (d) health and physical conditions, including medication management and other medical needs; (e) transportation to and from training sites and community resources or activities; and (f) general supports and safety supports; (3) a schedule of daily and weekly supports. • Skill building is a required component of this service and submitted documentation must include that in the Plan for Supports. • Documentation should include whether or not the sponsor is a paid family member. When a family member is the paid sponsor, documentation	• Prior to 1/1/17, the unit of service is an hour. After January 1, 2017, the unit of service is a day and shall not exceed 344 days per ISP year. • Paid family members can only provide care to family members who are 18 years of age or older. • This service will not be authorized for individuals who are simultaneously receiving shared living services, supported living services, in-home support services, or group home residential services. • Sponsored Residential services shall be limited to no more than two individuals per sponsor home.

		submitted must include the "Family Member as A Sponsor Provider Form."	
Supported Living Residential	FIS, CL	• Requests for Supported Living Residential services must delineate in the ISP (1) the individual's need to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings and (2) the supports required by the individual in any of the following areas: (a) personal care activities (such as ADLs, communication, and IADLs); (b) replacing challenging behaviors with positive, accepted behaviors; (c) health and physical conditions including medication or other medical needs; (d) transportation to and from training sites and community resources or activities; (e) general supports and safety supports; (3) a schedule of daily and weekly supports.	• The unit of service is a day and shall not exceed 344 days per ISP year. • Services must take place in a setting which is operated by a DBHDS licensed provider. This is often but not limited to apartment settings. • Supported living residential services shall be provided to the individual in the form of around-the-clock availability of paid provider staff who have the ability to respond in a timely manner. • These services may be authorized for a single individual or simultaneously to more than one individual living in the apartment, depending on the required support or supports. • The individual shall not be authorized to concurrently receive personal assistance services or any other residential service such as shared living services, group home supports, in-home supports or sponsored residential services. • This service is not to be used solely to provide routine or emergency respite care for the family/caregiver with whom the individual lives.
Therapeutic Consultation (TC) **-Behavioral Consultation** **-Therapeutic Consultation** **-Speech & Language Pathology** **-Occupational Therapy** **-Physical Therapy** **-Rehabilitation Engineering**	FIS, CL	• Requests for Therapeutic Consultation services must delineate in the ISP (1) the individual's need for consultation in any of these services' areas and (2) the resulting planned activities of the consultant to include (a) interviewing the individual and relevant others to identify desired outcomes of consultation; (b) observing the individual in daily activities and natural environments; (c) assessing the individual's need for an assistive device or evaluating the device's efficacy; (d) developing data collection mechanisms and collecting baseline data for the consultation service; (e) observing and assessing	• The unit of service is an hour. • The individual shall be receiving at least one other waiver service in order to be approved for Therapeutic Consultation. The exception to this is Behavioral Consultation. • Other than Behavioral Consultation, Therapeutic Consultation services shall not include direct therapy provided to the individual and shall not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance. Behavior consultation services may include direct behavioral

		the current interventions, support strategies, or assistive devices being used with the individual; (f) designing a written therapeutic consultation plan; (g) demonstrating specialized, therapeutic interventions, individualized supports, or assistive devices; (h) training relevant persons to assist the individual in using an assistive device or implement therapeutic interventions/appropriate support techniques; (i) intervening directly, by behavioral consultants, with the individual and demonstrating to family/caregivers/staff such interventions.	interventions and demonstration to family members/staff of such interventions. • Travel time, written preparation, and telephone communication shall be considered as in-kind expenses within this service and shall not be included in authorized hours.
Transition Services	BI, FIS, CL	• Requests for Transition Services must delineate in the ISP (1) the need of a transitioning individual (i.e., from an institution (nursing facility, specialized care facility/hospital, or ICF/IID) or licensed/certified provider-operated living arrangement to a living arrangement in a private residence for which he is directly responsible for his own living expenses) for set-up expenses in that new setting; (2) the types of items/expenses to be covered, which may include: (a) security deposits and the first month's rent that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or services access, including telephone, electricity, heating and water; (d) services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) fees to obtain a copy of a birth certificate or an identification card or driver's license; and (g) activities to assess need, arrange for, and procure needed resources.	• Transition Services may be authorized for one transition per individual and must be expended within nine months from the date of authorization. The total cost of these services shall not exceed $5,000, per person lifetime limit • The person is unable to meet such expenses himself and resources for such expenses cannot be obtained from another source. • Transition Services will not be authorized for ongoing monthly rental or mortgage expenses, food, regular utility charges, or household items that are intended for purely diversional/recreational purposes. • This service shall not include services or items that are covered under other waiver services.

		• Documentation must confirm community housing and the expected date of the move.	
Workplace Assistance Service	FIS, CL	• Requests for Workplace Assistance services must delineate in the ISP (1) that the individual has completed job development and completed or nearly completed job placement training (i.e., individual supported employment) and needs more than the typical job coach services to remain stable in his employment; (2) the supports required by the individual in any of the following areas: (a) habilitative supports related to non-work skills needed for the individual to maintain employment (i.e., behavior, health, time management, or other skills the absence of which would endanger the individual's continued employment); (b) habilitative supports to make and strengthen community connections; (c) supports to ensure the individual's health and safety; and (d) ADL supports (although this may not be the only type of support authorized under this service); (3) a schedule of daily and weekly supports. • Documentation of service delivered at a 1:1 ratio.	• The unit of service is an hour. No more than 40 hours per week will be authorized. Workplace assistance services, alone or in combination with community engagement, community coaching, supported employment, or group day services will not be authorized for more than 66 hours per week. • Workplace Assistance services are supplementary to individual supported employment services and shall not be work skills related training that would normally be provided by a job coach • Workplace Assistance services shall not be authorized simultaneously with work-related personal assistance services.

Support Coordination Manual
Developmental Disabilities
Chapter 8
Support Coordination Process:
Monitoring and Evaluation

Support Coordination Timelines

- Monthly Contact

Ongoing Assessment/Monitoring

- Is the PC ISP Implemented Appropriately?
- Status of Current Risks and Identifying New Risks
- Documenting Newly Identified Needs, Preferences, Supports, and Services
- Face-to-Face Visits
- Enhanced Case Management
- Ways to Minimize Risks
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- Ways to Address Changes in Needs, Preferences, Supports, and Services

Problem Solving and Addressing Barriers

PC ISP Updates

At A Glance

- ECM Flowchart
- DOJ Guidance on ECM
- Person Centered Review

Support Coordination Manual
Developmental Disabilities
Chapter 8
Support Coordination Process:
Monitoring Billable Activities and Evaluation

Support Coordination Timelines

Support Coordinators (SC) are knowledgeable of Person Centered Thinking and Person Centered Planning as part of the Person Centered Individual Support Plan (PC ISP) planning process. What is working and what is not working for the individual, as well as what is Important To and Important For the person drives outcome development for the PC ISP (what needs to be maintained, what needs to change, what could be enhanced). Through monitoring and evaluations, the SC takes the lead in ensuring that the support team follows through with the commitment(s) they made to support the person to reach their desired outcomes. This is accomplished through a number of billable and non-billable activities. It is important to know the difference, to assure that not only has a review of progress, satisfaction, and risk been completed, but also that an allowable activity has occurred so that the community services board/behavioral health authority (CSB/BHA) can bill for the support provided. To accurately monitor and evaluate each person, there are tasks that will need to occur, depending on the person, every 30, 60, or 90 days. Each SC is responsible for keeping up with their timelines and billable activities.

Monthly Contact

SCs must conduct a minimum of one contact or activity every month, defined as:

- Direct or in-person contact, communication or activity with the individual, their family/caregiver (as appropriate), service provider, or other organization on behalf of the individual

The assigned SC will provide Support Coordination services as frequently and timely as the person needs assistance. There must be at least one documented contact, activity or communication, as designated previously, and relevant to the Individual Support Plan, during any calendar month for which Support Coordination services are billed. **SCs are responsible for proactively identifying risks, implementing plans to mitigate previously known and newly identified risks, and resolving them in a timely manner.**

Billing will be submitted for an individual only for months in which direct or in-person contact, activity, or communication occurs and the SC's records document the billed activity. Service

providers will be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

The allowable support activities can include but are not limited to:

- Coordinating initial assessment and annual reassessment of the individual and planning services and supports, to include history-taking, gathering information from other sources, and the development of a PC ISP. This does not include performing medical or psychiatric assessments, but may include referral for such assessment.
- Coordinating services and supports planning with other agencies and providers. This includes making appointments.
- Linking the individual to services and supports specified in the PC ISP
- Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources, including crisis supports.
- Enhancing community integration by contacting other entities to arrange community access and involvement.
- Making collateral contacts with the individual to promote implementation of the PC ISP and successful community adjustment;
- Monitoring implementation of the PC ISP through regular contacts with service providers, as well as periodic site visits and home visits.
- Instruction and counseling which guides the individual in problem-solving and decision-making and develops a supportive relationship that promotes implementation of the PC ISP. Counseling in this context is defined as problem-solving activities designed to enhance an individual's ability to live in the community. Allowed instructional activities would include discussion about the benefits of the activities listed in the service plan
- Monitoring the quality of services.
- Assisting the individual to secure services in an Intermediate Care Facility/Intellectual or Developmental Disability (ICF/IDD), if the individual or family member requests institutional placement.
- Monitoring the PC ISP to ensure it is implemented as written and making **TIMELY** referrals, service changes, and amendments to the PC ISP.

The activity of writing the PC ISP, Person-Centered Review, or progress note is not considered a billable case management activity. However, developing the PC ISP through a team meeting is a billable activity.

There will be no maximum service limits for Support Coordination services, except for individuals residing in institutions or medical facilities. For these individuals, reimbursement for Support Coordination will be limited to 90 days pre-discharge (immediately preceding

discharge) from the institution into the community. While individuals may require re-entry to institutions or medical facilities for emergencies, discharge planning efforts should be significant to prevent readmission. For this reason, Support Coordination may be billed for only two 90-day pre-discharge periods in a 12-month period.

Ongoing Assessment/Monitoring

In Chapter 2, assessment was identified as the on-going process of gathering and summarizing information that guides the work between the SC and the person using services. The assessment not only helps to determine initial eligibility for services, but ongoing eligibility as well.

Is the PC ISP implemented appropriately?

Monitoring the PC ISP to determine if it is being implemented appropriately involves doing the following activities:

- Actively observe the person and service providers to make sure the plan is being properly implemented
- Make periodic site and home visits to assess the quality of care and satisfaction
- Make collateral contacts with people who support the individual (with whom there is a signed consent to exchange information) in various aspects (school, work, medical, friends, paid providers, family, etc.) to obtain a well-rounded picture of the person.
- Consistently support the person in identifying concerns, and modify the plan to reflect concerns and how concerns are addressed as necessary
- Follow-up with the individual and support partners to determine if instructions provided by qualified professionals are being followed.

Regularly meeting with people in their natural environment, for example their home, day program, or workplace will allow proper assessment of the plan implementation. Keep in mind that visiting someone at their worksite may be considered intrusive by the employer; therefore, the SC should identify alternative ways to monitor that service.

Status of Current Risks and Identifying New Risks

Ongoing assessment includes gathering information to make sure health and safety needs are met, as well as assessing the person's ability to independently care for themselves. Some risks, like pressure sores/decubitus ulcers, can be reduced by understanding who is at risk, recognizing early signs of skin breakdown, and implementing interventions early. While the SC may not be the one to see skin breakdown, they can promote risk mitigation by having knowledge of risk factors, who is at risk, and ensure that outcomes are added to the PC ISP to prevent skin breakdown for those at risk. SCs can inquire directly with support personnel; ask to see positioning logs, skin check logs, etc. to further monitor the risk. Prevention is the key! For more information, go to the Department of Behavioral Health and Developmental Services

(DBHDS) Office of Integrated Health (OIH) website for the presentation on Promoting Skin Integrity as well as other health and safety information.
http://www.dbhds.virginia.gov/office-of-integrated-health#

The SC should assess the status of current risks and evaluate the person's current living situation to determine if there are new risks. Some examples of areas the SC may want to pay close attention to are:

- The person's dietary and nutritional needs
- The current living situation
- Activities of daily living (ADLs)
- Risk of suicide or self-harm
- Social or environmental risk factors (family situation, lack of social support, or isolation)
- Change in mood or behavior

Documenting Newly Identified Needs, Preferences, Supports, and Services

When the SC is conducting monthly contacts, face-to-face visits and person centered reviews, all newly identified needs, preferences, supports and services should be documented in the progress notes. The PC ISP is updated when changes occur or new information is discovered, and updates are communicated with others supporting the person. Having ongoing and regular contacts with the person, service providers and family members, as appropriate, can help the SC assess and identify needed modifications to the PC ISP.

Refer to the 2018 PC ISP Training Modules – Module 3 Identifying Risk for more information.
https://dbhds.box.com/s/xz9x26lsfzvumliceu1u6tibsnt1hl70

Face-to-Face Visits

SCs will meet with each individual face-to-face as dictated by the person's needs. At face-to-face meetings, the SC will:

- Observe and assess for any previously unidentified risks, injuries, needs, or other changes in status
- Assess the status of previously identified risks, injuries, or needs, or other change in status
- Assess whether the person's service plan is being implemented appropriately and remains appropriate for the person
- Assess whether supports and services are being implemented consistent with the person's strengths and preferences and in the most integrated setting appropriate to the person's needs.

"Face-to-face visit" means an in-person meeting between the Support Coordinator and the individual and family/caregiver, as appropriate, for the purpose of assessing the person's status and determining satisfaction with services, including the need for additional services and supports.

Documentation must clearly state that:

- The SC was in the presence of the person, the date, and the location of the visit
- Unmet needs were identified, and a plan was developed to address the unmet need, if applicable
- Satisfaction with services was assessed
- Status of services was evaluated and adjusted as needed
- A face-to-face visit occurred, and there are observations or assessments of:
  - a newly identified need
  - change in status or preference
  - an inadequately addressed risk or need
  - any issues with implementation of the PC ISP

- Then the SC will:
  - Review and update the PC ISP as needed
  - Develop a mitigation plan
  - Document the issue

If any issues are identified during the face-to-face assessment, the individual's status or preferences have changed, or the PC ISP is not being implemented as written or needs to change, document this in your face-to-face visit note.

It may be appropriate to convene a team meeting to review and update the PC ISP. This can be done via conference calls with the individual/family and team members to update the PC ISP. If they receive DD Waiver services, it should also be determined if the individual needs assistance advocating for a change in their outcomes. If the CSB/BHA is the only service provider, determine whether the SC Part V should also be revised to address the identified needs. Determine if new services are needed, or if current services/support activities need to be modified. The SC should ensure that the PC ISP is amended when the reassessment indicates that revisions in the plan are needed to address and meet an individual's changed needs. The ISP should be updated as indicated and should include an implementation schedule for the changes needed to address the individual's needs.

Any identified issues should be addressed. Remember, the SC is responsible for coordination of services. The SC will make sure all team members are made aware of changes or newly identified risks that may affect their implementation of PC ISP outcomes.

Documenting and communicating information is very important. It also confirms and validates that support was provided and received. If an issue is identified, it must be documented along with its resolution and/or the attempts to address barriers.

The SC will conduct a face-to-face visit once every 90 days (with the allowance for a 10 day grace period) *unless* one of the following criteria are met.* The individual:

A. Receives services from providers having conditional or provisional licenses
B. Has more intensive behavioral or medical needs as defined by the Supports Intensity Scale® ("SIS®") category representing the highest level of risk to individuals*
C. Has an interruption of service greater than 30 days
D. Encounters the crisis system for a serious crisis, or for multiple less serious crises within a three-month period
E. Has transitioned from a Training Center within the previous 12 months
F. Resides in congregate settings of 5 or more individuals*

**Some exceptions apply – See below*

If one of the above criteria (A-F) are met, the individual meets criteria for *Enhanced Case Management*.

Enhanced Case Management

The Department of Justice (DOJ) Settlement Agreement (SA) identifies certain situations that history and evidence-based practice indicates increased risk for individuals with developmental disabilities. These high-risk situations require more vigilant oversight to ensure that the individual remains stable and/or does not further deteriorate. This oversight is called Enhanced Case Management (ECM). Refer to the Case Management Guidelines (Nov 2012) and the April Update (April 2014).

Review the need for Enhanced Case Management criteria on a regular basis and update as changes occur. ECM criteria will be applied to anyone:

- With a DD Waiver
- Receiving ID Case Management who is on the DD Waiver Waitlist and has a CCC+ Waiver
- Receiving DD Case Management while on the DD Waiver Waitlist with a specialized service need and has a CCC+ Waiver

ECM criteria only applies to people who are open to active Case Management. A person who is on the waitlist, but is in monitoring status would not receive enhanced Case Management, even if they met one of the above criteria, unless they accepted CM services and were opened to SC.

ECM criteria as identified by the SA:

- **Receive services from providers having conditional or provisional licenses**

SCs will fulfill the above face-to-face obligation for the entire time a provider is on a **conditional** (i.e. new) license or **provisional** (i.e. compliance violation) license. This level of face-to-face contact will continue for at least three months after a provider has been removed from **provisional** status.

The list of providers with either a conditional or provisional license can be found here: http://www.dbhds.virginia.gov/quality-management/Licensed-Provider-Location-Search

- **Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale® ("SIS") category, representing the highest level of risk to individuals**

If any response to the Virginia SIS® Supplemental Risk Assessment (also referred to as the Annual Risk Assessment), regarding an individual is "yes," the SC will meet with the individual face-to-face at least every thirty (30) days, with at least one visit every two months in the individual's residence, while those responses remain "yes."

Exception: A "yes" response to SIS Supplemental Risk Assessment Item #5 (fall risk) does not automatically constitute a more intensive behavioral or medical need requiring more frequent Case Management visits. Only if the individual has experienced an injury as a result of a fall in the past 90 days will a "yes" to item #5 necessitate the more frequent Case Management visits. In this circumstance, the SC will meet with the individual face-to-face at least every thirty (30) days, with one such visit every two months in the individual's residence, until the individual is stabilized.

If any item in sections 3a or 3b of the SIS® Supplemental Risk Assessment are scored "2" (i.e., extensive support needed), the individual will receive the more frequent face-to-face SC visits while those responses remain scored "2." The exceptions are a score of "2" on

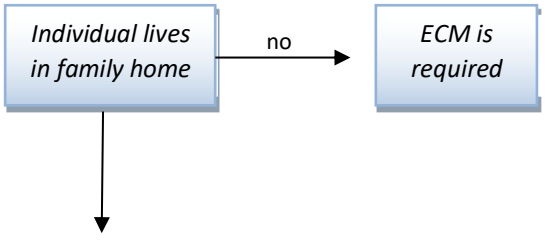
a) 3a #14 (lifting and/or transferring) unless an adverse event has occurred in the context of lifting or transferring in the past 90 days, in which case this level of contact will continue until the individual is stabilized, or

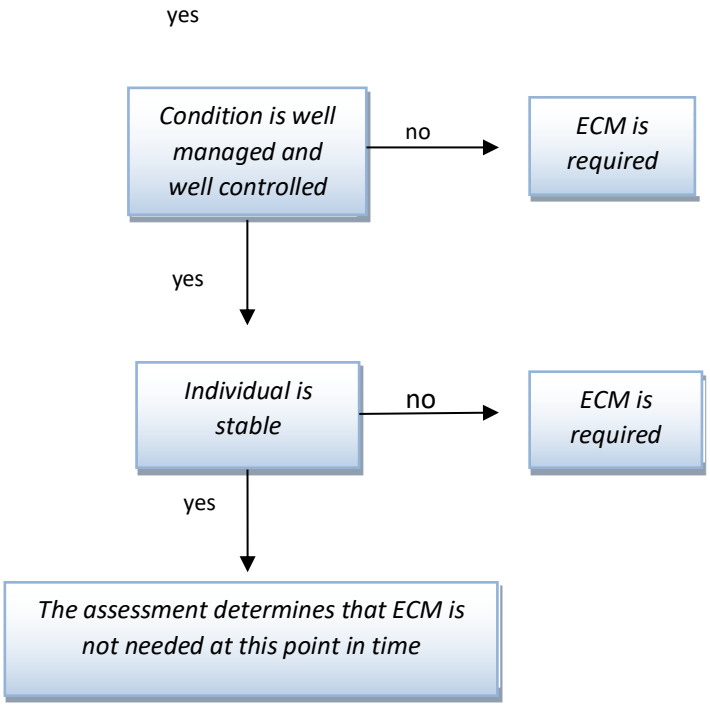
b) 3a #15 (therapy services).

Exception: For individuals who live in their family home and have more intensive behavioral or medical needs as defined by the SIS®, enhanced visits not be required if their medical/behavioral condition is well-controlled and well managed and the individual is stable.

Decision Tree:

Starting point: Has at least one "yes" on the SIS® Supplemental Risk Assessment or a score of 2 or higher in 3a or 3b on the SIS Exceptional Medical and Behavioral Supports Needs





If it is determined that ECM is not needed at this point in time, SCs would be required on at least a quarterly basis to assess whether the family member/caregiver is following medical orders and/or behavior treatment plan recommendations. If the individual were to encounter any of these triggers, then ECM would be provided and continue until the person was stable, as defined below.

Stable is defined as:
Living in the same home for at least one year, without significant events that threaten serious injury or death such as founded abuse and/or neglect; bowel obstruction; aspiration pneumonia; falls resulting in serious injury; or encounters with the crisis system for a serious crisis or for multiple less serious crises within a three month period.

- **Have an interruption in service greater than 30 days**

This means an interruption of any of the following waiver services:

- Congregate residential (including sponsored residential)
- In-home residential
- Personal Assistance (agency-directed or consumer-directed)
- Supported Employment
- Day Support
- Ongoing therapeutic services.

The SC will meet with the person face-to-face at least every thirty (30) days, with at least one such visit every two months in the individual's residence, until either services have resumed or the individual has lost his/her slot.

An extended vacation, when the person and his or her family are out of town, does not constitute an interruption of service. Extended vacations must be clearly documented in the individual's record.

- **Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period** -

Crisis includes both behavioral/psychiatric and medical events.

“Serious crisis” means admission to a Crisis Stabilization Unit (CSU), REACH, hospital (other than for routine or elective procedures) , hospital followed by admission to a Long Term Rehab facility, an out of home placement due to CPS or APS involvement, or incarceration.

“Multiple less serious crises” means assessment for admission to a CSU, REACH, hospital (other than for routine or elective procedures), hospital followed by admission to a Long Term Rehab facility, an out of home placement due to CPS or APS involvement, or incarceration three or more times in a twelve (12) month period.
30/12

The SC will meet face-to-face with the person at least every thirty (30) days, with at least one such visit every two months in the individual's residence, for six months after discharge or until stabilized, if not stabilized within six months.

"Stabilized" means that the individual has returned to his/her pre-crisis --i.e., typical or as near to typical as possible following the crisis – mode of functioning.

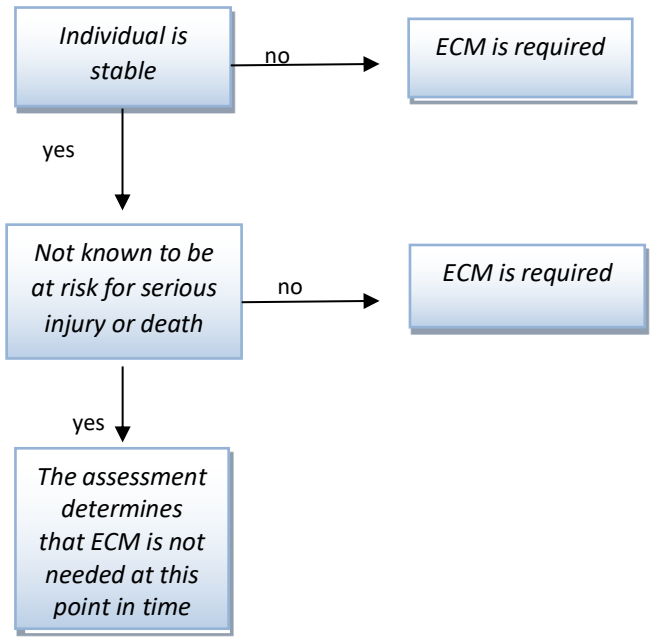
- **Have transitioned from a Training Center (TC) within the previous 12 months.**

The SC will meet face-to-face with the person at least every thirty (30) days, with at least one such visit every two months in the individual's residence, for twelve (12) months post TC discharge.

- **Reside in congregate settings of 5 or more**

If individuals qualify for enhanced visits solely because they live in a congregate setting of 5 or more individuals, and are known *not* to be at risk for serious injury and/or death, then enhanced visits may not be required. Prior to a person being designated as not needing ECM visits, the person has to be stable (defined above) for at least one year. The SC will meet face-to-face with the person at least every thirty (30) days, with at least one such visit every two months in the individual's residence.

Starting Point for Assessment – Lives in a congregate setting of 5 or more individuals



As with Support Coordination, when completing a face-to-face ECM visit, there is a 10-day grace period.

Link: ECM Flowchart At-A-Glance

DOJ Guidance Enhanced CM At-A-Glance

Ways to Minimize Risks

A SC can help to minimize the risks by:

- Identifying strengths (competencies, accomplishments, resources, support network)
- Understanding the capability of service providers to meet the person's needs and preferences.
- Reviewing assessments completing by qualified professionals
- Making referrals as appropriate to help mitigate newly identified risks or potential risks
- Following-up with the individual and any support partners to assure plan to mitigate risk are being developed and followed
- Link with assistive technology (AT) and environmental modifications (EM) as appropriate
- Being knowledgeable of community opportunities and resources.
- Helping people make informed decisions
- Ongoing collaboration with the person, family members, and service providers

Person Centered Review (PCR)

The SC will conduct a Person Centered Review (PCR) once every quarter, based on the start date of the ISP.

