CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 41. FAMILY SUPPORT SERVICES

317:30-5-410. Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

(a) The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with mental retardation and certain persons with related conditions that are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Each waiver allows payment for family support services as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS). Waiver services:

(1) when utilized with services normally covered by SoonerCare, other generic services, and natural supports provide for health and developmental needs of members who otherwise would not be able to live in a home or community setting;

(2) are provided with the goal of promoting independence through strengthening the member=s capacity for self-care and self-sufficiency;

(3) are centered on the needs and preferences of the member and support the integration of the member within his/her community; and

(4) do not include room and board. The costs associated with room and board must be met by the member.

(b) The DDSD case manager develops the Individual Plan (IP) and Plan of Care (Plan) per OAC 340:100-5-53. The IP contains descriptions of the services provided, documentation of the amount, frequency and duration of the services, and types of service providers.

(1) Services:

(A) are authorized per OAC 340:100-3-33 and 100-3-33.1.

(B) provided prior to the development of the IP or not included in the IP are not compensable. The Plan may not be backdated;

(C) may be provided on an emergency basis when approved by the area manager or designee. The plan must be revised to reflect the additional services; and

(D) are provided by qualified provider entities contracted with the OHCA.

(2) Members have freedom of choice of providers and in the selection of HCBS or institutional services.

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, AND COMMUNITY TRANSITION SERVICES

317:30-5-422. Description of services

Residential supports include:

(1) agency companion services (ACS) ~~provided in accordance with Part 1 of~~ per OAC 317:40-5;

(2) specialized foster care (SFC) ~~provided in accordance with Part 5 of~~ per OAC 317:40-5;

(3) daily living supports (DLS) ~~provided in~~:

(A) Community Waiver ~~in accordance with~~ per OAC 317:40-5-150; and

(B) Homeward Bound Waiver ~~in accordance with~~ per OAC 317:40-5-153;

(4) group home services provided ~~in accordance with~~ per OAC 317:40-5-152; and

(5) community transition services (CTS).

(A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide ACS, habilitation training specialist (HTS) services, or DLS, in addition to a contract to provide CTS.

(B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for the mentally retarded (ICF/MR) or provider-operated residential setting to the member's own home or apartment. The cost of Community Transition Services per member cannot exceed limitations set forth by OHCA. The member=s name must be on the lease, deed or rental agreement. CTS:

(i) ~~is~~ are furnished only when the member is unable to meet such expense and must be ~~authorized~~ documented in the member's Individual Plan (IP);

(ii) ~~includes~~ include security deposits, essential furnishings such as major appliances, dining table/chairs, bedroom set, sofa, chair, window coverings, kitchen pots/pans, dishes, eating utensils, bed/bath linens, kitchen dish towel/potholders, one month supply of laundry/cleaning products, setup fees or deposits for initiating utility ~~or~~ service ~~access~~, including phone, electricity, gas, and water~~,~~ . CTS also includes moving expenses, ~~and services~~ services/items necessary for the member's health and safety such as pest eradication, allergen control, one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, tempering valve or other anti-scald device when determined by the Team necessary to ensure the member=s safety~~. Utilities must be in the members's name~~; and

(iii) does not include:

(I) recreational items, such as television, cable ~~television access~~, satellite, internet, video cassette

recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, or computer used primarily as diversion or recreation; ~~and~~

(II) monthly rental or mortgage expense~~, food, or regular utility charges.~~ ;

(III) food;

(IV) personal hygiene items;

(V) disposable items such as paper plates/napkins, plastic utensils, disposable food storage bags, aluminum foil, plastic wrap;

(VI) items that could be considered decorative such as rugs, pictures, bread box, canisters, or more than one basic clock;

(VII) any item not considered an essential basic one time expense; or

(VIII) regular ongoing utility charges.

(iv) prior approval for exceptions and/or questions regarding eligible items and/or expenditures are directed to the program manager for community transition services at OKDHS/DDSD state office.

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH MENTAL RETARDATION AND/OR RELATED CONDITIONS

317:30-5-1010. Eligible providers

(a) **Eligible providers.** Services are provided by Oklahoma Department of Human Services (~~DHS~~ OKDHS) Developmental Disabilities Services Division (DDSD) case managers.

(1) **Certification requirements.** ~~Medicaid~~ SoonerCare Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services must be made available to all eligible ~~recipients~~ members and must be delivered on a statewide basis with procedures that assure 24 hour availability, the protection and safety of ~~recipients~~ members, continuity of services without duplication, and compliance with federal and State mandates and regulations related to servicing the targeted population are met in a uniform and consistent manner. A DDSDTCM must:

(A) be employed by the ~~DHS~~ OKDHS, DDSD.

(B) possess knowledge of:

(i) case management methods, principles and techniques;

(ii) types of developmental disabilities represented within the caseload;

(iii) types of providers and services available for ~~consumers~~ members;

(iv) the behavioral sciences and allied disciplines involved in the evaluation, care and training of persons with developmental disabilities;

(v) interviewing principles and techniques;
(vi) counseling principles and techniques; and
(vii) adaptive communication techniques and non-verbal communication.

(C) possess skill in:
(i) managing a caseload;
(ii) effectively intervening in crisis situations;
(iii) working cooperatively and effectively with other professionals in a team situation;
(iv) collecting and analyzing information;
(v) making decisions relating to services provided to ~~consumers~~ members;
(vi) developing a logical and practical plan of treatment for ~~consumers~~ members with developmental disabilities;
(vii) evaluating the progress of ~~consumers~~ members and the quality of their habilitation programs;
(viii) communicating effectively; and
(ix) mediating with providers and agencies to resolve problems.

(b) **Provider agreement.** A Provider Agreement between the Oklahoma Health Care Authority and the provider for DDSDTCM services must be in effect before reimbursement can be made for compensable services.

(c) **Provider selection.** ~~Provision of case management services must not restrict an individual's free choice of providers. Eligible recipients retain the right to free choice of qualified providers of targeted case management services identified by the State.~~ Target group consists of eligible members with developmental disabilities. Providers are limited to providers of case management services capable of ensuring that members with developmental disabilities receive needed services.

317:30-5-1010.1. Scope of service

(a) **Description of targeted case management services.**

(1) ~~Targeted case~~ Case management services are ~~activities that~~ services furnished to assist ~~the target population~~ members, eligible under the Medicaid State Plan, in gaining access to needed medical, social, educational and other services ~~and supports~~. ~~These supports and services include those not provided under the Oklahoma Home and Community Based Services waiver as well as those covered under the waiver. Services include~~ Case management includes the following assistance:

(A) assessment~~;~~ of a member to determine the need for medical, educational, social, or other services. Assessment activities include:

(i) taking member history;
(ii) identifying the member=s needs and completing related documentation; and

(iii) gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the member.

