DEPARTMENT OF HUMAN SERVICES
Seniors and People with Disabilities

Oregon Administrative Rules
Chapter 411, Division 340

SUPPORT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

EFFECTIVE APRIL 28, 2004

411-340-0010 *(Effective 12/28/03)*
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards, responsibilities, and procedures for Support Service Brokerages, for purchase of individual supports with support service funds, and for providers paid with support services funds to provide services to adults with developmental disabilities so that those adults may live in their own homes or in family homes. Services provided under this rule are intended to identify, strengthen, expand and, where required, supplement private, public, formal and informal support available to these adults so that they may exercise self-determination in the design and direction of their lives.

(2) Statutory authority. These rules are authorized by ORS 409.050 and ORS 410.070, and carry out the provisions of ORS 430.610 through 430.670, 427.005 through 427.007. These rules also carry out the provisions of ORS 417.340 through 417.348 for families of adults with developmental disabilities.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0020 *(Effective 12/28/03)*
Definitions

As used in OAR 411-340-0010 through OAR 411-340-0180:

(1) “Abuse” means:

(a) Except for Provider Organizations listed in OAR 411-340-0020(1)(b), one or more of the following:

(A) Any death caused by other than accidental or natural means or occurring in unusual circumstances;

(B) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(C) Willful infliction of physical pain or injury;

(D) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program and an adult; or

(E) Neglect that leads to physical harm through withholding of services necessary to maintain health and wellbeing.

(b) Activities described in OAR 411-320-0020 (2)(b) through (c)(F) for Provider Organizations qualifying to be paid with support services funds as:

(A) 24-Hour Residential Programs licensed under OAR Chapter 411, Division 325;

(B) Adult Foster Homes licensed under OAR 309-040-0000 through 309-040-0100;

(C) Employment and Alternative to Employment programs certified under OAR Chapter 411, Division 345; or

(D) Supported Living Services certified under OAR 309-041-0550 through 309-041-0830.

(2) “Abuse investigation and protective services” means reporting and investigation activities as required by OAR 309-040-0240 and any subsequent services or supports necessary to prevent further abuse.

(3) “Administration of medication” means the act of a person responsible for the individual's care and employed by or under contract to the individual, the individual’s legal representative, or a provider organization, of placing a medication in, or on, an individual's body.

(4) “Administrator” means the Assistant Director, Department of Human Services, and Administrator of Seniors and People with Disabilities or that person’s designee.

(5) “Adult” means an individual 18 years or older with developmental disabilities.

(6) “Basic Benefit” means the type and amount of Support Services available to each eligible individual, specifically:

(a) Access to Support Service Brokerage services listed in OAR 411-340-0120(1)(a) through (g) and, if required,

(b) Assistance with purchase of supports listed in OAR 411-340-0130(6)(a) through (p) with no more than:

(A) $9600 per Plan Year from July 1, 2001 through June 30, 2003, and thereafter an amount assigned and published by the Department, when an individual is a Medicaid recipient and is eligible for, and has chosen to receive, services available through the Support Services waiver; and

(B) An amount equal to the state’s General Fund contribution to the maximum amount available per Plan Year to a Medicaid recipient per OAR 411-340-0020(6)(b)(A) from July 1, 2001 through June 30, 2003,and thereafter an amount assigned and published by the Department, when an individual is either not eligible for Medicaid or Medicaid waiver services or does not otherwise receive Medicaid benefits.

(7) “Basic Supplement” means the amount of support services funds in excess of the Basic Benefit to which an individual may have access in order to purchase necessary supports based on demonstration of extraordinary long-term need on the Basic Supplement Criteria. A Basic Supplement is subject to limitations outlined in OAR 411-340-0130(4)(a)(A) and (B).

(8) “Basic Supplement Criteria” means the written inventory of an individual’s circumstances which is completed and scored by the Brokerage to determine whether the individual is eligible for annual support service funds in excess of the Basic Benefit due to extraordinary long-term need.

(9) “Certificate” means a document issued by the Department to a Support Services Brokerage or to a Provider Organization that certifies the Brokerage or Provider Organization is eligible to receive State funds for these services.

(10) “Choice” means the individual's expression of preference, opportunity for, and active role in decision-making related to: the selection of assessments, services, service providers, goals and activities, and verification of satisfaction with these services. Choice may be communicated verbally, through sign language, or by other communication method.

(11) “Chore services” mean services needed to maintain a clean, sanitary and safe environment in an individual’s home. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture for safe access and egress. These services are provided when no one in the household is capable of either performing, or paying for, the services and when no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision.

(12) “Client Process Monitoring System” or “CPMS” means the Department’s computerized system for enrolling and terminating services for individuals with developmental disabilities.

(13) “Community Inclusion Supports” means services that may include instruction in skills an individual wishes to acquire, retain or improve that enhance independence, productivity, integration, or maintain the individual’s physical and mental skills. These supports are provided:

(a) For an individual to participate in activities to facilitate independence and promote community inclusion and contribution; and

(b) At any time in community settings of the individual’s choice.

(14) “Community Living Supports” means services provided for the purpose of facilitating independence and promoting community integration by

supporting the individual to gain or maintain skills to live as independently as possible in the type of community-based housing the individual chooses, consistent with the outcome for community living defined in the individual's support plan. The type, frequency, and duration of direct support and other community living support is defined in the plan of care based on the individual's selected housing arrangement and assessed needs. Supports are available to individuals who live alone, with roommates, or with family. The services include support designed to develop or maintain skills required for self-care, directing supports, and caring for the immediate environment such as:

(a) Personal skills, including eating, bathing, dressing, personal hygiene, and mobility;

(b) Socialization, including development or maintenance of self-awareness and self-control, social responsiveness, social amenities, and interpersonal skills;

(c) Community participation, recreation or leisure, including the development or maintenance of skills to use generic community services, facilities, or businesses;

(d) Communication, including development or maintenance of expressive and receptive skills in verbal and non-verbal language and the functional application of acquired reading and writing skills; and

(e) Personal environmental skills including planning and preparing meals, budgeting, laundry, and housecleaning.

(15) "Community Developmental Disability Program" or "CDDP" means an entity that is responsible for planning and delivery of services for persons with mental retardation or other developmental disabilities in a specific geographic area of the state under a contract with the Department or a local mental health authority.

(16) "Comprehensive Services" means a package of developmental disability services and supports that includes one of the following living arrangements regulated by the Department alone or in combination with any associated employment or community inclusion program regulated by the Department:

(a) 24-hour residential services including, but not limited to, care provided in a group home, in a foster home, or through a supported living program; or

(b) Supports provided to an individual in the individual or family home that cost more than $20,000 in funds designated by the Department specifically for that purpose for individuals with developmental disabilities per Plan Year for the July 1, 2001 through June 30, 2003 biennium or more than $20,000 plus any legislatively-approved cost-of-living increments per Plan Year for each biennium thereafter.

(17) "Department" means the Oregon Department of Human Services, Seniors and People with Disabilities, an organizational unit within the Department that focuses on the planning of services, policy development and regulation of programs for persons that have developmental disabilities.

(18) "Developmental Disability" means a disability attributable to mental retardation, autism, cerebral palsy, epilepsy, or other neurological handicapping condition that requires training or support similar to that required by individuals with mental retardation, and the disability:

(a) Originates before the individual attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18; and

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the ability of the person to function in society; or

(d) Results in significant subaverage general intellectual functioning with concurrent deficits in adaptive behavior that are manifested during the developmental period. Individuals of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classifications must be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision. Mental retardation is synonymous with mental deficiency.

(19) “Emergent status” means a temporary, unpredictable situation when an individual enrolled in a Support Service Brokerage may be allowed to receive Department-paid support exceeding $20,000 per year to remain in his or her home or family home or to enter a short-term out-of-home residential placement without exiting Support Services. An individual will only be considered in emergent status if he or she is in jeopardy of losing his or her living situation due to inability or unavailability of the primary caregiver,when no alternative resources are available, and when the CDDP of the individual’s county of residence has determined that the individual meets criteria for crisis or diversion services according to OAR 411-320-0160. Services are provided while an individual is in emergent status to prevent the individual’s civil court commitment under ORS Chapter 427and imminent risk of loss of the individual’s community support system. Services to maintain the individual in the community and stabilize the situation are crisis/diversion services according to OAR 411-320-1060, which may include short-term residential placement services indicated in the individual’s Support Service Brokerage Plan of Care Crisis Addendum, as well as additional support in the individual’s home as described in the Support Services Individual Support Plan. Length of emergent status may only be authorized by the CDDP of the individual’s county of residence, or the Regional Crisis Program responsible for the individual’s county of residence, depending on the source of the crisis/diversion funds. In no case will emergent status for an individual exceed two hundred seventy (270) consecutive days in twelve (12) consecutive months.

(20) “Employer-related supports” means activities that assist individuals and, when applicable, their family members**,** with directing and supervising provision of services described in the Individual Support Plan. Supports to the employer include, but are not limited to: education about employer responsibilities; orientation to basic wage and hour issues; use of common employer-related tools such as job descriptions; and fiscal intermediary services.

(21) “Entry” means admission to a Department-funded developmental disability service provider.

(22) “Environmental Accessibility Adaptations” means physical adaptations that are necessary to ensure the health, welfare, and safety of the individual in the home, or that enable the individual to function with greater independence in the home.

(a) Examples of these services include, but are not limited to: environmental modification consultation to determine the appropriate type of adaptation; installation of shatter-proof windows; hardening of walls or doors; specialized, hardened, waterproof or padded flooring; an alarm system for doors or windows; protective covering for smoke detectors, light fixtures, and appliances; sound and visual monitoring systems; fencing; installation of ramps and grab-bars, installation of electric door openers; adaptation of kitchen cabinets/sinks; widening of doorways; handrails; modification of bathroom facilities; individual room air conditioners for individuals whose temperature sensitivity issues create behaviors or medical conditions that put themselves or others at risk; installation of non-skid surfaces; overhead track systems to assist with lifting or transferring; specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual; modifications to a vehicle to meet the unique needs of the individual (lift, interior alterations such as seats, head and leg rests and belts, special safety harnesses, or other unique modifications to keep the individual safe in the vehicle).

(b) Examples of what these services do not include:

(A) Adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair and central air conditioning; and

(B) Adaptations that add to the total square footage of the home.

(23) "Environmental Modification Consultant" means either an Independent Provider or a Provider Organization paid with support services funds to provide advice to an individual, the individual's legal representative, or the individual's Personal Agent about the environmental accessibility adaptation required to meet the individual's needs.

(24) "Exit" means either termination from a Department-funded program or transfer from one Department-funded program to another. Exit does not mean transfer within a service provider's program.

(25) "Family," for determining individual eligibility for Support Services Brokerage services as a resident in the family home and for determining

who may receive family training, means a unit of two or more persons that includes at least one person with developmental disabilities where the primary caregiver(s) is(are):

(a) Related to the individual with developmental disabilities by blood, marriage, or legal adoption; or

(b) In a domestic relationship where partners share:

(A) A permanent residence;

(B) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(C) Joint responsibility for supporting a member of the household with disabilities related to one of the partners by blood, marriage, or legal adoption.

(26) “Family Training” means training and counseling services for the family of an individual to increase capabilities to care for, support and maintain the individual in the home. This service includes: instruction about treatment regimens and use of equipment specified in the Individual Support Plan; information, education and training about the individual’s disability, medical, and behavioral conditions; and counseling for the family to relieve the stress associated with caring for an individual with disabilities. This service is provided by licensed psychologists, professionals licensed to practice medicine, social workers, counselors, or in organized conferences and workshops that are limited to topics related to the individual’s disability, identified support needs, or specialized medical or habilitative support needs. The training is not provided to paid caregivers.

(27) “Fiscal Intermediary” means a person or agency that receives and distributes Support Services funds on behalf of an individual according to an Individual Support Plan. The fiscal intermediary responsibilities may include activities and records related to payroll and payment of employer-related taxes and fees as an agent of individuals who employ persons to provide care, supervision, or training in the home or community. In this capacity, the fiscal intermediary does not recruit, hire, supervise, evaluate, dismiss or otherwise discipline employees.

(28) “General business provider” means an organization or entity selected by an individual or the individual’s legal representative, and paid with Support Service funds that:

(a) Is primarily in business to provide the service chosen by the individual to the general public;

(b) Provides services for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the persons who actually provide support for the individual.

(29) “Grievance” means a formal complaint by an individual,individual’s legal representative, or a person acting on his/her behalf about services or employees of a Support Service Brokerage or Provider Organization.

(30) “Habilitation services” mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. These services include supported employment, community living supports, and community inclusion supports.

(31) “Home” means an individual’s primary residence that is not licensed or certified by, and under contract with**,** the Department of Human Services as a foster home, residential care facility, assisted living facility, nursing facility, or other residential support program site.

(32) “Homemaker services” means support consisting of general household activities such as meal preparation and routine household care provided by a trained homemaker. The services are provided when the person regularly responsible for these activities as well as caring for an individual in the home is temporarily absent, temporarily unable to manage the home as well as care for self or the individual in the home, or needs to devote additional time to caring for the individual.

(33) “Incident report” means a written report of any injury, accident, act of physical aggression, or unusual incident involving an individual.

(34) "Independence" is defined in ORS 427.005 and means the extent to which persons with mental retardation or developmental disabilities exert control and choice over their own lives.

(35) "Independent Provider" means a person selected by an individual or the individual's legal representative and paid with Support Service funds who personally provides services to the individual.

(36) "Individual" means an adult with developmental disabilities for whom services are planned and provided.

(37) "Individual Support Plan" or "ISP" means the written details of the supports, activities, costs, and resources required for an individual to achieve personal goals. This ISP is developed by the individual, the individual's personal agent, the individual's legal representative (if any), and other persons who have been invited to participate by the individual or individual's legal representative. The ISP articulates decisions and agreements made through a person-centered process of planning and information-gathering. The ISP is the individual's Plan of Care for Medicaid purposes.

(38) "Integration" is defined in ORS 427.005 and means use by persons with mental retardation or other developmental disabilities of the same community resources that are used by and available to other persons and participation in the same community activities in which persons without a disability participate, together with regular contact with persons without a disability. It further means that persons with developmental disabilities live in homes which are in proximity to community resources and foster contact with persons in their community.