These reviews will evaluate the continued relevance of the ISP and the person's progress toward meeting their outcomes. The SC is reviewing not only the provider's Part V (if the individual has a DD Waiver), but is also reviewing their own Part V. The SC will update the PC ISP, if indicated, and implement any updates made.

These reviews will document evidence of progression toward or achievement of a specific targeted activity for each outcome.

For outcomes that were not accomplished by the identified target date, the SC and any appropriate team members will meet to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed.

Person Centered Review form At-A-Glance

Ways to address changes in needs, preferences, supports, and services

SCs can address changes in needs and preferences by:

- Educating service providers about the person and their plan
- Updating team members about significant events or changes that impact the person
- Collaborating to achieve outcomes
- Emphasizing opportunities for increased community integration, employment**,** and independent living
- Providing information about the process and options for change
- Assisting in problem solving
- Not prejudging who can and cannot achieve success

Problem Solving and Addressing Barriers

There are many situations in which problems can arise and SCs can help bring resolution and overcome barriers. This can be done by:

- Clarifying the problem
- Listing possible options
- Teaching and modeling problem solving for people with disabilities and supporters

- Assessing situations
- Defining barriers
- Listing solutions to barriers
- Identifying pros and cons
- Facilitating meetings to work together with the person/support team to accomplish any of the points listed here

Sometimes the problems are about conflicts between people. In those cases, SCs can manage the conflict by doing the following:

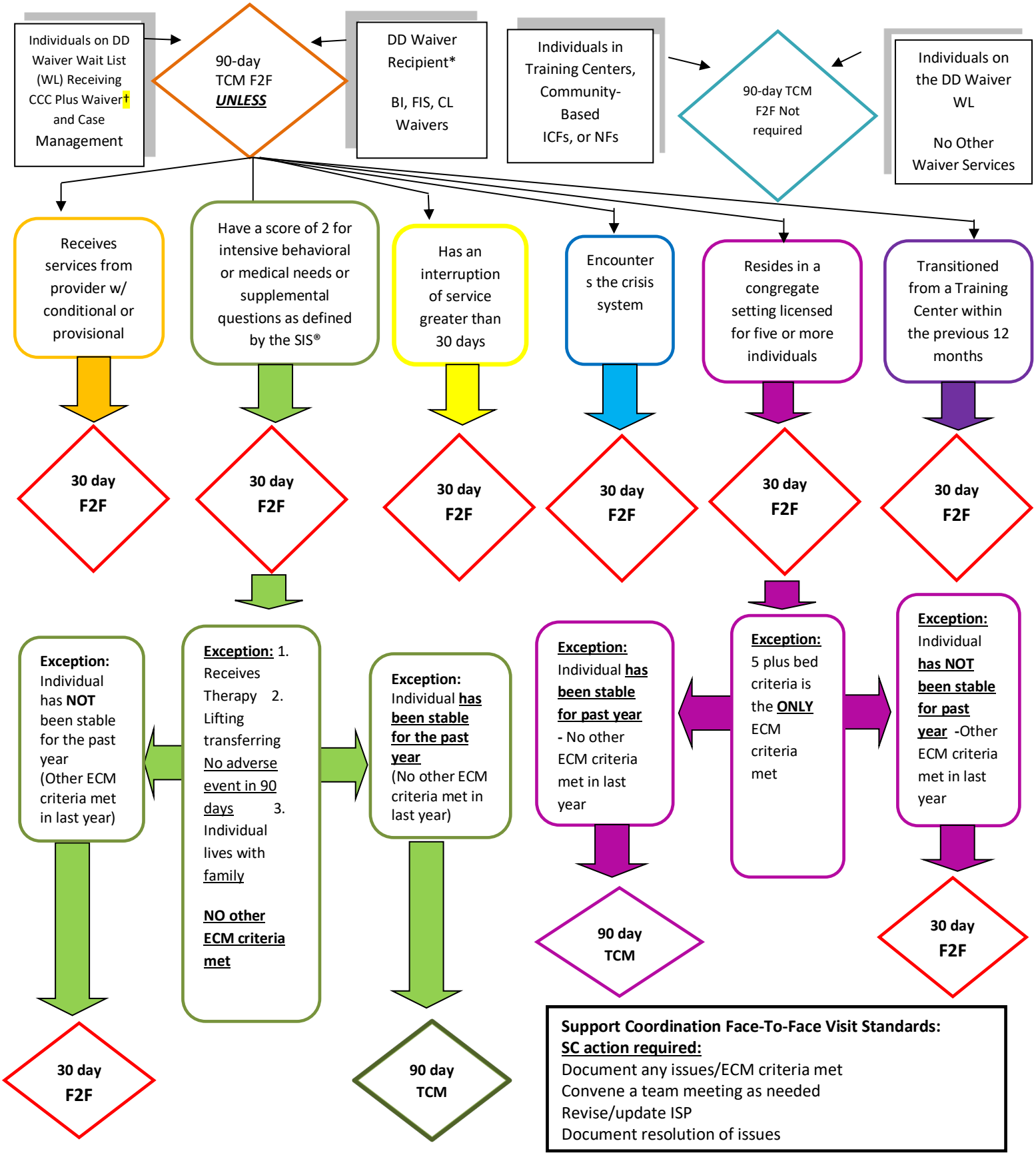
- Anticipate and help resolve emerging tensions between people
- Remain calm and constructive when confronted with people who are angry, critical, or threatening (seeking assistance if needed)
- Mediate conflicts among people with disabilities, family members, and other care providers

PC ISP Updates

When the SC identifies the need to update or modify a PC ISP, they must:

- Review current outcomes and make changes to the PC ISP to reflect any modifications. This includes updating the Case Management Plan for Supports.
- Review modified provider service plans in WaMS (for DD Waiver only)
- Submit the modified provider service plan (Part V Plan for Supports) for service authorization if there is a request for a change in hours or service providers
    - For SC responsibilities related to modifications in Service Authorizations (SA) use the WaMS CSB User guide section 12. Link to WaMS CSB User Guide at a glance
- Update the PC ISP Part I Essential Information, Part II Personal Profile, and Part III Shared plan (remember the SC can only update the Part III if they are adding or removing a provider from the outcomes. Any other changes to the Part III come from the provider,) as needed
- Obtain consent to exchange information forms for any new service providers
- Update the Informed Choice DMAS 460

Enhanced Case Management Flowchart Rev: July 2017



*This includes individuals currently on the BI, FIS and CL Waivers.

WL-†Offer 90-day TCM FF, repeat at least annually. If declined, document. ECM not required for individuals on the WL except as indicated.

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Enhanced Case Management Criteria
Instructions and Guidance

(April 2014)

As a result of feedback from meeting with ID CM CSBs last May, DBHDS requested 3 adjustments to Enhanced Case Management (ECM) criteria:

The first change included moving the 5 day grace period to 10 days to coincide with DMAS regulations and was approved effective May 1, 2014.

The second change requested establishing criteria to exclude those individuals currently considered stable in group homes of 5 beds or more from automatically requiring ECM.

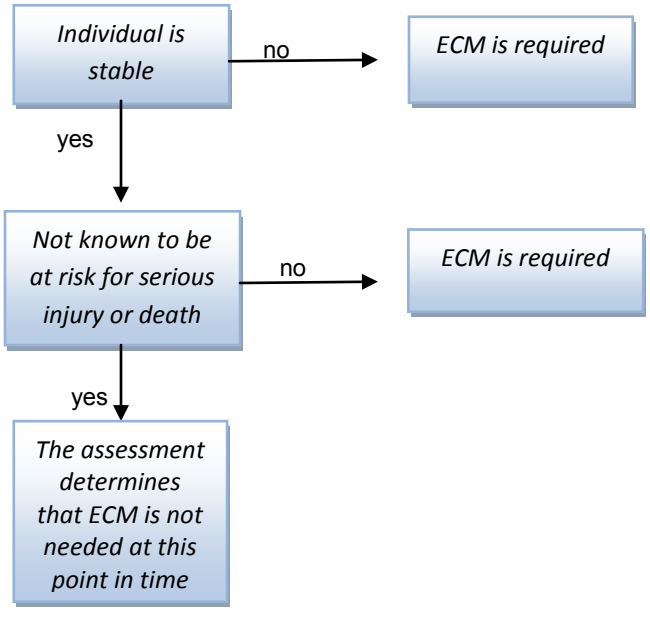
Prior to an individual being designated as not needing enhanced case management visits, an individual has to be stable for at least one year. Stable is defined as living in the same placement for at least one year prior to the ECM determination without significant events that threaten serious injury or death such as founded abuse and/or neglect; bowel obstruction; aspiration pneumonia; falls resulting in serious injury; or encounters with the crisis system for a serious crisis or for multiple less serious crisis within a three month period.

For those individuals who are currently living in a congregate setting with 5 or more beds, the Case Manager/Support Coordinator needs to determine:

- *Whether the individual is known to be at risk for serious injury or death*
- *Whether the individual has been stable for one year (living in the same place for one year without significant events that threaten serious injury or death*

Decision Tree

Starting Point for Assessment – Lives in a congregate setting of 5 or more individuals



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If the individual were to encounter any of these triggers, then enhanced case management visits would be provided and continue until the person was stable, as defined above.

There are individuals living in congregate settings of 5 or more who have been identified as being at risk for serious injury and/or death due to a specific condition or event. Some of these individuals are stable as defined above due in part to safety protocols being in place. When they experience any event or significant changes in the condition(s) related to their risk, enhanced case management visits would be required and would continue until the individual is once again stable. In addition, the safety protocols will be reviewed by staff when increased risks are identified and revised as needed. Examples of significant changes in conditions or events related to an individual's risk include any change in medications especially as the side effects may impact the risk (dizziness may contribute to falls), dental work as it relates to someone who is already at risk for choking, and constipation as it may lead to bowel obstruction.

The third change included establishing criteria for those who have more intensive behavioral or medical needs as defined by SIS when they live in the family home and their medical/behavioral condition is well-controlled and well-managed and the individual is stable (living in the family home for at least one year without significant events that threaten serious injury or death such as founded abuse and/or neglect; bowel obstruction; aspiration pneumonia; falls resulting in serious injury; or encounters with the crisis system for a serious crisis or for multiple less serious crises within a three month period).

For those individuals having more intensive behavioral or medical needs as defined by the SIS, the case manager/service coordinator needs to determine:

- *Whether the individual lives in their family's home with care and supports provided primarily by family members, and*
- *Whether medical/behavioral condition(s) is well controlled and well managed, and*
- *Whether the individual is stable (living in the family home for at least one year without significant events that threaten serious injury or death)*

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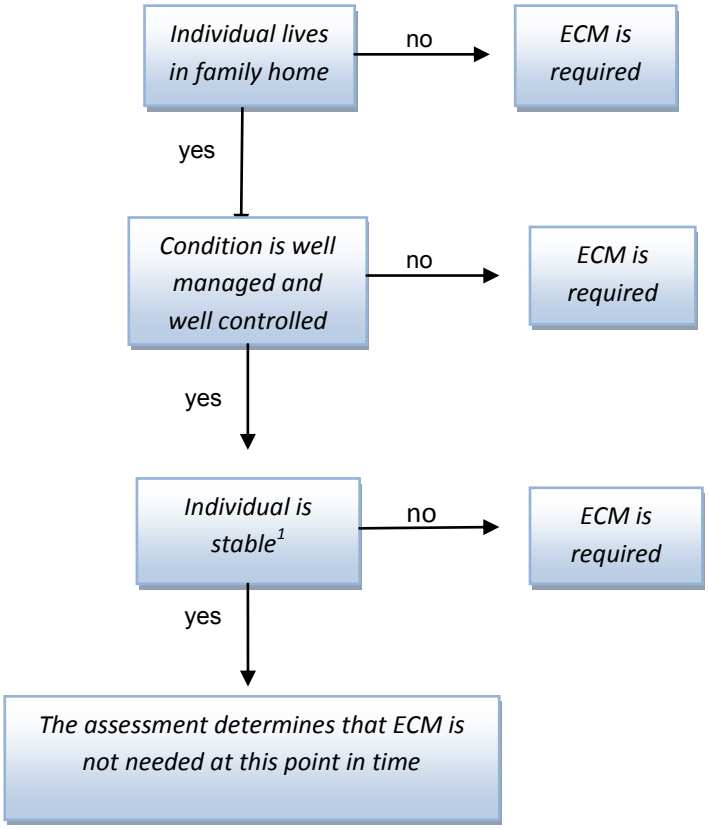
Decision Tree:

Starting point: Has at least one "yes" on the SIS Supplemental Risk Assessment or a score of 2 or higher in 3a or 3b on the SIS Exceptional Medical and Behavioral Supports Needs



If it is determined that ECM is not needed at this point in time, Case Managers/Support Coordinators would be required on a quarterly basis to assess whether the family member/caregiver is following medical orders and/or behavior treatment plan recommendations. If the individual were to encounter any of these triggers then enhanced case management would be provided and continue until the person was stable, as defined above.

There are individuals living with family who have been identified as being at risk for serious injury and/or death due to a specific condition or event. Some of these individuals are stable as defined above due in part to safety protocols being in place. When they experience any event or significant changes in the condition(s) related to their risk related to their risk, enhanced case management visits would be required and would continue until the individual is once again stable. In addition, the safety protocols would be reviewed by a provider or the CM/SC with family when increased risks are identified and revised as needed. Examples of significant changes in conditions or events related to an individual's risk include

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any change in medications especially as the side effects may impact the risk (dizziness may contribute to falls), dental work as it relates to someone who is already at risk for choking, and constipation as it may lead to bowel obstruction.

Expectations

The importance of on-going assessing of individuals needs cannot be stressed enough. Assessments are “snapshots in time” and the level of risk and conditions can change very quickly. When determining whether an individual should be receiving enhanced case management (based on the change in criteria) assessing the risk and potential of risk is necessary. Each individual who is moving in or out of enhanced case management should be assessed and the outcome of the assessment should be well documented either in a progress note or on an assessment “form”.

This instruction and guidance does not specify a specific assessment, but it is suggested that a review of current medical conditions, current medications, and any recent changes to medications, falls, recent changes in behaviors and recent medical procedures be reviewed. Upcoming medical procedures or any changes in living arrangements should also be reviewed. As previously stated the assessment needs to be clearly documented as this will demonstrate to Licensing and Human Rights in their reviews, that appropriate action was taken.

This quarterly review covers information from [enter date] through [enter date]
Service: ___________________ Provider: _____________________

Outcome Status

DESIRED OUTCOMES	**Status of outcome** *Achieved = accomplished, removing from plan* *On track = progressing as expected, no gaps/barriers* *Limited or no progress = experiencing gaps/barriers or regress*	**Plan updates**
Start date: End date: [Enter Outcome Statement]	☐ Achieved ☐ On track ☐ Limited or no progress Status description: **Comment based on status selected.**	Plan change needed? ☐ Yes ☐ No If yes, describe:
Start date: End date: [Enter Outcome Statement]	☐ Achieved ☐ On track ☐ Limited or no progress Status description: **Comment based on status selected.**	Plan change needed? ☐ Yes ☐ No If yes, describe:
Start date: End date: [Enter Outcome Statement]	☐ Achieved ☐ On track ☐ Limited or no progress Status description: **Comment based on status selected.**	Plan change needed? ☐ Yes ☐ No If yes, describe:

1.	For the reporting period have there been any **safety risks (health or behavioral)** identified?	☐ Yes ☐ No	If yes, describe risks and how they were/will be addressed and documented in the plan:
2.	Does the person or substitute decision-maker desire and/or need any **changes** to the plan or services and supports?	☐ Yes ☐ No	If yes, describe plans to address:
3.	Is the person and substitute decision-maker **satisfied** with all services and supports?	☐ Yes ☐ No	Describe how you know the response indicated and any plans to address dissatisfaction:
4.	Were **all Medicaid services** in the plan **implemented**?	☐ Yes ☐ No	If no, describe plans to address:
5.	Were there any **significant events** (health or otherwise) not reported above?	☐ Yes ☐ No	If yes, describe:

Completed by ____________________ (print) __________________________ (signature) Date: _________

This ISP belongs to:_________________ID# _____ISP Start: ________End: _______ Revision: ______

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Support Coordination Manual
Developmental Disabilities
Chapter 9
Support Coordination Process:
Transitions of Support

Life Transitions

Support Coordinators (SC) frequently work with people who are transitioning between services. In order to assure continuity of services, guidelines for transitions are outlined in the following pages.

Part C to Intellectual Disability/Developmental Disability Support Coordination (ID/DD SC)

When children who receive Part C Early Intervention (EI) supports and services reach the age of two, the Early Intervention team will begin to transition the child and their family to Part B services, and potentially ID/DD Support Coordination. It is important for the EI SC and the ID/DD SC to work collaboratively to ensure continuity of services if Support Coordination services will continue.

Part of this transition also includes Early Childhood Education through the Virginia Department of Education. The ID/DD SC can work with the EI team and the family to ensure the child is linked to their local Special Education division. More information about the transition from Early Intervention to Early Childhood Education can be found below.

Transition from Part C to Part B at a glance

The SC should check with their organization's policies specific to documentation regarding transitions.

School to Adult Services to Retirement

When a person with a disability is transitioning from school to adult services, it can be an exciting and challenging time for everyone involved. This transition period can be an extended process, as students may engage in career exploration, experience changing needs and a change in DD Waiver priority. During this period, especially as graduation nears, students and their families begin to think about life after high school. Starting at age 14, teams work to identify the student's and family's desired outcomes and to plan their community and school experiences to assure that they acquire the knowledge and skills needed to achieve their goals.

Additionally, the transition to retirement and older adulthood can also be a challenging and exciting time for people with disabilities. SCs providing support to adults with disabilities who are considering retirement can help the person develop a plan that focuses on their health, continued participation in their community, and security.

The transition planning processes should enable the person to move successfully to postsecondary education and training, employment, independent living, retirement, retirement living and community participation based on the person's preferences, interests, and abilities.

Transition planning for adult services can involve many topics including but not limited to:

- Employment opportunities
- Post-secondary education
- Social Security benefits
- Retirement benefits
- Senior Navigation resources

Supported decision making, can help guide the person and team to consider a variety of opportunities, identify barriers, and make decisions to achieve the life he/she wants. An SC can work with the person and their family by providing information and resources. See the websites and resources provided below. (See Supported decision making (link to Chapter 3)

BOX

Supported Decision Making information
http://www.doe.virginia.gov/special_ed/transition_svcs/va_intercommunity_transition_council/fact_sheets/supported_decision_making.pdf

Virginia Department of Education Transition Resources
http://www.doe.virginia.gov/special_ed/transition_svcs/index.shtml

Social Security Benefits https://www.ssa.gov/pubs/EN-05-11005.pdf

The Virginia Department of Aging and Rehabilitation Services
https://www.vadars.org/transitionservices.htm

Aging and Disability Networks
https://acl.gov/programs/aging-and-disability-networks

Senior Navigator http://seniornavigator.org/

Transfers between Support Coordinators Within the Same CSB

The relationship between the SC and the people they support is very important. At times, the person may feel the need to request a new SC. Licensing regulations dictate that all CSBs should implement a written policy describing how people are assigned SCs and how they can

request a change of their assigned SC. To proactively promote choice, SCs will review choice of providers when service changes occur, and include choice of current providers and SC at least annually by completing the Virginia Informed Choice form (DMAS 460) as required by Medicaid. When a person requests a change in SCs, the SC should check with their supervisor to learn their agency's policy and honor the request from the person for a change in SC whenever possible. Once the change has occurred it is important for the newly assigned SC to ensure that the record indicates the change in SC. Documentation of this change might include:

- Updating the PC ISP Part I Essential Information
- Recording the request from the person in the progress notes
- Completing the Virginia Informed Choice form (DMAS 460)
- Notifying all collateral contacts (family members, providers, professionals)

Transfer Protocols to/from Other CSBs

When a person moves to another locality it may become more challenging for a Support Coordinator to continue to monitor services. In this instance, the SC should work with the person to transfer Support Coordination services to another Community Services Board (CSB). For more detailed information about the protocol for transferring Support Coordination to another CSB, please see The VACSB Transfer Protocol At-A-Glance (link)

BOX

Transfers: SC responsibilities

The referring CSB, (typically the I/DD Director or designee) will notify, by telephone, the receiving CSB (typically the I/DD Director or designee) of the expected date of transfer. Date of transfer is usually 90 days from receipt of initial communication regarding the request to transfer.

The referring CSB will send a follow-up letter to the receiving CSB to formally inform the receiving CSB of the planned transfer. An SC should check with their supervisor on the internal guidelines for this process.

The letter must contain:

- The individual's name
- Medicaid number
- Date of transfer
- A listing of current services, providers and approved funding for services
- Any changes in providers or service levels that will occur with the move

The referring CSB's SC will work with the receiving CSB and provide copies of current assessments, PC ISP, and other relevant documentation required on the Transfer Summary. The

receiving CSB will respond in writing accepting the transfer, confirming the transfer date and identifying the SC who will be assigned, so both SCs can collaborate in the transfer.

The referring SC will:

- Participate in any intake meetings required by the receiving CSB.
- Update the date of transfer, the new CSB and new SC in WaMS
- Check with a supervisor for any additional internal procedures related to discharging the person from SC services at their CSB. This will typically include completion of a Discharge Summary, final Person Centered Review and final progress note at a minimum.

Additionally there are protocols developed by the Developmental Disabilities (DD) Council specific to transferring a person from one CSB to another, please see The VACSB Transfer Protocol At-A-Glance, linked above. For the most recent protocols, the SC should check with the Developmental Disability (DD) Director of the CSB.

Discharge/Transition Planning

All licensed providers are required to have written procedures that define the process for transitioning a person between or among services operated by the provider. At a minimum the policy shall address:

- Continuity of services during and following transition
- Participation of the person or his authorized representative in planning
- Process and timeframe for transferring access to the record and ISP
- Process and timeframe for completing the Transfer Summary

For more information on the DBHDS licensing regulations pertaining to discharge/transition planning, see the following link:
http://dbhds.virginia.gov/assets/doc/QMD/OL/ch.105.full.wemergcompliance.9.01.18docx.pdf

12VAC35-105-691. Transition of Individuals Among Services and 12VAC35-105-693. Discharge

Training Center Discharges

As mentioned in Chapter 2 of this manual, anyone who previously resided in a training center who now lives in the community is required to have a more intensive level of support from the SC. When a person residing in a training center is seeking discharge into the community, the SC plays an important role of ensuring a smooth transition. The assessment and plan development process for a person being discharged from a training center is similar to the process for someone already residing in the community. Additionally, there is further funding available to help someone move into the community. Please ask your supervisor for assistance with funding resources available in your locality. Virginia has approved limited funding as a part of the plan to support people transitioning from a Training Center or other state facility according to the "Community Move Process" to a community home of their choice. Transitional funding,

formerly known as “Bridge Funding,” can be used in a variety of ways to support the planning and move of these individuals to their own homes or to a provider home licensed by DBHDS.

Box

Transitional Funds Guidelines At-A-Glance
Transitional Funds Application At-A-Glance

State Psychiatric Hospital Discharge

Both CSBs and state psychiatric hospitals recognize the importance of timely discharge planning and implementation of discharge plans to serve persons in the community, as well as to ensure the ongoing availability of state hospital beds for people presenting with acute psychiatric needs in the community.

More information on the collaborative discharge protocols for state psychiatric hospital discharges can be found at the following link.
http://www.dbhds.virginia.gov/library/mental%20health%20services/omh-dischargeprotocols.pdf

Private Medical/Psychiatric Hospital

The SC may support a person who resides in a private hospital and is seeking discharge into the community. The SC should work collaboratively with the person, their family/guardian, and the hospital staff in order to assess the person’s needs upon discharge, identify risks, needs and preferences, address barriers and ultimately develop a plan that meets the person’s desired outcomes. Once the person returns to the community, the SC provides ECM services for one year and then determines if the person continues to meet the criteria for ECM services.

Moves to Different Level of Care

There are times when a person will need to move to a different level of care, such as a move from the family’s home to a group home, or the transition from high school to adult services. The SC should work with people to assess the need, identify resources/ service options and address barriers. As discussed earlier in this chapter, transitions can be challenging but with the correct resources and tools, the SC can ensure a smooth transition. Chapter 8 (link) identifies strategies the SC can use to help assess the situation and modify the plan as needed.

One major transition occurs when a person no longer needs Support Coordination. There are a number of reasons why a person may be discharged from SC services. Reasons may include, but are not limited to, :

- Person moves out of the CSB catchment area or out of the state

- Death
- Person chooses to no longer use Support Coordination services
- Person is no longer eligible for Support Coordination services
- Person no longer meets financial eligibility for Support Coordination services
- Person no longer has active or specialized need for Support Coordination services

It is essential for the SC to work carefully through the transition and discharge process. SCs must ensure there is agreement for ending of SC services with the person, the agency, and other appropriate parties. The SC should provide reasonable notice of discharge that is based upon the facts and circumstances of each person's life. The SC should document both verbal and written notice to the person leaving services and the other participating service providers. It is important to communicate pertinent information, with permission, when transitioning to other providers and supports to maximize positive outcomes. As part of a Discharge Summary, the SC will include linkage to other resources as needed for a smooth transition. Documentation includes completion of the required Discharge Summary, notice of appeal rights, final Person Centered review, and a progress note.