(B) ~~support/service planning;~~ development of a specific plan of care that:

(i) is based on the information collected through the assessment;

(ii) specifies the goals and actions to address medical, social, educational, and other services needed by the member;

(iii) includes activities such as ensuring the active participation of the eligible member; and working with the member or member=s authorized health care decision maker, and others to develop the goals; and

(iv) identifies a course of action to respond to the assessed needs of the eligible member.

(C) ~~monitoring and coordination; and~~ referral and related activities to help an eligible member obtain needed services including activities that help link a member with:

(i) medical, social, educational providers; or

(ii) other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the member.

(D) ~~reassessment.~~ monitoring and follow-up activities include activities and contact necessary to ensure the plan of care is implemented and adequately addressing the member=s needs. Activities and contact may be with the member, his or her family members, providers, other entities or individuals, and may be conducted as frequently as necessary including at least one annual monitoring to assure the following conditions are met:

(i) services are being furnished in accordance with the member=s plan of care;

(ii) services in the plan of care are adequate; and

(iii) if there are changes in the needs or status of the member, necessary adjustments are made to the plan of care, and to service arrangements with providers.

(2) ~~Targeted case management is designed to assist individuals in accessing services. The client has the right to refuse targeted case management and cannot be restricted from services because of a refusal for targeted case management services.~~ Case management may include contact with non-eligible individuals who are directly related to identifying the needs and supports for helping the eligible member to access services.

~~(3) Targeted case management does not include:~~

~~(A) physically escorting or transporting a client to scheduled appointment or staying with the client during an~~

~~appointment;~~
~~(B) monitoring financial goals;~~
~~(C) providing specific services such as shopping or paying bills; or~~
~~(D) delivering bus tickets, food stamps, money, etc.~~

(b) **Access to services.** DDSD assures that:

(1) case management services will be provided in a manner consistent with the best interest of members and will not be used to restrict a member=s access to other services under the plan;

(2) members will not be compelled to receive case management services, condition receipt of case management services on the receipt of other SoonerCare services, or condition receipt of other SoonerCare services on receipt of case management services;

(3) case management conducts activities to ensure the health and welfare of HCBS waiver members. For members who refuse case management services, these activities will be completed as follows:

(A) the member will develop an Individual Plan (IP) per OAC 340:100-5-50 through 340:100-5-58.

(B) the member will develop a plan of care requesting authorization for services and submit it with the IP to the Developmental Disabilities Services Division (DDSD) plan of care reviewer for review and approval per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(C) monthly progress reports, incident reports, OKDHS form 06HM005E, OKDHS form 06HM006E, and other documentation required to be submitted to case management will be submitted to the DDSD state office program manager for case management for monitoring and follow-up per OAC 340:100-3-27.

(D) monitoring visits required by OAC 340:100-3-27 will be conducted by DDSD Quality Assurance staff.

(E) the DDSD state office program manager will assign staff responsibility for maintaining the record in Client Contact Manager (CCM), obtaining necessary documents from the member and others for continuing service eligibility, providing information regarding available HCBS Waiver providers, making referrals to other programs and identifying training available to assist the member in completing the required tasks.

(4) providers of case management services do not exercise the agency=s authority to authorize or deny the provision of other services under the plan.

~~(b)~~ (c) **Non-Duplication of services.** To the extent any eligible recipients in the identified target population are receiving case management services from another provider agency as a result of being members of other covered target groups, the provider assures

that case management activities are coordinated to avoid unnecessary duplication of service.

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

317:35-9-5. Home and Community - Based Waiver Services for ~~the Mentally Retarded~~ persons with mental retardation or certain persons with related conditions

(a) Services provided through Home and Community - Based ~~Waiver~~ Services (HCBS) Waivers ~~for the Mentally Retarded (HCBW/MR) are services which~~ are outside the normal scope of ~~the Medicaid~~ SoonerCare services. HCBS Waivers are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Oklahoma=s Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of waiver administration. ~~The Medicaid waiver~~ HCBS Waivers ~~allows~~ allow the OHCA to offer certain home and community based services to categorically needy ~~individuals~~ members who, without such services, would be eligible for care in a facility for ~~the mentally retarded~~ persons with mental retardation.

(b) ~~Individuals~~ Members with mental retardation are eligible for ~~Medicaid~~ SoonerCare as categorically needy under the ~~HCBW/MR Program~~ HCBS Waiver program when ~~the following medical and financial~~ eligibility conditions in (1) through (5) are met:

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

(2) The ~~individual~~ member meets the Social Security Administration (SSA) ~~test for~~ definition of disability.

(3) The ~~individual~~ member requires a level of care provided in a public or private intermediate care facility for ~~the mentally retarded~~ persons with mental retardation (ICF/MR) and has ~~an IQ score of 75 or below~~ 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.

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

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS

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

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid ~~Home and Community-Based Services (HCBS)~~ Waivers 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 ~~Home and Community-Based Services~~ 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 shall not be construed as a limitation of the rights of class members set forth in the Consent Decree 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 recipient 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) **Program provisions.** Each individual requesting 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 HCBS Waiver services and institutional care.

(d) **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) HCBS Waiver services are available to Oklahoma residents meeting ~~Medicaid~~ 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 be determined financially eligible for ~~Medicaid~~ SoonerCare through the OKDHS Family Support Services Division per OAC 317:35-9-68. The ~~Medicaid~~ 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 ~~ICF/MR~~ Intermediate Care facility for the Mentally Retarded (ICF/MR). The individual may also not be receiving DDSD state-funded services such as the Family Support Assistance Payment, sheltered workshop services, community integrated employment services, or assisted living without waiver supports ~~as described in~~ 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 ~~Waivers~~ Waiver (IHSW), a person must:

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

(ii) be determined to have a disability, with 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, by:

(I) the Social Security Administration; or

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

(iii) be three years of age or older;

(iv) be determined by the ~~Oklahoma Health Care Authority, Level of Care Evaluation Unit,~~ OHCA/LOCEU to meet the ICF/MR Institutional Level of Care requirements ~~in accordance with~~ per OAC 317:30-5-122;

(v) 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) have critical support needs that can be met through a combination of non-paid, non-Waiver, and State Plan 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) 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:

(I) to have mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorder in Persons with Intellectual Disability or a related condition by the ~~Mental Retardation Authority~~ 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) to have a disability, with a diagnosis of mental retardation, by the Social Security Administration or the ~~Oklahoma Health Care Authority, Level of Care Evaluation Unit~~ OHCA/LOCEU; and

(III) to meet the ICF/MR Institutional Level of Care requirements by the ~~Oklahoma Health Care Authority, Level of Care Evaluation Unit~~ OHCA/LOCEU.

(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) of this Section; and

(iii) be determined to:

(I) have mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability or a related condition by ~~the Mental Retardation Authority~~ 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) meet the ICF/MR Institutional Level of Care requirements by the ~~Oklahoma Health Care Authority,~~

~~Level of Care Evaluation Unit~~ 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, current within one year, that includes:

(i) a functional assessment; and

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

(B) a social service summary, current within one year, that includes a developmental history; and

(C) a medical evaluation current within 90 days.

