TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-43. Services in an Intermediate Care Facility for the Mentally Retarded

Services in an ICF/MR facility are provided to individuals ~~with chronic mental retardation, a condition characterized by a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period. Care also can be provided for the individual who is not mentally retarded but has developmental disabilities closely related to or requiring treatment similar to mental retardation. In addition to the developmental disability, he must have one or more handicapping conditions which prevent communication of basic needs, ability to meet basic self-help needs, or requires care and treatment similar to that of a mentally retarded individual. To be eligible for ICF/MR services, mental retardation or developmental disability must have occurred prior to the individual's 22nd birthday~~ per OAC 317:30-5-122 and OAC 317:35-9-45.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES

317:30-5-122. Levels of care

~~The level of care provided by a long term care facility to a patient is based on the nature of the health problem requiring care and the degree of involvement in nursing services/care needed from personnel qualified to give this care.~~

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, Nursing Facility or Intermediate Care Facility for People with Mental Retardation (ICF/MR). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental and social/emotional status to determine the appropriate level of

care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** When total payments from all other payers are less than the ~~Medicaid~~ SoonerCare rate, payment is made for the Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for the Mentally Retarded.** ~~Care provided by a nursing facility to patients who require care and active treatment due to mental retardation or developmental disability combined with one or more handicaps. The mental retardation or developmental disability must have originated during the patient's developmental years (prior to 22 years of chronological age).~~ Care for persons with mental retardation or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) Self–care. The individual requires assistance, training or supervision to eat, dress, groom, bathe, or use the toilet.

(B) Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of requests or is unable to follow two-step instructions.

(C) Learning. The individual has a valid diagnosis of intellectual disability (mental retardation) as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without an assistive device.

(E) Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety or for legal, financial, habilitative or residential issues and/or has been declared legally incompetent. The individual is a

danger to himself or others without supervision.
(F) Capacity for independent living. The individual who is 7 years old or older and is unable to locate and use a telephone, cross the street safely or understand that it is unsafe to accept rides, food or money from strangers or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping or paying bills.

PART 41. FAMILY SUPPORT SERVICES

317:30-5-412. Description of services

Family support services include services identified in paragraphs (1) through (6). Providers of any family support service must have an applicable SoonerCare Provider Agreement for Home and Community Based Services (HCBS) Waiver Providers for persons with developmental disabilities.

(1) **Transportation services.** Transportation services are provided ~~in accordance with~~ per OAC 317:40-5-103.

(2) ~~**Adaptive equipment**~~ **Assistive technology (AT) devices and services.** ~~Adaptive equipment~~ Assistive technology devices and services, ~~also known as environmental accessibility adaptations, services~~ are provided in accordance with OAC 317:40-5-100.

(3) **Architectural modification.** Architectural modification services are provided ~~in accordance with~~ per OAC 317:40-5-101.

(4) **Family training.**

(A) **Minimum qualifications.** ~~Training providers must hold current licensure as a clinical social worker, psychologist, professional counselor, or registered nurse. Training may also be provided by other local or state agencies whose trainers have been approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) director of Human Resource Development.~~

(i) Individual providers must have a DDSD Family Training application and training curriculum approved by DDSD staff. Individual providers must hold current licensure, certification or a Bachelor's Degree in a human service field related to the approved training curriculum. Only individuals named on the SoonerCare Provider Agreement to provide Family Training services may provide service to members;

(ii) Agency or business providers must have a DDSD Family Training application and training curriculum approved by DDSD staff. Agency or business provider

training staff must hold current licensure, certification or a Bachelors Degree in a human service field related to the approved training curriculum. The credentials of new training staff hired by an approved DDSD HCBS Family Training agency or business provider must be submitted to and approved by the DDSD program manager for Family Training prior to new staff training members or their families.

(B) **Description of services.** Family training services include instruction in skills and knowledge pertaining to the support and assistance of members. Services are:

(i) intended to allow families to become more proficient in meeting the needs of members who are eligible;

(ii) provided in any community setting;

(iii) provided in either group, consisting of two to 15 persons, or individual formats; and

(iv) for ~~families of~~ members served through DDSD ~~Home and Community-Based Services (~~HCBS~~)~~ Waivers and their families. For the purpose of this service, family is defined as any person who lives with or provides care to a member served on the ~~waiver~~ Waiver.

(v) included in the member's Individual Plan (Plan) and arranged through the member's case manager; and

(vi) intended to yield outcomes as defined in the member's Plan.

(C) **Coverage limitations**. Coverage limitations for family training are:

(i) ~~Description:~~ Individual family training; Limitation: $5,500 per Plan of Care year; ~~and~~

(ii) ~~Description:~~ Group family training; Limitation: $5,500 per Plan of Care year~~.~~ ;

(iii) Session rates for individual and group sessions should not exceed a range comparable to rates charged by persons with similar credentials providing similar services;

(iv) Rates must be justified based on costs incurred to deliver the service and will be evaluated to determine if costs are reasonable.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(i) service date;

(ii) start and stop time for each session;

(iii) signature of the trainer;

(iv) credentials of the trainer;

(v) specific issues addressed~~. Issues must be identified in the member's Individual Plan (IP)~~;
(vi) methods used to address issues;
(vii) progress made toward outcomes;
(viii) member's response to the session or intervention; and
(ix) any new ~~issued~~ issues identified during the session.
(x) Progress reports for each member served must be submitted to the DDSD case manager per OAC 340:100-5-52.
(xi) An annual report of the provider's overall Family Training program including statistical information about members served, their satisfaction with services, trends observed, changes made in the program and program recommendations must be submitted to the DDSD program manager for Family Training on an annual basis.

(5) **Family counseling**.

(A) **Minimum qualifications.** Counseling providers must hold current licensure as a clinical social worker, psychologist, or licensed professional counselor (LPC).

(B) **Description of services.** Family counseling~~,~~ offered ~~specifically~~ to members and their natural, adoptive, or foster family members, helps to develop and maintain healthy, stable relationships among all family members.
(i) Emphasis is placed on the acquisition of coping skills by building upon family strengths.
(ii) Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home.
(iii) All family counseling needs are documented in the member's ~~IP~~ Plan.
(iv) Services are rendered in any confidential setting where the member/family resides or the provider conducts business.

(C) **Coverage limitations**. Coverage limitations for family counseling are:
(i) ~~Description:~~ Individual family counseling; Unit: 15 minutes; Limitation: 400 units per Plan of Care year; and
(ii) ~~Description:~~ Group (six person maximum) family counseling; Unit: 30 minutes; Limitation: 225 units per Plan of Care year.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(i) service date;
(ii) start and stop time for each session;
(iii) signature of the therapist;
(iv) credentials of the therapist;
(v) specific issues addressed~~. Issues must be identified in the member's IP~~;
(vi) methods used to address issues;
(vii) progress made toward resolving issues and outcomes;
(viii) member's response to the session or intervention; and
(ix) any new issue identified during the session.

(E) **Reporting requirements**. Progress reports for each member served must be submitted to the DDSD case manager per OAC 340:100-5-52.

(6) **Specialized medical supplies.** Specialized medical supplies are provided per 317:40-5-104.

~~(A) **Minimum qualifications.** Providers must:~~
~~(i) be registered to do business in Oklahoma or in the state in which they are domiciled;~~
~~(ii) have a Medicaid contract with Oklahoma Health Care Authority to provide unrestricted durable medical equipment to members receiving HCBS; and~~
~~(iii) enter into this agreement:~~
~~(I) giving assurance of ability to provide products and services; and~~
~~(II) agree to the audit and inspection of all records concerning goods and services provided.~~

~~(B) **Description of services.** Specialized medical supplies include supplies specified in the member's IP that enable the member to increase his or her ability in the performance of activities of daily living. Specialized medical supplies also include the purchase of ancillary supplies not available under the Medicaid State Plan.~~
~~(i) Supplies furnished through an HCBS waiver are in addition to any supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical and remedial benefit to the member.~~
~~(ii) All supplies must meet applicable standards of manufacture, design, and installation.~~
~~(iii) Supplies include, but are not limited to:~~
~~(I) adult briefs;~~
~~(II) nutritional supplements;~~
~~(III) supplies needed for respirator/ventilator care;~~
~~(IV) supplies needed for health conditions;~~

~~(V) supplies for decubitus care; and~~
~~(VI) supplies for catheterization.~~

~~(C) **Coverage limitations**. Specialized medical supplies are billed using the appropriate procedure code. Individual limits are specified in each member's IP. All services are authorized in accordance with OAC 317:40-5-104.~~

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 1. SERVICES

317:35-9-4. Services in Intermediate Care Facility for ~~Mentally Retarded~~ persons with Mental Retardation (public and private)

~~(a) Services in an Intermediate Care Facility for Mentally Retarded (ICF/MR) are provided to an individual with mental retardation, which is a chronic condition characterized by a significantly sub-average general intellectual functioning (IQ score of 75 or below) existing concurrently with deficits in adaptive behavior and originating during the developmental period. Care also can be provided for the individual who is not mentally retarded but has developmental disabilities closely related to or requiring similar treatment to mental retardation. In addition to the developmental disability, the individual must have one or more handicapping conditions which prevent communication of basic needs, ability to meet basic self-help needs, or require care and treatment similar to that of a mentally retarded individual (see OAC 340:100). To be eligible for ICF/MR services, mental retardation or developmental disability must have occurred prior to the individual's 22nd birthday.~~

~~(b) ICF/MR services are provided in long-term care facilities (public and private) which are licensed under state law to provide, on a regular basis, health related care and services to individuals who because of their physical or mental condition require services above the level of room and board care which can be made available to them only through an ICF/MR.~~

(a) Services in a private Intermediate Care Facility for persons with Mental Retardation (ICF/MR) may be provided to members requiring health or habilitative services above the level of room and board. Services are provided to members who meet level of care and eligibility requirements per OAC 317:30-5-122 and 317:35-9-45.

(b) Services in a public ICF/MR may be provided to members who require health or habilitative services above the level of room and board. Services are provided to members who meet level of care requirements per OAC 317:30-5-122.

317:35-9-5. Home and Community - Based ~~Waiver~~ Services (HCBS) Waivers for persons with intellectual disabilities (mental retardation) or certain persons with related conditions.

(a) ~~Services provided through Home and Community - Based Services(HCBS) Waivers are outside the normal scope of SoonerCare services.~~ ~~HCBS Waivers~~ Home and Community Based Services (HCBS) Waivers for persons with intellectual disabilities (mental retardation) or certain persons with related conditions are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) per OAC 317:40-1-1. Oklahoma's Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of ~~waiver administration~~ Waiver operation. HCBS Waivers allow the OHCA to offer certain home and community based services to categorically needy members who, without such services, would be eligible for care in ~~a facility~~ an Intermediate Care Facility for persons with ~~mental retardation~~ Mental Retardation (ICF/MR).

~~(b) Individuals with mental retardation are eligible for SoonerCare as categorically needy under the HCBS Waiver program when eligibility conditions in (1) through (5) are met:~~

~~(1) The individual is determined financially eligible per OAC 317:35-9-68;~~

~~(2) The individual meets the Social Security Administration (SSA) definition of disabled;~~

~~(3) The individual requires a level of care provided in a public or private intermediate care facility for persons with mental retardation (ICF/MR) and has a diagnosis of mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability;~~

~~(4) It is appropriate to provide care outside the ICF/MR; and~~

~~(5) The average cost of providing care outside the ICF/MR does not exceed the cost of providing institutional care.~~

(b) Members receiving HCBS Waiver services per OAC 317:40-1-1 are subject to HCBS Waiver service conditions (1)-(11) of this subsection. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.

(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.
(2) DDSD must limit the utilization of the HCBS Waiver services based on:
(A) the federally-approved member capacity for the individual HCBS Waivers; and
(B) the cost effectiveness of the individual HCBS Waivers as determined according to federal requirements; and
(3) DDSD must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.
(4) Members receiving Waiver services must have full access to State plan services for which they are eligible including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when children participate in a Waiver.
(5) A member's room and board expenses may not be paid through a Waiver. Room and board expenses must be met from member resources or through other sources.
(6) A member must require at least one Waiver service per month or monthly case management monitoring in order to function in the community.
(7) Waiver services required by a member must be documented in advance of service delivery in a written plan of care.
(8) Members exercise freedom of choice by choosing Waiver services instead of institutional services.
(9) Members have the right to freely select from among any willing and qualified provider of Waiver services.
(10) The average costs of providing Waiver and non-Waiver SoonerCare services must be no more costly than the average costs of furnishing institutional (and other SoonerCare state plan) services to persons who require the same level of care.
(11) Members approved for services provided in a specific Waiver must be afforded access to all necessary services offered in the specific Waiver if the member requires the service.