(39) "Legal Representative" means an attorney at law who has been retained by or for the adult, or a person or agency authorized by the court to make decisions about services for the individual.

(40) "Local Mental Health Authority" or "LMHA" means the county court or board of county commissioners of one or more counties that operate a community mental health and developmental disability program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health and developmental disability program, the board of directors of a public or private corporation.

(41) “Mandatory Reporter” means any public or private official who, while acting in an official capacity, comes in contact with and has reasonable cause to believe that an individual with disabilities has suffered abuse, or that any person with whom the official comes in contact while acting in an official capacity, has abused the individual with disabilities. Pursuant to ORS 430.765(2) psychiatrists, psychologists, clergy and attorneys are not mandatory reporters with regard to information received through communications that are privileged under ORS 40.225 to 40.295.

(42) “Medication” means any drug, chemical, compound, suspension or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(43) “Nurse” means a person who holds a valid, current license as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) from the Oregon Board of Nursing.

(44) “Nursing Care Plan” means a plan of care developed by a Registered Nurse (RN) that describes the medical, nursing, psychosocial, and other needs of the individual and how those needs will be met. It includes which tasks will be taught, assigned or delegated to the qualified provider or family.

(45) “Occupational Therapy” means the services of a professional licensed under ORS 675.240 that are defined under the approved State Medicaid Plan, except that the amount, duration and scope specified in the State Medicaid Plan do not apply.

(46) ”Personal Agent” means a person who works directly with individuals and families to provide or arrange for the services listed in OAR 411-340-0120(1)(a) through (g), who meets the requirements of OAR 411-340-0150(4)(a) through (b), and who is:

(a) A trained employee of a Support Service Brokerage; or

(b) A person who has been engaged under contract to the Brokerage to allow the Brokerage to meet responsibilities in geographic areas where Personal Agent resources are severely limited.

(47) "Personal Emergency Response Systems" means electronic devices required by certain individuals to secure help in an emergency for safety in the community.

(48) "Person-Centered Planning" means a process, either formal or informal, for gathering and organizing information that helps an individual:

(a) Determine and describe choices about personal goals and lifestyle preferences; and

(b) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources.

(c) The process helps the individual and those significant to the individual to identify, use, and strengthen naturally occurring opportunities for support at home and in the community. Methods for gathering information vary, but all are consistent with individual needs and preferences, ranging from simple interviews with the individual to informal observations in home and community settings to formally structured meetings.

(49) "Physical Therapy" means services provided by a professional licensed under ORS 688.020 that are defined under the approved State Medicaid Plan, except that the amount, duration and scope specified in the State Medicaid Plan do not apply.

(50) "Plan Year" means twelve (12) consecutive months used to calculate an individual's annual Basic Benefit. Unless otherwise set according to conditions of OAR 411-340-0120(4)(h) or OAR 411-340-0130(4)(b)(G), the initial Plan Year begins on the start date specified on the individual's first ISP after enrollment in a Brokerage after that ISP is approved and signed by the CDDP authorizing implementation; subsequent Plan Years begin on the anniversary of the start date of this initial plan.

(51) "Positive Behavioral Theory and Practice" means a proactive approach to individual behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abusive or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(52) "Prescription medication" means any medication that requires a physician prescription before it can be obtained from a pharmacist.

(53) "Primary Caregiver" means the person identified in an individual's ISP as providing the majority of care and support for an individual in the individual's home.

(54) "Productivity" is defined in ORS 427.005 and means engagement in income-producing work by a person with mental retardation or developmental disabilities which is measured through improvements in income level, employment status or job advancement or engagement by a person with mental retardation or developmental disabilities in work contributing to a household or community.

(55) "Provider Organization" means an entity selected by an individual or the individual's legal representative, and paid with Support Service funds that:

(a) Is primarily in business to provide supports for individuals with developmental disabilities;

(b) Provides supports for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the persons who actually provide support for the individual.

(56) "Provider Organization Director" means the employee of a Provider Organization responsible for administration and provision of services according to these rules.

(57) "Psychotropic medication" is defined as a medication whose prescribed intent is to affect or alter thought processes, mood, or behavior. This includes, but is not limited to, anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. Because a medication may have

many different effects, its classification depends upon its stated, intended effect when prescribed.

(58) “Quality Assurance” means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services.

(59) “Respite Care” means short-term care and supervision provided because of the absence, or need for relief of, persons normally providing the care to individuals unable to care for themselves. Respite may be provided in the individual’s or respite provider’s home, a foster home, a group home, a licensed day care center, or a community care facility that is not a private residence. Respite includes two types of care, neither of which can be characterized as 8-hours-a-day, 5-days-a-week services or are provided to allow caregivers to attend school or work:

(a) Temporary Respite Care, which is provided on less than a 24-hour basis, and

(b) 24-Hour Overnight Care, which is provided in segments of 24-hour units that may be sequential.

(60) “Restraint” means any physical hold, device, or chemical substance which restricts, or is meant to restrict, the movement or normal functioning of an individual.

(61) “Self-administration of medication” means the individual manages and takes his/her own medication. It includes identifying his/her medication and the times and methods of administration, placing the medication internally in or externally on his/her own body without staff assistance, upon written order of a physician, and safely maintaining the medication(s) without supervision.

(62) “Self-Determination” means a philosophy and process by which individuals with developmental disabilities are empowered to gain control over the selection of support services that meet their needs. The basic principles of self-determination are:

(a) Freedom—The ability for an individual with a developmental disability, together with freely-chosen family and friends, to plan a life with necessary support services rather than purchasing a predefined program;

(b) Authority—The ability for a persons with a developmental disability (with the help of a social support network if needed) to control a certain sum of resources in order to purchase support services;

(c) Autonomy—The arranging of resources and personnel—both formal and informal—that will assist an individual with a developmental disability to live a life in the community rich in community affiliations; and

(d) Responsibility—The acceptance of a valued role in a person's community through competitive employment, organizational affiliations, personal development, and general caring for others in the community, as well as accountability for spending public dollars in ways that are life-enhancing for persons with developmental disabilities.

(63) "Social Benefit" or "Social Service" means a service solely intended to assist an adult with disabilities to function in society on a level comparable to that of an adult who does not have such disability. Such a benefit or service does not:

(a) Duplicate benefits and services otherwise available to citizens regardless of disability;

(b) Provide financial assistance with food, clothing, shelter, and laundry needs common to persons with or without disabilities; or

(c) Replace other governmental or community services available to an individual. Financial assistance provided as a social benefit or social services does not exceed the actual cost of the support required by an individual and must be either:

(A) Reimbursement for an expense authorized in a previously-approved plan of service; or

(B) An advance payment in anticipation of an expense authorized in a previously negotiated and approved ISP.

(64) "Special Diet" means specially prepared food or particular types of food needed to sustain the individual in the family home. Special diets can

include: high caloric supplements; gluten-free supplements; diabetic, ketogenic or other metabolic supplements. Special diets are ordered by a physician and periodically monitored by a dietician. Special diets are supplements and are not intended to meet an individual's complete daily nutritional requirements. Special diets do not provide or replace the nutritional equivalent of meals and snacks normally required regardless of disability.

(65) "Specialized Medical Equipment and Supplies" mean devices, aids, controls, supplies, or appliances which enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. It does not include items not of direct medical or remedial benefit to the individual. All items meet applicable standards of manufacture, design, and installation.

(66) "Specialized Supports" mean treatment, training, consultation or other unique services necessary to achieve outcomes in the plan of care that are not available through State Medicaid Plan services or other Support Services listed in OAR 411-340-0130(6)(a) through (p). Typical supports include the services of a behavior consultant, a licensed nurse, or a social/sexual consultant to:

(a) Assess the needs of the individual and family, including environmental factors;

(b) Develop a plan of support;

(c) Train caregivers to implement the support plan;

(d) Monitor implementation of plan; and

(e) Revise the plan as needed.

(67) "Speech and Language Therapy services" means the services of a professional licensed under ORS 681.250 that are defined under the approved State Medicaid Plan, except that the amount, duration and scope specified in the State Medicaid Plan do not apply.

(68) “Support” means assistance individuals require--solely because of the effects of disability--to maintain or increase independence, achieve community presence and participation, and improve productivity. This assistance is flexible and subject to change with time and circumstances.

(69) “Supported Employment Services” means provision of job training and supervision available to assist an individual who needs intensive ongoing support to choose, get, and keep a job in a community business setting. Supported employment is a service planned in partnership with public vocational assistance agencies and school districts and through Social Security Work Incentives when available.

(70) “Support Services” means the services of a Support Services Brokerage listed in OAR 411-340-0120(1)(a) through (g) as well as the uniquely determined activities and purchases arranged through the Brokerage. Support Services:

(a) Complement the existing formal and informal supports that exist for an individual living in his or her own home or family home;

(b) Are designed, selected, and managed by the individual or individual’s legal representative;

(c) Are provided in accordance with an ISP; and

(d) May include purchase of supports as a social benefit required for an individual to live in the individual's home or the family home.

(71) “Support Service Brokerage” or “Brokerage” means an entity, or distinct operating unit within an existing entity, that performs the functions listed in OAR 411-340-0120(1)(a) through (g) associated with planning and implementation of Support Services for adults with developmental disabilities, using the principles of self-determination described in OAR 411-340-0020(62).

(72) “Support Service Brokerage Director” or “Brokerage Director” means the employee of a publicly- or privately-operated Support Service Brokerage who is responsible for administration and provision of services according to these rules.

(73) "Support Service Brokerage Plan of Care Crisis Addendum" means the short-term plan that is required by the Department to be added to an individual's ISP to describe crisis/diversion services an individual is to receive while he or she is in emergent status in a short-term residential placement. This short-term plan is coordinated by staff of the CDDP of the individual's county of residence.

(74) "Support Service Brokerage Policy Oversight Group" or "Policy Oversight Group" means the group formed to provide consumer-based leadership and advice to each Support Service Brokerage regarding issues such as development of policy, evaluation of services, and use of resources and which meets the requirements of OAR 411-340-0150(1)(a) through (d) for such groups.

(75) "Support Services Funds" means public funds designated by the Support Services Brokerage for assistance with the purchase of supports according to each ISP.

(76) "Support Specialist" means an employee of a CDDP that performs the essential functions necessary to ensure the proper use of support services resources for individuals served by a Brokerage and described in OAR 411-320-0010 through 411-320-0200.

(77) "Transportation" means services that allow individuals to gain access to community services, activities and resources that are not medical in nature.

(78) "Unusual Incident" means those incidents involving serious illness or accidents, death of an individual, injury or illness of an individual requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, or any incident requiring abuse investigation.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0030 *(Effective 12/28/03)*
Certification of Support Service Brokerages and Provider Organizations

(1) Certificate required. No person or governmental unit acting individually or jointly with any other person or governmental unit may establish, conduct,

maintain, manage or operate a Support Service Brokerage without being certified under these rules. No person or governmental unit acting individually or jointly with any other person or governmental unit may establish, conduct, maintain, or operate a Provider Organization without either certification under these rules or current Department license or certification described in OAR 411-340-0170(1).

(a) Not transferable. Each certificate is issued only for the Support Service Brokerage, or for the Provider Organization requiring certification under OAR 411-340-0170(2), and persons or governmental units named in the application and is not transferable or assignable.

(b) Terms of certificate. Each certificate is issued for a maximum of two years.

(c) Department review. The Department must conduct a review of the Brokerage or Provider Organization requiring certification under OAR 411-340-0170(2) prior to the issuance of a certificate.

(2) A Support Service Brokerage or a Provider Organization requiring certification under OAR 411-340-0170(2) must apply for initial certificate and for certificate renewal.

(a) Form. The application must be on a form provided by the Department and must include all information requested by the Department.

(b) Initial application. The applicant for certification as a Support Services Brokerage must identify the maximum number of individuals to be served.

(c) Renewal application. To renew certification, the Brokerage or Provider Organization requiring certification under OAR 411-340-0170(2) must make application at least 30 days but not more than 120 days prior to the expiration date of the existing certificate. On renewal of Brokerage certification, no increase in the maximum number of individuals to be served by the Brokerage may be certified unless specifically approved by the Department.

(d) Renewal application extends expiration date. Application for renewal must be filed no more than 120 days prior to the expiration date of the

existing certificate and will extend the effective date until the Department or its designee takes action upon such application.

(e) Incomplete or incorrect information. Failure to disclose requested information on the application or provision of incomplete or incorrect information on the application may result in denial, revocation or refusal to renew the certificate.

(f) Demonstrated capability. Prior to issuance or renewal of the certificate the applicant must demonstrate to the satisfaction of the Department that the applicant is capable of providing services identified in a manner consistent with the requirements of these rules.

(3) Certification expiration, termination of operations, certificate return.

(a) Expiration. Unless revoked, suspended or terminated earlier, each certificate to operate a Support Services Brokerage or a Provider Organization requiring certification under OAR 411-340-0170(2) will expire on the expiration date specified on the certificate.

(b) Termination of operation. If operation of a Support Services Brokerage or Provider Organization requiring certification under OAR 411-340-0170(2) is discontinued, the certificate terminates automatically on the date the operation is discontinued.

(4) Change of ownership, legal entity, legal status, management corporation. The Support Service Brokerage or Provider Organization requiring certification under OAR 411-340-0170(2) must notify the Department in writing of any pending action resulting in a 5% or more change in ownership and of any pending change in the Brokerage's or Provider Organization's legal entity, legal status or management corporation.

(5) New certificate required. A new certificate is required upon change in a Support Service Brokerage's or Provider Organization's ownership/legal entity or legal status. The Support Service Brokerage or Provider Organization must submit a certificate application at least 30 days prior to change in ownership/legal entity or legal status.