(3) The ~~Oklahoma Health Care Authority~~ 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.

(4) For individuals who are determined to have mental retardation or a related condition by ~~the Mental Retardation Authority~~ 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 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) **Waiting list.** When State DDSD resources are unavailable for new persons to be added to services funded through a ~~Home and Community-Based Services~~ HCBS Waiver, persons are placed on a statewide waiting list for services.

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

(2) The waiting list for persons requesting HCBS Waiver services is administered by DDSD uniformly throughout the state.

(3) An individual is removed from the waiting 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; or

(E) is offered Waiver services through either an ~~In-Home Supports Waiver~~ IHSW or the Community Waiver and declines services.

(f) **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.

(g) **Admission protocol.** Initiation of services funded through a ~~Home and Community-Based Services~~ HCBS Waiver occurs in chronological order from the waiting list in accordance with subsection (e) 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) 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 ~~intermediate care facility for persons with mental retardation (~~ICF/MR~~)~~ or who are children in the State's custody receiving services from OKDHS~~;~~ . ~~or~~ 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 residing in nursing facilities prior to January 1, 1989, 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 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 Waiver.

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

(1) When a ~~child~~ member receiving services funded through the IHSW for children becomes 18 years of age, services ~~under~~ 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 ~~person~~ 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.

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

(4) When ~~an individual~~ 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) **Continued eligibility for HCBS Waiver services.** Eligibility for children receiving HCBS Waiver services is re-determined if a determination of disability due to mental retardation has not been made by the Social Security Administration when~~:~~ the OHCA/LOCEU determines categorical relationship to the SoonerCare program

according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:35-9-5. DDSD may require a new diagnostic evaluation in accordance with paragraph (d)(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)(2) of this Section has been noted.

~~(1) a child who is receiving HCBS Waiver services prior to age six reaches age six. The child must be determined to continue to have a disability with a diagnosis of mental retardation. The determination must be made no later than the first Plan of Care review after the seventh birthday. A new diagnostic evaluation is required in accordance with paragraph (d)(2) of this subsection;~~

~~(2) a child who is receiving HCBS Waiver services reaches age 18. The service recipient must be determined to continue to have a disability with a diagnosis of mental retardation. The determination must be made at the first Plan of Care review after the nineteenth birthday. A new diagnostic evaluation is required in accordance with paragraph (d)(2) of this subsection; and~~

~~(3) required by DDSD. DDSD may require a new diagnostic evaluation in accordance with paragraph (d)(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)(2) of this Section has been noted.~~

(j) **HCBS Waiver services case closure.** HCBS Waiver services are terminated ~~when an individual receiving services~~:

(1) when a member or the ~~service recipient's~~ 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 ~~Oklahoma Health Care Authority Level of Care Evaluation Unit~~ 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) ~~or~~ 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) ~~or~~ 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 service recipient at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective; ~~or~~

(10) when the member is determined to no longer be ~~Medicaid~~ SoonerCare eligible~~.~~ ;

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

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

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

(3) a ~~service recipient~~ 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 ~~service recipient's Medicaid~~ member=s SoonerCare eligibility is re-established within 90 days of the date of ~~the DDSD Notice of Action~~ SoonerCare ineligibility.

SUBCHAPTER 5. MEMBER SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-1. Purpose of Agency Companion Services

~~(a) The Agency Companion Services (ACS) program serves persons with developmental disabilities who are 18 years of age or older.~~

~~(b) Persons under the age of 18 years may be served with approval from the Developmental Disabilities Services Division (DDSD) director or designee.~~

~~(c) Agency Companion services provides an individualized living arrangement with a companion eligible according to OAC 317:40-5-4, that offers up to 24 hour supervision, supportive assistance, and training in daily living skills.~~

317:40-5-3. ~~Scope of agency~~ Agency companion services

(a) Agency companion services (ACS):

(1) are provided by ~~private~~ agencies contracted with the Oklahoma Health Care Authority (OHCA);

(2) ~~are available to members who are eligible for services through the Community Waiver or Homeward Bound Waiver~~ provide a living arrangement developed to meet the specific needs of the member that includes a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(3) ~~are based on the member's need for support as described in the member's Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58~~ are available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under the age of 18 years may be served with approval from the DDSD director or designee;

(4) ~~are provided in a nurturing environment in the member's home, the companion's home, or in a mutually rented or owned home; and~~ are based on the member=s need for residential services per OAC 340:100-5-22 and support as described in the member=s Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58.

~~(5) support visitation desired by the member with his or her natural family and friends, and in accordance with the member's IP.~~

(b) An agency companion:

(1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services

Developmental Disabilities Services Division (DDSD);
(2) ~~is limited to serving as~~ may provide companion services for one member. Exceptions to serve as companion for two members may be ~~granted only upon review and approval~~ approved by the DDSD director or designee~~;~~ . Expections may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;
(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the DDSD director or designee;
(4) may not provide companion services to more than two members at any time;
(5) household may not serve more than three members through any combination of companion or respite services;
~~(3)~~ (6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.
(A) Employment as an agency companion is the companion's primary employment.
~~(B) The companion may have other employment when:~~
~~(i) serving members approved for intermittent or regular levels of support;~~
~~(ii) the Personal Support Team addresses all documented related concerns in the member's IP; and~~
~~(iii) the other employment is approved in advance by the DDSD area manager or designee; and~~
(B) The companion may not have other employment when:
(i) the member(s) require enhanced or pervasive level of support;
(ii) approved to serve two members regardless of the levels of support required by the members.
(C) The companion may have other employment when:
(i) the member requires intermittent or close levels of support;
(ii) the personal support Team documents and addresses all related concerns in the member=s IP; and
(iii) the other employment is approved in advance by the DDSD area manager or designee;
~~(4)~~ (7) approved for other employment may not be employed in another position that requires on-call duties.
(A) If, after receiving approval for other employment, authorized DDSD staff determines the other employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 days:
(i) the other employment; or

(ii) his or her employment as an agency companion.

(B) Homemaker, habilitation training specialist, and respite services are not provided in order for the companion to perform other employment.

(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's salary.

(1) Therapeutic leave:

(A) is a ~~Medicaid~~ SoonerCare payment made to the contract provider to enable the member to retain services; and

(B) is claimed when:

(i) the member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless of whether the companion is present; or

(ii) the companion uses authorized respite time;

(C) is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year; and

(D) cannot be accrued from one Plan of Care year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate which is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the salary that he or she would earn if the member were not on therapeutic leave.

(d) Levels of support for the member and corresponding payment are:

(1) determined by authorized DDSD staff in accordance with levels described in (A) through (D); and

(2) re-evaluated when the member has a change in agency companion providers which includes a change in agencies or individual companion providers.