BOX

Discharge from Support Coordination: SC responsibilities

- Complete SC agency's documentation requirements for discharge (discharge summary, case notes, final Person Centered Review, etc.)
- Submit a Notification of Right to Appeal letter regarding termination, if the person is receiving Medicaid billed State Plan Option (SPO) Targeted Case Management.
    - An exception to the need for a Notification of Right to Appeal letter is when the person has moved to another locality in Virginia and the receiving CSB will continue to provide TCM services. Because the SPO case management will continue, there is no need to send the appeal notification because no Medicaid services will be terminated.

DBHDS Licensing regulation 12VAC35-105-693 regarding Discharge (link)
http://dbhds.virginia.gov/assets/doc/QMD/OL/ch.105.full.wemergcompliance.9.01.18docx.pdf

Death

When a person who uses SC services passes away, there are a number of steps the SC takes to document the event. Each CSB has internal procedures, so the SC should check with their supervisor to ensure all documentation requirements have been completed.

Licensure regulations 12VAC35-105-160.C2 state that all serious incidents, including death, should be reported in writing to the DBHDS Office of Licensing within 24 hours. The state database system used to document serious incidents, such as death, is known as CHRIS (Computerized Human Rights Information System), accessible via the following link: http://www.dbhds.virginia.gov/quality-management/human-rights/shr-committee/computerized-human-rights-information-system-chris

https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=40

VIRGINIA DEPARTMENT OF EDUCATION
TECHNICAL ASSISTANCE RESOURCE DOCUMENT

Indicator 12: Part C to Part B Transition

Technical Assistance to provide a smooth and timely transition from Part C to Part B of the *Individuals with Disabilities Education Act* and report on Indicator 12.

VIRGINIA DEPARTMENT OF EDUCATION

COMMONWEALTH OF VIRGINIA
Department of Education
Division of Special Education and Student Services
Office of Special Education Instructional Services

The *Individuals with Disabilities Education Act* (2004) and the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* (2010) require that children who participate in early intervention services under Part C of the Act and who will participate in preschool programs under Part B of the Act experience a smooth and timely transition to early childhood special education programs. The U.S. Office of Special Education Programs (OSEP) requires states to include in their State Performance Plan (SPP) data regarding the percentage of children referred by Part C and found eligible for Part B who have an Individualized Education Program (IEP) implemented within the designated timeline. This is documented in Indicator 12. This document was developed for the purpose of providing technical assistance to support the effective transition from Part C to Part B and to provide information for reporting on Indicator 12.

Contact Information
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Early Childhood Special Education Specialist
Office of Special Education Instructional Services
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Dawn.hendricks@doe.virginia.gov

Web Site Information
http://doe.virginia.gov/special_ed/early_childhood/data/index.shtml
http://doe.virginia.gov/info_management/data_collection/special_education/index.shtml
http://va-leads-ecse.org/indicator-12

Indicator 12: Part C to Part B Transition Technical Assistance Document

Introduction to Indicator 12

The *Individuals with Disabilities Education Act* (IDEA; 2004) governs how states and public agencies provide early intervention, special education and related services to children. Part C of IDEA provides the regulations for early intervention to infants and toddlers from birth through age three. Part B of IDEA provides the regulations for special education and related services for school-aged children with disabilities (ages three-22 years).

The *Individuals with Disabilities Education Act* requires that children who participate in early intervention services under Part C of the Act and who will participate in preschool programs under Part B of the Act experience a smooth and timely transition to early childhood special education programs. The transition from Part C to Part B services necessitates data collection because the U.S. Office of Special Education Programs (OSEP) requires states to report *the percentage of children referred by Part C prior to age three, who are found eligible for Part B, and who have an Individualized Education Program (IEP) developed and implemented by the beginning of the school year if they turn age two by September 30 of that school year or by their third birthday*. This data provides the necessary information for Indicator 12.

States are required to submit a performance plan which includes baseline data, targets, and improvement activities for all data indicators, including Indicator 12. State data is reported in the State Performance Plan (SPP). Reports on the state-level data and progress toward meeting the state targets are described in the Annual Performance Report (APR). Indicator 12 is a compliance indicator, and therefore has a 100 percent compliance target. The OSEP's expectation is that states will meet the transition timeline with **100 percent** of all children transitioning from Part C to Part B.

Key Components of the Transition from Part C to Part B

Agencies

The Infant and Toddler Connection of Virginia (Part C of IDEA)[1] is managed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS). Early Childhood Special Education (Part B of IDEA) is managed by the Virginia Department of Education

[1] The Infant and Toddler Connection of Virginia (ITC) provides early intervention supports and services to infants and toddlers from birth up to age three who have certain levels of developmental delay, differences in development and/or a diagnosed condition. Referrals to the ITC of Virginia are made by contacting the early intervention "central point of entry" for the child's and family's locality. There are 40 points of entry throughout the state.

(VDOE). Both agencies have responsibilities for ensuring the smooth and timely transition of children. There are regulations governing both Part C and Part B of IDEA.[2]

The *Virginia Interagency Memorandum of Agreement among the Agencies Involved in Implementation of Part C of IDEA* documents the understandings and commitments of participating agencies in the Virginia statutory requirements related to Part C. The *Virginia Interagency Memorandum of Agreement* outlines the transition agreement between the DBHDS and VDOE. The Transition Agreement section of this document can be found on the DOE website at http://www.doe.virginia.gov/special_ed/early_childhood/transition/index.shtml.

The Memorandum of Agreement must be upheld by the local Infant and Toddler Connection (ITC) and Local Education Agencies (LEA)[3] as they work to transition children from Part C to Part B. Since local ITCs and LEAs must work together to develop understandings and procedures to ensure smooth and timely transitions, local interagency agreements that specify roles and responsibilities for accomplishing the transition planning and activities required under Part C and Part B of IDEA are required. It is critical for ITCs and LEAs to be aware of these local interagency agreements and to consider the effectiveness of such agreements and modify as needed.

Child's Age

In Virginia, children who reach the age of two on or before September 30 of any given year and who meet Part B eligibility requirements as defined in the *Code of Virginia* and in accordance with the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* are eligible to receive special education and related services through their local school divisions. Notwithstanding the availability of a free appropriate public education (FAPE) at age two, a child remains eligible to receive Part C services until his/her third birthday. Therefore, if a child turns two on or before September 30, parents may choose to have their child remain in Part C or transition to Part B. The LEA can determine whether to serve children who turn two after September 30 for that school year. The terminology "rolling enrollment" pertains to those children turning two after September 30.

Children eligible for Part B preschool services are to transition from Part C to B by their third birthday. Admission is to take place throughout the school year for these children.

Children who are two on or before September 30 and who meet eligibility requirements are expected to have the eligibility and IEP process completed for the child to start the first day of the school year. Children in Part C who are eligible for Part B and whose parents elect for them to continue in Part C until they are three are expected to have an IEP in place so the child can start Part B by their third birthday. In both situations, the referral from Part C to Part B is to be completed not fewer than 90 calendar days before that child reaches the age of eligibility. (See

[2] (Regulations for Part C can be found on the Infant and Toddler Connection of Virginia website at http://infantva.org/.) Regulations for Part B can be found on the Virginia Department of Education website at http://www.doe.virginia.gov/special_ed/regulations/state/index.shtml.

[3] Local Education Agency means a local school division governed by a local school board or a state-operated program that is funded and administered by the Commonwealth of Virginia.

the section titled, *Steps of a Smooth and Timely Transition* below for more information regarding referrals.)

According to the *Virginia Interagency Memorandum of Agreement Among the Agencies Involved in Implementation of Part C of IDEA,* DBHDS is to maintain financial responsibility and pay for supports and services listed on the Individualized Family Service Plan (IFSP) until the child's third birthday or the earlier date on which the child begins Part B services (e.g., the beginning of the school year in which the child is two years old by September 30), to the extent those services are not otherwise paid for by public or private insurance, family fees or other third party payor sources. Additionally, DBHDS remains financially responsible for two year olds who choose not to transition to Part B until their third birthday or who initially transition to Part B but choose to return to Part C prior to their third birthday. The VDOE is to accept financial responsibility and pay for all special education and related services, as listed on an IEP, to a Part B eligible child beginning on the child's third birthday or the earlier date on which the child is eligible for and the parent chooses to begin Part B services (e.g., the beginning of the school year in which the child is two years old by September 30 or some other point between the beginning of the school year and the child's third birthday if the local school division offers rolling admission).

Part B Eligibility

Any child receiving Part C services and suspected of having a disability may be referred to Part B. This is done by making a referral to the school division where the child resides. The eligibility requirements for Part C and Part B are different and can be found in the respective regulations. For a child to be eligible for Part B services, he or she is to be evaluated in accordance with the provisions of the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* and determined to have an intellectual disability, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disability (referred to in this part as "emotional disability"), an orthopedic impairment, autism, traumatic brain injury, any other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities who, by reason thereof, needs special education and related services. This also includes developmental delay if the local educational agency recognizes this category as a disability.

Steps of a Smooth and Timely Transition

Transition Conference

A Transition Conference is required, with parent consent, if the child is potentially eligible for Part B preschool services. The Transition Conference is coordinated by the local ITC and:

- Must be at least 90 days and can be up to nine months before the child's anticipated date of transition;
- Must meet the requirements of an Individualized Family Service Plan (IFSP) meeting;
- Must include the family;

- Must include a Part C representative;
- Must include an LEA representative who is knowledgeable about services available in Early Childhood Special Education (ECSE) programs (any staff familiar with the ECSE program that can explain the program to the family); and
- May be combined with a meeting to develop the transition plan.

Initial Referrals

In the case of a child who is suspected of having a disability and will soon reach the age of eligibility for preschool services under Part B, with parent consent, Part C is to provide notification to the LEA for the area in which a child resides. This is known as a referral and is done by transmitting each child's name, parent's name(s), address, phone number and birth date to the child's LEA of residence. The referral is to be completed not fewer than 90 calendar days before that child reaches the age of eligibility for Part B. Notification of children who will be age eligible for the coming school year is to be provided by April 1 to the LEA of the child's residence unless there is a local interagency agreement specifying otherwise. A notification will not be completed if a parent disagrees in accordance with the opt-out procedures specified in the Infant & Toddler Connection of Virginia Practice Manual.

The ITC and LEA must work together to ensure a smooth and timely transition. Therefore, the following must be determined at the local level:

- The person who sends the notification/referral from Part C;
- The person who receives the notification/referral at the LEA;
- How the information will be sent to the LEA;
- Whether the referral information will be sent individually or in batches; and
- The date by which referral information will be sent if earlier from those outlined in the *Virginia Interagency Memorandum of Agreement*.

By mutual agreement between the ITC and the LEA, notification of children who will be age eligible for the coming school year can occur at once or be spread out over time provided regulatory requirements are met. Local Education Agencies are to accept referrals any time of the year. Summer months and breaks are considered the same as other months of the school year.

The referral requires only the child's name, birthdate, parent(s) name and contact information. When the LEA special education designee receives the child's name and information, it is considered a referral and the regulatory timeline begins. The referral may also include the service coordinator's name and contact information and the language(s) spoken by the child and family. Assessment information and the IFSP are not required for it to be a referral.

Notification of the Referral to the Virginia Department of Education

Part C is to also notify VDOE of referrals made to LEAs. Notification to the VDOE will occur by entry or transfer of the notification information into a secure single sign-on web server hosted by VDOE.

Late Referral to Part C

If a child is referred to Part C between 45 and 90 days prior to the child being eligible to receive services from Part B, with parental permission, the LEA and Part C may conduct the eligibility evaluations together. For children determined eligible for Part C (and the child is potentially eligible for Part B) notification to the LEA and VDOE must occur as soon as possible after the determination of eligibility.

For a child referred to Part C fewer than 45 days prior to the child's third birthday, with parental consent, the local early intervention system refers the child to the LEA and VDOE. This is not considered notification from Part C. Part C is not required to conduct an evaluation, assessment or develop an initial IFSP or transition plan for such children. Part C may directly refer or have the parents refer the child to the LEA.

For children referred to Part C fewer than 45 days prior to the child's being age eligible at age two, to receive services from Part B, the local early intervention system is to directly refer or have the parent refer the child to the LEA. This may occur instead of or in addition to proceeding with the referral to Part C. If the referral to Part B is made by the parent or is made prior to determining eligibility under Part C, then this is not considered a notification from Part C.

Part B Eligibility

For all children suspected of having a disability, LEAs are to follow the regulations outlined in the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* (found at http://www.doe.virginia.gov/special_ed/regulations/state/index.shtml) for determining whether a child has a disability and is eligible for special education and related services.

A variety of assessment tools and strategies are used to gather relevant functional, developmental, and academic information about the child. No single measure is to be used as the sole criterion. Tools and strategies that provide information regarding the child's involvement and progress in appropriate activities:

- Must provide information about the child's physical condition, social or cultural background, and adaptive behavior;
- Must include information provided by the parent(s);
- Must include an observation in the child's learning environment (for the child less than school age, this is to be an environment appropriate for a child of that age that will provide authentic information regarding the child's development); and
- May include evaluation information from the Part C program as well as information from the IFSP.

Prior written notice of the eligibility decision is provided to the parents. This notice is required when a child is eligible, and when a child is not eligible for Part B services. The notice must

contain the required elements outlined in the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* including the parent(s) right to appeal the decision through the due process hearing procedures.

Timelines

Upon receipt of the referral from Part C, the LEA Special Education Administrator or designee is to begin the evaluation process. Part B eligibility must be determined within 65 business days of receipt of the referral. When the referral is received, the administrator shall within three business days:

- Initiate the evaluation process;
- Require that the school-based team review and respond to the request (the team is to meet within 10 business days following receipt of referral); or
- Deny the request and provide prior written notice and procedural safeguards to the parent(s), including the parent's right to appeal the decision through the due process hearing procedures.[4]

The 65 day timeline is the same during the entire year including the summer. Business days are Monday to Friday, except for state and federal holidays.

Team Membership

Membership at eligibility/IEP meetings includes parent(s), a regular education teacher, a special education teacher, an individual who can interpret the instructional implications of evaluations, and a representative of the LEA. Parents are to be informed that the Part C Service Coordinator or other representative may be invited to the Part B Eligibility and IEP meetings. Part C personnel are to be invited to the meeting(s) if the parent requests. The regulations do not address whether written notice to Part C is required. However, because States and LEAs are required to maintain records to show compliance with IDEA, it is good practice for the LEA to keep a record of the Part C person, or persons receiving the invitation, the date the invitation was sent, and a copy of the invitation or notes from a phone call extending the invitation.

The LEA is to take steps to ensure that one or both of the parents of the child with a disability are present at each IEP meeting or are afforded the opportunity to participate. If after multiple attempts, neither parent can attend, the LEA is to use other methods to ensure parent participation, including individual or conference telephone calls and audio conferences. Every effort is to be taken to ensure that the parent(s) understand the purpose and the proceedings of the IEP meeting.

[4] A child who is referred from Part C to Part B of IDEA and does not meet Part B eligibility criteria should be considered for eligibility under Section 504 of the Rehabilitation Act of 1973. A child, who previously qualified under Part C of IDEA, but does not meet eligibility criteria under Part B, may meet eligibility criteria under Section 504 and should be referred for a 504 evaluation.

Individualized Education Program (IEP)

If the child is found eligible for special education and related services an IEP is to be developed within 30 calendar days from the eligibility date. The IEP team is to determine if the child qualifies for Extended School Year services (ESY) and when services will begin.

The nature and amount of special education and related services is determined by the child's IEP team. The IEP team is to consider the child's IFSP and whether there are components to be incorporated into the child's IEP. A schedule comparable in length to school age students is to be made available if determined appropriate by the IEP team. Further, as stipulated in IDEA, to the maximum extent appropriate, children with disabilities must be educated with children who are not disabled. The LRE requirements of the IDEA apply to all children with disabilities who are served under Part B of the IDEA, including preschool children with disabilities.

IEP Implementation

Once an IEP is developed, it is implemented as soon as possible. The start date can be flexible but must be within a reasonable amount of time. If a child turns three during the summer months and is found eligible to receive services, the IEP team must determine when services begin. If the child turns three during the summer, special education and related services may begin in the new school year. For example, the IEP may be written in June to start in September (first day of school).

Once the IEP is implemented, Part C services are to be terminated. The child can continue receiving Part C services during the period of time when eligibility is being determined and the IEP being developed. Part C services are to be discontinued once Part B services begin. For some children who begin services and have an IEP implemented at the start of a new school year, it is possible for the child to continue receiving Part C services until the IEP is implemented.

Reporting Indicator 12

Indicator 12 data is to be entered through the VDOE Single Sign-on for Web System (SSWS) application "Special Education Indicators." The Instructions for Reporting Indicator 12 can be found in Appendix A.

The Reporting period for Indicator 12 is July 1 through June 30. An LEA must report on all children served and referred by Part C to Part B for eligibility determination. If a child has not been served by Part C and is referred for special education services for the first time, he or she will not be included in the Indicator 12 count. The child will be included in the Indicator 11 Child Find "timeline" indicator. This includes children referred by Part C but never evaluated or had an IFSP developed. For the reporting period, LEAs are to report on those children who were referred, found eligible, and had an IEP developed. If the child's third birthday occurs during the

summer, the IEP team must consider the date when services under the IEP will begin. If the child does not need ESY services, the date of initiation of services may be the beginning of the school year and the IEP is considered "implemented" by the child's third birthday for the purpose of Indicator 12.

Instructions

The LEAs are to report the children served and referred from Part C to Part B for eligibility determination. Based on this number, the percentage of children who have an IEP developed by their third birthday is calculated. The OSEP recognizes that not all children referred will be found eligible, thus not have an IEP developed. Further, OSEP recognizes that there are reasons that an IEP may not be developed by the child's third birthday that are beyond the control of the ITC and/or LEA. Therefore, there are a number of exceptions that result in the exclusion in the final calculation. These include:

- Children not determined eligible due to withdrawal of parental consent, the child moved, or any extenuating circumstance;
- Children that did not meet the time line because the parent repeatedly failed or refused to make the child available;
- Children for whom parent refusal to provide consent caused delays in evaluation or initial services (e.g., referred less than 65 business days prior to age of eligibility);
- Children who were referred to Part C less than 90 days before their third birthdays; or
- Children determined to be NOT eligible and whose eligibility was determined prior to their third birthdays.

All other reasons for a late IEP result in a finding of noncompliance. This includes children referred to Part C more than 90 days before the child's third birthday, served in Part C, but referred to Part B less than 90 days before the child's third birthday. In this case, the LEA is still responsible for ensuring that an initial evaluation under Part B is completed and, if the child is determined eligible, an IEP is developed and implemented by the child's third birthday. It is the responsibility of both programs to work together to make sure that the LEA notification and transition conference for children referred for Part B occur in a timely manner that enables the LEA to meet its responsibility to conduct an evaluation and, if the child is determined eligible under Part B, to develop and implement an IEP. Local Education Agencies are required to provide further documentation for those children that did not have an IEP implemented by the beginning of the school year if they turn age two by September 30 of that school year or by their third birthday. The actual number of days the IEP was late as well as the reason(s) are to be documented and reported.

Appendix A

Part B Special Education State Performance Plan (SPP) and Annual Performance Report (APR): Instructions for Reporting on Indicator 12

Percent of children referred by Part C prior to age 3, who are found eligible for Part B, and who have an IEP developed and implemented by the beginning of the school year if they turn age two by September 30 of that school year or by their third birthday.

- All data must be entered through the **SSWS application "Special Education Indicators."** Request access to the application from your local SSWS administrator.
- Reporting period is July 1, ____ through June 30, ____.
- Report only on children served and referred by Part C to Part B for eligibility determination.
- **Data must be submitted on or before _____.**

Data Entry

Section 1. Report on children served and referred from Part C to Part B

- A. Enter the number of children who have been served in Part C and referred to Part B for eligibility determination.
- B. Enter the number of children not determined eligible due to withdrawal of consent, the child moved, or any extenuating circumstance. This number is not included in the calculation.
- C. Enter the number of children that did not meet time line because parent repeatedly failed or refused to make the child available. This number is not included in the calculation.
- D. Enter the number of children for whom parent refusal to provide consent caused delays in evaluation or initial services (referred less than 65 business days prior to age of eligibility). This number is not included in the calculation.
- E. Enter the number of children who were referred to Part C less than 90 days before their third birthdays. This number is not included in the calculation.
- F. Enter the number of children determined to be NOT eligible and whose eligibility was determined prior to their third birthdays. This number is not included in the calculation.
- G. The cell automatically adds B, C, D, E, and F indicating the total number of exceptions.
- H. The cell automatically calculates A minus G. This number is the denominator.
- I. Enter the number of children found eligible and who have an IEP implemented by beginning of school year if two by September 30 or by 3rd birthday. This number is the numerator.
- J. Automatically calculated reflecting the number that did not meet timeline.
- K. Automatically calculated. K is the percent that will be reported to the public.

Section 2. Account for children in J. from Section 1.

- L. Enter the number of children who missed Indicator 12 timeline for each range of days. Use the exact number of business days, not an average, in determining the range.
- M. Enter the actual number of delays in Indicator 12 timeline for each listed applicable reason. Specify other reason not listed and the number of determinations beyond the timeframe.
- J, L, M must be the same or the application will not let you save the data. An error message in red will appear at the top of the page after hitting the save button.

Virginia Support Coordination/Case Management Transfer Procedures For Persons with a Developmental Disability

[As Originally Agreed Upon by the VACSB DS Council]

Support Coordination/Case Management Transfer Procedures For Persons with a Developmental Disability

This document has been developed to assure the compliance with the Person Centered Individual Support Plan (PCISP) to promote full community inclusion and to promote self-determination in the event that an individual's residency may be out of his/her home area. As one's comprehensive supports are defined for the most integrated settings, the following areas must be addressed:

- Employment
- Community Participation
- Skill Development
- Psychotropic Medication Use
- Monitoring
- Choice and Control
- Risk

The following procedures will be followed by all Virginia Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs) to address Support Coordination/Case Management (SC/CM) and service delivery responsibilities when individuals with an intellectual/developmental disability (IDD) move from one CSB/BHA jurisdiction to another regardless of providers, or when a request is made for SC/CM responsibilities to be transferred to another jurisdiction. These procedures apply to any individual who changes residency or requests a transfer of SC/CM responsibilities regardless of funding source including Medicaid Waiver, Community Intermediate Care Facility[1], Targeted Case Management (TCM) and those persons without specialized funding sources, and is compatible with the process outlined in the *Mental Retardation/Intellectual Disability Community Services Manua*l, Chapter IV. CSB/BHAs have the responsibility to participate in intense communication regarding individuals moving into a new CSB/BHA area who have complex behavioral, psychiatric, and/or medical needs (e.g. involvement with REACH, psychiatric facilities, rehabilitation facilities, emergency placements) to ensure the quality of care.

1. Preliminary Notification of Relocation

   A. When an individual plans to or relocates outside his/her CSB/BHA jurisdiction, either temporarily or permanently, the CSB/BHA of origin **will secure an authorization to release protected health information** and notify the receiving CSB/BHA Developmental Disability Director (DD) or Designee.

[1] While community ICFs, and other facilities provide case management services to their residents making CSB/BHA support coordination/case management not a billable service, liaison services by either the local CSB/BHA or CSB/BHA of origin (depending on circumstances) is advisable. Determination of which CSB/BHA should perform this function depends on individual/family choice, the elements of this protocol and residency (per Code requirements).

B. The CSB/BHA of origin shall advise the receiving CSB/BHA of any intensive support needs concerning the individual's placement such as a crisis plan, behavioral concerns/receiving behavioral health services, REACH, recent discharge information from training center or psychiatric hospitalization, medication management, medical, waiver waitlist status and/or need for other services.
C. If the receiving CSB/BHA questions the individual's ability to give informed consent, the DD Director or Designee of origin will be contacted for clarification.

2. Written Notification of Relocation

A. Upon notification of relocation, a transfer letter and required documentation packet as referenced in (**Attachment C)** will be sent by the CSB/BHA of origin to the receiving CSB/BHA **(Attachment A)**.

B. For an individual whose SC/CM **is being transferred**, the receiving DD Director will send a letter of acknowledgement to the CSB/BHA of origin.

C. For an individual whose SC/CM **is not being transferred**, on-going psychiatric services and medication management may need to be retained/coordinated by the jurisdiction of origin **(Attachment B)**.

3. Timeline for Transfer of SC/CM

A. Within **45 days** of receipt of the transfer information, any concerns shall be negotiated and resolved.

B. Unless a particular individual's situation meets the definition of "exception" as delineated in the exceptions listed below, the transfer of SC/CM responsibility will take place approximately **90 days** of written relocation notification date.

C. In cases of Medicaid billing, each CSB/BHA needs to be cognizant of regulations and communicate the billing end date for the CSB/BHA of origin and start date for the receiving CSB/BHA. The first of the month being preferred to avoid duplication of billing.

4. Exceptions

SC/CM will be retained by the CSB/BHA of origin in the following situations:

A. When an individual is relocating on a temporary basis and the CSB/BHA of origin agrees to provide SC/CM and has the ability to manage emergency situations.