(6) Certificate denial, revocation, refusal to renew. The Department may deny, revoke or refuse to renew a certificate when it finds the Brokerage or Provider Organization, the Brokerage or Provider Organization director, or

any person holding five percent or greater financial interest in the Brokerage or Provider Organization:

(a) Demonstrates substantial failure to comply with these rules such that the health, safety or welfare of individuals is jeopardized and fails to correct the noncompliance within 30 calendar days of receipt of written notice of non-compliance; or

(b) Has demonstrated a substantial failure to comply with these rules such that the health, safety or welfare of individuals is jeopardized during two inspections within a six year period (for the purpose of this subsection, "inspection" means an on-site review of the service site by the Department for the purpose of investigation or certification); or

(c) Has been convicted of a felony; or

(d) Has been convicted of a misdemeanor associated with the operation of a Brokerage or Provider Organization; or

(e) Falsifies information required by the Department to be maintained or submitted regarding care of individuals, program finances or individuals' funds; or

(f) Has been found to have permitted, aided or abetted any illegal act which has had significant adverse impact on individual health, safety or welfare; or

(g) Has been placed on the current Centers for Medicare and Medicaid Services list of excluded or debarred providers.

(7) Notice of certificate denial, revocation, or refusal to renew. Following a Department finding that there is a substantial failure to comply with these rules such that the health, safety or welfare of individuals is jeopardized, or that one or more of the events listed in section OAR 411-340-0030(6)(a) through (g) has occurred, the Department may issue a notice of certificate revocation, denial or refusal to renew.

(8) Immediate suspension of certificate. In any case where the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the certificate holder, immediately suspend a certificate

without a pre-suspension hearing and the service may not continue operation.

(9) Hearing. Following issuance of a notice of certificate denial, revocation, refusal to renew, or suspension, the Department will provide the opportunity for a hearing pursuant to OAR 411-340-0030(9)(a) through (c).

(a) Hearings rights and administrative review. An applicant for a certificate, or certificate holder, upon written notice from the Department of denial, suspension, revocation or refusal to renew a certificate, may request a hearing pursuant to the Contested Case Provisions of ORS Chapter 183. In addition to, or in lieu of, a contested case hearing, the applicant or certificate holder may request a review by the Department Administrator or designee of denial, suspension, revocation or refusal to renew a certificate. This review does not diminish the right of the applicant or certificate holder to a hearing.

(b) Request for hearing. Upon written notification by the Department of revocation, denial or refusal to renew a certificate, pursuant to OAR 411-340-0030(9)(a), the applicant/certified program will be entitled to a hearing in accordance with ORS Chapter 183 within 60 days of receipt of notice. The request for a hearing must include an admission or denial of each factual matter alleged by the Department and must affirmatively allege a short plain statement of each relevant, affirmative defense the applicant/certified program may have.

(c) Hearing rights under OAR 411-340-0030(8). In the event of a suspension pursuant to OAR 411-340-0030(8) and during the first 30 days after the suspension of a certificate, the certified program will be entitled to an administrative review within 10 days after its written request to the Department for a review regarding certificate suspension. Any review requested after the end of the 30-day period following certificate suspension will be treated as a request for hearing under OAR 411-340-0030(9)(b). If following the administrative review the suspension is upheld, the certified program may request a hearing pursuant to the Contested Case Provisions of ORS Chapter 183.

Stat. Auth.: ORS 409.050 & ORS 410.070

Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0040 *(Effective 12/28/03)*
Abuse and Unusual Incidents in Support Service Brokerages and Provider Organizations

(1) Abuse prohibited. Any adult as defined by OAR 411-340-0020(5) or individual as defined by OAR 411-340-0020(36) will not be abused nor will abuse be condoned by any employee, staff or volunteer of the Brokerage or Provider Organization.

(a) Basic personnel policies and procedures. Support Service Brokerages and Provider Organizations must have in place appropriate and adequate disciplinary policies and procedures to address instances when a staff member has been identified as an alleged perpetrator in an abuse investigation as well as when the allegation of abuse has been substantiated.

(b) Mandatory abuse reporting personnel policies and procedures. Any employee of a Brokerage or Provider Organization is required to report incidents of abuse when the employee comes in contact with and has reasonable cause to believe that an individual has suffered abuse or that any person with whom the employee comes in contact, while acting in an official capacity, has abused the individual. Notification of mandatory reporting status must be made at least annually to all employees on forms provided by the Department. All employees must be provided with a Department-produced card regarding abuse reporting status and abuse reporting.

(2) Unusual Incidents.

(a) Written report. A written report that describes any injury, accident, act of physical aggression or unusual incident involving an individual and a Brokerage or Provider Organization employee must be prepared at the time of the incident and placed in the individual's record. Such description must include:

(A) Conditions prior to or leading to the incident;

(B) A description of the incident;

(C) Staff response at the time; and

(D) Administrative review and follow-up to be taken to prevent recurrence of the injury, accident, physical aggression or unusual incident.

(b) Copies sent to Support Specialist and Brokerage. Copies of all unusual incident reports involving abuse that occurs while an individual is receiving Brokerage or Provider Organization services must be sent to the CDDP Support Specialist. Copies of reports of all unusual incidents that occur while the individual is receiving services from a Provider Organization, must be sent to the individual's Brokerage within five working days of the incident.

(c) Immediate notification of allegations of abuse and abuse investigations. The Brokerage must immediately report to the CDDP, and the Provider Organization must report to the CDDP with notification to the Brokerage, any incident or allegation of abuse falling within the scope of OAR 411-340-0020(1). When the CDDP has initiated an abuse investigation, the CDDP must ensure that either the Support Specialist or the Brokerage also immediately notify the individual's legal guardian or conservator. The parent, next of kin or other significant person may also be notified unless the individual requests the parent, next of kin or other significant person not be notified about the abuse investigation or protective services, or unless notification has been specifically prohibited by law.

(d) Immediate notification. In the case of a serious illness, injury or death of an individual, the Brokerage or Provider Organization must immediately notify:

(A) The individual's legal guardian or conservator, parent, next of kin, designated contact person or other significant person;

(B) The Community Developmental Disability Program; and

(C) In the case of the Provider Organization, the individual's Support Services Brokerage.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0050 *(Effective 12/28/03)*
Inspections and Investigations in Support Service Brokerages and Provider Organizations

(1) Inspections and investigations required. All services covered by this rule must allow the following types of investigations and inspections:

(a) Quality assurance and on-site inspections;

(b) Complaint investigations; and

(c) Abuse investigations.

(2) Inspections and investigations by the Department, CDDP or proper authority. The Department, CDDP, or proper authority will perform all inspections and investigations.

(3) Unannounced. Any inspection or investigation may be unannounced.

(4) Required documentation. All documentation and written reports required by this rule must be:

(a) Open to inspection and investigation by the Department, CDDP or proper authority; and

(b) Submitted to the Department within the time allotted.

(5) Priority of investigation under (1)(c) of this rule. When abuse is alleged or death of an individual has occurred and a law enforcement agency, or the Department or CDDP has determined to initiate an investigation, the Support Services Brokerage or Provider Organization must not conduct an internal investigation without prior authorization from the Department. For the purposes of this section, an internal investigation is defined as conducting interviews of the alleged victim, witness, the alleged perpetrator or any other person who may have knowledge of the facts of the abuse allegation or related circumstances; reviewing evidence relevant to the

abuse allegation, other than the initial report; or any other actions beyond the initial actions of determining:

(a) If there is reasonable cause to believe that abuse has occurred; or

(b) If the alleged victim is in danger or in need of immediate protective services; or

(c) If there is reason to believe that a crime has been committed; or

(d) What, if any, immediate personnel actions will be taken.

(6) The Department or CDDP must conduct investigations as prescribed in OAR 309-040-0200 through 309-040-0290, Abuse Reporting and Protective Services in Community Programs and Community Facilities, and must complete an Abuse Investigation and Protective Services Report according to OAR 309-040-0260(1). The report must include the findings based upon the abuse investigation. "Inconclusive" means that the matter is not resolved, and the available evidence does not support a final decision that there was reasonable cause to believe that abuse occurred or did not occur. "Not substantiated" means that based on the evidence, it was determined that there is reasonable cause to believe that the alleged incident was not in violation of the definitions of abuse and/or attributable to the person(s) alleged to have engaged in such conduct. "Substantiated" means that based on the evidence there is reasonable cause to believe that conduct in violation of the abuse definitions occurred and such conduct is attributable to the persons(s) alleged to have engaged in the conduct.

(7) Upon completion of the abuse investigation by the Department, CDDP, or a law enforcement agency, a service provider may conduct an investigation without further Department approval to determine if any other personnel actions are necessary.

(8) Abuse Investigation and Protective Services Report. Upon completion of the investigation report according to OAR 309-040-0260(1), the sections of the report that are public records and not exempt from disclosure under the public records law must be provided to the appropriate Support Service Brokerage or Provider Organization.

(9) Plan of improvement. A plan of improvement must be submitted to the Department for any noncompliance found during an inspection pursuant to OAR 411-340-0050(1)(a).

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0060 *(Effective 12/28/03)*
Grievances and Appeals in Support Service Brokerages and Provider Organizations

(1) Grievances. Support Services Brokerages and Provider Organizations must develop and implement written policies and procedures regarding individual informal complaints and formal grievances. These policies and procedures must at minimum address:

(a) Informal resolution. These policies and procedures must provide opportunity for an individual or someone acting on behalf of the individual to informally discuss and resolve any allegation that a Brokerage or Provider Organization has taken action which is contrary to law, rule, or policy and that does not meet the criteria for an abuse investigation. Choosing this opportunity must not preclude the individual or someone acting on behalf of the individual to pursue resolution through formal grievance processes;

(b) Receipt of grievances. The policies and procedures must describe how the Brokerage or Provider Organization receives and documents grievances from individual(s) and others acting on the behalf of individuals. If a grievance is associated in any way with abuse, the recipient of the grievance must immediately report the issue to the CDDP and notify the Brokerage Director and, if applicable, the Provider Organization Director;

(c) Investigation of the facts supporting or disproving the grievance;

(d) Taking appropriate actions on grievances within five working days following receipt of grievance;

(e) Review by the Brokerage Director if the grievance involves Brokerage staff or services, or by the Provider Organization Director if the

grievance involves Provider Organization staff or services, if the grievance is not or cannot be resolved with Brokerage or Provider Organization staff, respectively. Such review mustl be completed and a written response to the grievant provided within 15 days following receipt of the grievance; and

(f) Third-party review when grievances are not resolved by the Brokerage Director or Provider Organization Director.

(A) Unless the grievant is a Medicaid recipient who has elected to initiate hearing processes according to OAR 411-340-0060(3), grievances having to do with development of an individual's ISP, services at variance with the type, amount, frequency, or duration specified in an individual's written ISP, or the selection of any provider of service specified in the individual's ISP must be submitted to the CDDP for review.

(i) This review must be completed according to the CDDP dispute resolution policy and a written response must be provided to the grievant within the timelines described in that policy.

(ii) If the grievance remains unresolved after review by the CDDP, it may be submitted to the Department Administrator or designee for review. Such review must be completed and a written response to the grievant provided within 45 days of receipt of the grievant's written request for Department review. The decision of the Department Administrator or designee will be final unless the grievant is a Medicaid recipient who chooses to initiate further hearing according to OAR 411-340-0060(3).

(B) When a grievance does not involve the circumstances of OAR 411-340-0060(1)(f)(A), and the grievant is not a Medicaid recipient electing to initiate hearing processes according to OAR 411-340-0060(3), the grievance may be submitted directly to the Department Administrator or designee for review. Such review must be completed and a written response to the grievant provided within 45 days of receipt of the grievant's

written request for Department review. The decision of the Department Administrator or designee is final.

(g) Documentation of each grievance and its resolution must be filed or noted in the grievant's record. If a grievance resulted in disciplinary action against a staff member, the documentation must include a statement that disciplinary action was taken.

(h) Copies of all grievances to Support Specialist. Copies of the documentation on all grievances must be sent by the Brokerage or Provider Organization to the Support Specialist within 15 working days of initial receipt of the grievance.

(2) Notification. The Brokerage and Provider Organization must inform each individual, or the individual's legal representative, orally and in writing, of the Brokerage or Provider Organization grievance policy and procedures.

(a) The Brokerage and Provide Organization must inform each individual Medicaid recipient, or the individual Medicaid recipient's legal representative, orally and in writing, of the right of a Medicaid recipient to move directly to hearing as per OAR 411-340-0060(3) at any point if the Brokerage, Provider Organization or Department does not address a grievance satisfactorily.

(b) Information must be presented using language, format, and methods of communication appropriate to the individual's needs and abilities.

(3) Denial, termination, suspension, or reduction of services for individual Medicaid recipients.

(a) Each time the Brokerage takes an action to deny, terminate, suspend, or reduce an individual's access to services covered under Medicaid, the Brokerage must notify the individual or the individual's legal representative(s) of the right to a hearing and the method to obtain a hearing. The Brokerage must mail the notice, or personally serve it to the individual or the individual's legal representative(s) ten (10) days or more prior to the effective date of an action.

(A) The Brokerage must use the Oregon Medical Assistance Program (OMAP) form 3030, Notice of Hearing Rights, or comparable Department-approved form for such notification.

(B) This notification requirement will not apply if an action is part of, or fully consistent with, the ISP and the individual, or the individual's legal representative(s), has agreed with the action by signature to the plan.

(b) The individual or the individual's legal representative may appeal a denial of a request for additional or different services only if the request has been made in writing and submitted to the Brokerage. At the time the Brokerage denies a written request for additional or different services, it must notify the appealing party, in writing, of the information specified in section (3)(c) of this rule.

(c) A notice required by sections (3)(a) or (3)(b) of this rule must be served upon the appealing party personally or by certified mail. The notice must state:

(A) What action the Brokerage intends to take;

(B) The reasons for the intended action;

(C) The specific regulations that support, or the change in Federal or State law that requires, the action;

(D) The appealing party's right to a contested case hearing in accordance with OAR Chapter 137, Oregon Attorney General's Model Rules and 42 CFR Part 431, Subpart E;

(E) That the Brokerage's files on the subject of the contested case automatically become part of the contested case record upon default for the purpose of making a prima facie case;

(F) That the actions specified in the notice will take effect by default if the Department representative does not receive a request for a hearing from the party within 45 days from the date that the Brokerage mails the notice of action;

(G) In circumstances of an action based upon a change in law, the circumstances under which a hearing will be granted; and

(H) An explanation of the circumstances under which Brokerage services will be continued if a hearing is requested.