(A) **Intermittent level of support**. Intermittent level of support is authorized when the member:

(i) requires minimal assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) communicates needs and wants;

(iii) is able to spend short periods of time unsupervised inside and outside the home;

(iv) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities~~, and arranging transportation~~; and

(v) has stable or no ongoing medical or behavioral difficulties.

(B) **~~Regular~~ Close level of support**. ~~Regular~~ Close level of

support is authorized when the member:

(i) requires regular, frequent and sometimes constant assistance and support or is totally dependent on others to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) has difficulty or is unable to communicate basic needs and wants;

(iii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities~~, and arranging transportation~~; and

(iv) requires regular monitoring and assistance with health, medication, or behavior interventions, and may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support**. Enhanced level of support is authorized when the member:

(i) is totally dependent on others for:

(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities~~, and arranging transportation~~;

(ii) demonstrates ongoing complex medical or behavioral issues requiring specialized training courses per OAC 340:100-3-38.3; and

(iii) has medical support needs that are rated at Level 4, 5, or 6 on the Physical Status Review (PSR), per OAC 340:100-5-26. In cases where complex medical needs are not adequately characterized by the PSR, exceptions may be granted only upon review by the DDSD director or designee; or

(iv) requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must ~~be~~:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14; ~~and~~

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, and

(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be

provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system.

The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

317:40-5-5. Agency Companion Services provider responsibilities

(a) Providers of Agency Companion Services (ACS) are required to meet all applicable standards outlined in this subchapter and competency-based training described in OAC 340:100-3-38. The provider agency ensures that all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the service recipient, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, as described in subsection (b) of OAC 340:100-3-27, for the companion, and~~,~~ if warranted, revocation of approval of the companion.

(c) In addition to the criteria given in OAC 317:40-5-4, the companion:

(1) ensures no other adult or child is ~~served~~ cared for in the home on a regular or part-time basis including other Oklahoma Department of Human Services (OKDHS) placements, family members, and friends without prior written authorization from the ~~Oklahoma Department of Human Services'~~ OKDHS Developmental Disabilities Services Division (DDSD) area manager or designee;

(2) meets the requirements of OAC 317:40-5-103, Transportation. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the service recipient to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the service recipient's enhanced independence, self sufficiency, community inclusion, and well-being;

(5) participates as a member of the service recipient's Team and assists in the development of the service recipient's Individual Plan for service provision;

(6) with assistance from the DDSD case manager and the provider

agency program coordination staff, develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Individual Plan;

(A) The companion ~~develops and gives~~ documents and provides monthly data ~~collection~~ and health care summaries to the provider agency program coordination staff.

(B) The agency staff provides monthly reports to the DDSD case manager or nurse.

(7) delivers services at appropriate times as directed in the Individual Plan;

(8) 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);

(9) is sensitive to and assists the service recipient in participating in the service recipient's chosen religious faith. No service recipient is expected to attend any religious service against his or her wishes;

(10) participates in and supports visitation and contact with the service recipient's natural family, guardian, and friends, provided this visitation is desired by the service recipient;

(11) obtains permission from the service recipient's legal guardian, if a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) traveling out of state;

(B) overnight visits; or

(C) involvement of the service recipient in any publicity;

(12) serves as the service recipient's health care coordinator in accordance with OAC 340:100-5-26;

(13) ensures the monthly room and board contribution received from the service recipient as reflected on OKDHS Form DDS-SAB-1, Service Authorization Budget (SAB), is used toward the cost of operating the household;

(14) assists the service recipient ~~to access~~ in accessing entitlement programs for which the service recipient may be eligible and maintains records required for the service recipient's ongoing eligibility;

(15) works closely with the provider agency program coordination staff and the DDSD case manager to ensure all aspects of the service recipient's program are implemented to the satisfaction of the service recipient, the service recipient's family or legal guardian, when appropriate, and the service recipient's Team;

(16) assists the service recipient in achieving the service recipient's maximum level of independence;

(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the

service recipient;
(18) ensures that the service recipient's confidentiality is maintained in accordance with OAC 340:100-3-2;
(19) supports the service recipient in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
(20) implements training and provides supports that enable the service recipient to actively join in community life;
(21) does not serve as representative payee for the service recipient without a written exception approval from the DDSD area manager or designee;
(A) The written approval is retained in the service recipient's home record.
(B) When serving as payee, the companion complies with the requirements of OAC ~~340:100-3-4.1~~ 340:100-3-4.
(22) ensures the service recipient's funds are properly safeguarded.
(23) must obtain prior approval from the provider agency when making a purchase of over $50.00 with the service recipient's funds;
(24) allows the provider agency staff and DDSD staff to make announced and unannounced visits to the home;
(25) develops an Evacuation Plan, OKDHS Form ~~DDS-20~~ 06AC020E, for the home and conducts training with the service recipient;
(26) conducts fire and weather drills at least quarterly and maintains the Fire and Weather Drill Record, OKDHS Form ~~DDS-21~~ 06AC021E, available for review:
(27) develops and maintains a Personal Possession Inventory, OKDHS Form ~~DDS-22~~ 06AC022E, documenting the service recipient's possessions and adaptive equipment;
(28) supports the service recipient's employment program by:
(A) assisting the service recipient to wear appropriate work attire; and
(B) contacting the service recipient's employer only as outlined by the Team and in the Individual Plan; and
(29) follows all applicable rules promulgated by the Oklahoma Health Care Authority or DDSD, including:
(A) OAC 340:100-3-40~~, Community records system~~;
(B) OAC 340:100-5-50 through 100-5-58~~, Individual planning~~;
(C) OAC 340:100-5-26~~, Health services~~;
(D) OAC 340:100-5-34~~, Incident reporting~~;
(E) OAC 340:100-5-32~~, Medication administration~~;
(F) OAC 340:100-5-22.1~~, Community residential supports~~;
(G) OAC 340:100-3-24~~, Quality assurance~~; and
(H) OAC 340:100-3-38~~, Staff training~~.

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.

~~(a)~~ (b) **General information.** ~~Assistive technology (AT) services, also called Adaptive Equipment Services:~~

(1) ~~provide for evaluation,~~ AT devices include the purchase, rental, customization, maintenance, and repair of ~~specialized equipment for eligible persons, contingent on availability of resources;~~ devices, controls, and appliances. AT devices include:

(A) alarms;
(B) telecommunication devices (TDDS);
(C) telephone amplifying devices;
(D) other devices for protection of health and safety of members who are deal 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) enable persons receiving services to:~~
~~(A) perform daily living skills;~~
~~(B) socialize;~~
~~(C) engage in work activities with reduced reliance upon others; or~~
~~(D) promote or maintain health or safety;~~

(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) are supplied in any community setting as specified in the Individual Plan of the person receiving services;~~

~~(4)~~ (3) ~~are justified by professional assessment in accordance with subsection (c) of this Section;~~ 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) ~~require prior authorization; and~~ 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) ~~provide only equipment that~~ 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~~.~~ ; ~~DDSD state funds or funds through a Home and Community-Based Waiver are not used to purchase equipment such as:~~
~~(i) trampolines;~~
~~(ii) hot tubs;~~
~~(iii) bean bag chairs;~~
~~(iv) recliners; and~~
~~(v) computers, except as adapted for individual needs and approved in accordance with this Section;~~
(B) is not otherwise available through ~~Oklahoma's Title XIX State Plan~~ SoonerCare, Department of Rehabilitative Services,

or any other third party or known community resource; ~~and~~

(C) has no less expensive equivalent that meets the ~~person's~~ 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.