317:35-9-5.1. Home and Community Based Waiver Services for individuals with mental retardation and related conditions [REVOKED]

~~(a) Home and Community Based Waiver Services for individuals with mental retardation and related conditions are services which are outside the normal scope of Medicaid services. The Medicaid waiver allows the OHCA to offer certain home and community based services to categorically needy individuals who reside in nursing facilities and who have been determined~~

~~not to require that level of care.~~
~~(b) Individuals with mental retardation and related conditions are eligible for Medicaid as categorically needy under the HCBW Program when the following medical and financial eligibility conditions are met:~~
~~(1) The individual is categorically needy as his/her income and resources are within the standards as listed on the appropriate schedule of DHS Appendix C-1, Schedule VIII. B. and D.~~
~~(2) The individual meets the SSA test for disability.~~
~~(3) For an individual subject to the provisions of Public Law 100-203, the individual does not require the level of care provided in a nursing facility but resided there for at least 30 continuous months prior to January 1, 1989.~~
~~(4) The average cost of providing care outside the NF does not exceed the cost of providing ICF/MR care.~~
~~(5) The individual, or responsible party acting on his/her behalf, chooses HCBW Services.~~

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-45. Determination of medical eligibility for care in a private ~~ICF/MR~~ Intermediate Care Facility for ~~the Mentally Retarded~~ Persons with Mental Retardation

(a) **Pre-approval of medical eligibility**. Pre-approval of medical eligibility for private ICF/MR care is based on ~~results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of MR or related condition prior to age 22, and the need for active treatment according to federal standards~~ level of care requirements per OAC 317:30-5-122. Pre-approval is not necessary for individuals ~~who are severely or profoundly retarded~~ with a severe or profound intellectual disability (mental retardation). Pre-approval is made by Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit ~~LOCEU~~ (LOCEU) analysts.

(b) ~~**Medical eligibility**~~ **Application for ICF/MR services.** Within ~~10~~ 30 calendar days after services begin, the facility must submit:

(1) the original of the ~~Nursing Facility Level of Care Assessment (Form LTC-300R)~~ ICF/MR Level of Care Assessment form (LTC-300) to LOCEU. Required attachments include:

(A) ~~current~~ Current (within 90 days of requested approval date) medical information signed by a physician~~,~~.

(B) ~~a~~ A current (within 12 months of requested approval date) psychological evaluation~~,~~ by a licensed Psychologist or State staff supervised by a licensed Psychologist. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, a full-scale functional or adaptive assessment, as well as the age of onset.

(C) ~~a~~ A copy of the pertinent section of the Individual ~~Developmental~~ Plan or other appropriate documentation relative to ~~discharge planning~~ the ICF/MR admission and the need for ICF/MR level of care~~,~~.

(D) ~~and a~~ A statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal).

If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on an electronic medical case list known as MEDATS. Pre-approval is not needed for individuals ~~who are classified as being severely or profoundly mentally retarded on current psychological evaluation~~ with a severe or profound intellectual disability (mental retardation).

(c) **Categorical relationship**. Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances LOCEU will render a decision on categorical relationship using the same definition as used by the with SSA. A follow-up is required by the OKDHS social worker with the SSA to be sure that their disability decision agrees with the decision of LOCEU.

(d) **Medical eligibility for ICF/MR services.**

(1) Individuals must require active treatment per 42 CFR 483.440.

(2) Individuals must have a diagnosis of intellectual disability (mental retardation) or a related condition based on level of care requirements per OAC 317:30-5-122 and results of a current comprehensive psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist.

(A) Per the Diagnostic and Statistical Manual of Mental Disorders, intellectual disability (mental retardation) is a condition characterized by a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating before 18 years of age.

(B) Per 42 CFR 435.1010, persons with related conditions

means individuals who have a severe, chronic disability that meets the following conditions:

(i) It is attributable to cerebral palsy or epilepsy; or

(ii) it is attributable to any other condition, other than mental illness, found to be closely related to intellectual disability (mental retardation) because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability (mental retardation) and requires treatment or services similar to those required for these persons.

(iii) It is manifested before the person reaches age 22.

(iv) It is likely to continue indefinitely.

(v) It results in substantial functional limitations in three or more areas of major life activity per OAC 317:30-5-122.

(C) Conditions closely related to intellectual disability (mental retardation) include, but are not limited to the following:

(i) autism or autistic disorder, childhood disintegrative disorder, Rett syndrome and pervasive developmental disorder, not otherwise specified (only if "typical autism");

(ii)severe brain injury (acquired brain injury, traumatic brain injury, stroke, anoxia, meningitis);

(iii) fetal alcohol syndrome;

(iv) chromosomal disorders (Down syndrome, fragile x syndrome, Prader-Willi syndrome);and

(v) other genetic disorders (Williams syndrome, spina bifida, phenylketonuria).

(D) The following diagnoses do not qualify as conditions related to intellectual disability (mental retardation). Nevertheless, a person with any of these conditions is not disqualified if there is a simultaneous occurrence of a qualifying condition:

(i) learning disability;

(ii) behavior or conduct disorders;

(iii) substance abuse;

(iv) hearing impairment or vision impairment;

(v) mental illness that includes psychotic disorders, adjustment disorders, reactive attachment disorders, impulse control disorders, and paraphilias;

(vi) borderline intellectual functioning, developmental disability that does not result in an intellectual impairment, developmental delay or "at

risk" designations;
(vii) physical problems (such as multiple sclerosis, muscular dystrophy, spinal cord injuries and amputations);
(viii) medical health problems (such as cancer, acquired immune deficiency syndrome and terminal illnesses);
(ix) milder autism spectrum disorders (such as Asperger's disorder and pervasive developmental disorder not otherwise specified if not "atypical autism");
(x) neurological problems not associated with intellectual deficits (such as Tourette's syndrome, fetal alcohol effects and non-verbal learning disability);or
(xi) mild traumatic brain injury (such as minimal brain injury and post-concussion syndrome).

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities (mental retardation) or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per OAC 317:35-9-5, and as defined in Section 1915(c) of the Social Security Act ~~and administered by the Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD)~~. The specific waivers are the In-Home Supports Waiver (IHSW) for Adults, the In-Home Supports Waiver (IHSW) for Children, the Community Waiver, and the Homeward Bound Waiver.

~~(b) **Program Administration.** Services funded through a HCBS Waiver for persons with mental retardation or for certain persons with related conditions are administered by DDSD, under the oversight of the Oklahoma Health Care Authority (OHCA), the State Medicaid agency. The rules in this subsection do not limit the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.~~

~~(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.~~

~~(2) DDSD must limit the utilization of the HCBS Waiver services based on:~~

~~(A) the federally-approved member capacity for the individual HCBS Waivers;~~

~~(B) the cost-effectiveness of the individual HCBS Waivers as determined according to federal requirements; and~~

~~(C) State appropriations.~~

~~(3) DDSD must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.~~

~~(c)~~ (b) **Program provisions.** Each individual requesting services provided through a HCBS Waiver ~~services~~ and his or her family or guardian are responsible for:

(1) accessing, with the assistance of OKDHS staff, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under a HCBS Waiver program;

(2) cooperating in the determination of medical and financial eligibility, including prompt reporting of changes in income or resources; and

(3) choosing between services provided through a HCBS Waiver ~~services~~ and institutional care.

~~(d)~~ (c) **Waiver Eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in paragraph (1) of this Subsection and the criteria for one of the Waivers established in Subparagraph (A), (B), or (C) of this Subsection.

(1) Services provided through a HCBS Waiver ~~services~~ are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in subsection (a) of this Section, a person must ~~first~~ meet conditions per OAC 317:35-9-5. The individual must be determined financially eligible for SoonerCare ~~through the OKDHS Family Support Services Division~~ per OAC 317:35-9-68. The SoonerCare eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility as described in Section 1-819 of Title 63 of Oklahoma Statutes, or Intermediate Care facility for persons with mental retardation (ICF/MR). The individual may not be receiving DDSD state-funded services such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific

eligibility criteria.

(A) **In-Home Supports Waivers.** To be eligible for services funded through the In-Home Supports Waiver (IHSW), a person must:

(i) meet all criteria ~~for HCBS Waiver services~~ given in subsection ~~(d)~~ (c) of this Section; and

(ii) be determined to have a disability and a diagnosis of intellectual disability (mental retardation) by the Social Security Administration (SSA); or

~~(ii)~~ (iii) be determined to have a disability, ~~with~~ and a diagnosis of intellectual disability (mental retardation) as defined in the Diagnostic ~~Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability,~~ and Statistical Manual of Mental Disorders by~~:~~ the OHCA Level of Care Evaluation Unit (LOCEU)~~:~~ ;

~~(I) the Social Security Administration; or~~

~~(II) the OHCA, Level of Care Evaluation Unit (LOCEU);~~

~~(iii)~~ (iv) be three years of age or older;

~~(iv)~~ (v) be determined by the OHCA/LOCEU to meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122;

~~(v)~~ (vi)reside in:

(I) the home of a family member or friend;

(II) his or her own home;

(III) an OKDHS Children and Family Services Division (CFSD) foster home; or

(IV) a CFSD group home; and

~~(vi)~~ (vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and ~~State Plan~~ SoonerCare resources available to the individual, and with HCBS Waiver resources that are within the annual per capita Waiver limit agreed between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(B) **Community Waiver.** To be eligible for services funded through the Community Waiver, the person must:

(i) meet all criteria given in subsection ~~(d)~~ (c) of this Section;

~~(ii) be age three or older;~~

~~(iii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDSD Division Director or designee;~~

~~(iv) be determined, in accordance with either subunit I or both subunits II and III of this unit~~:

(ii) be determined to have a disability and a diagnosis of intellectual disability (mental retardation) by the SSA; or

~~(I)~~ (iii) ~~to~~ have intellectual disability (mental retardation) as defined in the Diagnostic ~~Manual of Intellectual Disability: A Textbook of Diagnosis of Mental Disorder in Persons with Intellectual Disability~~ and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 by the DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

~~(II)~~ (iv) ~~to~~ be determined to have a disability~~, with~~ and a diagnosis of intellectual disability (mental retardation) as defined in the Diagnostic and Statistical Manual of Mental Disorders ~~by the Social Security Administration~~ or the OHCA/LOCEU; and

(v) be three years of age or older; and

~~(III)~~ (vi) be determined by the OHCA/LOCEU, to meet the ICF/MR Institutional Level of Care requirements ~~by the OHCA/LOCEU.~~ per OAC 317:30-5-122; and

(vii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDSD Division Director or designee.

(C) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the person must:

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBS Waiver services given in subsection ~~(d)~~ (c) of this Section; and

(iii) be determined to~~:~~ have a disability and a diagnosis of intellectual disability (mental retardation) by SSA; or

~~(I)~~ (iv) have intellectual disability (mental retardation) as defined in the Diagnostic ~~Manual of Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability~~ and Statistical Manual of Mental Disorders

or a related condition per OAC 317:35-9-45 by DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

~~(II)~~ (v) ~~meet the ICF/MR Institutional Level of Care requirements~~ have a disability and a diagnosis of intellectual disability (mental retardation) as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU~~.~~ ; and

(vi) meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122 by the OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in subsection (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist, current within ~~one year~~ 12 months of requested approval date, that includes:

(i) a full scale functional and/or adaptive assessment; and

(ii) a statement of age of onset of the disability; and

(iii) intelligence testing that yields a full scale intelligence quotient.

(B) a social service summary, current within ~~one year~~ 12 months of requested approval date, that includes a developmental history; and

(C) a medical evaluation current within 90 days of requested approval date~~.~~; and

(D) a completed ICF/MR Level of Care Assessment form (LTC-300); and

(E) proof of disability according to SSA guidelines. If a disability determination has not been made by SSA, the OHCA/ LOCEU may make a disability determination using the same guidelines as the SSA.

(3) The OHCA reviews the diagnostic reports listed in paragraph (2) of this subsection and makes a determination of eligibility for DDSD ~~services and ICF/MR level of care for the services funded through an IHSW or the Community Waiver~~ HCBS Waivers.

(4) For individuals who are determined to have intellectual disability (mental retardation) or a related condition by DDSD in accordance with the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social

Security Act, DDSD reviews the diagnostic reports listed in paragraph (2) of this subsection and, on behalf of the OHCA, makes a determination of eligibility for DDSD ~~services~~ HCBS Waiver services and ICF/MR level of care.

(5) A determination of need for ICF/MR Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

~~(e)~~ (d) **~~Waiting~~ Request list.** When State DDSD resources are unavailable for new persons to be added to services funded through a HCBS Waiver, persons are placed on a statewide ~~waiting list for services~~ Request for Waiver Services List.

(1) The ~~waiting list~~ Request for Waiver Services List is maintained in chronological order based on the date of receipt of a written request for services.

(2) The ~~waiting list~~ Request for Waiver Services List for persons requesting services provided through a HCBS Waiver ~~services~~ is administered by DDSD uniformly throughout the state.