(d) If the individual or the individual's legal representative(s) disagree with a decision or proposed action by the Brokerage, the party may request a contested case hearing. The Department representative must receive the signed form within 45 days after the Brokerage mailed the notice of action.

(e) The individual or the individual's legal representative(s) may request an expedited hearing if he or she feels that there is immediate, serious threat to the individual's life or health should he or she follow the normal timing of the hearing process.

(f) If the individual or individual's legal representative(s) request an administrative hearing before the effective date of the proposed actions and requests that the existing services be continued, the Department must continue the services. The Department will continue the services until whichever of the following occurs first, but in no event must services be continued in excess of ninety days from the date of the individual's (or individual's legal representative's) request for an administrative hearing:

(A) The current authorization expires;

(B) The hearings officer issues a proposed order and the Department renders a final order about the complaint; or

(C) The individual is no longer eligible for Medicaid benefits.

(D) The Department must notify the individual or individual's legal representative(s) that it is continuing the service. The notice must inform the individual or individual's legal representative that, if the hearing is resolved against him or her, the Department may recover the cost of any services continued after the effective date of the continuation notice.

(g) The Department must reinstate services if:

(A) The Department takes an action without providing the required notice and the individual or individual's legal representative requests a hearing;

(B) The Department does not provide the notice in the time required in this rule and the individual or individual's legal representative requests a hearing within ten days of the mailing of the notice of action; or

(C) The post office returns mail directed to the individual or individual's legal representative, but the location of the individual or the individual's legal representative becomes known during the time that the individual is still eligible for services.

(D) The Department must promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the individual, or the Department decides in the individual's favor before the hearing.

(h) The Department representative and the individual or the individual's legal representative(s) may have an informal conference, without the presence of the hearings officer, to discuss any of the matters listed in OAR 137-003-0575, Prehearing Conferences. The informal conference may also be used to:

(A) Provide an opportunity for the Department and the individual or individual's legal representative to settle the matter;

(B) Ensure the individual or individual's legal representative understands the reason for the action that is the subject of the hearing request;

(C) Give the individual or individual's legal representative an opportunity to review the information that is the basis for that action;

(D) Inform the individual or individual's legal representative of the rules that serve as the basis for the contested action;

(E) Give the individual or the individual's legal representative and the Department the chance to correct any misunderstanding of the facts;

(F) Determine if the individual or the individual's legal representative wishes to have any witness subpoenas issued; and

(G) Give the Department an opportunity to review its action or the action of the Brokerage.

(i) The individual or individual's legal representative(s) may, at any time prior to the hearing date, request an additional conference with the Department representative. At his or her discretion, the Department representative may grant such a conference if it will facilitate the hearing process.

(j) The Department may provide to the individual or individual's legal representative the relief sought at any time before the final order is served.

(k) Withdrawals. An individual or the individual's legal representative may withdraw a hearing request at any time. The withdrawal will be effective on the date the Department or the hearings officer receives it. The Department must send a final order confirming the withdrawal to the last known address of the individual or the individual's legal representative. The individual or individual's legal representative may cancel the withdrawal up to the tenth workday following the date such an order is issued.

(l) Proposed and final orders.

(A) In a contested case, the hearings officer must serve a proposed order on the individual and the Department.

(B) If the hearings officer issues a proposed order that is adverse to the individual, the individual or the individual's legal representative may file exceptions to the proposed order to be considered by the Department. The exceptions must be in writing and must reach the Department not later than ten days after service of the proposed order. The individual or the

individual's legal representative may not submit additional evidence after this period unless the Department prior-approves.

(C) After receiving the exceptions, if any, the Department may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Department may issue an amended proposed order.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0070 *(Effective 12/28/03)*
Support Service Brokerage and Provider Organization Personnel Policies and Practices

(1) Personnel files and qualifications records. Brokerages and Provider Organizations must maintain up-to-date written position descriptions for all staff as well as a file available to the Department or CDDP for inspection that includes written documentation of the following for each staff person:

(a) Reference checks and confirmation of qualifications prior to hire;

(b) Written documentation of a criminal record clearance by the Department;

(c) Satisfactory completion of basic orientation, including instructions for mandatory abuse reporting and training specific to developmental disabilities and skills required to carry out assigned work if the employee is to provide direct assistance to individuals;

(d) Written documentation of employee notification of mandatory abuse reporter status;

(e) Written documentation of any substantiated abuse allegations;

(f) Written documentation of any grievances filed against the staff person and the results of the grievance process, including, if any, disciplinary action; and

(g) Legal U.S. worker status.

(2) General staff qualifications. Any employee providing direct assistance to individuals must be at least 18 years of age and capable of performing the duties of the job as described in a current job description signed and dated by the employee.

(3) Drug-Free Workplace. Each Brokerage and Provider Organization regulated by OAR Chapter 411, Division 340 must be a drug-free workplace.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0080 *(Effective 12/28/03)*
Support Service Brokerage and Provider Organization Records

(1) Confidentiality. Brokerage and Provider Organization records of services to individuals must be kept confidential in accordance with ORS 179.505, 45 CFR 205.50, 45 CFR 164.512 Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 HIPAA and any Department administrative rules or policies pertaining to individual service records.

(2) Disclosure and confidentiality. For the purpose of disclosure from individual medical records under these rules, Brokerages and Provider Organizations requiring certification under OAR 411-340-0170 (2) will be considered "providers" as defined in ORS 179.505(1), and ORS 179.505 will be applicable. Access to records by the Department does not require authorization by the individual or family. For the purposes of disclosure from non-medical individual records, all or portions of the information contained in these records may be exempt from public inspection under the personal privacy information exemption to the public records law set forth in ORS 192.502(2).

(3) General financial policies and practices. The Support Service Brokerage or Provider Organization must:

(a) Maintain up-to-date accounting records accurately reflecting all revenue by source, all expenses by object of expense, and all assets, liabilities, and equities, consistent with generally accepted accounting principles.

(b) As a Provider Organization, or as a Brokerage offering services to the general public, establish and revise as needed a fee schedule identifying the cost of each service provided. Billings for Title XIX funds must not exceed the customary charges to private clients for any like item or service charged by the Brokerage or Provider Organization.

(c) Develop and implement written statements of policy and procedure as are necessary and useful to assure compliance with any Department administrative rule pertaining to fraud and embezzlement.

(4) Records retention. Records must be retained in accordance with OAR Chapter 166, Secretary of State, Archives Division. Financial records, supporting documents, statistical records, and all other records (except individual records) must be retained for a minimum of three years after the close of the contract period. Individual records must be kept for a minimum of seven years.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0090 *(Effective 12/28/03)*
Common Standards: Variances

(1) Criteria for a variance. Variances may be granted to a Brokerage or Provider Organization if the Brokerage or Provider Organization lacks the resources needed to implement the standards required in OAR Chapter 411, Division 340 , if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules, or if there are other extenuating circumstances. OAR 411-340-0130, Using Support Services Funds to Purchase Support, and OAR 411-340-0140, Using Support Services Funds for Certain Services Is Prohibited, are specifically excluded

from variance except for individuals transitioning to Brokerage services from Self-Directed Support Services according to 309-041-1850(2)(a)(A) who may seek variance to continue supports arranged and paid through that service for the first 90 calendar days after enrollment in the Brokerage or up to the date of authorization of the initial ISP, whichever is earliest.

(2) Variance application. The Support Service Brokerage or Provider Organization requesting a variance must submit, in writing, an application to the Department that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) If the variance applies to an individual's services, evidence that the variance is consistent with a currently-approved ISP according to OAR 411-340-0120(6).

(3) Department review. The Administrator or designee may approve or deny the request for a variance.

(4) Notification. The Department must notify the Brokerage or the Provider Organization and the CDDP of the decision. This notice must be sent within 45 calendar days of the receipt of the request by the Department with a copy sent to all relevant Department programs or offices .

(5) Appeal. Appeal of the denial of a variance request must be made in writing to the Department Administrator or designee, whose decision is final.

(6) Duration of variance. The Department will determine the duration of the variance.

(7) Written approval. The Brokerage may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0100 *(Effective 12/28/03)*
Eligibility for Support Service Brokerage Services

(1) Non-discrimination. Adults determined eligible according to OAR 411-340-0100(2)(a) through (e) must not be denied Support Service Brokerage services or otherwise discriminated against on the basis of age or diagnostic or disability category. Access to service must also not be restricted due to race, color, creed, national origin, citizenship, income or duration of Oregon residence.

(2) Eligibility. The CDDP of an individual's county of residence may find the individual eligible for a Support Services Brokerage when:

(a) The individual is an Oregon resident who has been determined eligible for Developmental Disability Services by the CDDP;

(b) The individual is an adult living in his or her own home or family home and not receiving other Department-paid in-home or community living support other than State Medicaid Plan services;

(c) The individual is not enrolled in Comprehensive Services;

(d) At the time of initial proposed enrollment in the Brokerage, the individual is not receiving short-term services from the Department because she or he is eligible for, and at imminent risk of, civil commitment under ORS Chapter 427; and

(e) The individual or the individual's legal representative has chosen to use a Support Service Brokerage for assistance with design and management of personal supports.

(3) Concurrent services. Individuals must not be eligible for service by more than one Support Services Brokerage unless the concurrent service:

(a) Is necessary to effect transition from one Support Service Brokerage to another; and

(b) Is part of a collaborative plan between the affected Support Service Brokerages in which services and expenditures are not duplicated.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0110 *(Effective 12/28/03)*
Standards for Support Service Brokerage Entry and Exit

(1) Providing basic information. The Support Services Brokerage must make accurate, up-to-date information about the program available to individuals referred for services. This information must include:

(a) A declaration of program philosophy;

(b) A brief description of the services provided by the program, including typical timelines for activities;

(c) A description of processes involved in using the services, including application and referral, assessment, planning, and evaluation;

(d) A declaration of Support Service Brokerage employee responsibilities as mandatory abuse reporters;

(e) A brief description of individual responsibilities for use of public funds;

(f) An explanation of individual rights, including rights to:

(A) Choose a Brokerage among Department-contracted Brokerages in an individual's county of residence;

(B) Choose a Personal Agent among those available in the selected Brokerage;

(C) Select providers among those qualified according to OAR 411-340-0160, OAR 411-340-0170, and OAR 411-340-0180 to provide supports authorized through the ISP;

(D) Direct the services of support providers; and

(E) Raise and resolve concerns about Brokerage services, including specific rights to notification and hearing for Medicaid recipients according to OAR 411-340-0060(3) when services covered under Medicaid are denied, terminated, suspended, or reduced.

(g) Indication that additional information about the Support Service Brokerage is available on request. That information must include, but is not limited to:

(A) A description of the Support Service Brokerage's organizational structure;

(B) A description of any contractual relationships the Support Service Brokerage has in place or can establish to accomplish the Support Service Brokerage functions required by this rule; and

(C) A description of the relationship between the Support Services Brokerage and its Policy Oversight Group.

(h) The Brokerage must make information required in OAR 411-340-0110(1)(a) through (g) available using language, format, and presentation methods appropriate for effective communication according to individuals' needs and abilities.

(2) Entry into Support Service Brokerage services.

(a) An individual must enter Support Service Brokerage services within 90 calendar days of the date the CDDP has completed processes of eligibility determination, selection of Brokerage, application, and referral except during the period of statewide Support Service Brokerage development July 1, 2001 through June 30, 2005. During that period, and unless the Department has implemented statewide changes in the order of group enrollmentsaccording to OAR 411-340-0110(2)(a)(E), individuals who have been determined eligible, selected the Brokerage, and completed CDDP processes for application and referral to the Brokerage will enter in the following order:

(A) First, individuals living in the Brokerage's area of service and receiving, as of the date the Brokerage is certified to provide services only Self-Directed Support services regulated by 309-041-1110 through 1170 or a combination of Self-Directed Support services and Employment and Alternative to Employment services regulated by OAR Chapter 411, Division 345.

(B) Second, and continuing through June 30, 2005, individuals who are not receiving any Department-funded developmental disability services as of the date the Brokerage is certified to provide services, entering according to priorities and characteristics described in written Department guidelines and in order of date of formal application made during the CDDP referral process;

(C) Third, beginning while enrollment of individuals per OAR 411-340-0110(2)(a)(B) is still in progress and continuing through June 30, 2005, individuals receiving only Employment and Alternative to Employment services regulated by OAR Chapter 411, Division 345 in the Brokerage's area of service as of the date the Brokerage is certified to provide services; and

(D) Fourth, beginning while enrollment of individuals per OAR 411-340-0110(2)(a)(B) and 411-340-0110(2)(a)(C) is still in progress and continuing through June 30, 2005, individuals receiving Semi-Independent Living Services regulated by 309-041-015.

(E) Notwithstanding the order of group enrollments indicated in OAR 411-340-0110(2)(a)(A) through (D), the Department may implement changes in the order of enrollment on a statewide basis when the Department has determined that such changes are prudent and necessary for the continued development and operation of Support Services Brokerages .

(b) The Support Services Brokerage must not accept individuals for entry beyond the total number of individuals specified in its current contract with the Department.

(3) Exit from a Support Services Brokerage. An individual must exit a Support Services Brokerage:

(a) At the written request of the individual or the individual's legal representative to end the service relationship;

(b) No less than thirty (30) days after the Support Service Brokerage has served written notice of intent to terminate services, when the individual either cannot be located or has not responded to repeated attempts by Support Service Brokerage staff to complete plan development and monitoring activities and, further, does not respond to the notice of intent to terminate; or

(c) Whenever the individual's emergent status exceeds two hundred seventy (270) days in twelve (12) consecutive months.

(d) Each Support Service Brokerage must have policies and procedures for notifying the CDDP of an individual's county of residence when that individual plans to exit, or exits, Brokerage services. Notification method, timelines, and content must be based on agreements between the Brokerage and CDDP's of each county in which the Brokerage provides services.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0120 *(Effective 12/28/03)*
Support Service Brokerage Services

(1) Each Support Service Brokerage must provide or arrange for the following services as required to meet individual support needs:

(a) Assistance for individuals to determine needs, plan supports in response to needs, and develop individualized budgets based on available resources;

(b) Assistance for individuals to find and arrange the resources to provide planned supports;

(c) Assistance with development and expansion of community resources required to meet the support needs of individuals served by the Brokerage;

(d) Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct support providers;

(e) Fiscal intermediary activities in the receipt and accounting of Support Service funds on behalf of an individual in addition to making payment with the authorization of the individual;

(f) Employer-related supports, assisting individuals to fulfill roles and obligations as employers of support staff when plans call for such arrangements; and

(g) Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.