~~(b) **Applicability.** The rules in this Section address only equipment that is authorized by the Department of Human Services for purchase, rental, lease, or lease/purchase through a DDSD Home and Community-Based Waiver, or DDSD state funds. If the person receiving services, the family, or guardian desires to purchase assistive technology through other resources, these rules do not apply. The rules in this Section shall not be construed as a limitation of the rights of class members set forth in the Consent Decree in Homeward Bound vs. The Hissom Memorial Center.~~

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

~~(1) Prior to recommending assistive technology devices or services, the prescribing professional completes a decision-making review that provides justification for purchase, repair, rental, or fabrication of an assistive technology device.~~

~~(2)~~ (1) ~~The prescribing professional determines~~ 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.

~~(3)~~ (4) ~~Upon request by DDSD staff, the prescribing professional provides~~ 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.

~~(d)~~ (f) **Team decision-making process.** The ~~individual's~~ member=s Personal Support Team ~~considers the functional outcome to be achieved by the person's use of the proposed assistive technology service or equipment~~ reviews the licensed professional=s assessment and decision making review.

(1) The Team ~~considers~~ ensures the recommended AT ~~services that~~:

(A) ~~are~~ is needed by the ~~person~~ member to achieve a specific, identified functional outcome;

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

(ii) Functional outcomes must be reasonable and necessary given a member=s age ~~appropriate, considering~~ the ~~person's developmental functioning~~ diagnosis and abilities.

(B) ~~improve~~ allows ~~the ability of~~ the ~~person~~ member receiving services to:

(i) improve or maintain health and safety;
(ii) participate in community life;
~~(iii) establish meaningful relationships;~~
~~(iv)~~ (iii) express choices; or
~~(v)~~ (iv) participate in vocational training or employment; ~~or~~
~~(vi) live with dignity;~~

(C) ~~can~~ will be used frequently or in a variety of situations; ~~and~~

(D) ~~can~~ will fit easily into the ~~person's life style~~ member=s lifestyle and work place~~.~~ ;

(E) is specific to the member=s unique needs; and

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

~~(2) The Team recommends the most appropriate assistive technology based on the individual's:~~

~~(A) current situation;~~
~~(B) present needs;~~
~~(C) ability to use the device; and~~
~~(D) outcomes desired.~~

~~(3) When the Team determines that existing equipment no longer meets the needs of the person receiving services, the Team considers a new AT device. In recommending a new AT device, the Team:~~

~~(A) examines the history of other, similar equipment used by the person;~~
~~(B) considers the advantages or disadvantages of renting the device; and~~
~~(C) clearly defines functional outcomes anticipated with the use of the requested device(s).~~

~~(4) The Team documents:~~

~~(A) how the person and caregiver(s) are to be trained in the use of the assistive technology; and~~
~~(B) time frames for Team evaluation after the receipt of assistive technology to determine if the identified outcomes are achieved.~~

(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 game and toys.

~~(e)~~ (i) **Approval or denial of ~~assistive technology~~ AT.** DDSD approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease/purchase of the ~~device or equipment~~ AT is determined ~~in accordance with this subsection~~ per OAC 317:40-5-100.

~~(1) **Standard Assistive Technology List.** Requests for assistive technology that are authorized by the case manager are explained in this paragraph.~~

~~(A) The case manager may authorize requests for:~~

~~(i) devices which are included on the Standard Assistive Technology List, DHS Appendix D-30; or~~

~~(ii) emergency repairs included on DHS Appendix D-30, up to $350.00.~~

~~(B) The case manager contacts the vendor for a price quote for the service or device.~~

~~(C) The case manager provides a letter of authorization to the vendor or to the person receiving services for delivery to the vendor. The case manager keeps a copy of the letter of authorization and sends a copy to DDSD AT staff.~~

~~(D) The letter of authorization includes:~~

~~(i) the list of services or devices;~~

~~(ii) a complete description of each service or device;~~

~~(iii) the catalog number, if applicable;~~

~~(iv) the name and provider number of the vendor;~~

~~(v) the cost of the service(s) or device(s);~~

~~(vi) the authorization (PB) number; and~~

~~(vii) the case manager's signature.~~

~~(E) The AT staff is available for consultation if problems are encountered.~~

~~(2) **Other requests under $2,500.** Assistive technology devices not listed in DHS Appendix D-30 are requested in accordance with this paragraph.~~

~~(A) The case manager sends requests for assistive technology devices or services to the DDSD AT staff for approval or denial if the request is not included in DHS Appendix D-30, but costs less than $2,500.~~

~~(B)~~ (1) ~~The assistive technology request sent by the~~ The DDSD case manager sends the AT request to designated DDSD ~~Area Office~~ area office resource development staff ~~includes~~ with AT experience. The request must include:

~~(i)~~ (A) the licensed professional=s assessment and ~~professional prescription from the designated Team~~

~~professional~~ decision making review;

~~(ii)~~ (B) a copy of the Plan of Care;

~~(iii)~~ (C) documentation of current Team consensus, including consideration of issues ~~stated in subsection (d) of this Section~~ per OAC 317:40-5-100; and

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

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

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

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

~~(iii)~~ (C) the cost effectiveness of the ~~device(s) or service(s)~~ AT, as explained in subsection (a) of this Section.

~~(D)~~ (3) Authorization for purchase or a written denial is provided within ~~10~~ ten working days of receipt of a complete request.

~~(i)~~ (A) If the ~~device(s) or service(s)~~ AT is approved, a letter of authorization~~, as explained in subparagraph (e)(1)(D) of this Section,~~ is issued.

~~(ii) The prescribing professional supplies further information upon request of the designated Area Office staff.~~

~~(iii)~~ (B) If additional ~~information~~ documentation is required ~~in order for~~ by the ~~AT~~ area office resource development staff with AT experience, to authorize the ~~device(s) or service(s)cannot be readily obtained~~ 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.