(3) An individual is removed from the ~~waiting list~~ Request for Waiver Services List if the individual:

(A) is found to be ineligible for services;

(B) cannot be located by OKDHS;

(C) does not provide required information to OKDHS;

(D) is not a resident of the state of Oklahoma at the time of requested Waiver approval date; or

(E) ~~is offered~~ declines an offer of Waiver services ~~through either an IHSW or the Community Waiver and declines services~~.

~~(f)~~ (e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDSD ensures action regarding a request for services occurs within 45 days. If action is not taken within the required 45 days, the applicant may seek resolution as described in OAC 340:2-5.

(1) Applicants are allowed 60 days to provide information requested by DDSD to determine eligibility for services.

(2) If requested information is not provided within 60 days, the applicant is notified that the request has been denied, and the individual is removed from the ~~waiting list~~ Request for Waiver Services List.

~~(g)~~ (f) **Admission protocol.** Initiation of services funded through a HCBS Waiver occurs in chronological order from the ~~waiting list~~ Request for Waiver Services List in accordance with subsection ~~(e)~~ (d) of this Section based on the date of DDSD receipt of a completed request for services, as a result of the informed choice of the person requesting services or

his or her legal guardian, and upon determination of eligibility, in accordance with subsection ~~(d)~~ (c) of this Section. Exceptions to the chronological requirement may be made when:

(1) an emergency situation exists in which the health or safety of the person needing services, or of others, is endangered, and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself and:

(i) the person's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:

(I) is hospitalized;

(II) has moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) has died; and

(ii) there is no caretaker to provide needed care to the individual; or

(iii) an eligible person is living at a homeless shelter or on the street;

(B) the OKDHS finds that the person needs protective services due to experiencing ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.

(2) the Legislature has appropriated special funds with which to serve a specific group or a specific class of individuals under the provisions of a HCBS Waiver;

(3) Waiver services are required for people who transition to the community from a public or ICF/MR who are children in the State's custody receiving services from OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/MR and enters the Waiver;

(4) individuals subject to the provisions of Public Law

100-203 residing in nursing facilities for at least 30 continuous months prior to January 1, 1989, and who are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted pursuant to the provisions of 42 CFR 483.100 et seq to have intellectual disability (mental retardation) or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community or Homeward Bound Waiver.

~~(h)~~ (g) **Movement between DDSD HCBS Waiver programs.** A person's movement from services funded through one HCBS Waiver to services funded through another DDSD-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults become effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a member has critical support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDSD Director or designee; and

(B) funding is available ~~in accordance with subsection (b) of this Section~~ per OAC 317:35-9-5.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization has been within the per capita allowance of the IHSW.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

~~(i)~~ (h) **Continued eligibility for HCBS Waiver services.** Eligibility for ~~children~~ members receiving services provided through the HCBS Waiver ~~services~~ is re-determined by the OHCA/LOCEU ~~if~~ when a determination of disability ~~due to mental retardation~~ has not been made by the Social Security Administration. ~~when the~~ The OHCA/LOCEU determines categorical relationship to the SoonerCare ~~program~~ disabled category according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per ~~OAC 317:35-9-5~~ OAC 317:30-5-122 and confirms a diagnosis of intellectual disability (mental retardation) as defined in the Diagnostic and Statistical Manual of Mental Disorders. DDSD may require a new diagnostic evaluation in accordance with paragraph ~~(d)~~

(c) (2) of this subsection and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph ~~(d)~~ (c) (2) of this Section has been noted.

~~(j)~~ (i) **HCBS Waiver services case closure.** Services provided through a HCBS Waiver ~~services~~ are terminated:

(1) when a member or the member's legal guardian chooses to no longer receive Waiver services;

(2) when a member is incarcerated;

(3) when a member is financially ineligible to receive Waiver services;

(4) when a member is determined by the Social Security Administration to no longer have a disability qualifying the individual for services under these Waivers;

(5) when a member is determined by the OHCA/LOCEU to no longer be eligible;

(6) when a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;

(7) when a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive days;

(8) when the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process as described in OAC 340:100-5-50 through 340:100-5-58;

(9) when the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of OKDHS policy or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective;

(10) when the member is determined to no longer be SoonerCare eligible; or

(11) when there is sufficient evidence that the member or his/her legal representative has engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) when the member or his/her legal representative either cannot be located, has not responded to, or has not allowed case management to complete plan development or monitoring activities as required by policy and the member or his/her legal representative:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits case management (the case manager) from being able to complete plan development or monitoring activities as required by policy;

(13) when the member or his/her legal representative fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) when it is determined that services provided through a HCBS Waiver ~~services~~ are no longer necessary to meet the member's needs and professional documentation provides assurance that the member's health, safety, and welfare can be maintained without Waiver supports;

(15) when the member or his/her legal representative fails to cooperate with service delivery;

(16) when a family member, authorized representative, other individual in the member's household or persons who routinely visit, pose a threat of harm or injury to provider staff or official representatives of OKDHS; or

(17) when a member no longer receives a minimum of one Waiver service per month and DDSD is unable to monitor member on a monthly basis.

~~(k)~~ (j) **Reinstatement of services.** Waiver services are reinstated when:

(1) the situation resulting in case closure of a Hissom class member is resolved;

(2) a member is incarcerated for 90 days or less;

(3) a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 days or less; or

(4) a member's SoonerCare eligibility is re-established within 90 days of the date of SoonerCare ineligibility.

SUBCHAPTER 5. MEMBER SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-8. Agency companion services service authorization budget

Upon approval of the home profile per OAC 317:40-5-40, the companion, provider agency, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case manager, agency companion services (ACS) staff, and others as appropriate meet to develop a service authorization budget. The service authorization budget form is used to develop the individual service budget for the member's program and is updated annually by the member's Personal Support Team (Team).

(1) The companion receives:

(A) a salary based on the level of support needed by the

member. The level of support is determined by authorized DDSD staff per OAC 317:40-5-3. The ACS rate for the:

(i) employer model includes funding for the provider agency for the provision of benefits to the companion; and

(ii) contractor model does not include funding for the provider agency for the provision of benefits to the companion~~; and~~.

(B) any combination of hourly or daily respite per Plan of Care year to equal 660 hours in order to provide respite to the companion as reflected on the service authorization budget form.

(C) Habilitation training specialist (HTS) services:

(i) may be approved by the DDSD director or designee when providing ACS with additional support represents the most cost-effective placement for the member and the member has an ongoing pattern of not:

(I) sleeping at night; or

(II) working or attending employment services, with documented and continuing efforts by the Team.

(ii) may be approved when a time limited situation exists in which the ACS provider is unable to provide ACS and the provision of HTS will maintain the placement or provide needed stability to the member; and must be reduced when the situation changes.

(iii) must be reviewed annually or more often if needed, which includes a change in agencies or individual companion providers.

(2) The service authorization budget form reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the increase must be:

(A) agreed to by the member and, if applicable, legal guardian;

(B) recommended by the Team; and

(C) submitted with written justification attached to the service authorization budget form to the DDSD area manager or designee for approval.

(3) A back-up plan identifying respite staff is developed by the provider agency program coordination staff and companion, prior to the meeting to discuss the service authorization budget.

(A) The back-up plan:

(i) is submitted to the DDSD case manager ~~and attached to the completed service authorization form~~ for review and approval;

(ii) describes expected and emergency back-up support and program monitoring for the home; and

(iii) is ~~signed by the companion, provider agency representative, and DDSD case manager~~ reviewed initially and annually by the SFC specialist.

(B) The companion and provider agency program coordination staff equally share the responsibility to identify approved respite providers who are:

(i) knowledgeable about the member;

(ii) trained to implement the member's Individual Plan (Plan);

(iii) trained per OAC 340:100-3-38; and

(iv) when possible, involved in the member's daily life.

(C) The spouse or other adult residing in the home may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.

(D) The spouse or other adult residing in the home cannot serve as paid respite staff.

(4) The companion and respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.

(5) The member is allowed therapeutic leave per OAC 317:40-5-3.

PART 3. GUIDELINES TO STAFF

317:40-5-40. Home profile process

(a) **Applicability.** This Section ~~sets forth~~ establishes procedures for the home profile process ~~used for:~~. A home profile is required for:

(1) agency companion services (ACS);

(2) specialized foster care (SFC) services;

(3) respite services delivered in the provider's home;

(4) approving ~~a habilitation training specialist (HTS) or other provider to provide services overnight in the HTS's or other provider's home~~ services in a home shared by a non-relative provider and a member; and

(5) any other situation that requires a home profile.

(b) **Pre-screening.** Designated Developmental Disabilities Services Division (DDSD) staff provides the applicant with program orientation and pre-screening information that includes, but is not limited to:

(1) facts, description, and guiding principles of the Home and Community-Based Services (HCBS) program;

(2) an explanation of:
(A) the home profile process;
(B) basic qualifications of the provider;
(C) health, safety, and environmental issues; and
(D) training required per OAC 340:100-3-38;
(3) the Oklahoma Department of Human Services (OKDHS) Form 06AC012E, Specialized Foster Care/Agency Companion Information Sheet;
(4) explanation of a background investigation conducted on the applicant and any adult or child living in the applicant's home.
(A) Background investigations are conducted at the time of application and include, but are not limited to:
(i) Oklahoma State Bureau of Investigation (OSBI) name and ~~records~~ criminal records history search, including the Oklahoma Department of Public Safety (DPS), ~~and~~ Sex ~~Offenders~~ Offender Registry and Mary Rippy Violent Offender Registries;
(ii) Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant and any adult members of the household;
(iii) search of any involvement as a party in a court ~~involvement~~ action;
(iv) search of all OKDHS records, including Child Welfare records and Community Services Worker Registry; ~~and~~
(v) a search of all applicable out-of-state child abuse and neglect registries for any applicant or adult household member who has not lived continuously in Oklahoma for the past five years. The home is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state, for all adult household members living in the home. If no child abuse and neglect registry is maintained in the applicable state, a request for information is made to the applicable state; and
~~(v)~~ (vi) search of Juvenile Justice Information System (JOLTS) records for any child older than 13 years of age in the applicant's household.
(B) An application is denied if the applicant:
(i) or any person residing in the applicant's home has a criminal conviction of or pled guilty or no contest to:
(I) physical assault, battery, or a drug-related offense with the five year period preceding the application date;

(II) child abuse or neglect;
(III) domestic abuse;
(IV) a crime against a child, including, but not limited to, child pornography; ~~or~~
(V) a crime involving violence, including, but not limited to, rape, sexual assault, or homicide, but excluding physical assault and battery. Homicide ~~includes~~ including manslaughter; ~~and~~ or

(ii) does not meet the requirements of OAC 340:100-3-39;

(5) OKDHS Form 06AC015E, Agency Companion/Specialized Foster Care Employment Record;
(6) OKDHS Form 06AC016E, DDSD Reference Information Waiver;
(7) OKDHS Form 06AC029E, Employer Reference Letter; and
(8) OKDHS Form 06AC013E, Pre-Screening for Specialized Foster Care/Agency Companion Services.

(c) **Home profile process.** If the applicant meets the requirements of the prescreening, the home profile process described in (1) through (8) of this subsection is initiated.

(1) The applicant completes the required forms and returns the forms to the DDSD address provided. Required forms include OKDHS Forms:
(A) 06AC008E, Specialized Foster Care/Agency Companion Services Application;
(B) 06AC009E, Financial Assessment;
(C) 06AC011E, Family Health History;
(D) 06AC018E, Self Study Questionnaire;
(E) 06AC019E, Child's Questionnaire;
(F) 06AC010E, Medical Examination Report, if Form 06AC011E indicates conditions that may interfere with the provision of services;
(G) 06AC017E, Insurance Information; and
(H) 06AC020E, Evacuation/Escape Plan.

(2) If an incomplete form or other information is returned to DDSD, designated DDSD staff sends a letter to the provider or provider agency identifying information needed to complete the required forms. The home profile is not completed until all required information is provided to DDSD.

(3) Designated DDSD staff completes the home profile when all required forms are completed and provided to DDSD.

(4) For each reference provided by the applicant, designated DDSD staff completes OKDHS Form 06AC058E, Reference Letter;

(5) Designated DDSD staff, through interviews, visits, and phone calls, gathers information required to complete OKDHS Form 06AC047E, Home Profile.

(6) OKDHS Form 06AC069E, Review of Policies and Areas of Responsibilities, is dated and signed by the applicant and designated DDSD staff.

(7) The DDSD area residential services programs manager sends to the applicant:

(A) a provider approval letter confirming the applicant is approved to serve as a provider; or

(B) a denial letter stating the application is denied.

(8) DDSD staff records the dates of completion of each part of the home profile process.

(d) **Home standards.** In order to qualify and remain in compliance, the provider's home must meet the provisions in (1) through (11) of this subsection.

(1) **General conditions.**

(A) The home, buildings, and furnishings must be comfortable, clean, and in good repair and grounds must be maintained. There must be no accumulation of garbage, debris, or rubbish or offensive odors.