B. When an individual is a minor and receives services in one jurisdiction but his/her family retains legal residency in the CSB/BHA of origin's jurisdiction, and/or when individuals are receiving services through the Comprehensive Services Act.

C. When an individual is a minor and in the custody of the Department of Social Services (DSS), and is in foster care placement outside of the responsible DSS and CSB/BHA of origin's jurisdiction.

D. Should there be special circumstances in which it is beneficial for the CSB/BHA of origin to retain SC/CM for longer than **90 days**; an agreement will be negotiated between CSB/BHA DD Directors regarding length of time and exchange of information. Examples may include psychiatric or medical crisis, or termination of service placements is requested through the authorization process stability of placement, etc.

Attachment C outlines specific documents (This information will be updated when we have an updated manual, this info comes directly from the current manual) that are required to be shared between CSB/BHA's. The requirements for psychological evaluations are as follows:

> **Individuals six years of age or older must have a psychological evaluation completed by a licensed professional that indicates a diagnosis of MR/ID. The psychological evaluation must reflect the individual's current level of functioning and support the diagnosis of MR/ID as defined by the American Association of Intellectual and Developmental Disabilities (AAIDD):**
>
> **"Mental retardation/intellectual disability is a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18."**

The psychological evaluation or accompanying documentation must address intellectual functioning, adaptive behavior and age of onset. **(*Mental Retardation/ Intellectual Disability Community Services Manual Chapter IV pages 4-5 version 7/14/2010*).** Individuals less than age six must have a psychological or standardized developmental evaluation that reflects the child's current level of functioning and that states that the child has a diagnosis of MR/ID or is at developmental risk. Developmental risk is defined in the state regulations as:

> **"The presence before, during, or after birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through available diagnostic and evaluative criteria.". (*Mental Retardation/ Intellectual Disability Community Services Manual Chapter IV page 5 version 7/14/2010*).**

The requirements for medical evaluations are as follows:

> **There should be medical information in the case management record for any individual receiving MR/ID or DS Waiver services. Individuals receiving MR/ID or DS Waiver services must have a medical examination completed no earlier than 12 months prior to the start of waiver services. Documentation should indicate that additional evaluations occur whenever indicated. Medical examinations of children should follow the schedule of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) administered by DMAS. (*Mental Retardation/Intellectual Disability Community Services Manual Chapter VI page 9*).**

5. *Changes*

During the transfer process if there is any significant change with the transfer the receiving Director (DD Director) or designee should be notified. For example; if an individual initially moved to Chesapeake and moved again during the 90 day transfer period to Richmond both DD Directors should be notified. This notification provides closure and documentation to the original receiving CSB/BHA.

6. Disputes

Should concerns remain unresolved between the CSB/BHA of origin and the receiving CSB/BHA; the Transfer Protocol Committee Chair will be notified of the unresolved concerns. The chair will contact committee members to discuss and assist with identifying solutions. If the parties are unable to resolve and/or negotiate the transfer, the chair will contact the VACSB Director and ED Forum Chair to assist with the process.

DBHDS Transitional Funding Guidelines

What is Transitional Funding?

Virginia has approved limited funding as a part of the plan to support individuals transitioning from a Training Center or other state facility according to the "Community Move Process" to a community home of their choice. Transitional funding, formerly known as "Bridge Funding," can be used in a variety of ways to support the planning and move of these individuals to their own homes or to a provider home licensed by the DBHDS. The application is available on the Department of Behavioral Health and Developmental Services (DBHDS) website.

Transitional Funding may be used:

1. **Prior to discharge** *for those individuals who will reside in their own home or a provider home licensed by DBHDS of any size*.
2. **Post discharge** *for those individuals who will reside in their own home or a provider home licensed by DBHDS to access escrowed funds approved in the offsite supervision category. Post discharge funds are approved for up to 12 months post discharge.*

Transitional Funds will provide flexibility not currently available through existing federal or state programs. **Transitional Funding may NOT be used to purchase goods or services which may be funded through Medicaid or any other means at the time that funding is provided.** Transitional Funds may NOT be used to supplement transitional services currently available through the Money Follows the Person (MFP) Program and the Developmental Disability Waiver. Transitional funds may NOT be used to support individuals who have not discharged from a training center or other state institutional setting. Transitional funding is approved based on the individual's essential needs at the time of discharge.

Determinations as to whether or not to grant an application and provide Transitional Funds are at the sole discretion of DBHDS.

How Can Transitional Funding Be Used?

DBHDS Transitional Funding Guidelines

Transitional Funds may be used in a variety of ways to support individuals with costs associated with transitioning into a community home. The various types of Transitional Funding are described below:

Prior to discharge, supports such as the following may be funded:

Employment Services- This includes discovery, job development, placement and training and follow along for the purpose of assuring individuals have a successful transition into the community. This funding is limited to employment service organizations with a provider participation agreement with the Department for Aging and Rehabilitative Services (DARS). This funding is also limited to when DARS is operating with a waiting list and/or when DARS has deemed someone ineligible for services.

Environmental Modifications – This includes environmental modifications required to assure the individual has a safe and accessible home. One quote is required with application submission for each modification request. DBHDS reserves the right to request a second quote for competitive rate comparison.

Equipment- This includes equipment needed to support the individual based on their medical and/or behavioral diagnosis, and as outlined as an essential support need. Transitional funding will not cover equipment covered by any other source at the time of the funding request. One quote is required with application submission for each equipment request. DBHDS reserves the right to request a second quote for competitive rate comparison.

Vehicle Modifications- This includes modifications to a provider owned vehicle to ensure the vehicle is fully accessible to the individual. One quote should be submitted for all vehicle modifications. DBHDS reserves the right to request a second quote for competitive rate comparison.

Additional Staff Training – This includes individualized training to address the unique needs of the individual while preparing for transition from a training center or other state facility to a specific community provider. This can include specific discharge related training, or to support training which occurs during day, evening, and overnight visits.

Additionally, funding may be utilized for extensive, specialized training that is essential to ensuring the individual's safe transition. **This does not include state mandated training required of all licensed DBHDS providers.** Funding is approved based on staff participation hours spent in direct training and shall not exceed the allowable hourly rate as described within the waiver rate model, based on level, tier, and location of service.

Nutritional Supplements – Funding is available to pay for needed dietary supplements and special foods that do not meet the criteria for sole source of nutrition but are nevertheless required to support the health and weight of an individual residing in either a provider home licensed by DBHDS or his/her own home and *which are not available through current funding sources*. [See 12VAC30-50-165 (A), (M) for the definition of "sole source" or nutrition.] Funding is approved for up to 6 months post discharge.

Miscellaneous- This includes onetime expenses not covered by Medicaid but are none the less essential to the individual's health and well-being and are only covered up to one year post discharge.

ABA-Funding may be used when an individual residing in a provider home licensed by DBHDS or his/her own home has an acute behavioral need requiring direct therapy/interventions to ensure the safety of the individual or others. In order for an individual to receive funding for applied behavioral analysis, such supports must be provided by a Board Certified Behavioral Analyst.

Post-Discharge Supports will be available after discharge from a Training Center and support the following:

Off-Site Supervision – Funding should be used to support an individual receiving Congregate Residential Support who requires out of home care, such as hospitalization, each calendar year. Supervision may include assisting the individual when out of the residence to ensure that the individual's needs are understood by a provider/hospital. Funding is only approved for up to one year post discharge. Funding is approved based on the number of staff hours required to provide off-site supervision and shall not exceed the allowable hourly rate as described within the waiver rate model, based on level, tier,

and location of service. [Federal regulation against funding through Medicaid at 42 CFR 441.301(b)(1)(ii).]

How Can a Provider Access Transitional Funding?

- **Application** –The application shall include: the individual essential needs information; time line for provision of supports including an estimated start date, and one price quote for any home modification, vehicle modification, or equipment request. DBHDS reserves the right to request a second quote for competitive rate comparison. A copy of the "Discharge Plan and Discussion Record," must be attached.
- **Submission-**Applications should be submitted via email in a Word format to carrie.ottoson@dbhds.virginia.gov or directly to the training center Community Integration Manager for review. Handwritten or partially completed applications will be pended for editing.
- **Review –** The application package will be reviewed by the DBHDS Assistant Commissioner for Developmental Services and the Transitional Funding Manager to determine that the items requested to be funded are eligible for Transitional Funding and that the requested items may not be funded by Medicaid or any other funding sources. The Assistant Commissioner will make a decision on the application package and provide his decision to the Transitional Funding Manager within 10 working days of his receipt of a completed application package. The Transitional Funding Manager, shall notify the individual and the provider of the decision within 3 business days of the receipt of the decision from the Assistant Commissioner. If Transitional Funds are approved, DBHDS shall send the signed application packet to the provider via standard mail for signature.
- **Status Categories –** Approved, Denied, or Pended for More Information.

- Applications shall be denied if the Assistant Commissioner determines in his sole discretion that:
  - Items requested to be funded are not eligible for Transitional Funding;
  - Items requested to be funded may be funded by Medicaid or another source;
  - DBHDS allotted transitional funds have been expended; or
  - The individual did not discharge from a state institutional setting.

- For applications that are denied, DBHDS shall provide notice to the individual, and the provider stating the reason(s) for the denial and the process for requesting a reconsideration of the decision.
- If an application is denied, the individual, or the provider may submit a written request for reconsideration to the Assistant Commissioner within 10 days of the date of the written notice of the denial. The Assistant Commissioner shall provide an opportunity for the person requesting reconsideration to submit for review any additional information or reasons why Transitional Funding should be approved as requested. The Assistant Commissioner, after reviewing all submitted materials, shall render a written decision on the request for reconsideration within 15 business days of receipt of the request for reconsideration. The decision of the Assistant Commissioner shall be binding. Further review may be sought in accordance with the Virginia Administrative Process Act, Virginia Code § 2.2-4000 *et seq*.

How Can Providers Receive Transitional Funding Payments?

- **Transitional Funding Agreement -** After review and approval of the electronic file submitted, a signed original copy of the application packet will be mailed by DBHDS to the provider for signature. Once a signed application packet is returned to DBHDS, the provider and DBHDS shall enter into a Transitional Funding Agreement. No invoices will be processed without final signature from all parties. **Scanned signatures are not permitted**. Agreements will be effective on the latest date of signature, and will be extended for a 12 month period.

Providers who do not use the approved funds within this time frame will forfeit all remaining funds. Invoices submitted post one year will not be processed by DBHDS. Providers are responsible for submitting invoices by the close of the fiscal year or by May 1st of each year in which funding is approved. Should overpayment occur, the provider will be responsible for returning funds to DBHDS within 90 days.

- **Expensing Funds -** Providers shall send proof of expenditures by completing a DBHDS invoice which can be obtained from the Transitional Funding Manager or on the DBHDS website. The invoice and proof of expenditures should be submitted to the DBHDS Transitional Funding Manager by the 15th day of the following month, for each month in which reimbursement is being requested. Funding can take up to 30 days after submission for payments to be dispersed.

Provider Commitment

- **Provider Commitment** – A provider receiving Transitional Funds to support an individual shall support that individual for a minimum of 12 months unless the individual chooses to receive services from another provider or the provider becomes unable to meet the individual's needs. The provider must utilize all available interventions and technical assistance resources provided by DBHDS before recommending that the individual locate to another residence. If the provider is not able to fulfill its commitment to support the individual for a minimum of 12 months, DBHDS may request return of and recoup all Transitional Funds used for any home or vehicle modifications. However, if the individual or his AR chooses to receive services from another provider or if the provider will make the home/vehicle modifications funded with Transitional Funds available to another individual exiting a training center and the provider has addressed, through approved corrective action, any citations of violations of

the *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-105, and the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-115, DBHDS will not seek recovery of the Transitional Funds provided for those modifications. In the event that an individual is relocated, all adaptive equipment purchased specifically for the individual using Transitional Funds shall accompany him/her to the next residence.

Virginia Department of Behavioral Health & Developmental Services

DBHDS TRANSITIONAL FUNDING APPLICATION

SECTION 1.	CONTACT INFORMATION
DATE	Click here to enter a date.
INDIVIDUAL NAME	Click here to enter text.
INDIVIDUAL DOB	Click here to enter text.
INDIVIDUAL MEDICAID #	Click here to enter text.
CSB	Click here to enter text.
PROVIDER NAME	Click here to enter text.
PROVIDER MAILING ADDRESS	Click here to enter text. Click here to enter text.
LOCATION OF HOME	Click here to enter text. Click here to enter text.
PROVIDER POINT OF CONTACT	Click here to enter text.
PROVIDER PHONE NUMBER	Click here to enter text.
PROVIDER EMAIL	Click here to enter text.
TRAINING CENTER/STATE FACILITY	Click here to enter text.
HOW MANY BEDS IS THE HOME LICENSED FOR?	Click here to enter text.
SECTION 2.	**SUMMARY OF INDIVIDUAL SUPPORT NEEDS**
Please list the essential support needs documented in the Discharge Plan and Discussion Record, for which Transitional Funding is requested.	Click here to enter text.
SECTION 3.	**CATEGORIES: Describe the request for funding within each category. Complete only the categories under which Transitional Funds are requested**
ENVIRONMENTAL MODIFICATIONS	Click here to enter text.
EQUIPMENT	Click here to enter text.
VEHICLE MODIFICATIONS	Click here to enter text.
ADDITIONAL STAFF TRAINING	Click here to enter text.
OFF-SITE SUPERVISION	Click here to enter text.

DBHDS TRANSITIONAL FUNDING APPLICATION

NUTRITIONAL SUPPLEMENTS	Click here to enter text.
EMPLOYMENT SERVICES	Click here to enter text.
MISCELLANEOUS	Click here to enter text.

SECTION 4. FUNDING REQUESTED

FUNDING CATEGORY	DESCRIPTION	RATE	TOTAL
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
TOTAL REQUESTED:			$TOTAL

SECTION 5. TIME LINE (Complete this section based on discharge planning goals)

ASSESSMENT	Click here to enter a date.
INITIAL PROVIDER MEETING	Click here to enter a date.
DAY VISIT	Click here to enter a date.
EVENING VISIT	Click here to enter a date.
OVERNIGHT VISIT	Click here to enter a date.
FINAL PROVIDER MEETING	Click here to enter a date.
NEW STAFF HIRE	Click here to enter a date.
ENVIRONMENTAL MODIFICATIONS	Click here to enter a date.
LICENSING	Click here to enter a date.
DISCHARGE DATE	Click here to enter a date.

SECTION 6. SIGNATURES (Only original signatures permitted)

The following documentation is required with application submission. For assistance obtaining this information, please contact the training center Community Integration Manager:

- Discharge Plan and Discussion Record

Virginia Department of Behavioral Health & Developmental Services

DBHDS TRANSITIONAL FUNDING APPLICATION

- Quotes for Home Modifications, equipment, and vehicle modifications
- Copy of proposed monthly activities if applying for Employment Services.

This application is submitted by the parties below. All signatures MUST be original. No scanned/copied signatures accepted.

_____ _____

Signature of Provider/Title Date

_____ _____

Received by Date Received

SECTION 7.	AGREEMENT/FUNDING APPROVED

- This Transitional Funding Agreement is entered into by and between the Department of Behavioral Health and Developmental Services ("DBHDS"), and Click here to enter provider name..

- WHEREAS Virginia approved limited funding as a part of the plan to support individuals transitioning from Training Centers back to the community, according to the "Community Move Process;" and

- WHEREAS Transitional Funds support the planning and move of these individuals to their own homes or to a provider home licensed by the DBHDS; and

- WHEREAS DBHDS received a Transitional Funding Application for the individual named herein and DBHDS has approved Transitional Funding as specified herein.

- NOW, THEREFORE, in consideration of the agreements contained herein, DBHDS and Provider agree as follows:

1. ITEMS FOR WHICH TRANSITIONAL FUNDING IS PROVIDED.

In accordance with DBHDS Transitional Funding Guidelines and the Application, DBHDS has approved Transitional Funding for Click here to enter individual name.. Transitional Funding is approved for the following goods and/or services in the following amounts:

FUNDING CATEGORY	DESCRIPTION	RATE	TOTAL
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Virginia Department of Behavioral Health & Developmental Services

DBHDS TRANSITIONAL FUNDING APPLICATION

Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Choose an item.	Click here to enter text.	Click here to enter text.	Click here to enter text.
TOTAL REQUESTED:			$TOTAL

2. PROVISION OF TRANSITIONAL FUNDING.

Approved Transitional Funds will be distributed to reimburse Provider following the provision of services. Once the individual has been discharged, Provider shall send proof of expenditures to the DBHDS by the 15th day of each month in which reimbursement is being requested.

2.1 Invoices. Invoices will be approved once all signatures have been received and a transitional funding agreement has been entered into. Providers have 1 year from the date of application submission to use approved funds.

3. PROVIDER OBLIGATIONS.

3.1. Provider shall support the individual for a minimum of twelve (12) months unless the individual chooses to receive services from another provider or Provider becomes unable to meet the individual's needs. Provider must utilize all available interventions and technical assistance resources provided by DBHDS before recommending that the individual locate to another residence.

3.2. Provider shall use Transitional Funds only as specified in Section 4 of this Agreement. Provider shall comply with all requests by DBHDS for information and documents related to the provision and use of goods and services for which Transitional Funding has been provided.

3.3 In the event that the individual is relocated, all adaptive equipment purchased specifically for the individual using Transitional Funds shall accompany him or her to the next residence.

4. RIGHT TO RECOVER TRANSITIONAL FUNDING.

If Provider is not able to fulfill its commitment to support the individual for a minimum of twelve (12) months, DBHDS may request return of and recoup all Transitional Funds used for any home or vehicle modifications. However, if the individual or his AR chooses to receive services from another provider or if the provider will make the home/vehicle modifications funded with Transitional Funds available to another individual exiting a training center and the provider has addressed, through approved corrective action, any citations of violations of the *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-105, and the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-115, DBHDS will not seek recovery of the Transitional Funds provided for those modifications. In the event that an individual is relocated, all adaptive equipment purchased specifically for the individual using Transitional Funds shall accompany him/her to the next residence.

Virginia Department of Behavioral Health & Developmental Services

DBHDS TRANSITIONAL FUNDING APPLICATION

5. MODIFICATION.

Modifications to the amount or frequency of a good or service for which Transitional Funds are approved herein may be approved in writing at the sole discretion of DBHDS. No modifications to this Transitional Funding Agreement shall be permitted to change or substitute the type of good or service provided. In that event, a new application shall be submitted.

IN WITNESS WHEREOF, Provider and DBHDS have executed this Agreement as of the date of the latest signature.

PROVIDER:

Name: Click here to enter text.
Title: Click here to enter text.

Signature: _____

Date: _____

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES:

Name:
Title: Assistant Commissioner or Designee

Signature: _____

Date: _____

****Funds must be invoiced within 12 months of the latest signature noted above.****

Support Coordination Manual
Developmental Disabilities
Chapter 10
Health and Safety

- Introduction
- Support Coordinator's Role in Health & Safety
    - Assess
    - Plan Development
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Support Coordination Manual
Developmental Disabilities
Chapter 10
Health & Safety

Introduction

People with disabilities need health care and health programs for the same reasons anyone else does—to stay well, active, and a part of the community. Having a disability does not mean a person is not healthy or cannot be healthy. Being healthy means the same thing for all of us—getting and staying well so we can lead full, active lives. People with disabilities experience all the same common health issues as the general population, yet as a group, they have much greater health needs. People with disabilities can also be at higher risk for injuries and abuse. For these reasons, health and safety are core concerns for people with disabilities but these concerns do not override the person's fundamental right to the dignity of risk, the right to take risks when engaging in life experiences, and the right to fail in those activities. All too often people are limited from living their best lives under the guise of health and safety issues when it is really a lack of a creative, committed effort to provide individualized and meaningful supports.

Resource: **https://www.cdc.gov/ncbddd/disabilityandhealth/people.html**

Support Coordinator's Role in Health & Safety

The Support Coordinator (SC) should perform the same process steps regarding a person's health and safety that they do for other supports and services. Some of the particular duties regarding health and safety are outlined below.

Assess

- Ensure that fall risk assessments are completed annually per agency policy
- Complete an Annual Risk Assessment in non-SIS® years
- Request copies of and/or results of health risk assessments (HRA) completed annually by CCC+ care coordinators
- Participate in SIS® meetings.

Plan Development

- Document and reflect exceptional medical and behavioral needs as determined by the SIS® assessment, Annual Risk Assessment, CCC+ HRA and the annual risk assessment review in Part III of the shared plan
- Include linkages to services and providers in the Person Centered Individual Service Plan (PC ISP) Part III and SC Part V, to be completed by the SC to ensure health and safety. *Examples: Support Activities: to obtain housing for someone who is homeless, to obtain a ramp through an environmental modification, link to a psychiatrist to obtain needed for mental health support and medication monitoring, etc.,*

- Review provider Part V plans for supports to ensure they include supports as agreed upon in the shared planning needed information regarding exceptional medical and behavioral needs.

Plan Implementation/Coordination

- Communicate with providers to share vital information. *Example: a residential provider reports that someone they serve has received a new order from their physician that blood sugar levels have to be tested every 2 hours. The day support program will need to be informed so that they can also make sure the blood sugar levels are tested every 2 hours while that person is at their program.*
- Communicate with Care Coordinators of the Managed Care Organizations (MCOs) to update them on an individual's needs and services and obtain results of their HRAs.
- Collaborate with care coordinators regarding medically related issues to develop coordinated plans to mitigate risks and risks of harm
- Report alleged abuse, neglect or exploitation to Adult Protective Services (APS) and Child Protective Services.

Monitoring

- Review provider Person Centered Reviews and other documentation to obtain input on medical information, appointment information, and to ensure that all needed follow up has been done for all medical conditions and concerns.
- Obtain input from the person using services and their authorized representative or legal guardian, as appropriate on satisfaction with all services and providers in the areas of Medical/Psychiatric, Assistive Technology/Environmental Modifications, follow through by other service providers in carrying out physician's orders, etc.
- Obtain information on all medications a person takes and obtain side effect information from approved sources, i.e. Physician’s Desk Reference (PDR), approved web sites, etc.
- Document medication changes, communicate information to all providers.
- Review CHRIS Case Management Report and provider incident reports for injuries and medical concerns, and document communication with providers to ensure that all needed follow up occurred.
- Request needed medical records from family members, group home providers, and medical providers.
- Ensure that an individual obtains a physical within 12 months prior to enrollment into a DD Waive.

BOX

To find a list of suggested considerations/questions to ask regarding Health & Safety when conducting face to face visits, click here. Face to face visits At-a-Glance

Advocacy

- Advocate for annual physicals, dental exams, and other recommended preventative screenings and immunizations based on medical history, age and gender.
- Advocate for needed referrals. *Example: Someone has been having increased seizure activity. The Primary Care Physician has not ordered any blood work, medical tests, or shown any concern about this*

increased seizure activity. The SC can advocate for a referral to a specialist, such as a neurologist for more specialized care.

- Link to needed funding sources to cover someone's needs. *Example: drug companies frequently offer reduced rate medications programs for those unable to pay for their prescriptions.*

Optimal Health

Maintenance of optimal health is one of the most basic supports provided by the team serving a person with a disability. This is a shared responsibility among all entities who work with the person. It is a primary responsibility of the SC to lead the team in identifying health and safety risk factors, develop individualized supports, and to monitor the implementation of those supports and the person's wellbeing. The level of active involvement with health care practitioners depends on the risk factors of each person.

Achievement of OPTIMAL HEALTH is based upon these principles:

Person Centered: People participate in decisions about their health and are supported in making person-centered decisions about healthy lifestyles, such as food choices, and activity.

Access: People have adequate contact with health practitioners regarding their physical and mental health, receiving preventative health care and services, including recommended physical and dental exams, and timely assessment, treatment, and follow up for acute and chronic health issues.

Support: People are supported, as needed, in all aspects of their health care including decision making, access, and following their prescribed treatment plans (e.g., medications, diets, mealtime instructions).

Documentation: People's health related information, both current and historical, is documented accurately and available when needed. People have some form of identification, which includes emergency contact information, with them at all times.

PROACTIVE STEPS TO HEALTH

In the area of health and safety, there are proactive steps that can be taken that can contribute to optimal health in people with disabilities just as they do for the general population. These topics should be included in the discussion when developing a support plan. These include:

Good Nutrition

People with disabilities have the same needs for good nutrition and proper weight management as people without disabilities. Since developmental disabilities are often associated with other medical conditions, it may be recommended that a person adhere to a special diet for health reasons or food allergies. This may involve exploring outcomes with those supported about potentially serious consequences of consuming food items, such as nuts if allergic, nutritious and well-balanced meals, meal preparation, and food choice and amounts. Aging adults, whose nutritional needs, appetite, and vulnerability to illness are often changing, may require additional guidance and assistance. Note: No special diet should be implemented without checking first with the person's medical professional.

Attention to Personal Hygiene

Personal hygiene plays a major role in how others view a person. It is important for all of us to wear clean clothing, keep our hair clean and to bathe regularly. Because people with disabilities are often seen by others as "different," it is even more important to have good personal hygiene. Dirty clothing and sloppy appearances get in the way of meeting new people and making friends. When dressed in clean, well-fitting clothing, people are more likely to be seen in a positive manner. Some people with disabilities may need reminders, guidance, or physical intervention to assist with maintaining their personal appearance. Good hygiene, especially dental care, is also important for health reasons. Lack of attention to bathing or to routine care of teeth and gums can lead to serious medical conditions.