~~(3) **Requests costing $2,500 or more.**~~ (D) The authorization of ~~device(s) or service(s) costing~~ 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:

~~(A)~~ (i) ~~the AT staff obtains~~ solicits three bids for the ~~service(s) or device(s)~~ AT;

~~(B)~~ (ii) ~~the AT staff~~ submits the AT request, ~~the three~~ bids, and other relevant information to the DDSD State Office AT programs manager within ~~15~~ five working days of

receipt of the ~~complete request from the case manager~~ required bids; and

~~(C)~~ (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.

~~(4)~~ (j) **Approval of vehicle adaptations.** Vehicle adaptations are assessed and approved ~~in accordance with the requirements of this Section~~ per OAC 317:40-5-100. In addition, the requirements in this paragraph must be met.

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

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

~~(C)~~ (3) ~~AT services~~ Vehicle adaptations are ~~used to adapt~~ limited to one vehicle in a ten year period per ~~eligible individual~~ member. ~~Any additional adaptation request within~~ Authorization for more than one vehicle adaptation in a ~~5-year~~ 10-year period must be approved by the DDSD ~~Division Administrator~~ division administrator or designee.

~~(5)~~ (k) **Denial.** Procedures for denial of ~~acquisition of equipment or service(s)~~ an AT device or service are described in this paragraph.

~~(A)~~ (1) The person denying the AT request provides a written denial to the case manager ~~explaining the rationale~~ citing the reason for denial ~~and suggesting alternatives~~ per policy.

~~(B)~~ (2) The case manager ~~provides a verbal explanation and~~ sends the Notice of Action, ~~DHS form DDS-4~~ OKDHS form 06MP004E, to the ~~individual~~ member and his or her family or guardian.

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

~~(6)~~ (l) **Return of an AT device ~~or equipment~~.** 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, ~~decides~~ determines the device is not appropriate, the ~~prescribing~~ licensed professional sends a brief report describing the reason(s) for the change of ~~equipment~~ device recommendation to the DDSD case manager. The case manager forwards the report to the designated ~~Area Office~~ area office resource development staff, who arranges for the return of the equipment to the vendor or manufacturer.

~~(f)~~ (m) **Rental of AT devices.** ~~Assistive technology~~ AT devices are rented when the ~~DDSD area manager or designee~~ licensed professional or area office resource development staff with AT experience determines ~~that the cost of rental is less than the purchase price~~ 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 ~~person receiving service~~ member, unless otherwise stated in advance by the manufacturer or vendor.

(2) ~~Designated DDSD~~ Area ~~Office~~ 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 ~~person's~~ member=s need for the device ~~as described in subparagraph (d)(4)(B) of this Section~~ 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 ~~equipment~~ a device is rented for a trial use period, the Team decides within 90 days whether:

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

(B) to purchase the equipment or return it.

~~(g)~~ (n) **Assistive Technology Committee.** The ~~state-wide assistive technology (~~AT~~)~~ committee reviews equipment requests~~,~~ when ~~asked to do so by DDSD staff~~ 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 ~~DHS~~ 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 ~~DDSD Division Administrator or designee~~ 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..

~~(4) A referral to the AT committee:~~

~~(A) is decided within 10 working days; and~~

~~(B) suspends the time frames given in paragraphs (e)(2) and (e)(3) of this Section.~~

~~(h) **Voluntarily donated equipment.** Equipment acquired in accordance with this Section is the sole property of the person receiving services.~~

~~(1) If the person for whom the equipment was purchased no longer needs the equipment and decides to donate it to another individual, DDSD assists only:~~

~~(A) to identify a recipient; and~~

~~(B) to transfer the equipment from the donor to the recipient.~~

~~(2) The voluntarily donated equipment program is designed to match a donated piece of assistive technology with a person who can utilize and benefit from the equipment, according to the criteria given in subsection (d) of this Section.~~

~~(3) DDSD maintains a written record of equipment that is available for donation.~~

317:40-5-101. Architectural modifications

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

~~(a)~~ (b) **General information.** Architectural ~~modifications are performed by providers who have contractual agreements with the Oklahoma Health Care Authority to provide Home and Community-Based Services (HCBS) to the home of an eligible member with accessibility, behavioral, sensory, or environmental difficulties to enhance the member's independence and safety.~~ Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services;

(2) are performed on homes of eligible members who have disabilities that limit accessibility;

~~(1)~~ (3) ~~Architectural modifications~~ are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid,if applicable, ensuring the quality of materials and workmanship; ~~and~~

(D) ~~availability~~ lack of a less expensive equivalent, such as assistive technology, that meets the member's needs~~.~~ ; and

(E) safety and suitability of the home.

~~(2)~~ (4) ~~Necessary architectural~~ are limited to modifications ~~may be provided for each member for no more than~~ of two different residences within any ~~five~~ seven year period beginning with the member's first request for an approved architectural modification service~~.~~ ;

(5) are provided with assurance of plans for the member to remain in the residence for at least five years;

~~(3)~~ (6) ~~The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD)~~ may be ~~deny~~ denied ~~authorization for architectural modifications services to the home of a member~~ when DDSD determines the home is unsafe or otherwise unsuitable for architectural modifications.

(A) DDSD area office resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.

(B) Members needing home modification services and provider agencies assisting members to locate rental property ~~recommend~~ identify several homes, when possible, for screening in order ~~that~~ to select a home with ~~minimal~~ the fewest or most cost effective modifications ~~may be selected.~~ ;

~~(4)~~ (7) Architectural modifications are provided~~,~~ to eligible members with the homeowner's signed permission~~, to eligible members whether the member's home is rented or owned.~~ ;

~~(5)~~ (8) ~~Only modifications that~~ are specific to the member's unique needs ~~are authorized.~~ ;

~~(6)~~ (9) ~~Architectural modifications~~ are not ~~used~~ authorized to modify homes solely for family or staff convenience or for cosmetic preference~~.~~ ;

~~(7)~~ (10) ~~Modifications~~ are provided on finished rooms complete with wiring and plumbing~~.~~ ;

~~(8)~~ (11) ~~The DDSD director or designee may approve written requests for exceptions to requirements of OAC 317:40-5-1-1 in exceptional circumstances.~~ architectural modifications services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDSD division administrator or designee in exceptional circumstances; and

~~(9)~~ (12) ~~Authorization of architectural modifications complies~~ are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., §85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

~~(b)~~ (c) **Assessment and Team process.**

(1) Architectural modification assessments are performed by:

(A) DDSD area office resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or

(B) a licensed occupational therapist or physical therapist, at the request of designated DDSD area office resource development staff or area program supervisory staff, when the requested architectural modification ~~does not comply with~~ exceeds or requires a variance to applicable national

standards for persons with physical disabilities, ~~as applicable to private homes~~ or when such expertise is deemed necessary by DDSD area office resource development staff or area program supervisory staff.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's ~~present~~ needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) ~~are needed by the member to achieve an activity that is:~~ are necessary to ensure the health, welfare, and safety of the member; and

~~(i) meaningful to the member and requires another person to perform the activity, if the member cannot perform the activity independently, such as self-care, eating, or transfers; and~~

~~(ii) age appropriate, considering the member's level of functioning; and~~

(B) ~~enhance the member's ability to:~~ provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

~~(i) improve or maintain health and safety;~~

~~(ii) participate in community life;~~

~~(iii) establish meaningful relationships;~~

~~(iv) express choices; or~~

~~(v) live with dignity.~~

~~(c)~~ (d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed; ~~and~~

(B) following all applicable building codes~~.~~ ; and

(C) taking and providing pictures to area office resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. Area office resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;
(B) vehicle insurance; and
(C) worker's compensation insurance.