(h) Support Service Brokerages must apply the principles of self-determination as defined in OAR 411-340-0020(62) to provision of services required in OAR 411-340-0120(1)(a) through (g).

(2) Person-centered planning process required. A Support Service Brokerage must use a person-centered planning approach to assist individuals to establish outcomes, determine needs, plan for supports, and review and redesign support strategies.

(3) Health and safety issues. The planning process must address basic health and safety needs and supports, including, but not limited to:

(a) Identification of risks, including risk of serious neglect, intimidation, and exploitation;

(b) Informed decisions by the individual or the individual's legal representative regarding the nature of supports or other steps taken to ameliorate any identified risks; and

(c) Education and support to recognize and report abuse.

(4) Written plan required. The Personal Agent must write an initial ISP that is signed by the individual (or the individual's legal representative) and, unless circumstances allow exception under OAR 411-340-0120(4)(h), dated within 90 days of entry into Support Service Brokerage services and at least annually thereafter. When an individual's legal representative must sign the plan, the individual's Personal Agent must also work with the legal representative to inform the individual as completely as possible of the contents of the plan and to obtain, to the degree possible, the individual's agreement to the plan. The plan or attached documents must include:

(a) The individual's name;

(b) A description of the supports required, including the reason the support is necessary;

(c) Projected dates of when specific supports are to begin and end;

(d) Projected costs, with sufficient detail to support estimates;

(e) A list of personal, community, and public resources that are available to the individual and how they will be applied to provide the required supports;

(f) The providers, or when the provider is unknown or is likely to change frequently, the type of provider (i.e. independent provider, provider organization, or general provider) of supports to be purchased with support services funds; and

(g) Schedule of plan reviews.

(h) The schedule of the first new Support Services ISP developed in compliance with OAR 411-340-0120(2) after an individual enters a Brokerage may be adjusted to promote continuity of services one time for any individual entering a Brokerage in certain circumstances. Such an adjustment will interrupt any Plan Year in progress and establish a new Plan Year for the individual beginning on the date the first new ISP is approved and signed by the CDDP authorizing implementation. Circumstances where this adjustment is permitted include:

(A) Transition of individuals receiving Self-Directed Support Services governed by 309-041-1110 through 1170 to Support Services between November 1, 2001, through June 30, 2002. The date of the individual's first ISP after enrollment in a Support Services Brokerage may be adjusted to correspond to the expiration date of the individual's Self-Directed Support Plan in place at the time of transition to the Support Service Brokerage if the Self-Directed Support Plan otherwise meets the requirements of OAR 411-340-0120 (4)(a) through (g), has been approved for implementation by the CDDP Support Specialist prior to or upon the individual's enrollment in the Support Service Brokerage, and does not authorize support services fund expenditures in excess of the average monthly amount available through the Basic Benefit;

(B) Transition of individuals receiving Employment and Alternative to Employment services regulated by OAR Chapter 411, Division 345, without Department-paid residential services, to Support Services July 1, 2003. The date of the individual's first new Support Services ISP after enrollment in the Brokerage may be adjusted to correspond to the expiration date of the individual's ISP in place at the time of transition or to October 1, 2003, whichever is later, when the individual is among those required to transition into Support Services from Employment and Alternative to Employment services July 1, 2003, and when the ISP developed while the individual is still enrolled in Employment and Alternative to Employment services has been approved for implementation by the CDDP Support Specialist prior to or upon the individual's enrollment in the Support Service Brokerage;

(C) Transition of individuals receiving Family Support Services for Children with Developmental Disabilities, regulated by OAR Chapter 411, Division 305, Children's Intensive In-Home Services (CIIS), regulated by OAR Chapter 411, Division 300, or Medically Fragile Children (MFC) Services, regulated by OAR Chapter 309, Division 044, when those individuals are 18 years of age. The date of the individual's first new Support Services ISP after enrollment in the Brokerage may be adjusted to correspond to the expiration date of the individual's annual plan (Child and Family Support Plan (Family Support),

Complete Plan of Care (CIIS), or Comprehensive Plan of Care (MFC)) in place at the time the individual turns 18 years of age when the annual plan developed while the individual is still receiving Family Support, CIIS, or MFC services has been approved for implementation by the CDDP Support Specialist prior to or upon the individual's enrollment in the Support Service Brokerage; or

(D) Transition of individuals receiving other Department-paid services who are required by the Department to transition to Support Services. The date of the individual's first Support Services ISP may be adjusted to correspond to the expiration date of the individual's plan for services which has been developed according to regulations governing Department-paid services the individual receives prior to transition, is current at the time designated by the Department for transition to Support Services, and is approved for implementation by the CDDP Support Specialist prior to or upon the individual's enrollment in the Support Service Brokerage.

(5) Professional or Other Service Plans. When applicable:

(a) A Nursing Care Plan must be attached to the ISP when support services funds are used to purchase care and services requiring the education and training of a licensed professional nurse; and

(b) A Support Services Brokerage Plan of Care Crisis Addendum, or other document prescribed by the Department for use in these circumstances, must be attached when an individual enrolled in a Brokerage:

(A) Has been determined eligible for crisis/diversion services according to OAR 411-320-0160 by the CDDP of the individual's county of residence; and

(B) The individual is in emergent status in a short-term out-of-home residential placement as part of his or her crisis/diversion services

(6) CDDP Support Specialist approval prior to implementation. With the exception of circumstances indicated in 411-340-0120(6)(c), the Support

Services Brokerage must obtain written CDDP Support Specialist approval prior to implementation of:

(a) Initial and annual Individual Support Plans; and

(b) Significant changes in the ISP which include, but are not limited to, changes in the types of support purchased with support services funds and changes in supports which will cause total Plan Year expenses to exceed original estimates by more than 10%, but which do not include changes in the providers chosen to provide direct assistance to the individual.

(c) When immediate, unexpected, and significant change in the type of support purchased with support services funds is necessary outside of the normal hours of CDDP operation and to prevent injury or harm to the individual, the Brokerage may implement the change but must obtain written confirmation within 10 calendar days from the date of the change from the CDDP Specialist indicating that the change was appropriate and, if applicable, that ongoing change in services is approved.

(7) Periodic review of plan and resources. The Personal Agent will conduct and document reviews of plans and resources with the individual and the individual's legal representative as follows:

(a) At least quarterly, review and reconcile receipts and records of purchased supports authorized by the ISP;

(b) At least annually and as major activities or purchases are completed:

(A) Evaluate progress toward achieving the purposes of the plan, assessing and revising goals as needed;

(B) Record final Support Services fund costs;

(C) Note effectiveness of purchases based on Personal Agent observation as well as individual satisfaction; and

(D) Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports.

(8) Transition to another Support Service Brokerage. At the request of an individual enrolled in Brokerage services who has selected another Brokerage, the Support Service Brokerage must collaborate with the receiving Brokerage and the CDDP of the individual's county of residence to effect transition of support services.

(a) If the Department has designated and contracted funds solely for the support of the transitioning individual, the Support Services Brokerage must notify the Department to consider transfer of the funds for the individual to the receiving Support Services Brokerage.

(b) The ISP in place at the time of request for transfer may remain in effect 90 days after enrollment in the new Brokerage while a new plan is negotiated and approved.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0130 ***(Temporary** Effective[]**04/28/2004)***
Using Support Services Funds to Purchase Supports

(1) Approved written plan required. A Support Services Brokerage may use support services funds to assist individuals to purchase supports in accordance with an ISP which:

(a) Identifies supports that are necessary for an individual to live in his or her own home or in the family home;

(b) Specifies cost-effective arrangements for obtaining the required supports, applying public, private, formal, and informal resources available to the eligible individual;

(c) Projects the amount of support services funds, if any, which may be required to purchase the remainder of necessary supports and which are within the Basic Benefit limits, unless authorized for supplement to the Basic Benefit according to OAR 411-340-0130(4)(a) through (e); and

(d) Has been approved for implementation by the CDDP Support Specialist.

(2) Assistance is a social benefit. Goods and services purchased with support services funds on behalf of individuals are provided only as social benefits as defined in OAR 411-340-0020(63).

(3) Limits of financial assistance. Assistance with purchase of individual supports in any Plan Year as defined in OAR 411-340-0020(50) is limited to the Basic Benefit as defined in OAR 411-340-0020(6) unless individual circumstances meet the conditions of the exceptions indicated in OAR 411-340-0130(4)(a) through (e).

(a) Basic Benefit distribution for full Plan Year. Individuals must have access throughout the Plan Year to the total annual amount of support services funds determined necessary to implement an approved ISP, even if there is a delay in implementation of the plan, unless otherwise agreed to in writing by the individual or the individual's legal representative.

(b) Basic Benefit distribution adjustments. The Department may require that annual Basic Benefit amounts be calculated and applied on a monthly basis when an individual's eligibility for Medicaid changes during a Plan Year or when, for any reason, an individual's ISP is developed and written to be in effect for less than twelve months.

(A) In the case of an individual whose Medicaid eligibility changes, the monthly Basic Benefit limit will be one-twelfth of the annual Basic Benefit amount for which the individual would be eligible should the change in Medicaid status remain in effect for twelve calendar months. The monthly Basic Benefit limit will be applied each month for the remainder of the Plan Year in which the individual's change in Medicaid eligibility occurred, from the date the change occurred.

(B) In the case of an individual with an ISP developed for a partial Plan Year, the monthly Basic Benefit limit will be one-twelfth of the annual Basic Benefit amount for which the individual would be eligible should the individual's ISP be in effect for a twelve months. The monthly Basic Benefit limit will be applied each

month during which the ISP of less than 12 months' duration is in effect.

(c) Individual plan costs. Estimates of individual plan costs must be based on written guidelines for costs of frequently used services published and updated periodically by the Department.

(A) Department guidelines notwithstanding, final costs must not exceed local usual and customary charges for these services as evidenced by the Brokerage's own documented survey.

(B) The Support Service Brokerage must establish a process for review and approval of all budgets based on estimates exceeding published guidelines and must monitor the approved individual plans involved for continued cost effectiveness.

(4) Exceptions to Basic Benefit financial limits. Exceptions to the Basic Benefit annual Support Services fund limit may be only as follows:

(a) Extraordinary long-term need. Individuals with extraordinary long-term need as demonstrated by a score of seventy (70) or greater on the Basic Supplement Criteria may have access to more than the Basic Benefit Support Services fund limit in order to purchase necessary supports.

(A) For Medicaid recipients choosing services under the Support Services waiver, the supplement to the Basic Benefit must result in a Plan Year cost which is less than the minimum allowable Plan Year cost for Comprehensive In-Home Support Services in the same biennium; and

(B) For individuals who are not Medicaid recipients choosing services under the Support Services waiver, the supplement to the Basic Benefit must result in a Plan Year cost which is less than the state's General Fund contribution to the minimum allowable Plan Year cost for in-home Comprehensive Services in the same biennium, calculated according to the Medicaid match rate current at the beginning of the Plan Year and adjusted annually to correspond to changes in the Medicaid match rates; and

(C) The Brokerage Director, or a designee from Brokerage management and administration, must administer the Basic Supplement Criteria only after receiving Department-approved training. The Brokerage Director or designee must score Basic Supplement Criteria according to written and verbal instruction received from the Department.

(D) The trained Brokerage Director or designee must administer the Basic Supplement Criteria within 30 calendar days of the written request of the individual or the individual's legal representative.

(E) The Brokerage Director or designee must send written notice of findings regarding eligibility for a supplement to the Basic Benefit to the individual and the individual's legal representative within 45 calendar days of the written request for a supplement. This written notice must include:

(i) An offer for the individual and individual's legal representative to discuss the findings in person with the Director and with the individual's Personal Agent in attendance if desired; and

(ii) A notice of appeal processes under 411-340-0060.

(F) Annual ISP reviews for recipients of the supplement must include a review of circumstances and resources to confirm continued need.

(b) Transfers from Employment and Alternative to Employment, Semi-Independent Living, and Self-Directed Support services according to Department-designated schedule of group enrollments under OAR 411-340-0110(2). Support service fund expenditures for individuals enrolled in these services prior to the designated date of group enrollment in Support Services Brokerages may, for a limited amount of time, exceed the Basic Benefit financial limits. To qualify, individuals must be enrolled in Employment and Alternative to Employment services regulated by OAR Chapter 411, Division 345, enrolled in Semi-Independent Living Services regulated by OAR 309-041-0015 through 0024, or receive Self-Directed Support services regulated by OAR 309-041-1110 through 1170 during the month prior

to enrollment in a Support Services Brokerage and the Department's annual cost of this previous service must exceed the financial assistance available through the Basic Benefit.

(A) Each qualified individual transferring from Employment and Alternative to Employment Services November 1, 2001, through June 30, 2002, may have access to support services funds in an amount equal to the Department's previous cost for the individual in these services, as negotiated according to Department guidelines, for no more than three hundred sixty-five (365) calendar days from date of enrollment in the Support Services Brokerage;

(B) Each qualified individual transferring from Employment and Alternative to Employment Services beginning July 1, 2003, and who does not have any other Department-paid residential support services prior to that date, may have access to support services funds in an amount each month equal to the Department's previous Employment and Alternative to Employment monthly costs for the individual, as negotiated according to Department guidelines:

(i) For three hundred sixty-five (365) days, if he or she is a Medicaid recipient eligible for waiver services; or

(ii) For one hundred eighty (180) days, if he or she is not a Medicaid recipient eligible for waiver services.

(C) Each qualified individual transferring from Semi-Independent Living services may have access to support services funds in an amount equal to the Department's previous cost for the individual in these services, as negotiated according to Department guidelines, for no more than three hundred sixty-five (365) calendar days from date of enrollment in the Support Services Brokerage; and

(D) Each qualified individual transferring from Self-Directed Support services November 1, 2001, through June 30, 2002, may have access to support services funds in an amount equal to financial assistance authorized by his or her current Self-Directed Support Plan for no more than three hundred sixty-five

(365) calendar days from date of enrollment in the Brokerage when the individual is a Medicaid recipient choosing to receive Support Service waiver services and for no more than ninety (90) calendars days from date of enrollment in the Brokerage when the individual is not Medicaid-eligible or does not otherwise receive Medicaid benefits.