Exercise

Along with regular medical care and good nutrition, exercise is another important element for a healthy life. Many people have never experienced a regular exercise program. Though they may face some physical challenges, there are a variety of activities designed for older adults and people with disabilities. Exercise can be fun and exciting. All people benefit from moving more, so exploring physical activities the person enjoys doing and finding ways to include these activities in their daily routine can positively impact their overall health and wellbeing. Most major health organizations recommend at least 30 minutes of exercise most days of the week, using a combination of cardiovascular exercise (walking, swimming, and/or aerobics) and resistance exercise (weights). Encouraging creativity on the part of the person's support team can be a role of the Support Coordinator. No new exercise program should be implemented without checking with the person's medical professional.

Assistive Technology

Assistive technology refers an item, device, piece of equipment, or set of products that is used to maintain or improve ability. Assistive technology allows people to function with more independence, provides more choices, and results in an increased sense of confidence. Assistive technology devices may range from simple and inexpensive everyday items to complex computer systems.

Some devices are not designed just for people with disabilities; they can make life easier for anyone. Examples of assistive technology that enable people to carry out daily activities include: eating and cooking utensils fitted with oversize handles for easier gripping, shower benches and bathtub lifts, wheelchair ramps, programmable telephones, and picture boards. There are also assistive technology communication devices that provide assistance for people who do not communicate using words. The device can include speech, gestures, sign language, symbols, synthesized speech, dedicated communications aids, or microcomputers.

Assistive technology benefits people as they age. It may be a key element in helping people remain in their home and community. It also helps maintain as much independence as possible, as physical and cognitive abilities change due to the aging process. If any of these devices are thought to benefit an individual, the SC is responsible for investigating funding for such devices. It is possible that the needed item may be available through Medicaid or Medicare.

Regular Medical and Dental Care

Regular medical and dental care is crucial in helping people enjoy a healthy life. It is important for team members to work closely with each person's primary care physician and other medical and health professionals to make sure regular routine tests and screenings are completed and to assist in communicating to the health professional issues someone might be experiencing. All team members should be on the lookout for changes in appearance or behavior that may indicate some symptom of illness. Some people may not be able to fully communicate what they are feeling (physically and emotionally). It is important to be diligent in observing, monitoring, and reporting any of these changes. This role is usually done by the direct support professional (DSP) as they, are likely to have the consistency of contact needed to be aware of and note changes. It is the role of the SC to monitor changes in health and safety and to work with the person and the team to adjust supports accordingly.

Resource: Direct Support Professional Orientation Manual
https://partnership.vcu.edu/DSP_orientation/downloadables/DSP%20Orientation%20Manual%20-%20REVISED_08102016_with%20test_effective%20date09012016.pdf

Medication and Side Effects

Some people take multiple daily medications. All medications can have side effects – some of which can be harmful. Side effects may indicate that the medication dosage or type may need to change. In addition, people on more than one medication may experience symptoms related to the interactions of their medications. While it is impossible to remember all the possible side effects for medications, it is important that the SC know where to find this information. Reputable sites that include information about drugs, dosage, uses and side effects are:

https://www.webmd.com/drugs/2/index
www.drugs.com
www.rxlist.com

Barriers to Quality Healthcare

BOX

Barriers to Quality Healthcare for People with Disabilities

- Difficulties communicating signs and symptoms to a health care provider about treatable yet untreated health conditions
- Attitudes and assumptions of medical staff including discrimination and lack of empathy or caring for people with disabilities
- Untreated specific health issues related to the person's disability due to health care providers' inadequate knowledge
- Decreased access to generic/preventative health screening as well as to specialists services
- Lack of independent mobility causing reliance on others to attend appointments
- Behavior problems that may manifest themselves out of untreated medical conditions, fear or disorientation
- Lack of time and resources

Resource: http://scopeblog.stanford.edu/2017/09/18/barriers-in-health-care-for-people-with-disabilities-its-not-what-you-think/

Common Health Issues

People with disabilities experience all the same common health issues as the general population yet as a group, they have much greater health needs. Identification and treatment may be more complex, due in part to associated difficulties with communication, which leads to under-recognition of common illnesses and disorders. These common conditions include: (neaten this up in a table with hyperlinks)

- Coronary heart diseases, e.g. high blood pressure, high cholesterol, cardiovascular disease
  - http://www.heart.org/HEARTORG/Conditions/Answers-by-Heart-Fact-Sheets_UCM_300330_Article.jsp#.WobqIIPwapq
  - https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=97
- Respiratory diseases,
  - https://www.lung.org/lung-health-and-diseases/all-diseases.html
- Oral health issues,
  - http://www.adha.org/sites/default/files/7228_Oral_Health_Total.pdf
- Gastrointestinal diseases, e.g. dysphagia (difficulty in swallowing), aspiration pneumonitis, Gastroesophageal reflux disease (GORD), constipation)
  - https://www.iffgd.org/upper-gi-disorders.html
- Endocrine diseases, e.g. diabetes, thyroid conditions
  - https://www.cdc.gov/diabetes/diabetesatwork/pdfs/diabeteswhatisit.pdf
- Epilepsy
  - https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=88
- Bone health
  - https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=54
- Visual impairment and/or hearing loss
- Cancer
  - https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=75
- Mental and behavioral health issues
  - https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=48&key=M#M
  - https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=54
  - https://report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=38
- Dementia, e.g. Alzheimer's, vascular dementia
  - https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=107
  - https://www.alzheimers.org.uk/download/downloads/id/2369/easy_read_factsheet_what_is_dementia.pdf
- Dermatitis (skin issues)
  - https://www.mayoclinic.org/diseases-conditions/dermatitis-eczema/symptoms-causes/syc-20352380
- Sleep disorders
  - http://www.nsc.org/Fatigue%20Documents/Sleep-disorder-fact-sheet.pdf
- Obesity
  - https://www.cdc.gov/ncbddd/disabilityandhealth/documents/obesityfactsheet2010.pdf
- Hepatitis B
  - https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=125

These conditions while not unique to people with disabilities may occur more often or more seriously than in the general population and so are an important part of any assessment for the purpose of identifying and planning for appropriate supports.
Resource: http://www.intellectualdisability.info/changing-values/articles/assessment-in-primary-care

Eight Health Risks

The following is a list of areas in which changes may indicate signs of illness or a change in health status. There are **8 health issues** that are often overlooked and need to be more carefully monitored. These conditions can progress rapidly and result in bigger problems, even death. They are most likely to be identified and addressed by the DSPs who have regular contact with the person. However, the SC needs to be aware of the signs and symptoms of these health issues as well, so that they can properly monitor these conditions. The Department of Health and Developmental Services (DBHDS) Office of Integrated Health (OIH) has issued safety alerts on these conditions and provides a monthly newsletter that addresses health and safety issues. The 8 health risks include:

Skin Care (general)

Healthy skin aids in regulating body temperature, protecting internal organs from injury and environmental elements, and protecting against infection.

Things to look for, but not limited to, and/or reports of:

- Unusual or abnormal color (pale, pink, red, or bluish);
- Rashes, cuts, open sores, raised bumps, blisters, bruises;
- Changes in skin temperature (such as moist, hot, or cool to the touch); and
- Parasites.

Decubitus ulcers/ pressure ulcers (bed sores) Decubitus ulcers are injuries to skin and underlying tissue resulting from prolonged pressure on the skin. Bedsores most often develop on skin that covers bony areas of the body, such as the heels, ankles, hips and tailbone. People most at risk of bedsores are those with a medical condition that limits their ability to change positions or those who spend most of their time in a bed or chair. Bedsores can develop quickly. Most sores heal with treatment, but some never heal completely. Most pressure sores are preventable with the proper supports such as regular changes in positioning, different seating, use of adaptive equipment. When pressures sores are a risk, physician orders for positioning protocols need to be developed and implemented. Documentation should be maintained on positioning logs which can be monitored by SCs. Skin integrity training is routinely offered by OIH.

Things to look for include:

- Unusual changes in skin color or texture;
- Swelling;
- Pus-like draining;
- An area of skin that feels cooler or warmer to the touch than other areas;
- Tender areas; and
- If there are signs of infection, such as a fever, drainage from a sore, a sore that smells bad, or increased redness, warmth or swelling around a sore, immediate medical attention should be sought **www.mayoclinic.org**

Aspiration Pneumonia

Aspiration pneumonia is an inflammation of the lungs and airways to the lungs from breathing in foreign material. Aspiration pneumonia develops from inhaling food, vomit, liquids, or saliva into the lungs. This may occur when someone has difficulty swallowing (dysphagia) and has watery eyes or coughing while consuming food or fluids.

Things to look for, but not limited to, and/or reports of:

- Chest pain,
- Cough,
- Fatigue,
- Nausea,
- Fever,
- Shortness of breath, wheezing, and
- Bluish discoloration of the skin caused by lack of oxygen (e.g., mouth, nail beds, finger tips).

Falls

Fall risk is important to address as 1 in 3 older adults fall daily. Fall complications can include broken bones, head injuries, problem with daily activities, and need for home health care.

Things to look for, but not limited to, and/or reports of:

- Health issues and medication;
- Being shoved or running into a barrier;
- Cluttered rooms, area rugs, wet or slick surfaces, improper lighting;
- Wet or slick surfaces without non-skid footwear; and
- Lack of appropriate medical adaptive equipment, inappropriate footwear.

Urinary Tract Infections (UTI)

A UTI is an infection of the urinary tract, which is the body's system for removing wastes and extra water. Women are more susceptible than men due to their anatomy and reduced bladder function later in life and symptoms vary by age and gender. People who use wheelchairs and/or have reduced mobility are also more susceptible to developing UTIs. There are **two different types of UTIs** – the **lower UTI** relates to infections that occur in the urethra (a short narrow tube that carries urine from the bladder out of the body) and bladder – and the **upper UTI** is more severe and relates to infections that may involve the kidneys.

Things to look for, but not limited to, and/or reports of:

- Pain or burning during urination;
- Increased frequency, urgency of urination, incontinence;
- Lower abdominal, pelvic or rectal pain or pressure;
- Confusion, behavioral changes, increased falls;
- Mild fever or "just not feeling well;" and
- Changes in urine (such as milky, cloudy, bloody or foul-smelling).

Upper UTI symptoms develop rapidly and may not include the symptoms for a lower UTI and **require emergency care.**

Things to look for, but not limited to, and/or reports of:

- Fairly high fever (higher than 101F);
- Shaking chills;
- Nausea;
- Vomiting; and
- Flank pain (pain in the back or side, usually only on one side at waist level).

Dehydration

Dehydration occurs when we lose more fluids than we are taking in. The lack of water in the body may result from either a decrease in fluid intake or an increase in fluid loss. Water helps transport waste, supports tissue and cell hydration and helps regulate your temperature. Dehydration can be an important factor in illness and even death. Diarrhea and vomiting are the most common reasons why someone loses excess fluid.

Things to look for, **but not limited to**, **and/or reports of:**

- Urine is concentrated and more yellow,
- Dry mouth and nose,
- Dry skin,
- Decreased tear production,
- Headache,
- Dizziness,
- Sleepy or tired, and
- Light headed (especially when standing)

SEVERE dehydration symptoms can include, but are not limited to confusion, lack of sweating, little or no urination, weakness, coma, organ failure (especially kidney), changes in vital signs (increase in pulse and decrease in blood pressure), and “tenting” of skin (sticks together, stays upright when pinched together).

Constipation and Bowel Obstruction

Constipation is the slow movement of feces through the intestine which results in infrequent bowel movements and hard, dry stools. The longer it takes for stool to move through the large intestines, the more fluid is absorbed and the harder stool becomes, making it difficult and sometimes impossible to pass.

Things to look for, but not limited to, and/or reports of:

- Changes in bowel habits;
- Infrequent bowel movements (less than 3 a week or more than 3 days between);
- Difficulty passing stools – straining, painful;
- Hard, dry, lumpy, small stools;
- Belly pain relieved by bowel movements, swollen abdomen;
- Bright red blood in stools; and
- Leaks of wet, diarrhea-like stool between regular bowel movements.

Severe constipation can result in serious complications including rectal bleeding, nausea, vomiting, weight loss, bowel obstruction, fecal impaction, hemorrhoids, anal fissures and rectal prolapse. Two **serious**

constipation issues are fecal impaction and bowel obstruction. **Fecal impaction** is when hard, dry stool is in the large intestines, often the rectum and cannot be passed. Individuals with fecal impactions often have breathing difficulties due to the collection of the stool in the colon. Fecal impaction can be life threatening. A **bowel obstruction** is either a partial or complete blockage of the small or large intestines and requires immediate medical attention! People who use wheelchairs and/or have reduced mobility are also more susceptible to developing a bowel obstruction. Use of a log to track bowel movements may be recommended to ensure people are having regular adequate bowel movements. This log would typically be maintained by DSPs and can be monitored by SCs.

Bowel obstruction: Things to look for, but not limited to, and/or reports of:

- Abdominal pain;
- Swelling and fullness;
- Vomiting;
- Diarrhea; and Odor to breath.

Sepsis

Sepsis is a serious medical condition caused by an overwhelming immune response to infection. Sepsis can arise unpredictably and can progress rapidly. Sepsis springs from two factors: an infection (such as pneumonia or a urinary tract infection) and a powerful and harmful response by the body's own immune system.
In severe cases, one or more organs fail. In the worst cases, blood pressure drops, the heart weakens and the patient spirals towards septic shock. Once that happens, multiple organs – lungs, kidneys, liver – may quickly fail and the person can die.

Seizures

Seizures are defined as abnormal movements or behavior due to electrical activity in the brain. Seizures might include shaking and convulsions, and can last a few seconds or over 5 minutes. Seizures have many causes and can lead to brain damage or even death. Diagnosis occurs when a person has had two or more seizures. Providers should track and report seizures. SCs should routinely monitor seizure activity. There are many types of seizures.

Things to look for include, but not limited to, and/or reports of:

- Brief blackout followed by a period of confusion;
- Changes in behavior;
- Drooling or frothing at the mouth;
- Eye movements;
- Shaking of the entire body;
- Grunting or snorting;
- Loss of bladder or bowel control;
- Sudden falling;
- Teeth clenching;
- Tasting a bitter or metallic flavor;
- Temporary stop in breathing;
- Uncontrollable muscle spasms with twitching and jerking limbs; and
- Mood changes such as sudden anger, unexplainable fear, paranoia, joy or laughter

Specific Developmental Disabilities and Co-occurring Medical Concerns

The most common developmental disability is intellectual disability. According to the Centers for Disease Control (CDC), more than one out of every 100 school children in the United States has some form of intellectual disability. Cerebral palsy is the second most common developmental disability, followed by autism spectrum disorders.
http://www.firstsigns.org/delays_disorders/other_disorders.htm

For some syndromes or disability types, there are commonly co-occurring health issues. While people may not present with all of the co-occurring conditions that are associated with their disability, it is helpful to keep in mind these issues when supporting a person in their medical care. Following are the conditions associated with the most common developmental disabilities.

Down syndrome (the most frequently occurring form of ID)

- heart disease
- early onset dementia
- obesity
- disrupted sleep patterns and sleep disorders
- musculoskeletal conditions
- hearing loss
- vision problems
- hypothyroidism https://www.niddk.nih.gov/-/media/Files/...Diseases/Hypothyroidism_508.pdf?la=en
- diabetes
- infections
- blood disorders
- hypotonia
- gum disease and dental problems
- epilepsy
- digestive problems
- celiac disease
- mental health and emotional problems
  https://www.nichd.nih.gov/health/topics/down/conditioninfo/associated

Cerebral palsy

- oral motor impairment
- speech impairment
- intellectual disabilities
- learning difficulties
- visual impairment and blindness

- seizure disorder (epilepsy)
- sensory disorders

https://www.cerebralpalsyguide.com/cerebral-palsy/coexisting-conditions/

Autism spectrum disorders

- anxiety
- ADHD
- Depression
- Epilepsy
- immune disorders
- intellectual disabilities
- OCD
- sensory disorders
- sleep problems
- Tourette syndrome

http://raisingchildren.net.au/articles/autism_spectrum_disorder_comorbidity.html
http://nationalautismassociation.org/pdf/MedicalComorbiditiesinASD2013.pdf

Abuse, Neglect, and Exploitation

It is estimated that people with disabilities are between two and five times more likely to be victims of abuse as those without disabilities (Martin et al., 2006; Mitra, Mouradian, & Diamond, 2011; Plummer & Findley, 2011). Further, research has indicated that most abuse perpetrators are known by the person with DD and often include parents, intimate partners, extended family members, caregivers, teachers, bus drivers, and other paid service providers (Stevens, 2012). People with disabilities are also at greater risk of experiencing domestic and sexual abuse by non-intimate partners, including other family members and care providers within and outside of institutions (Chenoweth, 1996; Oktay & Tompkins, 2004; Saxton, et al., 2001; Young, et al., 1997).

With these statistics in mind, the chances that an SC will support someone who is experiencing or has in the past experienced abuse, neglect or exploitation will be great. The SC is a mandated reporter. The responsibilities of the SC regarding mandated reporting are found in Chapter 2. (link)

The definitions for abuse, neglect and exploitation as outlined in Administrative Code Code of Virginia (22VAC30-100-10) are:

"Adult abuse" means the willful infliction of physical pain, injury or mental anguish or unreasonable confinement of an adult as defined in § 63.2-1603 of the Code of Virginia

“Neglect" means that an adult as defined in § 63.2-1603 is living under such circumstances that he is not able to provide for himself or is not being provided such services as are necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his well-being. However, no adult shall be considered neglected solely on the basis that such adult is receiving religious nonmedical treatment or religious nonmedical nursing care in lieu of medical care, provided that such

treatment or care is performed in good faith and in accordance with the religious practices of the adult and there is written or oral expression of consent by that adult. Neglect includes the failure of a caregiver or another responsible person to provide for basic needs to maintain the adult's physical and mental health and well-being, and it includes the adult's neglect of self.

Neglect includes:

- The lack of clothing considered necessary to protect a person's health;
- The lack of food necessary to prevent physical injury or to maintain life, including failure to receive appropriate food for adults with conditions requiring special diets;
- Shelter that is not structurally safe; has rodents or other infestations which may result in serious health problems; or does not have a safe and accessible water supply, safe heat source or sewage disposal. Adequate shelter for an adult will depend on the impairments of an adult; however, the adult must be protected from the elements that would seriously endanger his health (e.g., rain, cold or heat) and could result in serious illness or debilitating conditions;
- Inadequate supervision by a caregiver (paid or unpaid) who has been designated to provide the supervision necessary to protect the safety and well-being of an adult in his care;
- The failure of persons who are responsible for caregiving to seek needed medical care or to follow medically prescribed treatment for an adult, or the adult has failed to obtain such care for himself. The needed medical care is believed to be of such a nature as to result in physical or mental injury or illness if it is not provided;
- Medical neglect includes the withholding of medication or aids needed by the adult such as dentures, eye glasses, hearing aids, walker, etc. It also includes the unauthorized administration of prescription drugs, over-medicating or under-medicating, and the administration of drugs for other than bona fide medical reasons, as determined by a licensed health care professional; and
- Self-neglect by an adult who is not meeting his own basic needs due to mental or physical impairments. Basic needs refer to such things as food, clothing, shelter, health or medical care.

“Exploitation" means the illegal, unauthorized, improper, or fraudulent use of an adult as defined in § 63.2-1603 of the Code of Virginia or his funds, property, benefits, resources, or other assets for another's profit, benefit, or advantage, including a caregiver or person serving in a fiduciary capacity, or that deprives the adult of his rightful use of or access to such funds, property, benefits, resources, or other assets.

"Adult exploitation" includes

- An intentional breach of a fiduciary obligation to an adult to his detriment or an intentional failure to use the financial resources of an adult in a manner that results in neglect of such adult;
- The acquisition, possession, or control of an adult's financial resources or property through the use of undue influence, coercion, or duress; and
- Forcing or coercing an adult to pay for goods or services or perform services against his will for another's profit, benefit, or advantage if the adult did not agree, or was tricked, misled, or defrauded into agreeing, to pay for such goods or services or perform such services.

Signs of abuse, neglect and exploitation may be found here. At-a-Glance link

Health Risk Assessment

If someone is enrolled with a Managed Care Organization through the Commonwealth Coordinated Care Plus (CCC+) Waiver, their Care Coordinator will conduct a Health Risk Assessment (HRA) with them. An HRA is a complete assessment of one's medical, behavioral, social, emotional, and functional status. The HRA may be done in person or over the phone. This assessment enables the Care Coordinator to understand someone's needs and help them get the care and education they need. The SC should collaborate with the care coordinator to obtain a copy of the HRA or results to mitigate risks.

End of Life

It is inevitable that Support Coordinators will experience the death of someone they are supporting. In some instances, the SC will have had a relationship with this person for years and they will experience grief and sadness. It is important that the SC reach out and rely on their own support systems during these times of loss. The relationship is a professional one, but also a human relationship, one with feelings, caring and regard. It is okay to acknowledge this and grieve. SCs may need to assist persons in obtaining end of life care through hospice or other medical providers.

https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=40

Questions/Considerations
Face to Face Visits

Here is a list of questions and considerations to think & ask about when conducting face to face visits. These may be tailored to a person's specific circumstance.

- Does the individual appear healthy and safe? Observe
  - General physical appearance
  - Hygiene
  - Clothing for appropriateness
  - Weight
  - Bruises
- Does the person appear happy and content?
- Is the person protected from abuse, exploitation, neglect, injury, physical harm, emotional distress?
- Are there any previously unidentified risks, injuries, needs, or other change in status?
- If there were any previously identified, what is the current status?
- Is the appropriate food available for a specialized diet?
- Are there opportunities for privacy?
- Have there been changes in health status?
  - seizure or aspiration frequency
  - sleep pattern
  - bowel/bladder function
  - activity level
  - mood, or other typical behavior/routines
  - significant weight gain or loss
  - frequent colds, coughs, sneezes or trouble breathing
  - wounds
  - behavior

- Are there any signs of pain including dental?
- Have there been any
  - Hospitalizations
  - ER visits
  - Medical appointments (scheduled, attended or missed) with primary care doctor, dentist, specialists? Were there specific concerns the doctor wants attention paid to?
  - Have there been any falls? Was a medical follow-up needed as a result of any recent falls or new condition?
  - Use of crisis services
- Have there been any medication changes or concerns about taking needed medications?
- Are there any changes needed to supports and services?
  - Adaptive equipment
  - Referral to new doctors/specialists
  - Accommodations at home/work
  - Education about health issues
- Does the individual have timely access to therapies per ISP?

- Is Durable Medical Equipment in good repair, clean, and proper fit?
- Are communication devices present, working and being used?
- Have there been any significant life changes or events?
- Do others who care about the person have any concerns about health or safety?
- Have there been changes regarding a designated health care representative?
- Is structural state of the home/workplace adequate & safe?
- Are there any safety issues present?
- Are there any concerns should there be an extended power, climate control failure?
- Are furnishings clean and safe?
- Are there working smoke detectors?
- Is there a wheelchair ramp for someone using a wheelchair?
- Are there foul odors that are not being addressed?
- For providers with a conditional or provisional license, ask, “What steps have been taken to address the conditional/provisional license?”

Indicators of Adult Abuse, Neglect or Exploitation

At a Glance

ABUSE		
• Multiple/severe bruises, welts • Bilateral bruises on upper arms • Clustered bruises on trunk • Bruises which resemble an object • Old and new bruises • Signs of bone fractures • Broken bones, open wounds, skull fracture • Striking, shoving, beating, kicking, scratching	• Internal injuries • Sprains, dislocation, lacerations, cuts, punctures • Black eyes • Bed sores • Untreated injuries • Broken glasses/frames • Untreated medical condition • Burns, scalding • Restrained, tied to bed, tied to chair, locked in, isolated • Overmedicated	• Verbal assaults, threats, intimidation • Prolonged interval between injury and treatment • Fear of caregiver • Individual is prohibited from being alone with visitors • Individual has recent or sudden changes in behavior • Unexplained fear • Unwarranted suspicion
SEXUAL ABUSE		
• Genital or urinary irritation, injury, infection or scarring • Presence of a sexually transmitted disease • Frequent, unexplained physical illness	• Intense fear reaction to an individual or to people in general • Mistrust of others • Nightmares, night terrors, sleep disturbance • Direct or coded disclosure of sexual abuse	• Disturbed peer interactions • Depression or blunted affect • Poor self-esteem • Self-destructive activity or suicidal ideation
NEGLECT		
• Untreated medical condition • Untreated mental health problem(s) • Bedsores • Medication not taken as prescribed • Malnourished • Dehydrated • Dirt, fleas, lice on person	• Fecal/urine smell • Animal infested living quarters • Insect infested living quarters • Non-functioning toilet • No heat, running water, electricity • Homelessness • Lacks needed supervision • Lack of food or inadequate food • Uneaten food over period of time	• Accumulated newspaper/debris • Unpaid bills • Inappropriate or inadequate clothing • Needs but does not have glasses, hearing aid, dentures, prosthetic device • Hazardous living conditions • Soiled bedding/furniture • House too hot or cold
FINANCIAL EXPLOITATION		
• Unexplained disappearance of funds, valuables, or personal belongings • Adult child is financially dependent upon the older person or the older person is dependent on caregiver • Misuse of money or property by another person • Transfer of property or savings	• Excessive payment for care and/or services • Individual unaware of the amount of his or her income • Depleted bank account • Sudden appearance of previously uninvolved relatives/friends • Change in payee, power of attorney or will • Caregiver is overly frugal • Unexplained cash flow	• Unusual household composition • Chronic failure to pay bills • Individual is kept isolated • Signatures on check that do not resemble the individual's signature • Individual doesn't know what happened to money • Checks no longer come to house • Individual reports signing papers and doesn't know what was signed

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- Department of Behavioral Health & Developmental Services
- American Association on Intellectual and Developmental Disabilities (AAIDD)
- The Arc of Virginia
- Centers for Independent Living
- Centers for Medicare & Medicaid Services
- Community Health Clinics
- Department for Aging and Rehabilitative Services
- Department of Education: Special Education
- Department of Health
- Department of Medical Assistance Services
- Department of Social Services
- disABILITY Law Center of Virginia
- Disability Navigator
- Early Periodic Supports Diagnosis & Treatment (EPSDT)
- National Gateway to Self-Determination
- The Olmstead Initiative
- Parent Educational Advocacy Training Center
- Partnership for People with Disabilities/Virginia Commonwealth University
- Positive Behavioral Supports
- Senior Navigator
- Social Security Administration
- Virginia 2-1-1
- Virginia Association of Community Service Boards
- Virginia Board for People with Disabilities
- Virginia Navigator
- Virginia Parks & Recreation

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Introduction

In addition to the private providers who provide services to individuals with developmental disabilities, the Support Coordinator (SC) relies on the supports and services of many organizations to help them carry out their job responsibilities. Below are just some of the resources.