(B) The home must:

(i) be accessible to school, employment, church, day programming, recreational activities, health facilities, and other community resources as needed;

(ii) have adequate heating, cooling and plumbing; and

(iii) provide space for the member's personal possessions and privacy and allow adequate space for the recreational and socialization needs of the occupants.

(C) Provisions for the member's safety must be present, as needed, including:

(i) guards and rails on stairways;

(ii) wheelchair ramps;

(iii) widened doorways;

(iv) grab bars;

(v) adequate lighting;

(vi) anti-scald devices; and

(vii) heat and air conditioning equipment guarded and installed in accordance with manufacturer requirements. Home modifications and equipment may be provided through HCBS Waivers operated by DDSD.

(D) Providers must not permit members to access or use swimming or other pools, hot tubs, saunas, ponds, or spas on the premises without supervision. Swimming pools, hot tubs, saunas, ponds, or spas must be equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.

(E) The household must be covered by homeowner's or renter's insurance including personal liability.

(2) **Sanitation.**

(A) Sanitary facilities must be adequate and safe, including toilet and bathing facilities, water supply, and garbage and sewer disposal.

(B) If a septic tank or other non-municipal sewage disposal system is used, it must be in good working order.

(C) Garbage and refuse must be stored in readily cleanable containers, pending weekly removal.

(D) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards.

(i) Proof of rabies or other vaccinations as required by a licensed veterinarian must be maintained on the premises for household pets.

(ii) Pets not confined in enclosures must be under control and not present a danger to members or guests.

(E) There must be adequate control of insects and rodents, including screens in good repair on doors and windows used for ventilation.

(F) Universal precautions for infection control must be followed in care to the member. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood or other body fluids.

(G) Laundry equipment, if in the home, must be located in a safe, well-ventilated, and clean area, with the dryer vented to the outside.

(3) **Bathrooms.** A bathroom must:

(A) provide for individual privacy and have a finished interior;

(B) be clean and free of objectionable odors; and

(C) have a bathtub or shower, flush toilet, and sink in good repair, and hot and cold water in sufficient supply to meet the member's hygiene needs.

(i) A sink must be located near each toilet.

(ii) A toilet and sink must be provided on each floor where rooms of members who are non-ambulatory or with limited mobility are located.

(iii) There must be at least one toilet, one sink, and one bathtub or shower for every six household occupants, including the provider and family.

(4) **Bedrooms.** A bedroom must:

(A) have been constructed as such when the home was built or remodeled under permit;

(B) be provided for each member.

(i) Minor members must not share bedrooms with adults in the household.

(ii) No more than two members may share a bedroom.

(iii) Exceptions to allow members to share a bedroom may be made by the DDSD area residential programs manager, when DDSD determines sharing a bedroom is in the best interest of the members;

(C) have a minimum of 80 square feet of usable floor space for each member or 120 square feet for two members and two means of exit. The provider, family members, or other occupants of the home must not sleep in areas designated as common use living areas, nor share bedrooms with members;

(D) be finished with walls or partitions of standard construction that go from floor to ceiling;

(E) be adequately ventilated, heated, cooled, and lighted;

(F) include an individual bed for each member consisting of a frame, box ~~springs~~ spring, and mattress at least 36 inches wide, unless a specialized bed is required to meet identified needs. Cots, rollaways, couches, futons, and folding beds must not be used for members.

(i) Each bed must have clean bedding in good condition consisting of a mattress pad, bedspread, two sheets, pillow, pillowcase, and blankets adequate for the weather.

(ii) Sheets and pillowcases must be laundered at least weekly ~~and~~ or more often if necessary.

(iii) Waterproof mattress covers must be used for members who are incontinent;

(G) have sufficient space for each member's clothing and personal effects, including hygiene and grooming supplies.

(i) Members must be allowed to keep and use reasonable amounts of personal belongings and have private, secure storage space.

(ii) The provider assists the member in furnishing and decorating the member's bedroom.

(iii) Window coverings must be in good condition and allow privacy for members;

(H) be on ground level for members with impaired mobility or who are non-ambulatory; and

(I) be in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with a call bell or intercom.

(5) **Food.**

(A) Adequate storage must be available to maintain food at proper temperature, including a properly working refrigerator. Food storage must be such that food is

protected from dirt and contamination and maintained at proper temperatures to prevent spoilage.

(B) Utensils, dishes, glassware, and food supplies must not be stored in bedrooms, bathrooms, or living areas.

(C) Utensils, dishes, and glassware must be washed and stored to prevent contamination.

(D) Food storage and preparation areas and equipment must be clean, free of offensive odors, and in good repair.

(6) **Phone.**

(A) A working phone must be provided in the home that is available and accessible for the member's use for incoming and outgoing calls.

(B) Phone numbers to the home and providers must be kept current and provided to DDSD and, if applicable, the provider agency.

(7) **Safety.**

(A) Buildings must meet all applicable state building, mechanical, and housing codes.

(B) Heating, in accordance with manufacturer's specifications, and electrical equipment, including wood stoves, must be installed in accordance with all applicable fire and life safety codes. Such equipment must be used and maintained properly and in good repair.

(i) Protective glass screens or metal mesh curtains attached at top and bottom are required on fireplaces.

(ii) Unvented portable oil, gas, or kerosene heaters are prohibited.

(C) Extension cord wiring must not be used in place of permanent wiring.

(D) Hardware for all exit and interior doors must have an obvious method of operation that cannot be locked against exit.

(8) **Emergencies.**

(A) Working smoke detectors must be provided in each bedroom, adjacent hallways, and in two story homes at the top of each stairway. Alarms must be equipped with a device that warns of low battery condition, when battery operated.

(B) At least one working fire extinguisher must be in a readily accessible location.

(C) A working flashlight must be available for emergency lighting on each floor of the home.

(D) The provider:

(i) maintains a working carbon monoxide detector in the home;

(ii) maintains a written evacuation plan for the home and conducts training for evacuation with the member;
(iii) conducts fire drills quarterly and severe weather drills twice per year and maintains and makes available fire drill and severe weather drill documentation for review by DDSD;
(iv) has a written back-up plan for temporary housing in the event of an emergency; and
(v) is responsible to re-establish a residence, if the home becomes uninhabitable.

(E) A first aid kit must be available in the home.

(F) The address of the home must be clearly visible from the street.

(9) **Special hazards.**

(A) Firearms and other dangerous weapons must be stored in a locked permanent enclosure. Ammunition must be stored in a separate locked location. Providers are prohibited from assisting members to obtain, possess, or use dangerous or deadly weapons per OAC 340:100-5-22.1.

(B) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers.

(C) Cleaning supplies, medical sharps containers, poisons, and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, food preparation areas, dining areas, and medications.

(D) Illegal substances are not permitted on the premises.

(10) **Vehicles.**

(A) All vehicles used to transport members must meet local and state requirements for licensing, inspection, insurance, and capacity.

(B) Drivers of vehicles must have valid and appropriate driver licenses.

(11) **Medication.** Medication for the member is stored ~~in accordance with~~ per OAC 340:100-5-32.

(e) **Evaluating the applicant and home.** The home profile includes, but is not limited to:

(1) evaluating the applicant's:

(A) interest and motivation;

(B) life skills;

(C) children in the home;

(D) methods of behavior support and discipline;

(E) marital status and background, household composition, and children;

(F) income and money management; and

(G) teamwork and supervision, back-up plan, and use of relief; and

(2) assessment and recommendation. DDSD staff:

(A) evaluates the ability of the applicant to provide services ;

(B) approves only applicants who can fulfill the expectations of the role of service provider;

(C) if the applicant does not meet standards per OAC 317:40-5-40, ensures the final recommendation includes:

(i) basis for the denial decision; and

(ii) effective date for determining the applicant as not meeting standards. Reasons for denying a profile may include, but are not limited to:

(I) lack of stable, adequate income to meet the applicant's own or total family needs or poor management of available income;

(II) a physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;

(III) the age, health, or any other condition of the applicant that impedes the applicant's ability to provide appropriate care for a member;

(IV) relationships in the applicant's household are unstable and unsatisfactory;

(V) the mental health of the applicant or other family or household member impedes the applicant's ability to provide appropriate care for a member;

(VI) references are guarded or have reservations in recommending the applicant;

(VII) the applicant fails to complete the application, required training, or verifications in a timely manner as requested or provides information that is incomplete, inconsistent, or untruthful; or

(VIII) the home is determined unsuitable for the member requiring placement;

(D) notifies the applicant in writing of the final recommendation; and

(E) if an application is canceled or withdrawn prior to completion of the profile, completes a final written assessment that includes:

(i) reason the application was canceled or withdrawn;

(ii) DDSD staff's impression of the applicant based on information obtained; and

(iii) effective date of cancellation or withdrawal. Written notice is sent to the applicant to confirm cancellation or withdrawal of the application, a copy

is included in local and State Office records.

(f) ~~**Annual**~~ **Frequency of evaluation.** Homes are assessed for initial approval. Agency Companion Services providers are assessed annually and as needed for compliance and continued approval. Specialized foster care and respite homes are assessed bi-annually and as needed for compliance and continued approval. Any other situations requiring a home profile are assessed annually and as needed for compliance and continued approval. The annual evaluation is a comprehensive review of the provider's continued ability to meet standards.

(1) The annual evaluation consists of information specifically related to the provider's home and is documented on OKDHS Form 06AC024E, Annual Review.

(2) OKDHS FORM 06AC010E must be completed a minimum of every three years following the initial approval, unless medical circumstances warrant more frequent completion.

(3) Input from the DDSD case manager, Child Welfare worker, Adult Protective Services staff, Office of Client Advocacy staff, and provider agency program coordinator is included in the evaluation, if applicable.

(4) The background investigation per OAC 317:40-5-40(b) is repeated every year, except the FBI national criminal history search.

(5) Providers are notified in writing of the continued recommendation of the use of the home.

(6) Copies of OKDHS Forms 06AC024E and, if applicable, 06AC010E, are included in local and State Office records.

PART 5. SPECIALIZED FOSTER CARE

317:40-5-55. Specialized Foster Care provider responsibilities

(a) **General responsibilities.** The responsibilities of all Specialized Foster Care (SFC) providers are listed in this ~~Subsection~~ Section.

(1) Providers of ~~Specialized Foster Care (~~SFC~~)~~ are required to meet all applicable standards ~~outlined in~~ per OAC 317:40-5-40.

(2) Providers of SFC are required to receive competency based training ~~as outlined in~~ per OAC 340:100-3-38. The provider keeps all required training up to date and submits documentation to the SFC specialist at the time training is completed.

(3) The provider ~~participates as a member~~ is an active participant of the ~~service recipient's~~ member's Team and assists in the development of the ~~service recipient's~~ member's Individual Plan~~,~~ (Plan) ~~as described in~~ per OAC 340:100-5-50 through 100-5-58.

(4) The provider documents and notifies the case manager of any changes in behaviors or medical conditions of the ~~service recipient~~ member within one working day. Incident reports are completed by the SFC provider and submitted to the Developmental Disabilities Services Division ~~DDSD~~ (DDSD) case manager ~~in accordance with~~ per OAC 340:100-3-34.

(5) The SFC provider is available to the ~~service recipient~~ member at any time.

(6) The primary ~~employment~~ responsibility of the SFC provider is to provide SFC services to the ~~service recipient~~ member. The SFC provider does not have ~~other~~ employment unless the ~~other~~ employment has been pre-approved by the ~~supervisor of the DDSD foster care unit~~ residential programs supervisor for DDSD.

(A) Generally, providers are not approved for ~~other~~ employment because the provider must be available before and after school or vocational programs and often during the day due to holidays or illnesses.

(B) If, after receiving approval for ~~other~~ employment, it is found that the SFC provider's employment interferes with the care, training, or supervision needed by the ~~service recipient~~ member, the provider must determine if he or she wants to terminate the ~~other~~ employment or have the ~~service recipient~~ member moved from the home.

(C) ~~The~~ DDSD does not authorize Homemaker, Habilitation Training Specialist, or respite services in order for the SFC provider to perform ~~other~~ employment.

(7) The provider does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals With Disabilities Education Act (IDEA-B).

(8) The provider allows the ~~service recipient~~ member to have experiences, both in and out of the home, to enhance the ~~service recipient's~~ member's development, learning, growth, independence, community inclusion, and well-being, while assisting the ~~service recipient~~ member to achieve his or her maximum level of independence.

(9) The provider ensures confidentiality is maintained regarding the ~~service recipient~~ member ~~in accordance with the DDSD confidentiality policy,~~ per OAC 340:100-3-2.

(10) The provider is sensitive to and assists the ~~service recipient~~ member in participating in the ~~service recipient's~~ member's choice of religious faith. No ~~service recipient~~ member is expected to attend any religious service against his or her wishes.

(11) The provider arranges, and ensures that the member obtains a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed.