(E) Upon individual enrollment in the Brokerage, the Brokerage must fully inform the individual and the individual's legal representative of the time limit for the supplement to the Basic Benefit.

(F) The Support Services Brokerage must complete assessment, identify resources, and develop a new individualized plan and budget during this period with a goal of reducing Support Services fund annual costs to less than or equal to financial assistance available in the Basic Benefit.

(G) At any point during the individual's first year of enrollment in the Brokerage that annual plan costs are successfully reduced to a cost less than or equal to that available in the Basic Benefit, the individual's new Plan Year will begin on the date the revised ISP is authorized for implementation by the individual's CDDP Support Specialist.

(c) Prior-authorized crisis/diversion *[]*services. Individuals who have been assessed as in need of, and meeting criteria for, crisis/diversion services by the CDDP of the individual's county of residence according to OAR 411-320-0160 may receive short-term assistance with purchase of support in excess of the Basic Benefit. Use of crisis/diversion services may only be authorized by the CDDP of the individual's county of residence or by the Regional Crisis Program responsible for the individual's county of residence.

(A) Funds associated with crisis/diversion services may be used to pay the difference in cost between the authorized ISP and budget in place at the time the individual is determined eligible for crisis/diversion services, and the supports authorized by either the CDDP of the individual's county of residence, or the Regional Crisis Program responsible for crisis/diversion services in the individual's county of residence, depending on

the source of crisis/diversion funds, to meet the short-term need.

(B) Although costs for crisis/diversion services may bring the individual's total Plan Year cost temporarily at or above the minimum allowable Plan Year cost of in-home Comprehensive Services in the same biennium, in no case may the individual's costs exceed the state's current ICF/MR daily cost per individual nor may Plan Year expenses at or above the minimum for Comprehensive Services make the individual eligible for Comprehensive Services.

(i) Individuals placed in emergent status due to receiving crisis/diversion services authorized and provided according to OAR 411-320-0160 may remain enrolled in, and receive Support Services from, the Support Service Brokerage while both crisis/diversion services and Support Services are required to stabilize and maintain the individual at home or in the family home. In no case, however, may the individual remain enrolled in the Support Service Brokerage under emergent status for more than 270 consecutive days in any 12-month period.

(ii) The individual's Personal Agent must participate with CDDP or regional crisis/diversion staff in efforts to stabilize supports and return costs to the Basic Benefit or approved supplement levels, documenting reviews of effectiveness at least every ninety (90) days while the individual is receiving crisis/diversion services.

(d) Conversions from other Department-regulated services. Individuals whose source of support funds are, in whole or in part, an individual-specific redirection of funds through Department contract from a Department-regulated residential, work, or day habilitation service to support services funds, or to Comprehensive In-Home Support funds regulated by OAR Chapter 411, Division 330 prior to enrollment in a Support Service Brokerage, may have access to the amount specified in the Department contract as available for the individual's use. This provision is only applicable when each transition is separate and specific to the individual and the services being

converted are not subject to statewide service transitions described in OAR 411-340-0130(4)(b).

(A) Individual Plan Year costs must always be less than the minimum allowable Plan Year cost for in-home Comprehensive Services in the same biennium; and

(B) The Brokerage must review the need for supports and their cost-effectiveness with the individual and, if applicable, the individual's legal representative at least annually, and must make budget reductions when allowed by the ISP.

(e) Funds designated for services to individuals eligible for, and at imminent risk of, civil commitment under ORS 427. Individuals whose support funds were specifically assigned through Department contract to Self-Directed Support Services prior to the date designated by the Department for transfer of the individual from Self-Directed Support services to a Support Service Brokerage may have access to the amount specified in the Department contract as available for the individual's use.

(A) Individual Plan Year costs must always be less than the minimum allowable Plan Year cost for in-home Comprehensive Services in the same biennium; and

(B) The Brokerage must review the need for supports and their cost-effectiveness with the individual and, if applicable, the individual's legal representative at least annually, and must make budget reductions when allowed by the ISP.

(f) Individuals transferring from Department waiver services for the Aged and Adults with Physical Disabilities. Individuals transferring from the Department's Home and Community-Based waiver services for the Aged and Adults with Physical Disabilities who have been determined ineligible for those waiver service funds, in accordance with OAR 411-015-0015 (4) (c) will have limited access to support service funds, as described in OAR 411, Division 340. The amount of support service funds available will be equal to the Department's previous service costs for the individual for no more than three hundred and sixty-five (365) calendar days. The three hundred and sixty-five (365) calendar days begins the date the individual starts

receiving support services exclusively through a Support Service Brokerage.

(5) Amount, method and schedule of payment.

(a) The Brokerage must disburse, or arrange for disbursement of, support services funds to qualified providers on behalf of individuals up to the amount agreed upon in an ISP that has been signed by the individual or the individual's legal representative and approved for implementation by the CDDP Support Specialist. The Brokerage is specifically prohibited from reimbursement of individuals or individuals' families for expenses related to services and from advancing funds to individuals or individuals' families to obtain services.

(b) The method and schedule of payment must be specified in written agreements between Brokerage and the individual or individual's legal representative.

(6) Types of supports purchased. Supports eligible for purchase with support services funds are:

(a) Chore services as defined in OAR 411-340-0020(11);

(b) Community inclusion supports as defined in OAR 411-340-0020(13);

(c) Community living supports as defined in OAR 411-340-0020(14);

(d) Environmental accessibility adaptations as defined in OAR 411-340-0020(22);

(e) Family training as defined in OAR 411-340-0020(26);

(f) Homemaker services as defined in OAR 411-340-0020(32);

(g) Occupational therapy services as defined in OAR 411-340-0020(45);

(h) Personal emergency response systems as defined in OAR 411-340-0020(47);

(i) Physical therapy services as defined in OAR 411-340-0020(49);

(j) Respite care as defined in OAR 411-340-0020(59);

(k) Special diets as defined in OAR 411-340-0020(64);

(l) Specialized medical equipment and supplies as defined in OAR 411-340-0020(65) as well as the following provisions:

(A) When specialized medical equipment and supplies are primarily and customarily used to serve a medical purpose, then purchase, rental, and repair with support services funds must be limited to the types of equipment and supplies permitted under the State Medicaid Plan and, specifically, those that are not excluded under OAR 410-122-0080. Support services funds may be used to purchase more of an item than the number allowed under the State Medicaid Plan after the limits specified in the State Medicaid Plan have been reached, requests for purchases have been denied by Medicaid State Plan or private insurance, and the denial has been upheld in applicable Medicaid contested case hearing or private insurance benefit appeals process; and

(B) Devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase his or her abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which he or she lives, may be purchased with support services funds when the individual's developmental disability otherwise prevents or limits the individual's independence in these areas. Equipment and supplies that can be purchased for this purpose must be of direct benefit to the individual and include:

(i) Adaptive equipment for eating (i.e. utensils, trays, cups, bowls that are specially designed to assist an individual to feed him/herself;

(ii) Adaptive beds;

(iii) Positioning devices;

(iv) Specially designed clothes to meet the unique needs of the individual with the disability, e.g. clothes designed to prevent access by the individual to the stoma, etc.);

(v) Assistive technology items;

(vi) Computer software used by the individual to express needs, control supports, plan and budget supports;

(vii) Augmentative communication devices;

(viii) Environmental adaptations to control lights, heat, stove, etc.; or

(ix) Sensory stimulation equipment and supplies that help an individual calm, provide appropriate activity, or safely channel an obsession (e.g. vestibular swing, weighted blanket, tactile supplies like creams and lotions)

(m) Specialized supports as defined in OAR 411-340-0020(66);

(n) Speech and language therapy services as defined in OAR 411-340-0020(67);

(o) Supported employment as defined in OAR 411-340-0020(69); and

(p) Transportation as defined in OAR 411-340-0020(77).

(7) Conditions of purchase. The Brokerage must arrange for supports purchased with support services funds to be provided:

(a) In settings and under contractual conditions that allow the individual to freely redirect support services funds to purchase supports and services from another qualified provider;

(A) Individuals who choose to combine support services funds to purchase group services must receive written instruction about the limits and conditions of such arrangements;

(B) Combined support services funds cannot be used to purchase existing, or create new, Comprehensive Services;

(C) Individual support expenses must be separately projected, tracked, and expensed, including separate contracts, employment agreements and timekeeping for staff working with more than one individual;

(D) Combined arrangements for community inclusion or supported employment services that result in creation of a provider organization as defined in OAR 411-340-0020(55) must be certified according to OAR Chapter 411, Division 340; and

(E) Combined arrangements for residential supports must include a plan for maintaining an individual at home after the loss of roommates.

(b) In a manner consistent with positive behavioral theory and practice as defined in OAR 411-340-0020(51) and where behavior intervention is not undertaken unless the behavior:

(A) Represents a risk to health and safety of the individual or others;

(B) Is likely to continue to become more serious over time;

(C) Interferes with community participation;

(D) Results in damage to property; or

(E) Interferes with learning, socializing, or vocation.

(c) In accordance with applicable state and federal wage and hour regulations in the case of personal care, training, and supervision;

(d) In accordance with applicable state or local building codes, in the case of environmental accessibility adaptations to the home;

(e) In accordance with the Oregon Board of Nursing Administrative Rules 851 when services involve performance of nursing care or delegation, teaching, and assignment of nursing tasks; and

(f) In accordance with OAR 411-340-0160 through 411-340-0180 governing provider qualifications and responsibilities.

(8) Independent Provider, Provider Organization, General Business Provider agreements and responsibilities. When Support Service funds are used to purchase care, training, supervision or other personal assistance for individuals, the Brokerage must require and document that providers are informed of:

(a) Mandatory responsibility to report suspected abuse as defined in OAR 411-340-0020(1);

(b) Responsibility to immediately notify the person or persons, if any, specified by the individual or individual's legal representative of any injury, illness, accident, or unusual circumstance that occurs when the provider is providing individual care, training, or supervision and which may have a serious effect on the health, safety, physical or emotional well-being, or level of services required;

(c) Limits of payment:

(A) Support Service fund payments for the agreed-upon services are considered full payment and the provider under no circumstances may demand or receive additional payment for these services from the individual, the family, or any other source unless the payment is a financial responsibility (spend-down) of an individual under the Medically Needy Program; and

(B) The provider must bill all third party resources before using Support Service funds unless another arrangement is agreed upon by the Brokerage and described in the ISP;

(d) The provisions of OAR 411-340-0130(9) regarding sanctions that may be imposed on providers; and

(e) The requirement to maintain a drug-free workplace.

(9) Sanctions for Independent Providers, Provider Organizations, and General Business Providers.

(a) Sanction(s) may be imposed on a provider when the Brokerage determines that, at some point after the provider's initial qualification and authorization to provide supports purchased with support services funds, the provider has:

(A) Been convicted of any crime that would have resulted in an unacceptable criminal history check upon hiring or authorization of service;

(B) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(C) Had his/her professional license suspended, revoked, or otherwise limited, or surrendered his/her license;

(D) Failed to safely and adequately provide the services authorized;

(E) Had an allegation of abuse or neglect substantiated against him or her;

(F) Failed to cooperate with any Department or Brokerage investigation, or grant access to or furnish, as requested, records or documentation;

(G) Billed excessive or fraudulent charges or been convicted of fraud;

(H) Made false statement concerning conviction of crime or substantiation of abuse;

(I) Falsified required documentation;

(J) Not adhered to the provisions of OAR 411-340-0130(8) or OAR 411-340-0140; or

(K) Been suspended or terminated as a provider by another agency within the Department.

(b) The following sanctions may be imposed on a provider:

(A) The provider may no longer be paid with support services funds;

(B) The provider may not be allowed to provide services for a specified length of time or until specified conditions for reinstatement are met and approved by the Brokerage or Department, as applicable;

(C) The Brokerage may withhold payments to the provider.

(c) If the Brokerage makes a decision to sanction a provider, the Brokerage must notify the provider by mail of the intent to sanction. The provider may appeal this action within 30 days of the date of the notice. The provider must appeal this action separately from any appeal of audit findings and overpayments.

(d) A provider of Medicaid services may appeal a sanction by requesting an administrative review by the Administrator of the Department or designee.

(e) For an appeal regarding provision of Medicaid services to be valid, written notice of the appeal must be received by the Department within 30 days of the date the sanction notice was mailed to the provider.

(f) At the discretion of the Department, providers who have previously been terminated or suspended by any Department agency may not be authorized as providers of Medicaid services.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0140 *(Effective 12/28/03)*
Using Support Services Funds for Certain Purchases Is Prohibited

Support Service funds must not be used to pay for:

(1) Services, materials, or activities that are illegal;

(2) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 411-340-0020(1);

(3) Services from persons who engage in verbal mistreatment and subject an individual to the use of derogatory names, phrases, profanity, ridicule, harassment, coercion or intimidation by threatening injury or withholding of services or supports;

(4) Services that restrict an individual's freedom of movement by seclusion in a locked room under any condition;

(5) Materials or equipment that have been determined unsafe for the general public by recognized consumer safety agencies;

(6) Individual or family vehicles;

(7) Health and medical costs that the general public normally must pay, including: medications; health insurance co-payments; dental treatments and appliances; medical treatments; dietary supplements including, but not limited to, vitamins and experimental herbal and dietary treatments; treatment supplies not related to nutrition, incontinence, or infection control;

(8) Ambulance services;

(9) Legal fees;

(10) Vacation costs for transportation, food, shelter, and entertainment that would normally be incurred by anyone on vacation, regardless of disability, and are not strictly required by the individual's need for personal assistance in all home and community settings;

(11) Individual care, training, or supervision that has not been arranged according to applicable state and federal wage and hour regulations;

(12) Services, activities, materials, or equipment that are not necessary or cost-effective, do not meet the definition of support as defined in OAR 411-340-0020(68), or do not meet the definition of social benefits as defined in OAR 411-340-0020(63);

(13) Educational services for school-age individuals over the age 18, including professional instruction, formal training and tutoring in communication,

socialization, and academic skills, and post-secondary educational services such as those provided through two- or four-year colleges for individuals of all ages;

(14) Services, activities, materials, or equipment that can be obtained by the individual or family through other available means such as private or public insurance, or other governmental or public services;

(15) Unless under certain conditions and limits specified in rate-setting guidelines published by the Department, employee wages or contractor charges for time or services when the individual is not present or available to receive services, including but not limited to employee paid time off, hourly “no show” charge, and contractor travel and preparation hours;

(16) Services or activities for which the Legislative or Executive Branch of Oregon government has prohibited use of public funds;

(17) Services when there is sufficient evidence to believe that the individual or individual’s representative has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP, refused to accept or delegate record keeping required to use Support Service Brokerage resources, or otherwise knowingly misused public funds associated with Brokerage services.