~~(d) **Standards for construction of architectural modifications.** All modifications are made in accordance with local and state housing codes, and permits are the sole responsibility of the contractor.~~

~~(1)~~ (5) All modifications meet ~~the applicable~~ national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

~~(2)~~ (6) Contractors complete construction in compliance with written assessment recommendations ~~and addenda~~ from the:

(A) DDSD area office resource development staff with architectural modification experience~~, when the requested architectural modification complies with applicable national standards for persons with physical disabilities as applicable to private homes~~; or

(B) a licensed professional.

~~(3)~~ (7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

~~(4)~~ (8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) All exterior wooden ramps are constructed of number two pressure treated wood.

(B) Surface of the ramp has a rough, non-skid texture.

(C) Ramps are assembled by the use of deck screws.

(D) Hand rails on ramps, if required, are sanded and smooth.

(E) Ramps can be constructed of stamped steel.

(F) Support legs on ramps are no more than six feet apart.

(G) Posts on ramps must be set or anchored in concrete.

~~(5)~~ (9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that ~~is sloped at least two inches from the outside walls down to the drain, when space permits. When space does not permit, the floor slopes as much as is possible and appropriate~~ slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 ~~to 36~~ inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

~~(6)~~ (10) DDSD area office resource development staff ~~inspects~~

inspect any or all architectural modification work ~~and takes pictures of the final project~~, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that ~~was~~ has been ~~architecturally~~ modified ~~using state or HCBS Waiver funds,~~ and the member will no longer be sharing the home, the member whose Plan of Care ~~includes~~ authorized the modifications is given the first option of remaining in the residence ~~if the roommates no longer wish to share a home~~.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class~~,~~ when a written agreement between the homeowner and DDSD director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDSD director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** ~~Architectural modification services make homes accessible according to the member's specific needs.~~ Architectural modifications do not include construction, reconstruction, or remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) ~~No square~~ Square footage is not added to the home as part of ~~the~~ an architectural modification ~~process~~.

(2) ~~The OKDHS does not authorize payment or provide any architectural modification~~ Architectural modifications are not performed during construction or remodeling of a home ~~that is owned or being built for the member or his or her family~~.

(3) Modifications ~~that are~~ not ~~considered architectural modifications and cannot be~~ authorized by the OKDHS include, but are not limited to:

(A) roofs;

(B) installation of heating or air conditioning units;

(C) humidifiers;

(D) water softener units;

(E) fences;

(F) sun rooms;

(G) porches;

(H) decks;

(I) canopies;

(J) covered walkways;

(K) driveways;

(L) sewer lateral lines or septic tanks;
(M) foundation work;
(N) room additions;
(O) carports;
(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;
(Q) non-adapted home appliances;
(R) carpet or floor covering~~, unless documented as necessary to aid the member in mobility; and~~ that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or
(S) ~~walk-in bathtubs~~ a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless~~:~~ needed by the member to move between the house and vehicle.

~~(A) needed by the member to move between the house and vehicle; and~~
~~(B) authorized by the DDSD director or designee. The DDSD director or designee may consider other sidewalk needs.~~

(g) **Approval or denial of architectural modification ~~requests~~ services.** DDSD approval or denial of ~~the~~ an architectural modification ~~request~~ service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request ~~sent~~ provided by the DDSD case manager to DDSD area office resource development staff includes:
(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;
(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101~~(b)~~; ~~and~~
(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months~~.~~ ; and
(D) an assurance by the member or legal guardian, if applicable, that the member will reside in the residence for five years.

(2) ~~Prior to authorization of architectural modification services, at least three competitive bids are obtained for services costing $750 or more.~~ The DDSD area office:
(A) authorizes architectural modification services ~~up to~~ less than $2500; and
~~(B) is responsible for all required documentation; and~~
~~(C)~~ (B) ~~sends~~ provides all ~~necessary~~ required information to the DDSD State Office architectural modification programs

manager for authorization of services costing $2500 or more.

(3) ~~If the DDSD area office resource development staff, therapist, or Team determines the service is not appropriate, the DDSD area office resource development staff or DDSD State Office programs manager for architectural~~ Architectural modifications ~~provides a brief report describing the reason for the denial to the DDSD case manager~~ may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals**. The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

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

317:40-7-6. Center-Based Services

(a) Center-Based Services are provided in segregated settings, where the majority of people served have a disability. Any employment service provided where a majority of the people at the site are persons with a disability is billed as Center-Based Services.

(b) Center-Based Services are pre-planned, documented activities that relate to the ~~service recipient's~~ member=s identified employment outcomes.

(c) Examples of Center-Based Services are active participation in:

(1) paid contract work which occurs in a workshop or other center-based setting.

(2) Team-prescribed therapy programs such as speech, physical therapy, or switch activation which are implemented by employment provider staff in the workshop or other center-based setting.

(3) unpaid training or paid work experience which occurs in a setting without opportunities for regular daily interactions with co-workers without disabilities or the general public.

(4) computer classes, GED preparation, job club, interviewing skills, or other classes whose participants all have disabilities, even if the location is in the community.

(d) Paid contract work is usually subcontracted, and the persons receiving services earn commensurate wage according to Department of Labor regulations.

(e) For Medicaid reimbursement in Center-Based Services, a ~~service recipient's~~ member=s pay cannot exceed 50% of minimum wage.

(f) Participation in Center-Based Services is limited to 15 hours per week for persons receiving services through the Homeward Bound Waiver, unless approved through the exception process explained in

OAC 317:40-7-21.
(g) Agency must meet physical plan expectations of OAC 340:100-17-13.
(h) During periods in which no paid work is available for members, despite the documented good faith efforts of the provider to secure such work, the employment provider agency ensures that each member participates in training activities that are age appropriate, work related, and consistent with the IP. Such activities may include, but are not limited to:
(1) resume development and application writing;
(2) work attire selection;
(3) job interview training and practice;
(4) job safety and evacuation training;
(5) personal or social skills training; and
(6) stamina and wellness classes.