~~(11)~~ (12) The provider has a valid ~~driver's~~ driver license, maintains a motor vehicle in working order, and complies with requirements of OAC 317:40-5-103, Transportation.

~~(12) The provider arranges, and ensures that the service recipient obtains, a medical and a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed.~~

(13) The provider transports or arranges transportation, using adapted transportation when appropriate, for the ~~service recipient~~ member to and from school, employment, church, recreational activities, and medical or therapy appointments.

(A) SFC providers may ~~sign~~ enter into a transportation contract.

(B) The provider must assure availability and use of an approved and appropriate child auto restraint system as required by law in transporting children and, in cases of adults receiving services, any additional ~~restraints~~ safety devices identified as necessary in the Plan.

(14) The provider assures the ~~person receiving services~~ member is clean, appropriately dressed, and on time for activities and appointments.

(15) The provider ensures no other adult or child is ~~served~~ cared for or resides in the home on a regular or part-time basis that was not approved through the home profile review process or without prior approval from the DDSD area manager or designee.

(16) The provider does not provide services to more than three individuals regardless of the type of service provided, including SFC, ~~DCFS~~ Children and Family Services Division foster care, respite, baby-sitting, or other such services. Any exception to this paragraph must be approved in writing by the director of DDSD or designee prior to authorization or service delivery.

(17) The provider permits visitation and monitoring of the home by authorized DDSD staff. In order to assure maintenance of standards, some visits are unannounced. The visits occur at least monthly and are not intended to be intrusive but to ensure the safety and well-being of the ~~service recipient~~ member.

(18) The provider encourages and cooperates in planning visits in the SFC home by relatives, guardians, or friends of the ~~service recipient~~ member. Visits by the ~~service~~

~~recipient~~ member to the home of friends or relatives must be approved by the ~~service recipient's~~ member's legally authorized representative.

(19) The provider abides by the policies of DDSD ~~found at~~ per OAC 340:100-3-12, Prohibition of client abuse, and OAC 340:100-5-58, Prohibited procedures. The provider is prohibited from signing an authorization for school personnel to use physical discipline or corporal punishment.

(20) The provider notifies the DDSD case manager when the need arises for substitute supervision in the event of an emergency, in accordance with the Backup Plan, ~~as specified in~~ per OAC 317:40-5-59. If the provider is out of the home for a short duration, a natural support in the home can provide time-limited supervision.

(A) A natural support is defined as an adult relative or spouse of the specialized foster parent that resides in the home.

(B) The Team approves the natural support and defines when this support may be accessed.

(C) Persons who are considered a natural support must complete training per OAC 340:100-3-38.12.

(D) Persons acting as a natural support may only provide supervision for brief, intermittent time periods.

(21) The provider provides written 30-day notice to the ~~service recipient~~ member and DDSD case manager when it is necessary for a ~~service recipient~~ member to be moved from the home.

(22) The SFC provider does not serve as representative payee for the ~~service recipient~~ member.

(23) The provider ensures the ~~service recipient's~~ member's funds are properly safeguarded.

(24) The provider assists the ~~service recipient~~ member in accessing and using entitlement programs for which the ~~service recipient~~ member may be eligible.

(25) The provider must use the room and board reimbursement payment to meet the ~~service recipient's~~ member's needs, as specified in the room and board contract.

(A) The provider retains a copy of the current room and board contract in the home at all times.

(B) Items purchased with the room and board reimbursement include, but are not limited to:

(i) housing;
(ii) food;
(iii) clothing;
(iv) care; ~~and~~
(v) incidental expenses such as:

(I) birthday and Christmas gifts;
(II) haircuts;
(III) personal grooming equipment;
(IV) allowances;
(V) toys;
(VI) school supplies and lunches;
(VII) school pictures;
(VIII) costs of recreational activities;
(IX) special clothing items required for dress occasions and school classes such as gym shorts and shirts;
(X) extracurricular athletic and other equipment, including uniforms, needed for the ~~service recipient~~ member to pursue his or her particular interests or job;
(XI) prom and graduation expenses including caps, gowns, rings, pictures, and announcements;
(XII) routine transportation expenses involved in meeting the ~~service recipient's~~ member's medical, educational, or recreational needs, unless the provider has a transportation contract;
(XIII) non-prescription medication; and
(XIV) other maintenance supplies required by the ~~service recipient~~ member.

(C) All items purchased for the ~~service recipient~~ member with the room and board payment are the property of the ~~service recipient~~ member and are given by the provider to the ~~service recipient~~ member when a change of residence occurs.

(D) The room and board payment is made on a monthly basis and is prorated based on the actual days the ~~service recipient~~ member is in the home on the initial and final months of residence.

(26) The provider maintains a Personal Possession Inventory Form 06AC022E (DDS-22) for each ~~service recipient~~ member living in the home.

(27) The provider maintains the ~~service recipient's~~ member's home record ~~in accordance with~~ per OAC 340:100-3-40.

(28) The provider immediately reports to the DDSD SFC staff all changes in the household including, but not limited to:

(A) telephone number;
(B) address;
(C) marriage or divorce;
(D) persons moving into or out of the home;
(E) provider's health status;
(F) provider's employment; and

(G) provider's income.

(29) The provider maintains home owner's or renter's insurance, including applicable liability coverages, and provides a copy to the SFC Specialist.

(30) The provider serves as the Health Care Coordinator and follows the Health Care Coordinator policy ~~outlined in~~ per OAC 340:100-5-26.

(31) Each SFC provider follows all applicable rules of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority, promotes the independence of the ~~service recipient~~ member, and follows recommendations of the ~~service recipient's~~ member's Team.

(b) **Responsibilities specific to SFC providers serving children.** The provider is charged with the same general legal responsibility any parent has to exercise reasonable and prudent behavior in his or her actions and in the supervision and support of the child.

(1) The provider works with the DDSD case manager and ~~Division of Children and Family Services (DCFS)~~ CFSD staff when the provider needs respite for a child in custody.

(2) The provider participates in the development of the Individual Education Plan (IEP) and may serve as surrogate parent when appropriate.

(3) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDSD case manager prior to traveling out of state for an overnight visit. If the child is in the custody of the OKDHS, the permission of the ~~DCFS~~ CFSD specialist is also secured.

(4) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDSD case manager prior to involvement of the child in any publicity. If the child is in OKDHS custody, the permission of the ~~DCFS~~ CFSD specialist is also secured.

(c) **Responsibilities specific to SFC providers serving adults.** Additional SFC provider responsibilities for serving adults are given in this Subsection.

(1) The provider obtains permission from the ~~service recipient's~~ member's legal guardian, when applicable, and notifies the DDSD case manager, prior to:

(A) traveling out of state for an overnight visit.

(B) involvement of the ~~service recipient~~ member in any publicity.

(2) When the ~~service recipient~~ member is his or her own payee or has a representative payee, the provider ensures the monthly contribution for services as identified in a written agreement between the ~~service recipient~~ member and the provider, is used toward the cost of food, rent, and

household expenses.

(A) The ~~service recipient's~~ member's minimum monthly contribution is $250.00 per month.

(B) Changes in the ~~service recipient's~~ member's monthly contribution are developed on an individualized basis by the ~~service recipient's~~ member's Team.

317:40-5-59. Back-up Plan for persons receiving Specialized Foster Care

Prior to a ~~service recipient~~ member moving into Specialized Foster Care (SFC), the SFC provider ~~the Developmental Disabilities Services Division (DDSD) case manager, and other appropriate Team members cooperatively~~ and the SFC specialist develop a Back-up Plan. The SFC specialist communicates the Back-Up Plan in writing to the DDSD case manager for incorporation into the Individual Plan.

(1) The Back-up Plan identifies the person(s) who provides emergency back-up supports.

(2) The ~~service recipient's~~ member's natural family is considered as the first resource for the Back-up Plan at no cost to OKDHS, unless the member is in the custody of the Oklahoma Department of Human Services.

(3) The Back-up Plan contains the name(s) and current telephone number(s) of the person(s) providing back-up service.

(4) ~~The~~ When paid providers are necessary, the Back-up Plan explains specifically where the service is to be provided.

(A) If back-up service is to be provided outside the SFC home, a Home Profile must be completed for the back-up staff per OAC 317:40-5-40.

(B) If back-up service is to be provided in the SFC home, the person providing this service must have completed all necessary requirements to become a paid provider, including:

(i) ~~criminal background check~~ an Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search , including the Department of Public Safety (DPS), Sex Offender, and Mary Rippy Violent Offender Registries;

(ii) ~~traffic record check~~ a Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant;

(iii) ~~valid driver license~~ a search of any involvement as a party in a court action;

(iv) ~~Division of Children and Family Services (DCFS) abuse registry check~~ a search of all Oklahoma Department of Human Services (OKDHS) records,

including child welfare (CW) records;
(v) a search of all applicable out-of-state child abuse and neglect registries for any applicant who has not lived continuously in Oklahoma for the past five years. The applicant is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state;
~~(v)~~ (vi) Community Services Worker registry check;
~~(vi) a check of the Juvenile On-Line Tracking System (JOLTS) for children residing in the home;~~
(vii) Oklahoma statutorily mandated liability insurance ~~of 10/20/10 minimum~~ coverage, and a valid driver license; and
(viii) completion of required DDSD training per OAC 340:100-3-38.4.

(C) The Back-up Plan details where the ~~service recipient~~ member and provider will stay if the provider's home is not habitable. If there is a fee to stay in the alternate location, the fee is paid by the provider and not reimbursed by DDSD.

(5) The Back-up Plan is jointly reviewed at least monthly by ~~the DDSD case manager and~~ the SFC specialist and the SFC provider to ensure the Back-up Plan continues to be appropriate and current.

(6) The SFC provider is responsible to report any needed changes in the Back-up Plan to the ~~case manager and~~ SFC specialist.

(7) The SFC specialist will report any changes in the Back-up Plan to the case manager.

PART 9. SERVICE PROVISIONS

317:40-5-100. Assistive technology devices and services

(a) **Applicability.** The rules in this Section apply to assistive technology (AT) services and devices authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.**

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:

(A) visual alarms;
(B) telecommunication devices (TDDS);
(C) telephone amplifying devices;
(D) other devices for protection of health and safety of

members who are deaf or hard of hearing;
(E) tape recorders;
(F) talking calculators;
(G) specialized lamps;
(H) magnifiers;
(I) braille writers;
(J) braille paper;
(K) talking computerized devices;
(L) other devices for protection of health and safety of members who are blind or visually impaired;
(M) augmentative and alternative communication devices including language board and electronic communication devices;
(N) competence based cause and effect systems such as switches;
(O) mobility and positioning devices including:
(i) wheelchairs;
(ii) travel chairs;
(iii) walkers;
(iv) positioning systems;
(v) ramps;
(vi) seating systems;
(vii) standers;
(viii) lifts;
(ix) bathing equipment;
(x) specialized beds;
(xi) specialized chairs; and
(P) orthotic and prosthetic devices, including:
(i) braces;
(ii) prescribed modified shoes;
(iii) splints; and
(Q) environmental controls or devices;
(R) items necessary for life support and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare.

(2) AT services include:
(A) sign language interpreter services for members who are deaf;
(B) reader services;
(C) auxiliary aids;
(D) training the member and provider in the use and maintenance of equipment and auxiliary aids;
(E) repair of AT devices; and
(F) evaluation of the AT needs of a member.

(3) AT devices and services must be included in the member's Individual Plan (IP) and arrangements for this

HCBS service must be made through the member's case manager.

(4) AT devices are provided by vendors with a Durable Medical Equipment (DME) contract with the Oklahoma Health Care Authority (OHCA).

(5) AT devices and services are authorized in accordance with requirements of The Oklahoma Central Purchasing Act, other applicable statutory provisions, OAC 580:15 and OKDHS approved purchasing procedures.

(6) AT services are provided by an appropriate professional services provider with a current HCBS contract with OHCA and current unrestricted licensure and certification with their professional board, if applicable.

~~(6)~~(7) AT devices or services may be authorized when the device or service:

(A) has no utility apart from the needs of the person receiving services;

(B) is not otherwise available through SoonerCare, AT retrieval program, Department of Rehabilitative Services, or any other third party or known community resource;

(C) has no less expensive equivalent that meets the member's needs;

(D) is not solely for family or staff convenience or preference;

(E) is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;

(F) is of direct medical or remedial benefit to the member;

(G) enables the member to maintain, increase, or improve functional capabilities;

(H) is supported by objective documentation included in a professional assessment except as specified per OAC 317:40-5-100;

(I) is within the scope of assistive technology per OAC 317:40-5-100; and

(J) is the most appropriate and cost effective bid if applicable.

(K) exceeds a cost of $50. AT devices or services with a cost of $50 or less are not authorized through DDSD HCBS Waivers.