(18) Services which, in the opinion of the individual’s Personal Agent, are characterized by failure to act/neglect that leads to or is in imminent danger of causing physical injury, through negligent omission, treatment, or maltreatment of an adult, including but not limited to the failure to provide an adult with adequate food, clothing, shelter, medical care, supervision, or through condoning or permitting abuse of an adult by any other person. However, no person may be deemed neglected for the sole reason that he or she voluntarily relies on treatment through prayer alone in lieu of medical treatment.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0150 *(Effective 12/28/03)*
Standards for Support Services Brokerage Administration and Operations

(1) Individual and family leadership. The Brokerage must develop and implement procedures for incorporating the direction, guidance and advice of individuals and family members of individuals in the administration of the organization.

(a) The Support Services Brokerage must establish and utilize a Policy Oversight Group, of which the membership majority must be individuals with developmental disabilities and family members of individuals with developmental disabilities.

(b) Brokerage procedures must be developed and implemented to assure the policy oversight group has the maximum authority that may be legally assigned or delegated over important program operational decisions, including such areas as program policy development, program planning and goal setting, budgeting and resource allocation, selection of key personnel, program evaluation and quality assurance, grievance or appeal resolution.

(c) If the Policy Oversight Group is not also the governing body of the Support Services Brokerage, then the Brokerage must develop and implement a written procedure that describes specific steps of appeal or remediation to resolve conflicts between the Policy Oversight Group and the governing body of the Brokerage***.***

(d) A Policy Oversight Group must develop and implement operating policies and procedures.

(2) Full-Time Brokerage Director required. The Support Services Brokerage must employ a full-time Director who is responsible for daily Brokerage operations in compliance with these rules and has authority to make budget, staffing, policy, and procedural decisions for the Brokerage.

(3) Director qualifications. In addition to general staff qualifications of OAR 411-340-0070(1) through (2)***,*** the Brokerage Director must have a minimum of a bachelor's degree and two years experience, including supervision, in developmental disabilities, social services, mental health or a related field; or six years of experience, including supervision, in the field of developmental disabilities or a social service/mental health field.

(4) Fiscal Intermediary requirements.

(a) Individuals or entities providing fiscal intermediary services must:

(A) Demonstrate a practical understanding of laws, rules and conditions that accompany the use of public resources;

(B) Develop and implement accounting systems that operate effectively on a large scale as well as track individual budgets;

(C) Establish and meet the time lines for payments that meet individuals' needs;

(D) Develop and implement an effective payroll system, including meeting payroll-related tax obligations;

(E) Generate service, management, and statistical information and reports required by the Brokerage Director and Policy Oversight Group to effectively manage the Brokerage and by individuals to effectively manage supports;

(F) Maintain flexibility to adapt to changing circumstances of individuals; and

(G) Provide training and technical assistance to individuals as required and specified in ISPs;

(b) Contractor and employee qualifications. The Support Brokerage must obtain and maintain written evidence that:

(A) Contractors providing fiscal intermediary services have sufficient education, training, or work experience to effectively and efficiently perform all required activities; and

(B) Employees providing fiscal intermediary services have sufficient education, training, or work experience to effectively and efficiently perform all required activities prior to hire or that the Brokerage has provided requisite education, training and experience.

(5) Personal Agent qualifications. Each Personal Agent must have:

(a) An undergraduate degree in a human services field and at least one year experience in the area of developmental disabilities; or

(b) Five years of equivalent training and work experience related to developmental disabilities.

(6) Separation of duties. When a CDDP operates a Brokerage:

(a) Support Specialist and Personal Agent activities, responsibilities, and costs must be clearly separated and delineated in individual files, staff job descriptions, and CDDP financial and service reports; and

(b) The individual's Personal Agent must not also be the individual's Support Specialist.

(7) Personal Agent training. The Brokerage must provide or arrange for Personal Agents to receive training needed to provide or arrange for Brokerage services, including, but not limited to: principles of self-determination, person-centered planning processes, identification and use of alternative support resources, fiscal intermediary functions, basic employer/employee roles and responsibilities, developing new resources, major public health and welfare benefits, constructing and adjusting individualized support budgets, and assisting individuals to judge and improve quality of personal supports.

(8) Individual record requirements. The Brokerage must maintain current, up-to-date records for each individual served and must make these records available on request for Department review: These records must include, at minimum:

(a) Application and eligibility Information received from the referring CDDP;

(b) An easily-accessed summary of basic information, including individual name, family name (if applicable), individual's legal guardian or conservator (if applicable), address, telephone number, date of entry into the program, date of birth, sex, marital status, individual financial resource information, and Plan Year anniversary date;

(c) Documents related to determining eligibility for Brokerage services and the amount of support services funds available to the individual, including Basic Supplement Criteria if applicable.

(d) Records related to receipt and disbursement of funds, including expenditure authorizations, expenditure verification, copies of CPMS expenditure reports, verification that providers meet requirements of OAR 411-340-0160 through 0180;

(e) Documentation, signed by the individual or individual’s legal representative, that the individual or individual’s legal representative has been informed of responsibilities associated with the use of support services funds;

(f) Incident reports;

(g) Assessments used to determine supports required, preferences, and resources;

(h) Individual Support Plan and reviews;

(i) Personal Agent correspondence and notes related to resource development and plan outcomes; and

(j) Information about individual satisfaction with personal supports and the Brokerage services.

(9) Special records requirements for Support Services fund expenditures. The Brokerage must develop and implement written policies and procedures concerning use of support services funds. These policies and procedures must include, but may not be limited to:

(a) Minimum acceptable records of expenditures:

(A) Itemized invoices and receipts to record purchase of any single item which costs $25.00 or more;

(B) A trip log indicating purpose, date, and total miles to verify vehicle mileage reimbursement;

(C) Signed contracts and itemized invoices for any services purchased from independent contractors and professionals; and

(D) Pay records, including timesheets signed by both employee and employer, to record employee services.

(b) Procedures for confirming the receipt, and securing the use of, specialized medical equipment and environmental accessibility adaptations:

(A) When equipment is obtained for the exclusive use of an individual, the Support Services Brokerage must record the purpose, final cost, and date of receipt;

(B) The Brokerage must secure use of equipment or furnishings costing more than $500 through a written agreement between the Brokerage and the individual or individual’s legal representative which specifies the time period the item is to be available to the individual and the responsibilities of all parties should the item be lost, damaged, or sold within that time period;

(C) The Brokerage must ensure that projects for environmental accessibility adaptations involving renovation or new construction in an individual’s home costing $5000 or more per single instance or cumulatively over several modifications:

(i) Are approved by the Department before work begins and before final payment is made;

(ii) Are completed or supervised by a contractor licensed and bonded in the State of Oregon; and

(iii) That steps are taken as prescribed by the Department for protection of the Department's interest through liens or other legally available means; and

(D) The Brokerage must obtain written authorization from the owner of a rental structure before any environmental accessibility adaptations are made to that structure.

(c) Return of purchased goods. Any goods purchased with support services funds that are not used according to an ISP or according to an agreement securing the State's use may be immediately recovered. Failure to furnish written documentation upon written request from the Department, the Oregon Department of Justice Medicaid Fraud Centers for Medicare and Medicaid Services or their authorized representatives immediately or within timeframes specified in the written request may be deemed reason to recover payments or deny further assistance.

(10) Quality Assurance.

(a) The Brokerage Policy Oversight Group must develop a Quality Assurance Plan and review this plan at least twice a year. The plan must include a written statement of values, organizational outcomes, activities, and measures of progress that:

(A) Uses information from a broad range of consumer, advocate, professional and other sources to determine community support needs and preferences;

(B) Involves individuals in ongoing evaluation of the quality of their personal supports; and

(C) Monitors:

(i) Customer satisfaction with the services of the Brokerage and with individual plans in areas such as individual access to supports, sustaining important personal relationships, flexible and unique support strategies, individual choice and control over supports, responsiveness of the Brokerage to changing needs and preferences of individuals; and

(ii) Service outcomes in areas such as achievement of personal goals and effective use of resources.

(b) The Brokerage must participate in statewide evaluation, quality assurance, and regulation activities as directed by the Department.

(11) Brokerage referral to affiliated entities.

(a) When a Brokerage is part of, or otherwise directly affiliated with, an entity that also provides services an individual may purchase with private or support services funds, Brokerage staff must not refer, recommend or otherwise support the individual to utilize this entity to provide services unless:

(A) The Brokerage conducts a review of provider options which demonstrates that the entity's services will be cost-effective and best-suited to provide those services determined by the individual to be the most effective and desirable for meeting needs and circumstances represented in the ISP; and

(B) The entity is freely selected by the individual and is the clear choice by the individual among all available alternatives.

(b) The Brokerage must develop and implement a policy that addresses individual selection of an entity of which the Brokerage is a part or otherwise directly affiliated to provide services purchased with private or support services funds. This policy must address, at minimum:

(A) Disclosure of the relationship between the Brokerage and the potential service provider;

(B) Provision of information about all other potential service providers to the individual without bias;

(C) A process for arriving at the option for selecting the service provider;

(D) Verification of the fact that the service providers were freely chosen among all alternatives;

(E) Collection and review of data on services purchased by individual enrolled in the Brokerage by an entity of which the Brokerage is a part or otherwise directly affiliated; and

(F) Training of Personal Agents and individuals in issues related to selection of service providers.

(12) General operating policies and practices. The Support Services Brokerage must develop and implement such written statements of policy and procedure in addition to those specifically required by this rule as are necessary and useful to enable the agency to accomplish its objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0160 *(Effective 12/28/03)*
Standards for Independent Providers Paid with Support Services Funds

(1) General independent provider qualifications. Each independent provider who is paid as a contractor, a self-employed person, or an employee of the individual or individual's legal representative to provide homemaker, respite, habilitation, transportation, chore, family training, occupational therapy, physical therapy, speech and language, dietician, or specialized supports must:

(a) Be at least 18 years of age;

(b) Have approval to work based on current Department policy and procedures for review of criminal history;

(c) Be legally eligible to work in the United States;

(d) Not be a spouse of the individual;

(e) Demonstrate by background, education, references, skills, and abilities that he or she is capable of safely and adequately performing the tasks specified on the ISP, with such demonstration confirmed in writing by the individual or individual's legal representative and including:

(A) Ability and sufficient education to follow oral and written instructions and keep any records required;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the individual;

(D) Training of a nature and type sufficient to ensure that the provider has knowledge of emergency procedures specific to the individual being cared for;

(f) Hold current, valid, and unrestricted appropriate professional license or certification where care and supervision requires specific professional education, training and skill;

(g) Understand requirements of maintaining confidentiality and safeguarding individual information;

(h) Not be on the current Centers for Medicare and Medicaid Services list of excluded or debarred providers; and

(i) If providing transportation, have a valid driver's license and proof of insurance, as well as other license or certification that may be required under state and local law depending on the nature and scope of the transportation service;

(2) Behavior consultants providing specialized supports must:

(a) Have education, skills, and abilities necessary to provide behavior consultation services, including knowledge and experience in developing plans based on positive behavioral theory and practice;

(b) Have received at least two days of training in the Oregon Intervention Services behavior intervention system, and have a current certificate; and

(c) Submit a resume to the brokerage indicating at least one of the following:

(A) A bachelor’s degree in Special Education, Psychology, Speech and Communication, Occupational Therapy, Recreation, Art or Music Therapy, or a behavioral science field and at least one

year of experience with people with developmental disabilities who present difficult or dangerous behaviors; or

(B) Three years experience with people with developmental disabilities who present difficult or dangerous behaviors and at least one year of that experience must include providing the services of a behavior consultant.

(3) Social/sexual consultants providing specialized supports must:

(a) Have the education, skills, and abilities necessary to provide social/sexual consultation services; and

(b) Submit a resume to the Brokerage indicating at least one of the following:

(A) A bachelor's degree in Special Education, Psychology, Social Work, Counseling or other behavioral science field and at least one year of experience with people with developmental disabilities; or

(B) Three years experience with people with developmental disabilities who present social or sexual issues and at least one year of that experience must include providing the services of a social/sexual consultant.

(4) Nursing consultants providing specialized supports must:

(a) Have a current Oregon nursing license; and

(b) Submit a resume to the Brokerage indicating the education, skills, and abilities necessary to provide nursing services in accordance with State Law, including at least one year of experience with people with developmental disabilities.

(5) Environmental modification consultants must be licensed general contractors and have experience evaluating homes, assessing the needs of the individual and developing cost-effective plans that will make the home safe and accessible for the individual.

(6) Environmental accessibility adaptation providers must be building contractors licensed as applicable under either OAR Chapter 812, Construction Contractor's Board, or OAR Chapter 808, Landscape Contractors.

(7) Providers of family training must be:

(a) Psychologists licensed under ORS 675.030;

(b) Social workers licensed under ORS 675.530;

(c) Counselors licensed under ORS 675.715; or

(d) Medical professionals licensed under ORS 677.100.

(8) Dieticians providing specialized diets must be licensed according to ORS 691.415 through 691.465.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0170 *(Effective 12/28/03)*
Standards for Provider Organizations Paid with Support Services Funds

(1) Provider Organizations with current license or certification. A provider organization's license under OAR Chapter 411, Division 325 for 24-Hour Residential Programs or OAR 309-040-0000 through 309-040-0100 for Adult Foster Homes or certified under OAR Chapter 411, Division 345, Employment and Alternative to Employment Services, or OAR 309-041-0550 through 309-041-0830, Supported Living Services, may not require additional certification as an organization to provide respite, supported employment, community living, community inclusion, or emergent services.