Department of Behavioral Health and Developmental Services

www.dbhds.virginia.gov 804-786-3921

- ***Division of Developmental Services***
http://www.dbhds.virginia.gov/developmental-services

- ***Waiver Services*** http://www.dbhds.virginia.gov/developmental-services/waiver-services

- ***Crisis Services*** — (REACH Adult DD Crisis Services, REACH Children DD Crisis Services, Statewide and Regional Resources/Documents)
http://dbhds.virginia.gov/developmental-services/Crisis-services

- ***Community Integration and Transition Supports*** (Training Center Transition Services, Regional Support Teams, Guardianship, Family Resource Consulting, Single Point of Entry for ICF/IIDs, Incident Management/Quality assurance)
http://www.dbhds.virginia.gov/developmental-services/training-centers

- ***Community Support Services*** (Employment, Housing, Individual Family Support Program)
Employment - http://www.dbhds.virginia.gov/developmental-services/employment
Housing - http://www.dbhds.virginia.gov/developmental-services/housing
Individual Family Support Program (IFSP) - IFSP is designed to assist those on the DD Waiver Wait List and their families to access short-term, person/family centered resources, supports and services. These services and items funded through the IFSP are intended to support the continued residence of an individual in their own or family home in the community. Support Coordinators can encourage families and individuals to

apply for this funding and offer support, as needed, in the application process. More information can be found at the IFSP website. https://ifsponline.dbhds.virginia.gov/

- ***Department of Justice Agreement***
  http://www.dbhds.virginia.gov/doj-settlement-agreement

- ***Home and Community Based Settings Regulations***
  http://www.dmas.virginia.gov/#/hcbs

- ***My Life My Community***
  http://www.dbhds.virginia.gov/developmental-services/my-life-my-community-waiver

  - **Search for Providers** http://ejiujiu0.wixsite.com/providersurvey

  - **Virginia DD Waiver Guidance** http://www.mylifemycommunityvirginia.org/
    1-844-603-9248

  - **Waiver Amendments/Regulations**
    http://www.townhall.virginia.gov/L/ViewStage.cfm?stageId=7420

- ***Office of Integrated Health***
  http://www.dbhds.virginia.gov/office-of-integrated-health#

- ***Office of Human Rights***
  http://www.dbhds.virginia.gov/quality-management/human-rights

- ***Office of Licensing, Licensed Providers and Provider Inspection/Investigation Reports Search***
  http://www.dbhds.virginia.gov/quality-management/Office-of-Licensing
  http://www.dbhds.virginia.gov/quality-management/Licensed-Provider-Location-Search

American Association on Intellectual and Developmental Disabilities (AAIDD)

www.aamr.org | 202-387-1968

The Arc of Virginia

https://thearcofva.org/

Centers for Independent Living

https://www.vadars.org/cbs/cils.htm

Centers for Medicare & Medicaid Services

www.cms.gov

Community Health Clinics
https://vacommunityhealth.org/about-the-association/about-chcs/

Department for Aging and Rehabilitative Services
www.dars.virginia.gov

Department of Education: Special Education
www.doe.virginia.gov/special_ed/index.shtml

Department of Health
www.vdh.virginia.gov

Department of Medical Assistance Services
www.dmas.virginia.gov | (804) 786-7933 (General Information), (800) 343-0634 (TDD Relay)

Department of Social Services
www.dss.virginia.gov | (804) 726-7000 (General Information)

disABILITY Law Center of Virginia
www.dlcv.org | 800-552-3962

Disability Navigator
https://disabilitynavigator.org/

Early Periodic Supports Diagnosis & Treatment (EPSDT)
https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

National Gateway to Self-Determination
http://www.ngsd.org/

The Olmstead Initiative
https://www.olmsteadva.com/

Parent Educational Advocacy Training Center
http://www.peatc.org/

Partnership for People with Disabilities/Virginia Commonwealth University

www.partnership.vcu.edu | 804-828-3876 (Voice), 800-828-1120 (TDD Relay)

Positive Behavioral Supports
http://www.personcenteredpractices.org/launch_vpbs.html

Senior Navigator
https://seniornavigator.org/

Social Security Administration
www.ssa.gov

Virginia 2-1-1
https://www.211virginia.org/consumer/index.php

Virginia Association of Community Service Boards
www.vacsb.org | 804-330-3141

Virginia Board for People with Disabilities
https://www.vaboard.org/

Virginia Navigator
http://virginianavigator.org/

Virginia Parks & Recreation
http://www.dcr.virginia.gov/state-parks/

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- Employment Family FAQ
- Employment Options Discussion
- Resources for Employment
- Resources for Post-secondary Opportunities
- Employment Letter MOU DBHDS and DARS

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Why Work?

We derive meaning and a sense of self from many things in our life including our family, our friends, and our work. Employment contributes much to the way we view ourselves. Employment can impact our sense of self in many positive ways especially when we find the right job with the right support. These simple truths are no different for a person with a disability.

Impacts of Employment

BOX

Economics. Unlike the majority of the population, most people with developmental disabilities live at or near the national poverty level. Income from paying jobs can supplement resources and improve the quality of lives.

Relationships. Employment is where people develop relationships, friendships, and acquaintances with other people. Through work, people with developmental disabilities have more opportunities to become connected to the greater community. People with disabilities who are employed report having a higher number of friendships with people without disabilities than those who do not work.

Meaning. Our society values employment for all adults. Through employment, people with developmental disabilities gain skills, experience, and often a better understanding of the world around them. Being employed, in addition to the financial benefits, can make people feel there is a purpose to their lives.

Self Esteem. Employment can contribute to a sense of accomplishment, increasing one's sense of competence and self-worth. People with developmental disabilities who work believe more in their abilities and develop higher expectations for what they can accomplish. This can spread to other areas of their lives.

Identity. Much of who we are and how we are perceived by others is related to our employment in where we work, what we do, and the connections we make. People with development disabilities can benefit in the same way from employment.

Virginia's Recognition of the Importance of Work

On October 4, 2011, by a certificate of recognition signed by governor, Bob McDonnell, Virginia joined a number of states who have declared themselves as **Employment First** states. (link to at a glance)

The **Association of People Supporting Employment First (APSE)** defines Employment First as the following:

> *Employment in the general workforce is the first and preferred outcome in the provision of publicly funded services for all working age citizens with disabilities, regardless of level of disability.*

In its official statement on Employment First, APSE maintains the following:

- Access to “real jobs with real wages” is essential if citizens with disabilities are to avoid lives of poverty, dependence, and isolation.
- It is presumed that all working age adults and youths with disabilities can work in jobs fully integrated within the general workforce, working side-by-side with co-workers without disabilities, earning minimum wage or higher.
- As with all other individuals, employees with disabilities require assistance and support to ensure job success and should have access to those supports necessary to succeed in the workplace.
- All citizens, regardless of disability, have the right to pursue the full range of available employment opportunities, and to earn a living wage in a job of their choosing, based on their talents, skills, and interests.
- Implementation of Employment First principles must be based on clear public policies and practices that ensure employment of citizens with disabilities within the general workforce is the priority for public funding and service delivery.

Ethical Standards and Guidelines from APSE that influence SC work

BOX

APSE believes:

- everyone has employable strengths and can work in the competitive labor force with the right measure of support and in jobs well-matched and sometimes customized to their interests and abilities;
- people with disabilities are the experts about themselves and should play a leading role in decisions that affect their lives;
- companies who hire people with disabilities will profit in many ways, including financially;
- the focus of publicly funded services should be strengths-based—what people can do, not what they cannot do;
- an important role of the organization is to educate policy makers, including elected officials, on advocating for equal opportunities and fair treatment in the workplace.

The case has already been made for employment for all based on economics, relationships, meaning, self-esteem, and identity. Who can argue the value of each of these aspects and how they improve one’s quality of life? Yet, according to the U.S Bureau of Labor Statistics, in 2017, 18.7 percent of people age 16 and older with a disability were employed. That compares with 65.7 percent of people without a disability.

In Virginia, the concept of Employment First, means offering the option of integrated, competitive employment as the first choice of day activity to people entering services; it means no longer asking whether a person can work, but instead asking what employment best matches the person’s strengths, skills, interests and conditions for success

Definition of Employment

BOX

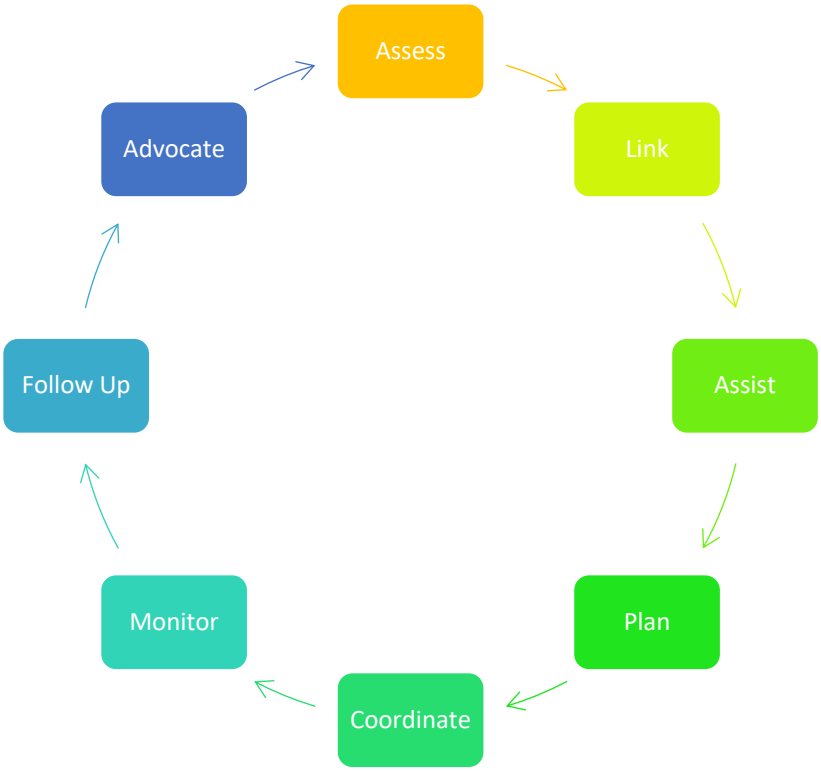
Employment means

- working in a typical work setting where the employee with a disability works along-side co-workers without disabilities
- earning a competitive wage, i.e. minimum wage or better along with related benefits

- doing meaningful task i.e. work/tasks that contribute to the organization or business, with an opportunity for career advancement

Role of the Support Coordinator

The role of the Support Coordinator (SC) is multi-faceted. A SC needs to be able to wear a variety of hats in supporting a person achieve their employment goals. Below is a diagram illustrating the diversity of the SC's role. Each facet of the wheel will be discussed along with how these activities translate into helping a person achieve meaningful employment.



Assess

An SC should begin by using active listening skills to discover how the person they serve views employment, whether they want to work, what their employment dreams and goals are, what interests, experiences and skills they have that will lead the way to paid employment, and how they would be best supported in a working environment.

Often a person with a developmental disability will have no reference for choosing work. In order to appropriately assess this, the person who is being assessed has to understand what work is, what the benefits of work are, and what the possibilities of working can be. The provision and review of all the relevant information can help to ensure the person is making an informed choice. Examples of relevant information include such things as:

1. potential opportunities to learn about work, the types of jobs people do, and exposure to working people within their interest areas;
2. the skill sets required by different jobs;
3. what the person may need to do to acquire those skills;
4. which supports the person may need on the job.

Information gathered from both the person who wants to work and the team who knows them well may come from asking the following types of questions:

1. From the Personal Profile, what is there that demonstrates a skill or talent that might be used in a work environment or would be valuable to a prospective employer? For example does the person have a good memory, are they friendly, are they organized?
2. Has the person had experiences that could lead to paid work? Have they held volunteer or paid jobs in the past? What did they like/dislike in each of these experiences?
3. Does the person have career interests and/or places where they may want to work? (Word of caution: the obvious isn't always the best. An interest in animals does not mean that someone wants to work with them. Also do not make the assumption that a first job will be the only job a person will ever hold. Just as employment is an exploratory process for most of us; so to it should be for a person with a disability. Imagine being **placed in a job** and the expectation of keeping that same job until retirement.)
4. Looking at "Important To and Important For" (part of developing the Person Centered Plan), is there anything that could help the person be successful in their areas of interest or places where they want to work?
5. Does the person have behavioral issues either in the past or present that are causing the person to be held to a higher standard around employment, in order to be given a chance to work, than others in the community? Can some of these issues be addressed through the right job match? Should overcoming them be a requirement of becoming employed? Is this fair?

A good resource for collecting information about interests, possible job avenues, best support and involving someone in writing their own resume is the I Want to Work Workbook and Partner Guide. Free copies may be obtained, as long as supplies last, from the Partnership for People with Disabilities/VCU. Contact dmmachonis@vcu.edu.

Link

As a SC, linking a person with the right resources, including resources already present in their lives is another key element of success. While all efforts around work should focus on the person first, it is important to remember we all have support networks that help us to achieve our goals. Family, friends, professionals and advocates are often members of the "typical" team for a person with disabilities, yet the truth is the team can be comprised of anyone the person thinks can support them in achieving their employment goals. Part of getting the answers and helping the person achieve their goals is helping them to identify and leverage their personal networks. Many people find their first job and other jobs through people they know. This is no different for someone with a disability. Therefore, understanding and knowing the people who comprise the person's personal network can be critical to ensuring success. Success is equally dependent on linking personal networks with other professionals supporting the person in achieving their employment dreams. There can never be enough linking or educating about organizations that support people in working towards employment. The SC can:

- Explore personal networks for employment resources and connect them with professionals if needed

- Connect the person to appropriate professional resources
    - Department of Aging and Rehabilitative Services (DARS)
    - Employment Service Organizations (ESOs)
    - Benefits Planning Services
- Connect DARS and ESOs to people in the person's network
- Discuss educational and post-secondary educational opportunities to enhance skills for employment (link post-secondary section)
- Connect to community learning opportunities

Assist

Assisting the person means helping them to reach their goals. There are legitimate things that may have to occur in order for a person to be successful in the job that they choose. Supporting persons in selecting among options based on the relevant information and then honoring individual choice is essential. Recognizing that the choices people make may be different from the choices other team members might make for them is fundamental to creating a respectful, supportive environment. Identifying any barriers is critical, and equally important is developing a game plan to break down those barriers. All members of the person's team are needed to address barriers. The team should not identify a barrier and determine it to be insurmountable. Moving from a mind-set of "can't" to "how" is imperative. Team members will need to be focused and creative in addressing issues around barriers that interfere with the choices a person has made, especially issues involving staffing and transportation. In this instance, the "more heads are better than one" adage could not be truer. The more minds there are trying to find solutions to overcome barriers, the better, as there will be more creativity involved.

It is the SC's role to lead the team in creativity, ingenuity and determination to problem solve.

- Who is in the person's personal network that can help work toward finding and keeping employment?
- Ask the question: What could we do NOW to help the person be employed in the future? What are skills and talents that could be tapped into?
- What activities in the current Day Support situation could expand their options and knowledge of work and career possibilities?
- Ask about obstacles? What are they? What could be done NOW to help overcome these obstacles?
- Garner support from current providers to think outside the box and put something into place in the person's current plan to address these obstacles.

BOX for the design- put the barriers in a box—around the box put the following possible ways to address barriers:

- Explore local funding
- Consider self-pay
- Consider natural supports
- Use work incentives
- ABLE accounts
- PASS plan
- Educate job seekers and family members- show videos from www.realworkstories.org
- Advertise with personal networks
- Look at small business and local companies
- Ride share, community transportation
- Family peer mentoring

Common Barriers

Barriers to employment will be unique to each person served but several barriers are common. These barriers include:

Lack of funding If someone does not have waiver services, paying for job development & support services for many families is impossible. DARS may be used as a resource, but often their resources are limited.

Misconceptions about benefits Families at times fear that employment will mean a loss of government benefits such as SSI link to misconceptions

Attitudes Lack of belief that a person with developmental disabilities can work may be present in families, employers, and even the person themselves

Lack of opportunity This is true especially in rural areas where job opportunities for all people are limited.

Lack of transportation

Resource: Employment Programs for Persons with Developmental Disabilities--Department of Health and Human Services OFFICE OF INSPECTOR GENERAL August 1999

BOX

Building a Resume

Anyone interested in working needs a resume. Throughout the process of assisting someone in securing employment, there are many activities a person can do to add to and build their resume. While working on finding a paid job, meaningful, productive activities can help increase skills, knowledge, experiences and be fun. As with all employment-related pursuits, these should be based on the interests and preferences of the person being supported. Activities may include but are certainly not limited to:

- Volunteer work
- Taking classes at technical school, community college, community adult education, and/or local cultural sites, such as museums or art studios
- Taking online courses
- Attending workshops, seminars or conferences
- Internships
- Joining service or charitable organizations
- Participating in charitable events
- Attending camps that stress academics, teach skills, or show team-building
- Joining advocacy organizations
- Developing hobbies in which one learns job related skills

All of these activities should be tracked and added to a resume.

Plan

Recognizing that a person you support knows the most about their situation necessitates the involvement of them in every decision. The person should be an active participant in developing their person-centered plan, including discussion of integrated, competitive employment services at least annually and inclusion of employment goals or goals that breakdown barriers to employment in an individualized support plan. Remember “nothing about me without me!” How can this be done?

In thinking about a first job, imagine it to be the only job or employment to which one is tied until retirement. Many of the general population today would be working as camp counselors, fast food employees, grass

cutters or babysitters. With people with disabilities, we sometimes forget that a person's first job is not necessarily meant to be their last job. In fact, the people we support should have the same opportunities to grow, learn and change as the rest of the population.

The SC's role is to help people they support identify what they want their future to look like. This is called career planning and it involves:

- Recognition that planning goes beyond getting the person a job yet at the same time understanding and communicating with the job seeker and their family that most first jobs help people develop valuable work skills that may lead to advancement .
- Identifying what someone's long term career aspirations are and assisting in developing plans for 2, 5, or 10 years into the future.
- Identifying what additional educational and/or training opportunities will help the person get where they want to go.

Planning is also an opportunity to expand a person's understanding of the importance of employment through conversations:

- asking the person why they are working and explaining the importance of the tasks they are being asked to complete.
- helping them to see where they fit in the organization and brainstorming opportunities for advancement that might exist.
- explaining the dignity of work, the value that they add to the organization through the tasks they perform, and how they **earn** a paycheck.

It is important for the Support Coordinator to talk with the person about how it is possible that advancement in a job may happen over time; but this may not be the case for everyone. Teaching the person how to grow in their current position, to master new skills, and to branch out to learn other areas, actually supports the person in becoming a more valuable and hopefully more satisfied employee.

Coordinate

Coordination of services ensures that multiple people providing support are not working on the same things. Teams can move more quickly if they divide up responsibilities and each members take a role in helping the person achieve their employment goals. Having a coordinated plan will minimize confusion.

- Coordinate Responsibilities
    - Who will be carrying out which duties?
    - Who will make necessary appointments with other professionals?
    - Who will accompany them to intake appointments?
    - Does the person need supports and services – not all of the people SCs support do?
    - Is there funding available for services/supports? How can it be accessed?
    - Are the right supports available? Who will coordinate their involvement and implementation?
- What are transportation options open to the individual if they have a job? How are they accessed? How will they be paid for?
- Is there a provider that a referral could be made to now? If not, what information could be provided that would assist in the choice of provider at a later date?

Monitor

Monitoring services will ensure that the person maintains the paid and unpaid supports and assistance that they need. The Support Coordinator's role in monitoring is different depending on whether or not the person has a job and whether or not paid supports are in place. Monitoring when the person does not have a job means ensuring the team continues to identify and address barriers, while at the same time providing

education and training around realistic expectations of themselves and of potential employers. When the person has a job, monitoring ensures that the person still has the job they want, that their hours are working for them, and that they are happy where they work. This monitoring ensures that a person has an opportunity to share when/if they are unhappy in their work or would like to pursue another job.

BOX

Questions to Ask

- Is the person working? If no
  - Are the barriers that have been identified being addressed? This requires thinking "outside the box" in many instances.
  - Is the team job developing consistently?
  - Are they (the person and other team members) satisfied with the supports and services implemented towards securing employment?
  - Refer them to experts who can provide counseling on benefits such as SSI, SSDI, Medicaid and Medicare (see the box below under Misinformation about Employment and People with Disabilities for information about these experts)

- Is the person working? If yes
  -- Are they happy in their job?
  -- Is it the job they want?
  -- Do the hours work?
  -- Are there any unmet employment needs?
  _ Is the team actively involved, on the same page?

Supporting the person through training in self advocacy and/or encouraging discussion with the job coach, supervisor, employer and/or the employment service provider by role playing to increase effective communication can help a person raise and address changes that are needed in order to ensure greater job satisfaction. It is also helpful for the Support Coordinator and the rest of the support team to share with the person the fact that people aren't always 100% happy in their jobs. It may be that a person cannot always be accommodated for everything that they want. However, there is a balance to be achieved between the perfect job and an awful job; that is a job that meets our most important needs, provides fair compensation, and engages us in meaningful work and gain skills for our next opportunity.

Follow-up

Once the Support Coordinator has assessed, linked, assisted, coordinated, and monitored, the next step in supporting a person achieve their goals is follow-up. The Support Coordinator with the assistance of the right people, work together to ensure the person and their dream is not forgotten.

- Are the barriers that have been identified being worked on?
  - Have alternatives been identified?
- Are they job developing consistently?
  - If no why not, how can this be resolved?
- Are they satisfied with the supports and services implemented towards getting them a job?
  - Who can help them to become satisfied?

Does the person still need the same level of supports and services?

Does the person needs assistance with managing their benefits?

Advocate

Support Coordinators serve a critical role in advocating for the person in several instances such as:

- When support network members in their effort to act in what they believe is the person's best interest, may hinder the person;
- Dispelling myths and misconceptions, both positive and negative about a person's ability or lack of ability;
- Creatively addressing barriers and concerns that are raised. The Support Coordinator need not have all the answers but instead should know where to connect the person to get them. The Support Coordinator should be the initiator of brainstorming efforts and steer clear of shutting down discussions that may be "outside the box."

Support Coordinators also play an important role in system transformation, as this can only occur when advocates come together, united to educate and change the system. Often Support Coordinators are leaders in this effort as they can do much to educate the community at large through their day to day responsibilities. Support Coordinators:

- Educate families, individuals and team members about the value of employment;
- Identify barriers to employment in communities;
- Leverage personal and professional networks and communicate the value of employing individuals with disabilities; and when needed
- Work-with Employment Service Organizations to overcome those barriers.

Box

Three resource documents

Employment Support Coordinator FAQ at a glance (link)

Employment Family FAQ at a glance (link)

Employment Options Discussion at a glance (link)

Transportation Resources

As stated above, lack of transportation is a common barrier to obtaining and keeping employment. Support Coordinators can link those they support with a variety of options, granted that as with other problem solving, this may take some creativity. Some resources are:

Personal Networks

When looking for work, is it possible for the job seeker to find work within walking distance or at or near a business in which they already know someone? Explore networks in a person's life for transportation resources. Family, friends or a privately paid acquaintances may be transportation resources. "Carpooling" with a co-worker may be an option in which the non-driver contributes gas money in place of their turn to drive. Also private companies such as Uber or Lyft could be used for occasional needs. A program called Go Go Grandparent (open to anyone 18+) acts as an intermediary with transportation companies for those who may not have a smartphone. https://gogograndparent.com/

Public Transportation/Travel Training

Many people get to their places of employment by using public transportation, such as buses and subways.

Travel training teaches people a variety of travel skills that will enable them to ride local transportation independently. Depending on what part of the state the Support Coordinator works, will determine if travel training is available. Here are some of the available resources in Virginia but the SC should continue to search for others on the internet.