(c) **Assessments.** Assessments for AT devices or services are performed by a licensed professional service provider(s) and reviewed by other providers whose services may be affected by the type of device selected. A licensed professional must:

(1) determine whether the person's identified outcome can be accomplished through the creative use of other resources

such as:

(A) household items or toys;

(B) equipment loan programs;

(C) low-technology devices or other less intrusive options; or

(D) a similar, more cost-effective device.

(2) recommend the most appropriate AT based on the member's:

(A) present and future needs, especially for members with degenerative conditions;

(B) history of use of similar AT, and ability to use the device currently and for at least the foreseeable future (no less than 5 years); and

(C) outcomes.

(3) complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:

(A) review of device considered;

(B) availability of device rental with discussion of advantages and disadvantages;

(C) how frequently and in what situations device will be used in daily activities and routines;

(D) how the member and caregiver(s) will be trained to use the AT device; and

(E) features and specifications of the device that are necessary for the member, including rationale for why other alternatives are not available to meet the member's needs.

(4) provide a current, unedited videotape or pictures of the person member using the device, including the time frames of the trials recorded, upon request by DDSD staff.

(d) **Authorization of repairs, or replacement of parts.** Repairs to AT devices, or replacement of device parts, do not require a professional assessment or recommendation. DDSD area office resource development staff with assistive technology experience may authorize repairs and replacement of parts for previously recommended assistive technology.

(e) **Retrieval of assistive technology devices.** When devices are no longer needed by a member, OKDHS/DDSD staff may retrieve the device.

(f) **Team decision-making process.** The member's Personal Support Team reviews the licensed professional's assessment and decision making review. The Team ensures the recommended AT:

(1) is needed by the member to achieve a specific,

identified functional outcome;

(A) A functional outcome, in this Section, means the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the activity independently, such as self-care, assistance with eating, or transfers.

(B) Functional outcomes must be reasonable and necessary given a member's age the diagnosis and abilities.

(2) allows the member receiving services to:

(A) improve or maintain health and safety;

(B) participate in community life;

(C) express choices; or

(D) participate in vocational training or employment;

(3) will be used frequently or in a variety of situations;

(4) will fit easily into the member's lifestyle and work place;

(5) is specific to the member's unique needs; and

(6) is not authorized solely for family or staff convenience.

(g) **Requirements and standards for AT devices and service providers.**

(1) Providers guarantee devices, work, and materials for one year, and supply necessary follow-up evaluation to ensure optimum usability.

(2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluate the need for AT and individually customize AT devices as needed.

(h) **Services not covered through AT devices and services.** Assistive technology devices and services do not include;

(1) trampolines;

(2) hot tubs;

(3) bean bag chairs;

(4) recliners with lift capabilities;

(5) computers except as adapted for individual needs as a primary means of oral communication and approved per OAC 317:40-5-100;

(6) massage tables; ~~and~~

(7) educational games and toys~~.~~<u>; or</u>

<u>(8) generators.</u>

(i) **Approval or denial of AT.** DDSD approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease/purchase of the AT is determined per OAC 317:40-5-100.

(1) The DDSD case manager sends the AT request to designated DDSD area office resource development staff with

AT experience. The request must include:

(A) the licensed professional's assessment and decision making review;

(B) a copy of the Plan of Care (POC);

(C) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-100; and

(D) all additional documentation to support the need for the assistive technology device or service.

(2) The designated area office resource development staff, with AT experience, approves or denies the AT request when ~~there is no fixed rate for the device and~~ the device has a cost less than $2500, and the POC is below the State Office reviewer limit based on~~:~~

~~(A) the criteria given in subsection (d) of this Section;~~

~~(B)~~ the scope of the program, as explained in subsection ~~(a)~~ (b) of this Section~~; and~~ .

~~(C) the cost effectiveness of the AT, as explained in subsection (a) of this Section~~.

(3) The State Office programs manager for AT approves or denies the AT request when the device has a cost less than $2500, and the POC is above the area office reviewer limit based on the scope of the program, as explained in subsection (b) of this Section.

~~(3)~~ (4) Authorization for purchase or a written denial is provided within ten working days of receipt of a complete request.

(A) If the AT is approved, a letter of authorization is issued.

(B) If additional documentation is required by the area office resource development staff with AT experience, to authorize the recommended AT, the request packet is returned to the case manager for completion.

(C) If necessary, the case manager will contact the licensed professional to request the additional documentation and the licensed professional will supply further documentation ~~upon request of the area office resource development staff with AT experience~~.

(D) The authorization of AT that ~~has no fixed rate and~~ is $2,500 or more is performed as in paragraph (2) of this subsection, except that the area office resource development staff with AT experience:

(i) solicits three bids for the AT;

(ii) submits the AT request, bids, and other relevant information to the DDSD State Office AT programs manager within five working days of receipt of the required bids; and

(iii) the State Office AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five working days of receipt of all required documentation for AT.

(j) **Approval of vehicle adaptations.** Vehicle adaptations are assessed and approved per OAC 317:40-5-100. In addition, the requirements in this paragraph must be met.

(1) The vehicle to be adapted must be owned or in the process of being purchased by the member receiving services or his or her family.

(2) The AT request must include a certified mechanic's statement that the vehicle and adaptations are mechanically sound.

(3) Vehicle adaptations are limited to one vehicle in a ten year period per member. Authorization for more than one vehicle adaptation in a 10-year period must be approved by the DDSD division administrator or designee.

(k) **Denial.** Procedures for denial of an AT device or service are described in this paragraph.

(1) The person denying the AT request provides a written denial to the case manager citing the reason for denial per policy.

(2) The case manager sends the Notice of Action, OKDHS form 06MP004E, to the member and his or her family or guardian.

(3) Denial of assistive technology services may be appealed through the OKDHS hearing process per OAC 340:2-5.

(l) **Return of an AT device.** If, during a trial use period or rental of a device, the therapist or Team including the licensed professional if available, who recommended the AT, determines the device is not appropriate, the licensed professional sends a brief report describing the reason(s) for the change of device recommendation to the DDSD case manager. The case manager forwards the report to the designated area office resource development staff, who arranges for the return of the equipment to the vendor or manufacturer.

(m) **Rental of AT devices.** AT devices are rented when the licensed professional or area office resource development staff with AT experience determines rental of the device is more cost effective than purchase of the device or the licensed professional recommends a trail period to determine if the device meets the needs of the member.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.

(2) Area office resource development staff with AT experience monitor use of equipment during the rental

agreement for:

(A) cost effectiveness of the rental time frames;

(B) conditions of renewal; and

(C) the Team's re-evaluation of the member's need for the device per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device whenever such option is available from the manufacturer or vendor.

(4) If a device is rented for a trial use period, the Team decides within 90 days whether:

(A) the equipment meets the member's needs; and

(B) to purchase the equipment or return it.

(n) **Assistive Technology Committee.** The committee reviews equipment requests when deemed necessary by the OKDHS/DDSD state office assistive technology programs manager.

(1) The AT committee is comprised of:

(A) DDSD professional staff members of the appropriate therapy;

(B) DDSD AT state office programs manager;

(C) the DDSD area manager or designee; and

(D) an AT expert not employed by OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria given in this Section. Any endorsement or denial includes a written rationale for the decision and, if necessary, an alternative solution(s), directed to the case manager within 20 working days of receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified in OAC 317:40-5-100.

317:40-5-103. Transportation

(a) **Applicability.** The rules in this Section apply to transportation services provided through the Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS) Waivers.

~~(a)~~(b) **General Information.** Transportation services include ~~acquisition of, and payment for the use of,~~ adapted, non-adapted, and public transportation.

(1) Transportation services ~~is~~ are provided to promote inclusion in the community, access to programs and services, and participation in activities to enhance community living skills. Members are encouraged to utilize natural supports or community agencies that can provide transportation without charge before accessing

transportation services.

(2) Services include, but are not limited to, transportation to and from medical appointments, work or employment services, recreational activities, and other community activities within the number of miles authorized in the Plan of Care.

(A) Adapted or non-adapted transportation ~~is~~ may be provided for each eligible person; or

(B) Public transportation ~~is~~ may be provided up to a maximum of $5,000 per Plan of Care year. The director of DDSD or designee may approve requests for public transportation services totaling more than $5,000 per year ~~if~~ when public transportation is the most cost-effective ~~alternative~~ option. For the purposes of this Section, public transportation is defined as:

(i) ~~public transportation~~ services~~,~~ such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) a transportation program operated by the ~~service recipient's~~ member's employment services or day services provider.

(3) ~~Services are provided to eligible service recipients in accordance with the service recipient's Plan of Care.~~ Transportation services must be included in the member's Individual Plan (Plan) and arrangements for this service must be made through the member's case manager.

(4) Authorization of Transportation Services is based on:

(A) Team consideration, ~~in accordance with~~ per OAC 340:100-5-52, of the unique needs of the person and the most cost effective type of transportation services that meets the ~~service recipient's~~ member's need, in accordance with subsection (d) of this Section; and

~~(B) the service recipient's participation in Waiver services; and~~

~~(C)~~ (B) the scope of ~~the~~ transportation services ~~program~~ as explained in this ~~section~~ Section.

~~(b)~~ (c) **Standards for transportation providers.** All drivers employed by contracted transportation providers must have a valid and current Oklahoma ~~drivers~~ driver license, and the vehicle(s) must meet applicable local and state requirements for vehicle licensure, inspection, insurance, and capacity.

(1) The provider must ensure that any vehicle used to transport ~~service recipients~~ members:

(A) meets the needs of the ~~service recipient~~ member;

(B) is maintained in a safe condition;

(C) has a current vehicle tag; and

(D) is operated in accordance with local, state, and

federal law, regulation, and ordinance.

(2) The provider maintains liability insurance in an amount sufficient to pay for injuries or loss to persons or property occasioned by negligence or malfeasance by the agency, its agents, or employees.

(3) ~~The transportation provider must adequately maintain equipment installed to provide supports for service recipients~~. Regular maintenance and repairs of vehicles are the responsibility of the transportation provider. Providers of adapted transportation services are also responsible for maintenance and repairs of modifications made to vehicles. Providers of non adapted transportation with a vehicle modification funded through HCBS assistive technology services may have repairs authorized per OAC 317:40-5-100.

(4) Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(A) the service date;

(B) the location and odometer mileage reading at the starting point and destination;

(C) the name of the ~~service recipient~~ member transported; and

(D) the purpose of the trip~~; and~~ .

~~(E) the starting point and destination~~.

(5) A family member, including a family member living in the same household, of an adult ~~service recipient~~ member may establish a contract to provide transportation services to:

(A) work or employment services;

(B) medical appointments; and

(C) other activities identified in the Individual Plan as necessary to meet the needs of the ~~service recipient~~ member, as defined in OAC 340:100-3-33.1.

(6) Individual transportation providers must provide to the DDSD Area Office verification of vehicle licensure, insurance and capacity before a contract may be established, and updated verification of each upon expiration. Failure to provide updated verification of current and valid Oklahoma driver license, vehicle licensure, and as applicable may result in cancellation of the contract.

~~(c)~~ (d) **Services not covered.** Services that cannot be claimed as transportation services include:

(1) services not approved by the Team;

(2) services not authorized by the Plan of Care;

(3) trips that have no specified purpose or destination;

(4) trips for family, provider, or staff convenience;

(5) transportation provided by the ~~person receiving services,~~ member;

(6) transportation provided by the ~~service recipient's~~ member's spouse~~,~~; ~~or~~

(7) transportation provided by the ~~mother or father~~ biological, step or adoptive parents of the ~~service recipient~~ member or legal guardian, ~~if~~ when the ~~service recipient~~ member is a minor;

~~(6)~~ (8) trips when the ~~service recipient~~ member is not in the vehicle;

~~(7)~~ (9) transportation claimed for more than one ~~service recipient~~ member per vehicle at the same time or for the same miles, except public transportation;

~~(8)~~ (10) transportation outside the State of Oklahoma unless:

(A) the transportation is provided to access the nearest available medical or therapeutic service; or

(B) advance written approval is given by the DDSD ~~Area Manager~~ area manager or designee;

~~(9)~~ (11) services which are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;

~~(10)~~ (12) transportation that occurs during the performance of the ~~service recipient's~~ member's paid employment, even if the employer is a contract provider~~.~~ ; or

(13) transportation when a closer appropriate location was not selected.

~~(d)~~ (e) **Assessment and Team process.** At least annually, the Team addresses the ~~service recipient's~~ member's transportation needs. The Team determines the most appropriate means of transportation based on the:

(1) present needs of the ~~person receiving services~~ member. When addressing the possible need for adapted transportation, the Team considers the needs of the ~~service recipient~~ member only. The needs of other individuals living in the same household are considered separately;

(2) ~~service recipient's~~ member's ability to access public transportation services; and

(3) the availability of other transportation resources including ~~family, neighbors, friends~~ natural supports, and community agencies.