(a) Current license or certification may be considered sufficient demonstration of ability to:

(A) Recruit, hire, supervise, train qualified staff;

(B) Provide services according to Individual Support Plans; and

(C) Develop and implement operating policies and procedures required for managing an organization and delivering services, including provisions for safeguarding individuals receiving services.

(b) Provider organizations must assure that all individuals directed by the provider organization as employees, contractors, or volunteers to provide services paid for with support services funds meet standards for qualification of independent providers outlined in OAR 411-340-0160.

(c) Provider Organizations developing new sites, owned or leased by the Provider Organization, that are not reviewed as a condition of the current license or certification and where individuals are regularly present and receiving services purchased with support services funds, must meet the conditions of OAR 411-340-0170(2)(f) in each such site.

(2) Provider Organizations requiring certification under OAR Chapter 411, Division 340. A Provider Organization without current license under OAR Chapter 411, Division 325 for 24-Hour Residential Programs or OAR 309-040-0000 through 309-040-0100 for Adult Foster Homes or current certification under OAR Chapter 411, Division 345, Employment and Alternative to Employment, or OAR 309-041-0550 through 309-041-0830, Support Living Services, must be certified as a provider organization according to these rules prior to selection for providing services listed in OAR 411-340-0130(6)(a) through (p) and paid for with support services funds.

(a) Basic policies and procedures required. The provider organization must develop and implement policies and procedures required for administration and operation in compliance with these rules, including, but not limited to:

(A) Policies and procedures required in OAR 411-340-0040 through OAR 411-340-0090 related to abuse and unusual incidents, inspections and investigations, grievances and appeals, personnel policies and practices, records, and variances.

(B) Individual rights. The program must have and implement written policies and procedures which:

(i) Provide for individual participation in selection, training, and evaluation of staff assigned to provide the individual's services;

(ii) Protect individuals during hours of service from financial exploitation which may include, but is not limited to: staff borrowing from or loaning money to individuals; witnessing wills in which the staff or provider organization is beneficiary; or adding the staff member or provider organization name to the individual's bank account(s) or other personal property without approval of the individual or individual's legal representative; and

(C) Policies and procedures appropriate to scope of service, including but not limited to those required to meet minimum standards set forth in (OAR) 411-340-0170(2) (f) through (k) and consistent with written service agreements for individuals currently receiving services.

(b) Written service agreement. The provider organization must develop a written service agreement with the individual or individual's legal representative and must deliver services according to that agreement. The written service agreement must be consistent with the individual's ISP and must describe at minimum:

(A) Type of service to be provided;

(B) Hours, rates, location of services, and expected outcomes of services; and

(C) Any specific individual health, safety and emergency procedures that may be required, including action to be taken if an individual is unable to provide for his or her own safety and is missing while in the community under the care of the provider agency.

(c) Individual Records. The program must maintain a current record for each individual receiving services. The record must include:

(A) The individual's name, current home address, and home phone number;

(B) Current written service agreement, signed and dated by the individual or individual’s legal representative;

(C) Contact information for the legal representative and any other persons designated by the individual or individual’s representative to be contacted in case of incident or emergency;

(D) Contact information for the Support Services Brokerage assisting the individual to obtain services; and

(E) Records of service provided, including type of services, dates, hours, and personnel involved.

(d) Staff, contractors, or volunteers who provide services to individuals must meet independent provider qualifications in OAR 411-340-0160. Additionally, those staff, contractors or volunteers must have:

(A) Current CPR and first aid certification, obtained from a recognized training agency prior to working alone with an individual; and

(B) Written documentation of a TB test within two weeks of being engaged by the provider organization to provide services.

(e) General training requirements. The provider organization must ensure that employees, contractors, and volunteers receive training appropriate to scope of the provider organization’s services.

(f) Additional standards for services provided in provider organization owned or leased site. Provider organizations that own or lease sites, provide services to individuals at those sites, and regularly have individuals present and receiving services at those sites must meet the following minimum requirements:

(A) Written Plan. A written emergency plan must be developed and implemented and must include instructions for staff and

volunteers in the event of fire, explosion, accident, or other emergency including evacuation of individuals served.

(B) Posting of emergency information.

(i) The telephone numbers of the local fire, police department and ambulance service, or "911" service where available, must be posted by designated telephone(s); and

(ii) The telephone numbers of the Provider Organization Director, and other persons to be contacted in case of emergency must be posted by designated telephone(s).

(C) Quarterly safety review. A documented safety review must be conducted quarterly to ensure that the service site is free of hazards. These reports must be kept in a central location by the Provider Organization for three years.

(D) Emergency evacuations. The support agency must train all individuals when they begin attending the service site to leave the site in response to an alarm or other emergency signal and to cooperate with assistance to exit the site.

(i) Each support agency must conduct an unannounced evacuation drill each month when individuals are present;

(ii) Exit routes must vary based on the location of a simulated fire.

(iii) Any individual failing to evacuate the service site unassisted within the established time limits set by the local fire authority for the site must be provided specialized training or support in evacuation procedures.

(iv) Written documentation must be made at the time of the drill and kept by the support agency for at least two years following the drill. It must include:

(I) The date and time of the drill;

(II) The location of the simulated fire;

(III) The last names of all individuals and staff present at the time of the drill;

(IV) The amount of time required by each individual to evacuate if the individual needs more than the established time limit; and

(V) The signature of the staff conducting the drill.

(v) In sites providing services to individuals who are medically fragile or have severe physical limitations, requirements of evacuation drill conduct may be modified. The modified plan must:

(I) Be developed with the local fire authority, the individual or individual's legal representative, and the provider organization director; and

(II) Be presented as a variance request per OAR 411-340-0090.

(E) Adaptations required for sensory or physically impaired. The support agency must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(F) Health and safety inspections. The provider organization must assure that at least once every three years health and safety inspection(s) are conducted.

(i) The inspection(s) must cover all areas and buildings where services are delivered to individuals, administrative offices and storage areas.

(ii) The inspection(s) must be performed by: the Oregon Occupational Safety and Health Department; the service's worker's compensation insurance carrier; or an appropriate expert such as a licensed safety engineer or consultant as approved by the Department; and the Oregon Health Department, when necessary.

(iii) The inspection(s) must cover:

(I) Hazardous material handling and storage;

(II) Machinery and equipment used by the service;

(III) Safety equipment;

(IV) Physical environment; and

(V) Food handling, when necessary.

(iv) The documented results of the inspection, including recommended modifications or changes, and documentation of any resulting action taken must be kept by the provider for five years.

(G) Fire and Life Safety Inspections for Owned, Leased, or Rented Buildings and Property. The service provider must ensure that each service site has received initial fire and life safety inspections performed by the local fire authority or a Deputy State Fire Marshal. The documented results of the inspection, including documentation of recommended modifications or changes, and documentation of any resulting action taken, must be kept by the provider for five years.

(H) Staffing requirements.

(i) Direct service staff must be present in sufficient number to meet health, safety, and service needs specified in the individual written agreements of the individuals present.

(ii) When individuals are present, staff must have the following minimum skills and training:

(I) At least one staff member on duty with CPR certification at all times;

(II) At least one staff member on duty with current First Aid certification at all times;

(III) At least one staff member on duty with training to meet other specific medical need(s) identified in the individual service agreement; and

(IV) At least one staff member on duty with training to meet other specific behavior intervention need(s) as identified in individual service agreements.

(g) Additional standards for assisting individuals with health and medical needs. Provider organizations providing services to individuals that involve assistance with meeting health and medical needs must:

(A) Develop and implement written policies and procedures addressing: emergency medical intervention; treatment and documentation of illness and health care concerns; administering, storing and disposing of prescription and non-prescription drugs including self administration, emergency medical procedures including the handling of bodily fluids, and confidentiality of medical records;

(B) Maintain a current written record for each individual receiving assistance with meeting health and medical needs that includes: health status; changes in health status observed during hours of service; any remedial and corrective action required and when such actions were taken if occurring during hours of service; and a description of any restrictions on activities due to medical limitations;

(C) If providing medication administration when the individual is unable to self-administer medications and there is no other responsible person present who can lawfully direct administration of medications, the provider organization must:

(i) Have a written order or copy of the written order, signed by a physician or physician designee, before any medication, prescription or non-prescription, is administered;

(ii) Administer medications per written orders;

(iii) Administer medications from containers labeled as specified per physician written order;

(iv) Keep medications secure and unavailable to any other individual and stored as prescribed; and

(v) Record administration on an individualized Medication Administration Record (MAR), including treatments and PRN, or “as needed”, orders.

(vi) Unused, discontinued, outdated, or recalled drugs must not be administered by the agency provider.

(D) If required to maintain a Medication Administration Record, the MAR must include:

(i) The name of the individual;

(ii) The brand name or generic name of the medication, including the prescribed dosage and frequency of administration as contained on physician order and medication;

(iii) Times and dates the administration or self-administration of the medication occurs;

(iv) The signature of the staff administering the medication or monitoring the self-administration of the medication;

(v) Method of administration;

(vi) Documentation of any known allergies or adverse reactions to a medication;

(vii) Documentation and an explanation of why a PRN, or “as needed”, medication was administered and the results of such administration; and

(viii) An explanation of any medication administration irregularity with documentation of administrative review by the provider organization director or designee.

(E) Safeguards to prevent adverse medications reactions must be utilized that include:

(i) Maintaining information about the effects and side-effects of medications the agency has agreed to administer;

(ii) Communicating any concerns regarding any medication usage, effectiveness or effects to the individual, individual’s designee, or individual’s legal representative; and

(iii) Prohibiting the use of one individual's medications by another. A record of visits to medical professionals, consultants or therapists if facilitated or provided by the service.

(h) Additional standards for providing transportation. Provider organizations that own or operate vehicles that transport individuals must:

(A) Maintain the vehicles in safe operating condition;

(B) Comply with Department of Motor Vehicles laws;

(C) Maintain insurance coverage on the vehicles and all authorized drivers; and

(D) Carry in vehicles a fire extinguisher and first aid kit.

(E) Assign drivers who meet applicable Department of Motor Vehicles requirements to operate vehicles transporting individuals.

(i) Additional standards for assisting an individual to manage personal funds. If assisting with management of funds, the provider organization must have and implement written policies and procedures related to the oversight of the individual's financial resources that include:

(A) Procedures that prohibit inappropriately expending an individual's personal funds, theft of an individual's personal funds, using an individual's funds for staff's own benefit, commingling an individual's personal funds with program or another individual's funds, or the program becoming an individual's guardian or conservator; and

(B) The program’s reimbursement to the individual of any funds that are missing due to theft or mismanagement on the part of any staff of the program, or of any funds within the custody of the program that are missing. Such reimbursement must be made within 10 working days of the verification that funds are missing.

(j) Additional standards for assisting individuals to manage difficult behavior.

(A) Written policy. The provider organization must have and implement a written policy concerning behavior intervention procedures. The provider organization must inform the individual and individual’s legal representative of the behavior intervention policy and procedures prior to finalizing the written service agreement.

(B) Any intervention to alter an individual’s behavior must be based on positive behavioral theory and practice as defined by OAR 411-340-0020(51) and must be:

(i) Approved in writing by the individual or the individual’s legal representative;

(ii) Described in detail in the individual’s record.

(C) Psychotropic medications and medications for behavior must be:

(i) Prescribed by physician through a written order; and

(ii) Monitored by the prescribing physician for desired responses and adverse consequences; and

(k) Additional standards for supports that involve restraints.

(A) The provider organization must only employ physical restraint:

(i) As part of an ISP that meets OAR 411-340-0020(37);

(ii) As an emergency measure, but only if absolutely necessary to protect the individual or others from immediate injury; or

(iii) As a health-related protection prescribed by a physician, but only if necessary for individual protection during the time that a medical condition exists.

(B) Staff training. Provider organization staff members who need to apply restraint under an individual’s service agreement must be trained by a Department-approved trainer and documentation of the training must be maintained in his/her personnel file.

(C) Physical restraints in emergency situations. Physical restraints in emergency situations must:

(i) Be only used until the individual is no longer a threat to self or others;

(ii) Be authorized by the agency provider director or designee, or individual’s physician;

(iii) Be authorized within one hour of application of restraint;

(iv) Result in the immediate notification of the individual's designee or legal representative; and

(v) Prompt a review of the written service agreement, initiated by the agency provider, if used more than three times in a six month period.

(D) Physical restraint must be designed to avoid physical injury to the individual or others, and to minimize physical and psychological discomfort.

(E) Incident report. All use of physical restraint must be documented and reported according to procedures described in OAR 411-340-0040 . The report must include:

(i) The name of the individual to whom the restraint is applied;

(ii) The date, type and length of time, of restraint application;

(iii) The name and position of the person authorizing the use of the restraint;

(iv) The name of the staff member(s) applying the restraint; and

(v) Description of the incident.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348

411-340-0180 *(Effective 12/28/03)*
Standards for General Business Providers

(1) General Business Providers providing services to individuals and paid with support services funds must hold any current license appropriate to function required by the State of Oregon or federal law or regulation, including but not limited to:

(a) A license under ORS 443.015 for a home health agency;

(b) A license under ORS 443.315 for an in-home care agency;

(c) A current license and bond as a building contractor as required by either OAR Chapter 812, Construction Contractor's Board or OAR Chapter 808, Landscape Contractors , as applicable,for a provider of environmental accessibility adaptations;

(d) Public transportation providers must be regulated according to established standards and private transportation providers must have business license and drivers licensed to drive in Oregon;

(e) Current retail business license for vendors and medical supply companies providing specialized medical equipment and supplies, including enrollment as Medicaid providers through the Oregon Office of Medical Assistance Program if vending medical equipment;

(f) A current business license for providers of personal emergency response systems; and

(g) Retail business licenses for vendors and supply companies providing specialized diets.

(2) Services provided and paid for with support services funds must be limited to those within the scope of the general business provider's license.

Stat. Auth.: ORS 409.050 & ORS 410.070
Stats. Implemented: ORS 430.610 through 430.670, 427.005 through 427.007 & 417.340 through 417.348