NOVA https://thearcofnova.org/programs-services/independent-living/travel-training-program/

https://www.ecnv.org/traveltraining

https://www.wmata.com/rider-guide/new-riders/Travel-Training.cfm

Richmond metro http://ridegrtc.com/services/travel-training-program

Paratransit

Paratransit is a specialized, door-to-door transport service for people with disabilities who are not able to ride fixed-route public transportation.
https://seniornavigator.org/article/12605/fact-sheet-paratransit-services (Link)

Medicaid Non-emergency Transport

For people who use waiver services, each of the three DD Waivers includes a service entitled employment and community transportation, which includes assistance with getting and going to a job. See chapter 6 for more about this service. (link)

If someone has Fee-For-Service (FFS) Medicaid, Managed Care Organization (MCO), or Commonwealth Coordinated Care Plus (CCC+) they may be eligible for Non-Emergency Medical Transportation (NEMT) services. This service will take you to Medicaid-covered services such as medical and health care appointments, supported employment and day support programs.

Parking placards and plates for people with disabilities

DMV offers parking placards and plates for customers with temporary or permanent disabilities that limit or impair their mobility. They are also available to customers with a condition that creates a safety concern while walking (examples are Alzheimer's disease, blindness or developmental amentia).

These placards and plates entitle the holder to park in special parking spaces reserved for individuals with disabilities. Institutions and organizations that operate special vehicles equipped to carry persons with disabilities may also obtain parking placards and plates entitling them to special parking privileges.
http://virginianavigator.org/article/64321/parking-placards-and-plates-virginians-disabilities

Vehicle Modifications

For those who use waiver services, environmental modifications are included on all three DD Waivers and may include reimbursement for changes to a personal vehicle.
http://virginianavigator.org/article/64327/vehicle-modifications

Misinformation about Employment and People with Disabilities

There are assumptions about people with disabilities and employment, such as

- **Not everyone can work!** Everyone should be given the opportunity to explore work. Even people with the most significant disabilities can and **do** work. https://www.realworkstories.org/

- **You can't work and keep benefits!** Support Coordinators recognize that the person (and their family) may have real concerns about work, income, and its impact on benefits. It may have taken them a long time to be approved for benefits. They are concerned that they will lose their benefits. Fear of losing cash benefits, as well as medical coverage under Medicaid (SSI) or Medicare (SSDI), often persuades individuals to severely limit their employment participation and earnings or, more commonly, not to enter the labor force at all. Unfortunately, beneficiaries are often told that employment will lead to the loss of their benefits.

BOX Additional Information about Benefits

- Special rules make it possible for an individual with disabilities receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) to work and still receive monthly payments and Medicaid or Medicare. Social Security calls these rules **"work incentives".**
- If the person currently receives Medicaid, they should be eligible to continue to receive Medicaid even after they stop receiving Supplemental Security Income (SSI) cash benefits due to work. Section 1619(b) of the Social Security Act provides some protection. To be eligible, they need to meet certain requirements, which include earnings below a threshold amount set by Virginia ($33,862/2014). Even if their earnings exceed the state threshold, they may still be eligible under certain circumstances.
- If they earn enough that their Social Security Disability Insurance (SSDI) checks stop, Medicare can continue for up to 93 months.
- Individuals do not need to reapply if their benefits have ended within the past five years due to their earnings and they meet a few other requirements, including that they still have the original medical condition or one related to it that prevents them from working. This is a work incentive called **"Expedited Reinstatement".**
- Social Security ordinarily reviews an individual's medical condition from time to time to see whether they are still disabled, using a process called the medical Continuing Disability Review, or medical CDR. If they participate in the Ticket To Work program with either the State Vocational Rehabilitation Agency (DARS) or another Employment Network (EN), and make "timely progress" following their individual work plan, Social Security will not conduct a review of their medical condition. If a medical CDR has already been scheduled for them before they assigned their ticket, Social Security will continue with the medical CDR.
- MEDICAID WORKS is a work incentive opportunity offered by the Virginia Medicaid program for people with disabilities who are employed or who want to go to work. MEDICAID WORKS is a voluntary Medicaid plan option that will enable workers with disabilities to earn higher income and retain more in savings, or resources, than is usually allowed by Medicaid. This program provides the support of

continued health care coverage so that people can work, save and gain greater independence. More information on Medicaid Works may be found at http://www.dmas.virginia.gov/content_pgs/rcp-mbi.aspx.

- **You only get one chance to work!** Sometimes, a job comes along but it is the wrong job, the wrong time or, the wrong supervisor. People with disabilities are no different in this regard; sometimes it takes a couple of times to find the right job, at the right time, with the right people!

- **People with disabilities can only do entry level work in the food, cleaning, and manufacturing industries!** This is not true. People with disabilities in Virginia are working as advocates, data entry specialists, mechanics, hospital workers, etc. People are only limited by society's perception of them.

Employment Services under Waivers

If someone has one of the three Developmental Disabilities Waivers, there are employment services offered. All three waivers provide:

- Supported Employment, both individual and group
- Community Engagement - a service where employment skills can be built
- Group Day Services - a service where employment skills can be built

An additional employment service, Workplace Assistance, is also provided under the Community Living Waiver and the Family and Individual Support Waiver.

Ordinarily DARS would be a first option for referral for employment services for those people who use waiver services. However, when DARS has a waitlist, this may be bypassed. See the DARS/DBHDS Memorandum of Understanding. (link at a glance)

All of these services are described in chapter 6. (link)

Integrated Employment Models

There are a variety of community integrated employment models used in Virginia and across the country

- **Individual Supported Employment** is one person, one job, with supports based on the needs of the person
- **Entrepreneurship** involves a person starting their own business
- **Business within a Business** is an employment model where someone opens a complimentary business within an existing business. For example, a barista at a local hotel.
- **Group Supported Employment,** often referred to as enclave or mobile work crews, involves small groups (no more than 8 individuals) working in a community business, while they have ongoing supports. The supports are there to fully integrate the person into the work environment and help them develop meaningful relationships with their coworkers while supporting them with their tasks.

The goal of each of these employment models and services is to support individuals in integrated work settings, doing meaningful work, for which they are paid the minimum or competitive wage.

Benefits Counseling

The Support Coordinator need not be, nor should they, act as a benefits advisor to the people they serve. Knowing all the rules governing work and its impact on an individual's benefits is best left to the experts. Benefits analysis is complicated and work incentives are specific to the type of benefit(s) a person receives. Inaccurate information can lead to an "overpayment" and even a loss of benefits. Income can also have an impact on other federal, state and local programs including food stamps, Section-8 housing vouchers, etc. Below is information on experts to whom you may refer those you support.

BOX
Experts on Benefits and the Services Provided

Work Incentive Planning and Assistance (WIPA) projects are funded by the Social Security Administration (SSA) to provide information and benefits planning to enable beneficiaries with disabilities to make informed choices about work. WIPA projects hire and train **Community Work Incentives Coordinators (CWICs**) who work with individuals receiving Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) to provide in-depth counseling about benefits and the effect of work on those benefits. In Virginia, The vaACCSES - WIPA project provides Community Work Incentives Counselors and Benefits Specialists to provide all SSA disability beneficiaries (including transition-to-work aged youth) with access to benefits planning and assistance services. The ultimate goal of the WIPA project is to assist SSA's beneficiaries with disabilities in meeting their employment goals.
To learn more about the function of these specialists and how to contact them, go to

- contact the Ticket to Work Help Line at 1 (866) 968-7842 or 1 (866) 833-2967 TTY
- visit www.socialsecurity.gov/work
- visit http://www.choosework.net.
- http://www.vaaccses.org/wipa/

Work Incentive Specialist Advocates (**WISA**) Work Incentives Specialist Advocates (WISA's), are individuals who have been certified to provide work incentives counseling services to DARS clients who are receiving Social Security Disability (SSDI) and/or Supplemental Security Income (SSI) benefits. To learn more about the function of these specialists and how to contact them go to https://www.vadars.org/gsp/wisa.htm.

Employment Resources at a glance (link)

Post-Secondary Opportunities

Postsecondary education and training are for persons who want to continue to expand their opportunities and meet their career and life goals. People with disabilities may choose to continue to learn in another environment at any time after high school. Their reasons are diverse for pursuing further education, such as: obtaining credentials in a field of interest, experiencing life away from home, or securing a better paying job. Postsecondary options are varied and may include public or private universities, colleges, community colleges, career/technical schools, vocational/trade schools, centers for continuing education, campus transition programs, and apprenticeship programs.

For a person who is just graduating from high school, their IEP team (of which their Support Coordinator may be a member) may participate with the person in planning for this transition to a post-secondary program. If the person has already graduated from school, it may require exploration on the part of the Support

Coordinator with the person and other support network members to see if post-secondary education opportunities are of interest to the person or if they can assist them in meeting their career and life goals.

Person centered practices, a support network, and each of the steps in the above wheel describing the Support Coordinators varied roles, can be used in exploring an interest in post-secondary education, much in the same way as they are used to investigate and support employment possibilities. Resources for post-secondary information may be found at **Post-Secondary Resources At-a-Glance.**

CERTIFICATE of RECOGNITION

By virtue of the authority vested by the Constitution in the Governor of the Commonwealth of Virginia, there is hereby officially recognized:

EMPLOYMENT FIRST INITIATIVE

WHEREAS, a "Commonwealth of Opportunity" includes all Virginians regardless of disability; and

WHEREAS, Virginians with disabilities have the ability, and desire to seek employment in integrated business settings, to be compensated fairly through competitive wages, and to achieve economic self-sufficiency as equal members of the workforce; and

WHEREAS, individuals with disabilities are a largely untapped resource for employers and the hiring of Virginians with disabilities represents a viable business solution to meet the needs of employers while providing opportunities for individuals with disabilities to use their strengths and their skills toward the economic good of the Commonwealth; and

WHEREAS, Virginia is dedicated to bolstering the economy through the recruitment and retention of jobs; and creating awareness for employers regarding the benefit of hiring individuals with disabilities will allow Virginia to maintain this commitment; and

WHEREAS, implementation of an Employment First Initiative in Virginia will lead to increased employment opportunities for Virginians with disabilities, resulting in immeasurable benefits for individuals, families, employers and communities;

NOW, THEREFORE, I, Robert F. McDonnell, do hereby recognize the **EMPLOYMENT FIRST INITIATIVE** in our **COMMONWEALTH OF VIRGINIA**, and I call this observance to the attention of all our citizens; and

BE IT FURTHER RECOGNIZED, I call upon government, business and industry to seek and employ Virginians with disabilities and to recognize them as a valuable part of the workforce, and I urge citizens to commit their support to this initiative; and

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused to be affixed the Lesser Seal of the Commonwealth of Virginia this 4th Day of October 2011.

Governor

Secretary of the Commonwealth

Support Coordinator FAQ
Supporting Individuals in Exploring Employment

1. **Can everyone work?**
   The simple answer is yes. A lot of people with all levels of support needs, including people with significant support needs are successfully employed because of new job opportunities, natural supports and services, and technological advances to name a few.

2. **Are all employment service organizations equipped to help all people?**
   No. Not all organizations are equipped to provide employment services, that is why it is important to make a referral to the Department for Aging and Rehabilitative Services (DARS). DARS will assist the individual in making an informed choice by choosing a provider who will best support the individual's needs. If categories are closed and a referral to DARS is not needed contact DBHDS for recommendations based on unique support needs.

3. **What is a meaningful conversation?**
   A meaningful employment conversation starts with the belief that everyone can work. It acknowledges that a reframing of work may need to occur as some of today's jobs (and those of the future) look different than jobs 5-10+ years ago. It ensures that everyone has all of the information they need to make an informed choice. It focuses on the person's awareness of the personal, social and financial benefits of employment. It considers the person's grasp of and experience with work and leads to actions that ensure any decision to work is pursued and any decision not to work is explored and explained.

4. **What is an employment related goal?**
   A meaningful employment related goal focuses on removing barriers to employment or the information needed to make an informed decision regarding employment. Employment related goals should focus on what is important to the individual related to their desire for employment. Person centered planning practices should be implemented to ensure the person's autonomy, needs, preferences, desired outcomes, likes and dislikes are implemented into their employment goal.

5. **What information should I provide to an individual and family about employment services available?**
   When talking about employment, guide the conversation to what people are interested in for work and/or concerns they have about working. Discuss the variety of supports available and explain that an assessment regarding employment support needs will be completed, but do not promise any specific type of employment or employment supports/services.

6. **What if a family has concerns about their loved one working?**
   Some families may not believe their loved one can work. Some are concerned about health and safety at the workplace. Others are concerned about the loss of or impact on financial benefits. There are many places where families can get information and support. You do not need to have all the answers. You just need to know where to point people. There are benefits planners available across the state through DARS and the Waiver. There are Family to Family and Peer to Peer mentor programs supported by DBHDS and the Waiver that can pair people with disabilities and families for emotional, informational, and systems navigational support. Encourage the individual or family to contact ESO's or DARS to gather additional information.

Support Coordinator FAQ
Supporting Individuals Once Enrolled in Employment Services

1. **What can I expect from an employment service organization?**

   Employment Service Organizations (ESO) are not your typical Habilitative provider. They stay only as long as needed and work hard to limit that amount of time. Some services provided include:

   - Job development: used for determining the person's needs, interests, hobbies,; researching jobs that match these identified areas; may or may not be at a regularly scheduled time.
   - Situational Assessment: allow the person to try different employment opportunities through short-term job try-outs. Individuals can fully explore their vocational interests and options in order to gain a good understanding of what certain jobs entail so that they can make informed choices about the type of work they would ultimately like to pursue.
   - Placement and Training: supports the person through the employer with orientation and training, learning all job duties, developing natural supports on the job, creating a routine with their work, and when necessary accessing reasonable accommodations and addressing any issues or concerns that arise on the job.
   - Follow along: involves the job coach touching base with the individual, the employer and with permission other members of the person's team. Follow along is limited and if it exceeds 50% of the time a person is on the job then workplace assistance should be explored and implemented.

2. **What do I do when a family member calls with a concern about the job, schedule, ESO provider, etc.?**

   Support Coordinator can act as the liaison between the family and the job coach or can direct the family to contact the ESO. The support coordinator should not contact the employer directly and should discourage the family from doing the same. Business relationships are cultivated over years and one negative experience can influence a business's decision to hire additional people with disabilities. As you do not ask others to contact your employer on your behalf, we should proceed in the same vain with supported employment.

3. **Should I visit people at their job?**

   While it helps to observe people in a variety of environments, including their place of employment, any visits must be coordinated at the request of the individual and through the job coach to ensure that it is not disruptive to work. It is important to understand that some employers may not give permission for visits during work time due to security or other concerns. It is important to respect the employer's rules for visiting. Best practice would be not to visit the jobsite unless you are invited by the individual.

What are employment services?
What can I expect?

What are supported employment services?

Supported employment services are for people with disabilities who are interested in working and who need support in finding and keeping a job. Supported Employment services focus on competitive (e.g. minimum wage or higher), integrated employment opportunities in community businesses. According to Virginia's Employment First initiative, competitive and integrated employment is the first and preferred option for people with disabilities. Depending on eligibility funding maybe available through federal, state, waiver or local dollars.

How are employment services different from day support services?

Employment services are interactive, and are a collaborative effort between the person seeking employment and a job coach. Activities that can be done in employment services include exploring jobs, writing resumes, and preparing for interviews. In addition, once the person secures employment, a job coach will support that individual with orientation, learning job tasks, and developing natural supports on-site. These services are done one-to-one with the job coach, on a schedule agreed upon between the person and the job coach. Usually, services are evaluated and authorized on a month to month basis, depending on the supports needed.

Day support services include training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. Day support services focuses on enabling the individual to attain or maintain his/her maximum functional level. These services can be center based, or community based services, with both focusing on community inclusion. Day support services can be part-time or full-time and can occur for as long as you remain eligible and funding is available.

Who is eligible for employment services?

You may be eligible if you have a physical, developmental, or behavioral health related disability and:

- The disability keeps you from finding or keeping a job,
- You want to work and you think employment services can help you, and
- You are in Virginia (live in, or are moving to Virginia).

If you think you have a disability but have never been diagnosed, you may also apply.

How do I get started?

If your child is 13 through 21 and still in school, talk to the person who coordinates your child's 504 Plan or Individualized Education Program (IEP). That person can help you with a referral to an adult service agency, such as DARS, and invite a representative, with your written consent, to your child's meeting. If education rights have transferred to your child, they will provide consent to invite someone from outside of the school. You or your child may invite someone to the meeting, and that does not require consent.

If you are over 22 years old and have a support coordinator, call your support coordinator/case manager. He or she will help you start the DARS referral process.

If you are over 22 years old and do not have a support coordinator, you can find more information at www.vadars.org or by dialing 1-800-552-5019.

Who provides funding for employment services?

The Virginia Department for Aging and Rehabilitative Services (DARS) determines eligibility for employment services. If you are found eligible, DARS will provide the service through state and federal funding, although in some circumstances, a job seeker or family may need to contribute financially. If DARS is not able to provide funding, people with disabilities who have a Medicaid Waiver can receive funding for job development services through the waiver. You can also check with your locality to see if they offer employment funding. In some cases private pay options are available.

How long does the eligibility process take?

By law, DARS has 60 days to decide if you are eligible for employment services. During these 60 days, a DARS counselor will review paperwork you have from school and/or doctors about your disability. They will also ask about any money you have. If you live at home, they may also ask about your family's income. In some case when the DARS counselor is not able to determine eligibility within 60 days they may extend the time it takes by using Trial Work. Your DARS counselor can explain what Trial work entails.

Employment Options Discussion

On-going Employment Choice discussions recognize that a person's interests, available services, and support options change over time. Rooted in person-centered thinking, support coordinators facilitate Employment Choice conversations between the person and their authorized representatives/legal guardian (decision maker) to ensure their career desires, interests and support/service needs are assessed. Specifically, Support Coordinators are responsible for the following related to Employment Choice:

- Identifying a person's interests regarding employment.
- Reviewing available options.
- Addressing the person's satisfaction or dissatisfaction with current services.
- If the person and/or Decision Maker does not want to explore or pursue options:
    - Identifying barriers related to exploring or pursuing employment options.
    - Addressing barriers, as applicable and develop outcomes/support activities related to barriers
- Indicating a timeline for reviewing options in the future; no less than annually
- Documenting that the above were discussed and any actions taken as a result.

Documentation example:

Example 1:

During the annual meeting John indicated interest in earning income. The Support Coordinator, John, and AR discussed his interests that could provide income/employment options. The SC shared information on the local Department for Aging and Rehab Services (DARS) office and the role they can play in helping people obtain and maintain paid jobs in their community. John and his AR agreed this seemed like a great next step. Additionally, the SC agreed to discuss the expressed interest in finding work related to computers with his day support provider to determine if they can help gather data for the DARS referral and support John's career planning efforts around computer work. John's ISP was updated with new objectives of increasing his access to and improving computer skills through the day support provider (if available) and working with DARS to explore community-based work opportunities.

Example 2:

In the annual meeting, the support coordinator discussed employment as an option for Jane. Jane indicated she enjoys attending her current day support program. The SC asked Jane what about the day program she enjoyed. She and the AR explained her friendships, the community outings, and consistency of a schedule. The SC shared ways that these needs could be met while pursuing employment as an option. Jane and her AR said they are not interested in changes. The SC also suggested referring Jane to a Peer Mentor. All agreed that they would discuss employment options again at the next annual meeting. The SC reminded Jane that if at any point she or her AR are dissatisfied, other providers/service options can be pursued.

Example 3:

In the annual meeting, the support coordinator discussed employment as an option for Tana. Tana was not able to participate in the discussion verbally although would smile or turn her head. Tana requires total physical care and is in a prone position 20 out of 24 hours per day. Tana's mom indicated she could not work nor has she ever expressed an interest in work. Support coordinator asked Tana if she wanted to work and Tana smiled at Support Coordinator which was interpreted by mom to be more an indication of pleasure with the interaction than with the idea of work. Support Coordinator talked to mom and Tana about Tana's interests and if any of those could be explored in a meaningful way towards employment. Mom and support staff expressed concern regarding what Tana could do given her limited use of her hand and a lack of a consistent yes/no response. Support coordinator discussed Tana's interests and how they might relate to employment and then asked Tana and her team what her priority was currently. Mom and support team are skeptical about employment but did not rule it out but agreed that right now Tana was best supported in her day program. The support coordinator agreed to reach out and gather information to share with the family about other individuals with significant disabilities and how they have been supported to find employment.

Employment resources At-a-Glance

Employment First	Technical assistance on implementing Employment First	Anita Mundy Anita.Mundy@dbhds.virginia.gov
Department of Aging and Rehabilitative Services (DARS)	Mission: to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.	www.dars.virginia.gov
Work Incentives Specialist Advocates (WISA's)	People who have been certified to provide work incentives counseling services to DARS clients who are receiving Social Security Disability (SSDI) and/or Supplemental Security Income (SSI) benefits.	https://www.vadars.org/gsp/wisa.htm
Social Security Administration	Ticket to Work Work Incentives Medicaid Works	https://www.ssa.gov/redbook/ www.socialsecurity.gov/work link to document
Employment Service Organizations (ESOs)	Operate primarily for the purpose of providing employment and vocational rehabilitation services to people with disabilities.	https://www.vadars.org/essp/eso.htm
Americorps	Gives 17-24 year-olds the chance to make a difference through a national network of hundreds of programs throughout the U.S., as well as the Student Conservation Association, which has conservation programs (jobs and internships) throughout the U.S. for adults 18 or older	https://www.nationalservice.gov/programs/americorps
Office of Disability Employment		https://www.dol.gov/odep/

Post-Secondary Opportunities At-a-Glance

Think College	a national organization dedicated to developing, expanding, and improving inclusive higher education options for people with intellectual disability	https://thinkcollege.net/
ACE-IT in College at Virginia Commonwealth University	an inclusive learning and training program for transition-age adults with intellectual & developmental disabilities	http://www.aceitincollege.org/
The Center on Transition Innovations (CTI) at Virginia Commonwealth University	provides evidence-based resources and information along with emerging practices in the field, at	https://centerontransition.org/transition/postEd/index.html
Postsecondary Education Options for Students with Intellectual Disabilities		http://www.communityinclusion.org/article.php?article_id=178
PAVE J. Sargeant Reynolds Community College	Program for Adults in Vocational Education (PAVE) is a two-year vocational training program which serves students with intellectual, physical, emotional, and learning disabilities.	http://www.reynolds.edu/student_services/pave/default.aspx

COMMONWEALTH of VIRGINIA

S. HUGHES MELTON, MD, MBA
FAAFP, FABAM
COMMISSIONER

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To: Case Managers/Support Coordinators, Employment Service Organizations, Service Authorization, VR Counselors, and Community Resource Consultants

From: Heather Norton, Director, Community Support Services
Donna Bonessi, Deputy Director, Employment Services
Ann Bevan, Director, Division of Developmental Disabilities and Behavioral Health

Re: Employment Services through DARS and Waiver

Date: 8/10/2018

Effective July 1, 2018, DARS and DBHDS have entered into a memorandum of agreement that helps to streamline the process for accessing employment supports when DARS has closed all categories under order of selection. When DARS closes all categories, this is an indication that funding is not available to immediately provide VR services and that individuals determined eligible will be placed on to a waitlist for services.

When a person with a DD waiver wants to access employment, it is expected that the Case Manager will refer the individual to DARS prior to offering choice of employment service organizations. However, when DARS has categories closed, the case manager may refer a DD waiver recipient to an employment services organization after offering choice of waiver employment providers without referring the individual to DARS. However, if at any time the individual requests to be referred to DARS or requires DARS vocational rehabilitation services, then referral to DARS must be made. The employment services organization, case managers and service authorization will all be notified by DBHDS Developmental Services Division when categories are both closed and opened. When category one is open at DARS, all individuals with a DD waiver must be referred to DARS prior to accessing services under the waiver.

It should be noted that all expectations under the waiver are the same as expectations from DARS. The individual must go through job development and assessment and demonstrate that Individual supported employment with or without workplace assistance is not a viable option prior to accessing group supported employment.

All regulations regarding the Workforce Innovation and Opportunities Act (WIOA) and the Home and Community Based Setting Rule should be adhered to in working with individuals to determine best employment options. This is particularly critical for young adults up to the age of 24 where there are very specific expectations about accessing different services and supports. Please assure your familiarity with these.

Additionally, once a person is open to DD waiver employment services, they do not need to return to DARS when a category opens, unless they are seeking a new job and starting the employment process again.

Finally, the MOU allows for braiding of funding between DARS and Waiver when the team feels the individual needs additional supports under the DD waiver. There will be soft limits around this with regards to job development in particular.

An FAQ and additional information will be forthcoming to add clarity.

If you have any questions please do not hesitate to contact Anita Mundy at anita.mundy@dbhds.virginia.gov, Heather Norton at heather.norton@dbhds.virginia.gov or Donna Bonessi at donna.bonessi@dars.virginia.gov .

Support Coordination Manual
Developmental Disabilities
Chapter 13
Housing

- Introduction
- Integrated, Independent Housing
- The Support Coordinator's Role in Integrated, Independent Housing
    - Support Coordinator Training and Resources/Tools
- Integrated, Independent Housing Resources and Options
    - State Rental Assistance Program
- Regional Housing Specialists' Role
- Centers for Medicare and Medicaid Services Home and Community Based Services Settings Regulations
- At-a-Glance
    - Regional Housing Specialists

Support Coordination Manual
Developmental Disabilities
Chapter 13
Housing

Introduction

Historically, people with developmental disabilities (DD) have experienced major barriers to living in their own homes, including affordability, accessibility, and lack of supportive services options. Over the past several years, the Commonwealth has focused on addressing these obstacles and making significant investments to:

- Redesign its system of Home and Community based services for people with DD and offer a broader array of services to support people in their own homes,
- Offer rent assistance,
- Provide funds to assist with upfront costs to secure housing, and
- Help modify units so people can live in the same types of housing in the community that people without disabilities do.