~~(e)~~ (f) **Adapted Transportation.** Adapted transportation ~~provides~~ may be transportation provided in modified vehicles ~~or vehicles specifically procured to~~ with wheelchair or stretcher safe travel systems or lifts that meet medical ~~or behavioral~~ needs of the ~~service recipient~~ member ~~which~~ that cannot be met with the use of a standard passenger vehicle~~.~~,

including a van when the modification to the vehicle was not funded through HCBS assistive technology service and is owned or leased by the DDSD HCBS provider agency. ~~Vehicle modifications that may be needed include, but are not limited to, wheelchair safe travel systems, wheelchair lifts, raised roofs and doors, and exterior mounted wheelchair or scooter carriers.~~

(1) Adapted transportation is not authorized when a provider agency leases an adapted vehicle from a member or a member's family.

(2) Exceptions to receive adapted transportation services for modified vehicles other than those with wheelchair/stretcher safe travel systems and lifts may be authorized by the DDSD program manager for transportation services when documentation supports the need and there is evidence the modification costs exceeded $10,000. All other applicable requirements of OAC 317:40-5-103 must be met.

(3) Adapted transportation services do not include vehicles with modifications including, but not limited to:

(A) restraint systems;

(B) plexi-glass windows;

(C) barriers between the driver and the passengers;

(D) turney seats; and

(E) seat belt extenders.

~~(1)~~ (4) The Team determines if the ~~service recipient~~ member needs adapted transportation according to:

(A) the ~~service recipient's~~ member's need for physical support when sitting;

(B) the ~~service recipient's~~ member's need for physical assistance during transfers from one surface to another;

(C) the portability of the ~~service recipient's~~ member's wheelchair;

(D) associated health problems the ~~service recipient~~ member may have; and

(E) ~~behavioral issues related to vehicle travel~~ less costly alternatives to meet the need.

~~(2)~~ (5) The transportation provider and the equipment vendor ensure that requirements of the Americans with Disabilities Act are met ~~when Team-recommended vehicle modifications are installed~~.

~~(3)~~ (6) The transportation provider ensures that all staff assisting with transportation have been trained according to the requirements specified by the Team and the equipment manufacturer.

~~(4) The adapted transportation rate is not paid when a vehicle has been adapted with funds from the HCBWS program.~~

~~(f)~~ (g) **Authorization of transportation services.** The ~~authorization~~ limitations given in this subsection include the total of all transportation units on the Plan of Care, not just the units authorized for the residential setting identified.

(1) Up to 12,000 units of transportation services may be authorized in a ~~service recipient's~~ member's ~~plan of care in accordance with~~ Plan of Care per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(2) When there is a combination of non-adapted transportation and public transportation on a Plan of Care, the total cost for transportation cannot exceed the cost for non-adapted transportation services at the current non-adapted transportation reimbursement rate multiplied by 12,000 miles for the Plan of Care year.

~~(2)~~ (3) The ~~Area Manager~~ area manager or designee may approve:

(A) up to 14,400 miles per Plan of Care year for people who have extensive needs for transportation services~~.~~ ; and

(B) a combination of non-adapted transportation and public transportation on a Plan of Care, when the total cost for transportation does not exceed the cost for non-adapted transportation services at the current non-adapted transportation reimbursement rate multiplied by 14,400 miles for the Plan of Care year.

~~(3)~~ (4) The ~~Division Director~~ division director or designee may approve:

(A) transportation services in excess of 14,400 miles per Plan of Care year in extenuating situations when person-centered planning has identified specific needs which require additional transportation for a limited period; or

(B) any combination of public transportation services with adapted or non-adapted; or

(C) public transportation services in excess of $5000 when this is the most cost effective service option for necessary transportation.

317:40-5-113. Adult Day Services

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care Authority contract for providing Adult Day Services. This service is available through the Community Waiver and through the In-Home Supports Waiver for Adults. Adult Day Services is a structured,

comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day. ~~Individuals~~ Members who participate in adult day services receive these services on a planned basis during specified hours. Adult day services are designed to work toward the goals of:

(1) promoting the member's maximum level of independence;

(2) maintaining the member's present level of functioning as long as possible, preventing or delaying further deterioration;

(3) assisting the member in achieving the highest level of functioning possible;

(4) providing support, respite, and education for families and other caregivers; and

(5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible members whose teams have determined the service is appropriate to meet their needs. Members must:

(1) require ongoing support and supervision ~~in a safe environment~~ when away from their own residence;

(2) be 18 years of age or older; and

(3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:

(1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;

(2) comply with OAC 310:605, Adult Day Care Centers;

(3) allow DDSD staff to make announced and unannounced visits to the facility during the hours of operation;

(4) provide the DDSD case manager a copy of the individualized plan of care;

(5) submit incident reports per OAC 340:100-3-34;

(6) maintain a copy of the member's Individual Plan (Plan);

(7) submit Oklahoma Department of Human Services (OKDHS) ~~Adult Day Services Progress Report Form 06WP046E to the DDSD case manager by the tenth of each month for the previous month's services~~, Provider Progress Report for each member receiving services; and

(8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The member's Plan contains detailed descriptions of services to be provided and ~~documentation of~~ specifies hours of services. All services must be authorized in the Plan and reflected in the approved plan of care. Arrangements for care must be made with the member's case manager.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-5. Community-Based Services

Community-Based Services are provided in sites and at times typically used by others in the community and promote independence, inclusion within the community, and the creation of natural supports. Community-based services must reflect the ~~service recipient's~~ member's choice and values in situations that are typical for age and culture.

(1) Approved Community-Based Services are individualized work-related supports targeting inclusion into integrated experiences. Community-Based Services are pre-planned, documented activities supported by a schedule relating to the ~~service recipient's~~ member's identified employment outcomes. Approved activities include:

(A) active participation in formalized volunteer activities;

(B) active participation in paid or unpaid work experience sites in community settings;

(C) training through generic entities such as trade schools, Vo Techs, junior colleges, or other community groups. The provider is paid for the time during which direct supports are necessary and provided;

(D) stamina-enhancing programs that occur in integrated settings;

(E) transportation to and from employment or community-based activities;

(F) meals and breaks which must occur during the conduct of the ~~service recipient's~~ member's employment activities;

(G) job tours or job shadowing scheduled with and provided by a community business entity;

(H) using Workforce OK services; and

(I) attending job fairs.

(2) Any other work-related community-based activities must be approved through the exception process described in OAC 317:40-7-21.

(3) Community-Based Services continue if the ~~service recipient~~ member has to go to a center-based facility for support such as repositioning or personal care, as long as the ~~service recipient~~ member returns immediately to a planned community-based activity. The amount of time for the repositioning and personal care are based upon a health care positioning plan approved by the Team.

(4) ~~Community-Based Services are provided to groups of no more than five people~~. Community-Based Services are

available for individual and group placements.

(A) Individual placement means the member is provided supports that enable him or her to participate in approved community-based activities described in this Section individually and not as part of a group placement.

(B) Group Placement means two to five members are provided supports that enable him or her to participate in approved community-based activities described in this Section.

317:40-7-7. Job coaching services

(a) Job coaching services:

(1) are pre-planned, documented activities related to the member's identified employment outcomes that include training at the work site and support by provider agency staff ~~certified as a job coach,~~ who have completed DDSD sanctioned training per OAC 340:100-3-38.2;

(2) promote the member's capacity to secure and maintain integrated employment at a job of the member's choice paying at or more than minimum wage, or working to achieve minimum wage;

(3) provide active participation in paid work. Efforts are made in cooperation with employers to adapt normal work environments to fit the needs of members through the maintenance of an active relationship with the business;

(4) are available for individual and group placements.

(A) Individual placement is:

(i) one member receiving job coaching services who:

(I) works in an integrated job setting;

(II) is paid at or more than minimum wage;

(III) does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;

(IV) is employed by a community employer or provider agency; and

(V) has a job description that is specific to the member's work; and

(ii) authorized when on-site supports by a certified job coach are provided more than 20% of the member's compensable work time. Job coaching services rate continues until a member reaches 20% or less job coach intervention for four consecutive weeks, at which time stabilization services begin.

(B) Group placement is two to eight members receiving continuous support in an integrated work site, who may earn less than minimum wage ; and

(5) are based on the amount of time for which the member is compensated by the employer, except per OAC 317:40-7-11.

(b) For members in individual placements, the Personal Support Team (Team):

(1) evaluates the need for job coaching services at least annually; and

(2) documents a plan for fading job coaching services as the member's independence increases.

(c) When the member receives commensurate compensation, employment goals include, but are not limited to, increasing:

(1) productivity;

(2) work quality;

(3) independence;

(4) minimum wage opportunities; and

(5) competitive work opportunities.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services Waivers

(a) The Developmental Disabilities Services Division (DDSD) case manager, member, a member's family or, if applicable, legal guardian, and provider develop a preliminary plan of services including:

(1) site and amount of the services to be offered;

(2) types of services to be delivered; and

(3) expected outcomes.

(b) To promote community integration and inclusion, employment services are only delivered in non-residential sites.

(1) Employment services through Home and Community-Based Services (HCBS) Waivers cannot be reimbursed if those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home.

(2) No exceptions to OAC 317:40-7-15(b) are authorized.

(c) Providers of HCBS employment services comply with OAC 340:100-17.

(d) The service provider is required to notify the DDSD case manager in writing when the member:

(1) is placed in a new job;

(2) loses his or her job. A Personal Support Team (Team) meeting must be held if the member loses the job;

(3) experiences significant changes in the community-based schedule or employment schedule; or

(4) experiences other circumstances, per OAC 340:100-3-34.

(e) The provider submits Oklahoma Department of Human Services (OKDHS) ~~Form 06WP066E, Employment Progress Report, to the DDSD case manager by the tenth of each month for the previous month's services~~ Provider Progress Report per OAC 340:100-5-

52, for each member receiving services.
(f) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed $25,000 per Plan of Care year.
(g) Each member receiving residential supports per OAC 340:100-5-22.1 or group home services is employed for 30 hours per week or receives a minimum of 30 hours of employment services, adult day services per OAC 317:40-5-113, or a combination of both, each week, excluding transportation to and from the member's residence.

(1) Thirty hours of employment service each week can be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, and job coaching services. Center-based services cannot exceed 15 hours per week for members receiving services through the Homeward Bound ~~waiver~~ Waiver.

(2) Less than 30 hours of employment activities per week requires approval per OAC 317:40-7-21.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in OAC 317:40-7 are:

(1) approved ~~in accordance with~~ per OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the Personal Support Team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan (Plan) process per OAC 340:100-5-50 through 340:100-5-58; and

(4) documented and recorded ~~on Oklahoma Department of Human Services (OKDHS) Form 06WP047E, Exception Request for Waiver Employment Services,~~ in the Individual Plan by the Developmental Disabilities Services Division (DDSD) case manager after Team approval.

(b) A request for an exception to the minimum of 30 hours per week of employment services, adult day services per OAC 317:40-5-113, or a combination of both, per OAC 317:40-7-15, includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans;

(2) plan with specific steps and target dates to address

the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and

(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.

(c) A request for an exception to the maximum limit of 15 hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(d) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

~~(e) Within ten working days of the annual Individual Planning or interim meeting, the DDSD case manager sends OKDHS Form 06WP047E to area employment services staff, who reviews the form to ensure all criteria per OAC 317:40-7-21 are met. If criteria are:~~

~~(1) not met, employment services staff returns OKDHS Form 06WP047E with recommendations to the DDSD case management supervisor and case manager for resubmission; or~~

~~(2) met, employment services staff returns OKDHS Form 06WP047E to the case management supervisor to resume the approval process and input of units on the member's Plan of~~

~~Care.~~

~~(f)~~ (e) Exception requests per OAC 340:40-7-21(f) are documented by the DDSD case manager after Team consensus and submitted ~~via OKDHS Form 06WP047E~~ to the DDSD area manager or designee within ten working days after the annual IP or interim Team meeting. The area manager approves or denies the request with a copy to the DDSD area office claims staff and case manager based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives.

(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:

(A) Team's discussion of current specific situation that requires an exception;

(B) specific medical issues necessitating the exception request; and

(C) a projection of units needed to complete the State fiscal year.

(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans.

~~(g)~~ (f) The DDSD director or designee may review exceptions granted per OAC 317:40-7-21, directing the Team to provide additional information, if necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.

SUBCHAPTER 9. SELF-DIRECTED SERVICES

317:40-9-1. Self-Directed Services (SDS)

(a) Applicability. The rules in this section apply to self-directed services provided through Home and Community Based Service (HCBS) Waivers operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD).

(b) Traditional service delivery methods are available for eligible members who do not elect to self-direct their services.

(c) General Information. Self-Direction is an option for members receiving Home and Community Based Services (HCBS)

through the In-Home Supports Waiver for Adults (IHSW-A) or the In-Home Supports Waiver for Children (IHSW-C). Self-Direction provides the opportunity for a member to exercise choice and control in identifying, accessing, and managing specific waiver services and supports in accordance with their needs and personal preferences. Self-Directed Services (SDS) are Waiver services that the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) specifies may be directed by the member or representative using both employer and budget authority.