317:40-7-8. Employment training specialist services

Employment training specialist (ETS) services include evaluation, training, and supportive assistance that allow the member to obtain and engage in remunerative employment. ETS services are:
(1) provided by a certified job coach;
(2) not available when subcontracting;
(3) used to help a member with a new job in a generic employment setting.
(A) ETS services are:
(i) not available if the member held the same job for the same employer in the past;
(ii) available when the member requires 100% on-site intervention for up to the number of hours the member works per week for six weeks per Plan of Care year; and
(iii) used in training members employed in individual placements on new jobs when the:
(I) member receives at least minimum wage; and
(II) employer is not the employment services provider.
(B) If the member does not use all of the training units on the first job placement in the Plan of Care year, the balance of training units may be used on a subsequent job placement with the current provider, or with a new provider;
(4) used in assessment and outcome development for members residing in the community who are new to the provider agency, when determined necessary by the Personal Support Team (Team). The provider:
(A) may claim a documented maximum of 20 hours per member for initial assessment. The projected units for the assessment and outcome development must:
(i) be approved in advance by the Team; and
(ii) relate to the member's desired outcomes; and

(B) cannot claim the same period of time for more than one type of service;

(5) used in Team meetings, when the case manager has requested participation of direct service employment staff in accordance with OAC 340:100-5-52, up to 20 hours per Plan of Care year;

(6) used in job development for a member on an individual job site upon the member's completion of three consecutive months on the job.

(A) Up to 40 hours may be used during a Plan of Care year after documentation of job development activities is submitted to the case manager.

(B) The job must:

(i) pay at least minimum wage;

(ii) employ each member at least 15 hours per week; and

(iii) be provided by an employer who is not the member's contract provider;

(7) used in development of a Plan for Achieving Self-Support (PASS) up to 40 hours per Plan of Care year after documentation of PASS development, if not developed by ~~an Oklahoma Benefit Specialist~~ a Community Work Incentives Coordinator or the Department of Rehabilitation Services, and implementation of an approved PASS after documentation has been submitted to the case manager;

(8) used in development of an Impairment Related Work Expense (IRWE) up to 20 hours per Plan of Care year after documentation of IRWE development, if not developed by ~~an Oklahoma Benefit Specialist~~ a community Work Incentives Coordinator or Oklahoma Department of Rehabilitation, and implementation of an approved IRWE after documentation is submitted to the case manager; and

(9) used in interviewing for a job that is eligible for ETS services.

(10) If the member needs job coach services after expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan. The plan should include the process for fading as the member=s independence increases and progress documented on OKDHS form 06WP066E.

317:40-7-11. Stabilization Services

Stabilization Services are ongoing support services needed to maintain ~~one or two service recipients~~ a member in an integrated competitive employment site. Stabilization Services are provided for up to two years per job. Stabilization Services continue until the next Plan of Care following the end of two years of Stabilization Services. ~~If the service recipient needs job coach services after the expiration of Stabilization Services, Job Coach~~

~~Services may be authorized for the hours necessary to provide direct support to the service recipient or consultation to the employer as described in outcomes and methods in the Individual Plan.~~

(1) Stabilization Services are provided when the job coach intervention time required at the job site is 20% or less of the ~~service recipient's~~ member=s total work hours for four consecutive weeks or when the ~~service recipient~~ member moved from Department of Rehabilitation Services (DRS) services.

(A) If, after the ~~service recipient~~ member moves to Stabilization, the Team determines that support is needed above 20% for longer than two weeks, the Team may revise the ~~service recipient's~~ member=s Plan of Care to reflect the need for Job Coaching Services.

(B) A ~~person~~ member receiving services from DRS moves to services funded by DDSD upon completion of the Job Stabilization milestone. The employment provider agency submits the request for transfer of funding during the Job Stabilization milestone as described in the DRS Supported Employment contract.

(2) Stabilization Services must:

(A) identify the supports needed, including development of natural supports;

(B) specify, in a measurable manner, the services to be provided.

(3) Reimbursement for Stabilization Services is based upon the number of hours the ~~service recipient~~ member is employed at a rate of minimum wage or above.

(4) If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan.

317:40-7-13. Supplemental Supports for Center-Based Services

(a) In those instances when a ~~service recipient~~ member receiving Center-Based Services needs additional supports, the provider assigns staff in patterns that most effectively meet the needs of each ~~service recipient~~ member as indicated by a personal care and/or a risk assessment and defined in the Individual Plan (IP) or Protective Intervention Plan.

(b) If re-arranging staff patterns is not sufficient to meet the ~~service recipient's~~ member=s needs, the provider may file a request and plan for Supplemental Supports utilizing Vocational Habilitation Training Specialist Services. Supplemental Supports can be claimed only if provided by a staff member who has completed all specialized training and individual-specific training prescribed by the Team in accordance with OAC 340:100-3-38.

(c) Supplemental Supports for Center-Based Services include two types of services, behavioral continuous support, and personal care intermittent support.

(1) **Continuous Supplemental Supports.** Continuous Supplemental Supports cannot exceed 15 hours per week for persons receiving services through the Homeward Bound waiver unless specifically approved through the exception process described in OAC 317:40-7-21.

(A) To be eligible for continuous supplemental supports, the ~~service recipient~~ member must have:

(i) a protective intervention plan that:

(I) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(II) has been submitted to the Human Rights Committee (HRC) ~~in accordance with~~ per OAC 340:100-3-6; and

(III) has been approved by the State Behavior Review Committee (SBRC) ~~in accordance with~~ per OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff ~~in accordance with subsection (d) of~~ per OAC 340:100-5-57; or

(ii) procedures included in the protective intervention plan which address dangerous behavior that places the ~~service recipient~~ member or others at risk of serious physical harm. The Team submits documentation of this risk and the procedures to the DDSD positive support field specialist to assure that positive approaches are being used to manage dangerous behavior.

(B) The Team documents discussion of the need for continuous Supplemental Supports.

(2) **Intermittent Supplemental Supports.** To receive personal care intermittent support, a ~~service recipient~~ member must have a personal care need ~~which~~ that requires staffing of at least one-to-one during that time frame when the support is needed.

(A) If a ~~service recipient~~ member needs intermittent personal care support during Center-Based Services, the Team documents discussion of:

(i) the specific support need(s) of the ~~service recipient~~ member, such as staff-assisted repositioning, lifting, transferring, individualized bathroom assistance, or nutritional support; and

~~(ii) the number of staff necessary to provide the support; and~~

~~(iii)~~ (ii) the calculations ~~which~~ that combine the time increments of support to determine the total number of units needed on the Plan of Care.

(B) The case manager sends the documentation to the case management supervisor for approval.

(C) The case management supervisor signs and forwards a copy of the approval, denial, or recommended modifications to the case manager within two working days of receipt.

(D) A ~~service recipient~~ member may receive Center-Based Services and Intermittent Supplemental Supports at the same time.

(d) Supplemental Support for Center-Based Services described in this Section cannot be accessed in Community-Based Services.

(e) Sufficient staff must be available in the center-based facility to provide the supplemental support in order for a provider to claim the units.