As people learn about these new opportunities and see others enjoying greater choice and control over where they live, with whom they spend their time, who supports them, and what they do with their day, more people with disabilities are opting to live in integrated, independent housing.

Box

Virginia's vision

Virginians with DD, including those in the Settlement Agreement population, will have greater access to housing resources that offer increased opportunities for integrated, independent living.

In keeping with Virginia's vision for people with disabilities, the state has developed *Virginia's Plan to Increase Independent Living Options* to increase access and availability of integrated, independent housing options with appropriate supportive services for people with developmental disabilities. The plan's primary focus is to house 1,866 Virginians with developmental disabilities in the Settlement Agreement population in independent housing and to create 847 new independent housing options for the Settlement Agreement population by the end of FY 2021.

The Department of Behavioral Health and Developmental Services (DBHDS) has placed Regional Housing Specialists in each of the five Developmental Services Regions to assist in making this plan a reality. (Regional Housing Specialists at a glance link in introduction)

What Is Integrated, Independent Housing?

Integrated, Independent Housing is built on the following paradigm:

Individuals have the right to:

- Choose where they live
- Choose who to live with

- Choose who will provide supports needed to be safe, healthy and independent – these supports can be paid or non-paid (natural supports)
- Community inclusion

Integrated, Independent Housing has the following core features:

- Individual does not reside with a parent, grandparent or guardian
- Individual can live in housing types that anyone without a disability lives in, based on income
- Individual has social, religious, educational and personal opportunities to fully participate in community life
- Housing is affordable (individual pays no more than 30% to 40% of his/her adjusted gross income)
- Housing is accessible (barrier free)
- Housing is leased or owned by the person using services
- Housing is not contingent upon participation in services (and vice versa)

Support Coordinator Role in Integrated, Independent Housing

Support Coordinators (SCs) are primarily responsible for assessing individual needs, developing plans for support to help reach individual outcomes, linking people to services and resources, and monitoring whether services are helping achieve intended outcomes. When it comes to integrated, independent housing, the responsibilities are very similar. SCs convene the person-centered planning team and "coordinate" with members of the team to ensure a person's plan for housing is fully implemented.
Here is a more detailed description of what the SC's role is specific to housing:

Support Coordinator's Role	**What This Role Looks Like in Housing**
Provide Choice and Use a Person-Centered Approach	Provide Education about Independent Housing Options (contact Regional Housing Specialist for assistance) • Review housing assistance options available in the individual's community • Share links to housing videos and information sessions about housing options What Is the Person's Vision for Housing? • What does the person's desired housing arrangement look like? • Where does the person want to live? With whom? • What is important to/for the person in housing?
Assess Individual Needs	Assess Individual's Readiness for Housing and Specific Housing Needs • Who (if anyone) will the individual live with? • What supports does the individual need to obtain and maintain housing? Who do they

	want to provide the supports? Does the person have access to these supports? • Does the person have a realistic budget to obtain and maintain housing? What income and assets does he/she have? • Does the person have the documents he/she needs to obtain housing (e.g., Social Security card, birth certificate, government photo I.D.)? • What specific housing features does the person need (e.g., specific location, unit size, accessibility features)? • What barriers does the person face to obtaining rent assistance and housing (e.g., poor credit, prior evictions or lease violations, criminal history, etc.)? • Evaluate eligibility for different sources of housing assistance and whether these sources are available.
Develop Plans for Support	Based on the assessment above, develop plans which support the transition to independent housing and ability to maintain housing • Identify and get commitments from any roommates and/or live-in aides • Outline plans to secure needed supports in housing, including funding sources (if any), providers, and proposed support schedule. • Determine ways to increase income, reduce expenses and access alternative resources to offset expenses (e.g., SNAP, fuel assistance, etc.). • Define financial responsibilities (e.g., who will pay for specific upfront and ongoing housing expenses and how will payments be made) • Identify documents needed to apply for housing and who will assist with securing them. • Review potential housing options and locate properties that may meet the individual's needs. • Identify housing assistance programs for which the individual is eligible and would like to apply. • Investigate approaches to reduce or remove barriers (e.g., reasonable accommodation requests, credit reparation, tenant training)
Link to Services and Resources	Based on the plan above, this may include:

	• Submitting a housing resource referral for housing assistance • Assisting the individual with completing housing assistance applications and eligibility interviews • Supporting the individual with applicant briefings for housing assistance • Connecting the person to affordable rental properties that may meet his/her needs and/or accept rent assistance • Coordinating resources and services to assist with the housing search, lease review and the move (e.g., family, support services, Flexible Funding) • Helping individual access funding sources to cover upfront expenses related to securing housing (e.g., application fees, security deposits, utility deposits, etc.) • Assisting individuals with requesting reasonable accommodations and modifications in housing assistance programs and housing.
Monitor Whether Services are Achieving Intended Outcomes	If an individual who lives in independent housing receives no other Waiver services in the home, the SC should: • provide two in-home visits per year to review whether the housing environment continues to meet the person's needs • complete two telephone contacts per year with the individual to monitor rent and utility payments and satisfaction with the housing arrangement • make two collateral contacts per year with the landlord and two contacts with the housing program to support compliance with the lease and the housing assistance program's participation requirements. If an individual lives in independent housing and receives Waiver services in the home, the SC should • provide at least one, in-home visit per year to review whether the housing environment continues to meet the person's needs. • complete two telephone contacts per year with the individual to monitor rent and utility payment, satisfaction with housing arrangement

	• make two collateral contacts per year with the landlord, and two contacts with the housing program, to support compliance with the lease and housing assistance program participation requirements. • review quarterly reports from the service providers to determine whether service providers that support the individual in the home report changes in the person's housing needs, satisfaction with the housing arrangement, rent/utility payment status, or compliance with lease or housing assistance program requirements.

Support Coordinator Training & Resources/Tools

DBHDS has created Independent Housing Training for SCs. This training is **required** within the first 30 days of employment to ensure SCs are aware of independent housing resources and options available, as well as the process to access those resources. The Independent Housing Training for SCs can be found on the Commonwealth of Virginia Learning Center https://covlc.virginia.gov. To access the Independent Housing Training, after logging in, please type in "Housing" in the search bar.

There are a number of tools and resources available on the DBHDS Housing website for SCs. For example, the following helpful tools are available:

- **Support Coordinator Checklist** This checklist will assist the SC in ensuring that those who want to use DBHDS housing assistance have completed the necessary steps to apply.

- **Housing Readiness Assessment** The purpose of the housing assessment is to help assess someone's readiness for integrated, independent housing and eligibility for various housing options and resources in the community. DBHDS requires a Housing Readiness Assessment to be completed for anyone being referred for rental assistance. NOTE: The Housing Readiness Assessment will be transitioned to WaMS in early 2019.

- **Housing Action Plan** Using the information from the Housing Readiness Assessment, those seeking housing and SCs can develop a housing action plan to guide the transition to independent housing. A comprehensive plan will help address barriers and ensure supports, accommodations and modifications are in place to facilitate a smooth transition into a home of one's own.

- **Independent Housing Monitoring Assessment** When visiting individuals who have transitioned to their own homes, SCs can use this tool to monitor and record observations regarding an individual's housing stability in the areas of lease compliance, ability to maintain the unit, and general health and safety. If issues are observed, SCs and individuals can address these issues in the context of the individual service plan.

Please use one of the links below to access the above referenced tools and resources.

http://www.dbhds.virginia.gov/developmental-services/housing/the-path-to-housing

http://www.dbhds.virginia.gov/developmental-services/housing/resources-for-support-coordinators-and-case-managers.

Integrated, Independent Housing Resources and Options

Box

SCs must submit a DBHDS Housing Readiness Assessment and DBHDS Housing Resource Referral Form to access the following housing resources for individuals they serve. The Housing Readiness Assessment is currently available at http://www.dbhds.virginia.gov/developmental-services/housing/resources-for-support-coordinators-and-case-managers . The DBHDS Housing Referral Form is currently available at http://www.dbhds.virginia.gov/developmental-services/housing/the-path-to-housing. ***However, both of these forms will be transitioned to WaMS in early 2019.***

If the individual does not meet the readiness criteria outlined on the Readiness Assessment, the SC must develop a Housing Action Plan with the individual and his/her planning team, and submit the Action Plan for DBHDS review before a referral can move forward. The purpose of the Action Plan is to create a path to readiness. The individual and the planning team will work on the Action Plan together. Once the person meets the readiness criteria, DBHDS will place the referral in the queue to be assigned a housing resource.

Individuals on the waiver waitlist also access their housing resources through the DBHDS referral system and have housing referrals submitted by a support coordinator. In the absence of waiver case management, CSBs may utilize Medicaid SPO case management for eligible individuals to complete support coordination activities associated with housing.

Housing Choice Voucher Special Admissions Preference and the State Rental Assistance Programs

The Housing Choice Voucher Special Admissions Preference Program and the State Rental Assistance Program both provide rent assistance designated for eligible people with DD in the Settlement Agreement population through the WaMS/DBHDS housing resource referral system. Typically, the individual/household receives a voucher or certificate that can be used at any rental property in the community that will accept rent assistance. A unit must have a rent that is within the program's maximum subsidy limit and must pass a safety inspection. If the unit is approved, the individual/household will pay 30%-40% of their monthly adjusted income towards rent, minus an allowance for tenant-paid utilities. The balance of rent (up to the maximum allowable by the program) is paid directly to the landlord by the rental assistance program administrator.

Rental Properties with a Leasing Preference for the Settlement Agreement Population

Certain rental properties, known as Low Income Housing Tax Credit (LIHTC) properties, have units that are available on a preferential basis for people with DD in the Settlement Agreement population. A growing number of LIHTC properties, including some with project-based rental assistance, provide this leasing preference. The leasing preference gives individuals in the Settlement Agreement population priority over other applicants for certain available units at these rental properties. Individuals must still qualify for the

apartments (e.g., meet income and other tenant selection criteria). Rental assistance may or may not be available at the property. For information about rental properties with a leasing preference in your region, contact your Regional Housing Specialist.

DBHDS Flexible Funding

DBHDS has partnered with one or more Community Services Board (CSB) in each region that serve as Flexible Funding program administrators to help people with DD in the Settlement Agreement Population afford the costs associated with making the initial transition to their own rental housing or maintaining housing if they are at risk of eviction. Some examples of costs that Flexible Funding could help pay for are as follows:

Assistance with Initial Transition to Housing (one time allotment of up to $5,000 for the ***initial move***)

- rental application fees
- utility deposits and/or connection fees
- security deposits
- moving expenses
- essential furniture and other household supplies (these items have maximum allowable payment/reimbursement limits)
- non-reimbursable environmental modifications or assistive technology
- temporary rent to allow completion of environmental modifications
- direct support with housing location and pre-tenancy activities
- temporary support staffing to help individuals get acclimated to new housing (e.g., apartment building and community orientation, instruction in use of appliances and environmental controls)
- shared living provider start-up activities (e.g., identifying roommate preferences, advertising for a roommate, assisting with interviews, performing background checks, arranging for required trainings, conducting visual inspection of the housing unit, facilitating discussions of support expectations, assisting with completion of the Supports Agreement)

Assistance with Maintaining Housing/Eviction Prevention (one time allotment of up to $5,000 – can be drawn upon until allotment is depleted)

- emergency rent and associated late fees
- last resort utility assistance
- household management activities (specialized cleaning, pest extermination)
- unit repairs
- temporary relocation

SCs complete and submit applications for Flexible Funding on behalf of individuals. CSB Flexible Funding program administrators can either reimburse individuals (or their families) for eligible, out-of-pocket expenses, purchase items on behalf of individuals or pay vendors directly. Reimbursement requests must be accompanied by itemized receipts, and receipts must be submitted within 60 days of the expenditure.

Role of Regional Housing Specialists

DBHDS understands that helping someone through the housing process can seem like a daunting task. Housing Specialists are available in each region of the Commonwealth to make the transition process as smooth as possible.

Housing Specialists provide technical assistance to help those eligible and SCs access housing resources in the community. Housing Specialists can:

- provide information about available housing resources;
- assist with developing a Housing Action Plan and implementing the Plan;
- assist with submitting a DBHDS Housing Resource Referral;
- assist with locating housing and completing rental and housing assistance applications;
- assist with preparing a reasonable accommodation or modification request;
- assist with developing approaches to address fair housing and/or tenant-landlord concerns; and
- assist with securing resources to cover transition expenses such as security deposits, basic household furniture and supply needs.

Regional Housing Specialists

Name	Title	Region	Email	Phone Number
Marie Fraticelli	Housing Specialist	Western	marie.fraticelli@dbhds.virginia.gov	434-953-7146
Jeannie Cummins Eisenhour	Senior Housing Specialist/Acting Housing Manager	NOVA	j.cummins@dbhds.virginia.gov	804-836-4308
Anna Bowman	Housing Specialist	Southwestern	anna.bowman@dbhds.virginia.gov	804-839-0476
Sheree Hilliard	Housing Specialist	Central	sheree.hilliard@dbhds.virginia.gov	804-371-2154 or 804-629-1675
Kimberly Rodgers	Housing Specialist	Eastern	kimberly.rodgers@dbhds.virginia.gov	804-629-1674

Centers for Medicare & Medicaid Services (CMS) Setting Regulations

The Home and Community-Based Services (HCBS) settings regulations (previously known as the "Final Rule") published in the Federal Register, became effective March 17, 2014. They were designed to enhance the quality of HCBS, provide additional protections, and ensure full access to the benefits of community living. Settings regulations establish requirements for the qualities of settings for those who use Medicaid-reimbursable HCBS services.

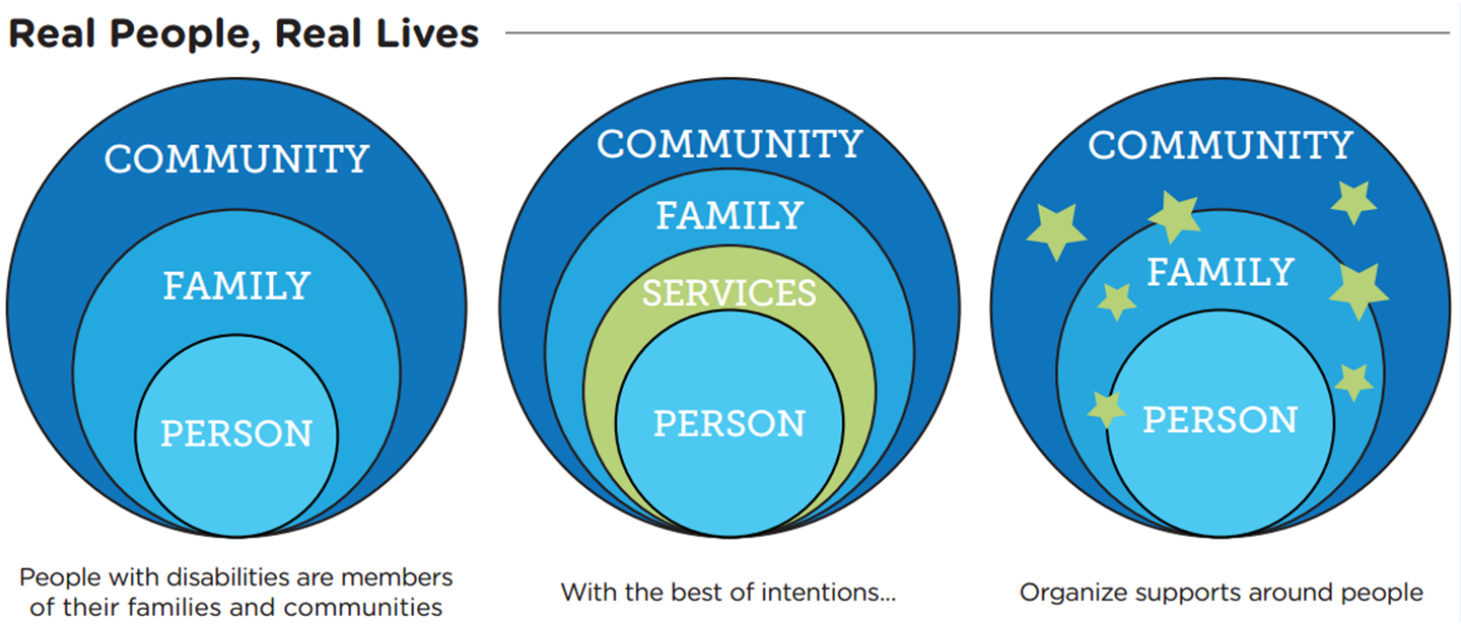
BOX

Mandated Qualities for Residential/Non-residential Settings

- Supports full access to the greater community
  - Provide opportunities to seek employment, work in competitive integrated settings, engage in community life, control personal resources, and
  - Ensure that people use services in the community, to the same degree of access as those not using HCBS;
- Selected by the person served from among setting options including non-disability specific settings and options for a private unit in a residential setting;
  - Person-centered service plans document the options based on the person's needs, preferences, and for residential settings, resources available for room and board

- Ensures a person's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes one's initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact; and
- Facilitates one's choice regarding services and supports, and who provides them.

The integration of services in a person's life, family and community are depicted in the third circle in the following diagram.



Resource: Michelle 'Shelli' Reynolds, PhD UMKC Institute for Human Development

A residential setting that is provider-owned or controlled is subject to additional requirements. These settings include group homes, sponsored placements and supported living situations.

BOX

Mandated Qualities for Residential Settings

- Have a lease, or other signed legally enforceable agreement providing similar protections
- Have access to privacy in their sleeping units
- Have entrances lockable by the individual, with keys provided to appropriate staff as needed
- Have a choice in selecting their roommate(s), if they share a room
- Have the freedom to decorate and furnish their sleeping and/or dwelling unit
- Have the ability to control their daily schedules and activities and have access to food at any time
- Be able to have visitors at any time; and,
- Be able to physically maneuver within the setting (e.g., setting is physically accessible).

Though it is not the responsibility of the SC to ensure that providers adhere to the additional requirements, it is important that the SC familiarize themselves with these requirements as they may need to discuss the settings regulations with providers.

To read a HCBS settings rule companion guide go to
http://www.aucd.org/docs/policy/HCBS/HCBS%20Settings%20Rules_What%20You%20Should%20Know!%20Final%201%2022%202016.pdf

REGIONAL HOUSING SPECIALISTS At-a-Glance

Name	Title	Region	Email	Phone Number
Marie Fraticelli	Housing Specialist	1 - Western	marie.fraticelli@dbhds.virginia.gov	434-953-7146
Jeannie Cummins Eisenhour	Senior Housing Specialist/Acting Housing Manager	2 - Northern	j.cummins@dbhds.virginia.gov	804-836-4308
Anna Bowman	Housing Specialist	3 - Southwestern	anna.bowman@dbhds.virginia.gov	804-839-0476
Sheree Hilliard	Housing Specialist	4 - Central	sheree.hilliard@dbhds.virginia.gov	804-371-2154 or 804-629-1675
Kimberly Rodgers	Housing Specialist	5 - Eastern	kimberly.rodgers@dbhds.virginia.gov	804-629-1674

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Developmental Disabilities
Chapter 14
Reviews

- Importance of reviews
- Internal
- External
    - DBHDS
        - Office of Licensing (OL)
            - DBHDS Annual Medical and Behavioral Health Reviews
        - Office of Human Rights (OHR)
        - Quality Service Reviews- Qlarant
        - National Core Indicators (NCI)- VCU
    - DMAS Quality Management Review (QMR)
    - Department of Justice (DOJ) Settlement Agreement Independent Reviewer

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Importance of Reviews

Documentation is an important part of the Developmental Disability (DD) Services delivery system. It serves as a means to help identify whether or not people's needs are being identified and met through person-centered values and planning. Reviews also ensure that services are being provided in the most integrated setting appropriate to person's needs and consistent with their informed choice. Reviews ensure that people have opportunities for integration in all aspects of their lives.

It is important for Support Coordinators (SC) to know and understand the different entities that currently review the DD service system.

Internal

All licensed providers are responsible for conducting qualitative and quantitative reviews to evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. SC supervisory and internal quality assurance reviews are conducted regularly to ensure the SC is consistently interpreting and applying licensure regulations and Medicaid documentation requirements. Internal reviews allow the SC to learn methods to improve the quality of services they provide and ensure that the supports are in line with agency standards.

External

Reviews and audits are conducted by several agencies that are not part of the Community Services Board (CSB) or SC organization. External reviews are often conducted by an independent review organization or a state organization. The goals of external reviews are to provide a review free from conflict of interest, establish standard requirements and qualifications, and to provide fair and impartial reviews.

Department of Behavioral Health and Developmental Services (DBHDS)

DBHDS provides oversight to a number of different units that provide regular reviews of the DD service delivery system. Some of those units are employed by DBHDS and others are contracted to provide the reviews. Below is a description of the four review units associated with DBHDS.

DBHDS Office of Licensing (OL)

Licensing specialists are employed by DBHDS in the Office of Licensing (OL) to license, monitor and provide oversight and technical assistance to licensed public and private providers that deliver services to people with mental illness, developmental disabilities or substance use disorders. They conduct announced or unannounced onsite inspections, inspect buildings and locations, review staff qualifications, review individual plans, and investigate complaints regarding potential violations of licensing regulations.

DBHDS licenses services that provide treatment, training, support and habilitation to people who have mental illness, developmental disabilities or substance use disorders, to people using services under the Medicaid DD Waiver, or to people with brain injuries using services in residential facilities.

You can learn more about this department at
http://dbhds.virginia.gov/quality-management/Office-of-Licensing

DBHDS OL Annual Reviews

On an annual basis DBHDS will conduct announced and unannounced onsite reviews to determine compliance on preventing specific risks to people with disabilities. More information about the DBHDS Annual Medical and Behavioral Health Reviews can be located in the Emergency Regulations 12VAC35-105-70.

(link) http://dbhds.virginia.gov/assets/doc/QMD/OL/ch.105.full.wemergcompliance.9.01.18docx.pdf

DBHDS Office of Human Rights (OHR)

Human Rights advocates are employed by DBHDS in the Office of Human Rights (OHR). They advocate for the rights of people using services in DBHDS licensed programs and facilities. They monitor provider compliance with human rights regulations, provide consultation and education to people with disabilities, families and providers about the human rights regulations. OHR manages the DBHDS human rights dispute resolution program by investigating complaints regarding potential violation of the human rights regulations, reviewing provider's policies to ensure compliance with the human rights regulations, and providing technical assistance to the Local Human Rights Committees (LHRC's).

SCs help protect the basic human rights of people with disabilities. They ensure that people are treated with dignity and respect and are free from abuse, neglect and exploitation. The SC should ensure that the person and their legal guardian (LG)/authorized representative (AR) is involved in all aspects of care including person centered planning and signed consents for

treatment. In the event that a person's rights have been violated, the SC should ensure the person, their family and the LG/AR know who to contact if either has a complaint.

You can find more information about OHR at the following site.

http://dbhds.virginia.gov/quality-management/human-rights

Quality Service Reviews
Qlarant

DBHDS contracts with Qlarant to conduct Quality Service Reviews (QSRs) of those with a developmental disability (DD) who use services under the Department of Justice (DOJ) settlement agreement. This includes people using services through the Medicaid Home and Community-Based (HCBS) Services DD Waivers who live the community.

The purpose of the QSRs is to evaluate the quality of services and determine if people are achieving outcomes, particularly in the areas of person centered planning, integrated settings and community inclusion. The QSR consists of Person Centered Reviews (PCR) and Provider Quality Reviews (PQR). The person using services has a voice as part of each process which is measured during interviews with the person, their authorized representative or legal guardian. During a QSR, the SC can expect to be interviewed by Qlarant reviewers. QSRs also include provider and SC record reviews. A website for Qlarant can be found at the following site. http://www.qlarant.com/

National Core Indicators (NCI)

DBHDS contracts with the Partnership for People with Disabilities at Virginia Commonwealth University to collect National Core Indicators (NCI). NCI is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.

NCI gathers information through face-to-face interviews about satisfaction with supports and services from the people who use them. The survey instruments are used by a majority of states in the U.S. Information is also gathered from families about satisfaction with supports and services via mail-in surveys. Major activities of NCI include:

- Conduct interviews with people who use supports and services across the state
- Send mail-in surveys to family members of people who use supports and services

- Analysis and reports of findings may be found at Virginia's NCI website: www.vcu.edu/partnership/nci/ and at the National NCI website: www.nationalcoreindicators.org

Department of Medical Assistance Services (DMAS) Quality Management Review (QMR)

QMR Reviewers are employed by the Department of Medical Assistance Services (DMAS). They complete reviews of provider documentation and personnel records for compliance with Medicaid policies and regulations, provide technical assistance related to onsite reviews and will refer to the DMAS Integrity unit when fraud is suspected or retractions in funding are warranted. A link to the website is provided on this slide. You can find more information about the QMR at the following link:
https://law.lis.virginia.gov/admincode/title12/agency30/chapter120/section990/
Department of Justice (DOJ) Settlement Agreement Independent Reviewer

Department of Justice (DOJ) Settlement Agreement Independent Reviewer

As a result of the DOJ settlement, an independent reviewer, separate from the state of Virginia conducts reviews and submits reports every 6 months on their findings.