(1) Services may be directed by:

(A) an adult member, if the member has the ability to self-direct; or

(B) a legal representative of the member, including a parent, spouse or legal guardian; or

(C) a non-legal representative freely chosen by the member or their legal representative.

(2) The person directing services must:

(A) be 18 years of age or older;

(B) comply with OKDHS/DDSD and Oklahoma Health Care Authority (OHCA) rules and regulations;

(C) complete required OKDHS/DDSD training for self-direction;

(D) sign an agreement with OKDHS/DDSD;

(E) be approved by the member or their legal representative to act in the capacity of a representative; and

(F) demonstrate knowledge and understanding of the member's needs and preferences.

(d) SDS program includes:

(1) SDS Budget. A plan of care is developed to meet the member's needs without consideration of SDS. The member may elect to self-direct part or all of the amount identified for traditional Habilitation Training Specialist (HTS) services. This amount is under the control and discretion of the member in accordance with this policy and the approved IHSW, and is the allocated amount which may be used to develop the SDS budget. The SDS budget details the specific plan for spending.

(A) A SDS budget is developed annually at the time of the annual plan development and updated as necessary by the member, case manager, parent, legal guardian, and others the member invites to participate in the development of the budget.

(B) Payment may only be authorized for goods and services not covered by SoonerCare or other generic funding sources, and meets the criteria of service

necessity per OAC 340:100-3-33.1.

(C) The member's SDS budget includes the actual cost of administrative activities including fees for services performed by a Financial Management Services (FMS) subagent, background checks, workers compensation insurance and the amount identified for SD-HTS and SD-GS.

(D) The SDS budget is added to the plan of care to replace any portion of traditional HTS services to be self-directed.

(2) The SD-Habilitation Training Specialist (SD-HTS) supports the member's self-care, daily living and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion and well-being. SD-HTS must be included in the approved SDS budget. Payment will not be made for routine care and supervision that is normally provided by a family member or the member's spouse. SD-HTS are provided only during periods when staff is engaged in purposeful activity that directly or indirectly benefits the member. At no time are SD-HTS services authorized for periods during which the staff are allowed to sleep. Legally responsible persons may not provide services per OAC 340:100-3-33.2. Other family members providing services must be employed by provider agencies per OAC 340:100-3-33.2. For the purpose of this policy family members include parents and siblings including step and half and anyone living in the same home as the member. Payment does not include room and board, maintenance, upkeep or improvements to the member's or family's residence. A SD-HTS must:

(A) be 18 years of age;

(B) pass a background check per OAC 340:100-3-39;

(C) demonstrate competency to perform required tasks;

(D) complete required training per OAC 340:100-3-38.5;

(E) sign an agreement with OKDHS/DDSD and the member;

(F) be physically able and mentally alert to carry out the duties of the job;

(G) not work more than 40 hours in any week in the capacity of a SD-HTS; and

(H) not implement restrictive or intrusive procedures per OAC 340:100-5-57.

(3) Self-Directed Goods and Services (SD-GS). SD-GS are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure

skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care. These goods and services must be included in the individual plan and approved SDS budget. SD-GS must meet the following requirements:

(A) The item or service is justified by a recommendation from a licensed professional.

(B) The item or service is not prohibited by Federal and State statutes and regulations.

(C) One or more of the following additional criteria are met:

(i) the item or service would increase the member's functioning related to the disability;

(ii) the item or service would increase the member's safety in the home environment; or

(iii) the item or service would decrease dependence on other SoonerCare funded services.

(D) SD-GS may include, but are not limited to:

(i) fitness items that can be purchased at most retail stores;

(ii) personal emergency monitoring systems;

(iii) food catcher;

(iv) specialized swing set;

(v) toothettes or electric toothbrush;

(vi) seat lift;

(vii) weight loss program; or

(viii) gym memberships when:

(I) there is an identified need for weight loss or increased physical activity~~.~~ ;

(II) justified by outcomes related to weight loss, increased physical activity or stamina; and

(III) in subsequent plan of care year requests, documentation is provided that supports member's progress toward weight loss or increased physical activity or stamina.

(E) SD-GS may not be used for:

(i) co-payments for medical services;

(ii) over-the-counter medications;

(iii) items or treatments that have not been approved by the Food and Drug Administration;

(iv) homeopathic services;

(v) services available through any other funding source such as SoonerCare, Medicare, private insurance, public school system, Rehabilitation Services or natural supports;

(vi) room and board, including deposits, rent and mortgage payments;

(vii) personal items and services not directly related to the member's disability;
(viii) vacation expenses;
(ix) insurance;
(x) vehicle maintenance or any other transportation related expense;
(xi) costs related to internet access;
(xii) clothing;
(xiii) tickets and related costs to attend recreational events;
(xiv) services, goods or supports provided to or benefiting persons other than the member; or
(xv) experimental goods or services.
(xvi) personal trainers;
(xvii) spa treatments; or
(xviii) goods or services with costs that significantly exceed community norms for the same or similar good or service.

(F) SD-GS are reviewed and approved by DDSD division director or designee.

(e) Member Responsibilities. When the member chooses the SDS option, the member or member's representative is the employer of record and must:

(1) enroll and complete the OKDHS/DDSD sanctioned training course in self-direction. The training must be completed prior to the implementation of self-direction and will cover the following areas:
(A) staff recruitment;
(B) hiring of staff as employer of record;
(C) orientation and instruction of staff in duties consistent with approved specifications;
(D) supervision of staff including scheduling and service provisions;
(E) evaluation of staff;
(F) discharge of staff;
(G) philosophy of self-direction;
(H) OHCA policy on self-direction;
(I) individual budgeting;
(J) development of a self-directed support plan;
(K) cultural diversity; and
(L) rights, risks, and responsibilities.
(2) sign an agreement with OKDHS/DDSD;
(3) agree to utilize the services of a FMS subagent;
(4) agree to pay administrative costs for background checks, FMS subagent fee, and worker's compensation insurance from their SDS budget;
(5) comply with federal and state employment laws and

ensure no employee works more than 40 hours per week in the capacity of SD-HTS;
(6) ensure that each employee is qualified to provide the services for which he/she is employed and that all billed services are actually provided;
(7) ensure that each employee complies with all OKDHS/DDSD training requirements for In-Home Support Waivers per OAC 340:100-3-38.5;
(8) recruit, hire, supervise, and discharge when necessary all employees providing self-directed services;
(9) verify employee qualifications;
(10) obtain a background screening on all employees providing SD-HTS per OAC 340:100-3-39;
(11) send ~~monthly~~ progress reports ~~to the case manager by the 10th of each month for the preceding month of service via mail, e-mail or personal delivery~~ per OAC 340:100-5-52.
(12) participate in the Individual Plan and SDS budget process;
(13) immediately notify the case manager of any changes in circumstances or emergencies, which may require modification of the type or amount of services provided for in the member's Individual Plan or SDS budget;
(14) wait for approval of budget modifications before implementing changes;
(15) comply with OKDHS/DDSD and OHCA administrative rules;
(16) cooperate with OKDHS/DDSD monitoring requirements per OAC 340:100-3-27;
(17) cooperate with all requirements of the FMS subagent to ensure accurate records and prompt payroll including:
(A) reviewing and signing employee time cards;
(B) verifying the accuracy of hours worked; and
(C) ensuring the appropriate expenditure of funds.
(18) complete all required documents within established timeframes;
(19) pay for services incurred in excess of the budget amount;
(20) pay for services not identified and approved in the member's SDS budget;
(21) pay for services provided by an unqualified provider;
(22) determine staff duties, qualifications, and specify service delivery practices consistent with SD-HTS waiver service specifications;
(23) orient and instruct staff in duties;
(24) evaluate staff performance;
(25) identify and train back-up staff when required;
(26) determine amount paid for services within Plan limits;
(27) schedule staff and the provision of services;

(28) ensure SD-HTS do not implement restrictive or intrusive procedures per OAC 340:100-5-57; and

(29) sign an agreement with OKDHS/DDSD and the SD-HTS.

(f) Financial Management Services (FMS) subagent responsibilities. The FMS subagent is an entity designated as an agent by OKDHS/DDSD to act on behalf of members who have employer and budget authority for the purpose of managing payroll tasks for the member's employee(s) and for making payment of SD-GS as authorized in the member's Plan. FMS subagent duties include, but are not limited to:

(1) compliance with all OKDHS/DDSD and OHCA administrative rules and contract requirements;

(2) compliance with random and targeted audits conducted by OKDHS/DDSD or the OHCA;

(3) provision of financial management support to the member by tracking individual expenditures and monitoring SDS budgets;

(4) processing the member's employee payroll, withholding, filing and paying of applicable federal, state and local employment-related taxes and insurance;

(5) collection and process of employee's time sheets and making payment to member's employees;

(6) processing and payment of invoices for SD-GS as authorized in the member's SDS budget;

(7) providing each member with information that will assist with managing the SDS budget;

(8) providing reports to members/representatives, as well as OKDHS/DDSD monthly and to OHCA upon request;

(9) providing OKDHS/DDSD and OHCA authorities access to individual member's accounts through a web-based program;

(10) assisting members in verifying employee citizenship status;

(11) maintaining separate accounts for each member's SDS budget;

(12) tracking and reporting member funds, disbursements and the balance of member funds;

(13) receiving and disbursing funds for the payment of SDS under an agreement with the OHCA; and

(14) executing and maintaining contractual agreement between OKDHS/DDSD and the SD-HTS (employee).

(g) OKDHS/DDSD Case Management responsibilities in support of SDS.

(1) The case manager develops the member's Plan per OAC 340:100-5-50 through 58;

(2) The DDSD case manager meets with the member and/or the member's representative or legal guardian to discuss the following service delivery options in the HCBS Waiver:

(A) traditional Waiver services; and

(B) self-directed services including information regarding scope of choices, options, rights, risks, and responsibilities associated with self-direction.

(3) If the member chooses self-direction, the case manager will:

(A) discuss with member or representative the amount available in the budget;

(B) assist member or representative with the development and modification of the SDS budget;

(C) submit request for SD-GS to the DDSD division director or designee for review and approval prior to the case manager's approval of the SDS budget;

(D) approve the SDS budget and modifications;

(E) assist member or representative with developing or revising an emergency back-up plan;

(F) provide FMS subagent a copy of the member's authorized SDS budget and any modifications;

(G) monitor implementation of the Plan per OAC 340:100-3-27.

(H) ensure that services are initiated within required time frames;

(I) conduct ongoing monitoring of the implementation of the Plan and the member's health and welfare;

(J) specify additional employee qualifications in the Plan based on the member's needs and preferences so long as such qualifications are consistent with approved waiver qualifications;

(K) specify in the Plan how services are provided;

(L) refer potential SD-HTS providers to the FMS subagent for enrollment;

(M) assist in locating and securing services and other community resources that promote community integration, community membership and independence, as provided in the member's Plan; and

(N) ensure any restrictive or intrusive procedures per OAC 340:100-5-57 are not implemented by the SD-HTS. If the Team determines restrictive or intrusive procedures are necessary, SD-HTS is not appropriate to meet the needs of the member and traditional services must be used.

(h) OKDHS/DDSD serves as the Organized Health Care Delivery System (OHCDS) as well as the FMS provider in a Centers for Medicare and Medicaid Services (CMS) approved Government Fiscal/Employer Agent model. OKDHS/DDSD has an interagency agreement with OHCA.

(i) Voluntary Termination of Self-Directed Services. Members

may discontinue self-directing services without disruption at any time, provided traditional waiver services are in place. Members or representatives may not choose the self-directed option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next plan of care. Any member desiring to file a complaint must follow the procedures set forth by OKDHS at OAC 340:2-5-61.

(j) Involuntary Termination of Self-Directed Services.

(1) Members may be terminated involuntarily from self-direction and offered traditional waiver services when it has been determined by OKDHS/DDSD Director or designee that any of the following exist:

(A) immediate health and safety risks associated with self-direction, such as, imminent risk of death or irreversible or serious bodily injury related to waiver services;

(B) intentional misuse of funds following notification, assistance and support from OKDHS/DDSD;

(C) failure to follow and implement policies of self-direction after technical assistance and guidance from OKDHS/DDSD;

(D) fraud; or

(E) it is determined that restrictive or intrusive procedures are essential for safety.

(2) When action is taken to terminate the member from self-directed services involuntarily, the case manager assists the member in accessing needed and appropriate services through the traditional waiver services option, ensuring that no lapse in necessary services occurs for which the member is eligible.

(3) The Fair Hearing process as described in OAC 340:100-3-13 applies.

(k) Reporting requirements. While operating as an Organized Health Care Delivery System, OKDHS/DDSD will provide to the OHCA reports detailing provider activity in the format and at such times as required by the OHCA.