# DEPARTMENT OF HUMAN SERVICES
# DEVELOPMENTAL DISABILITIES
# OREGON ADMINISTRATIVE RULES

## CHAPTER 411
## DIVISION 340

## SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

## EFFECTIVE JULY 1, 2013

### 411-340-0010 Statement of Purpose
*(Amended 7/1/2009)*

(1) The rules in OAR chapter 411, division 340 prescribe standards, responsibilities, and procedures for support services brokerages for purchase of individual supports with support services funds, and for providers paid with support services funds, to provide services to adults with developmental disabilities so that the adults with developmental disabilities may live in their own homes or in family homes.

(2) Services provided under these rules are intended to identify, strengthen, expand, and where required, supplement private, public, formal, and informal support available to adults with developmental disabilities so that adults with developmental disabilities may exercise self-determination in the design and direction of their lives.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

### 411-340-0020 Definitions
*(Temporary Effective 4/1/2013 - 9/28/2013)*

As used in OAR chapter 411, division 340:

(1) "Abuse" means abuse of an adult as defined in OAR 407-045-0260.

(2) "Abuse Investigation and Protective Services" means reporting and investigation activities as required by OAR 407-045-0300 and any

subsequent services or supports necessary to prevent further abuse as required by OAR 407-045-0310.

(3) "Activities of Daily Living (ADL)" mean the self-care activities accomplished by an individual for continued well-being.

(4) "Adaptive Behavior" means the degree to which an individual meets the standards of personal independence and social responsibility expected for age and culture group.

(5) "Administration of Medication" means the act of placing a medication in, or on, an individual's body by 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.

(6) "Administrative Review" means the formal process that is used when the individual or the individual's legal representative is not satisfied with the decision made by the brokerage about a complaint involving the provision of services or a provider.

(7) "Administrator" means the Administrator of the Department, or that person's designee. The term "Administrator" is synonymous with "Assistant Director".

(8) "Adult" means an individual 18 years or older with developmental disabilities.

(9) "Alternative Resources" mean possible resources, not including support services, for the provision of supports to meet an individual's needs. Alternative resources includes but is not limited to private or public insurance, vocational rehabilitation services, supports available through the Oregon Department of Education, or other community supports.

(10) "Basic Benefit" means the type and amount of support services available to each eligible individual, specifically:

> (a) Access to the brokerage services listed in OAR 411-340-0120(1); and if required

(b) Access to an amount of support services funds used to assist with the purchase of supports listed in OAR 411-340-0130(6).

(11) "Basic Supplement" means an 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 Inventory, Form DHS 0203.

(12) "Basic Supplement Criteria Inventory (Form DHS 0203)" means the written inventory of an individual's circumstances that is completed and scored by the brokerage to determine whether the individual is eligible for a basic supplement.

(13) "Benefit Level" means the total annual amount of support service funds for which an individual is eligible. The benefit level includes the basic benefit and any exceptions to the basic benefit financial limits.

(14) "Certificate" means a document issued by the Department to a brokerage, or to a provider organization requiring certification under OAR 411-340-0170(2), that certifies the brokerage or provider organization is eligible to receive state funds for support services.

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

(16) "Chore Services" mean services needed to maintain a clean, sanitary, and safe environment in an individual's home. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy items of furniture for safe access and egress.

(17) "Client Process Monitoring System (CPMS)" means the Department's computerized system for enrolling and terminating services for individuals with developmental disabilities.

(18) "Community Developmental Disability Program (CDDP)" means an entity that is responsible for planning and delivery of services for individuals with developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, Local Mental Health Authority, or other entity as contracted by the Department.

(19) "Community Living and Inclusion Supports" mean services that facilitate independence and promote community integration by supporting the individual to gain or maintain skills to live as independently as possible in the type of home the individual chooses. Community living and inclusion supports provide support for the individual to participate in activities in integrated settings that promote community inclusion and contribution.

(a) Community living and inclusion supports include supports designed to develop or maintain skills for self-care, ability to direct supports, care of the immediate environment, and 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. Community living and inclusion supports include supports in the following areas:

(A) Personal skills, which includes eating, bathing, dressing, personal hygiene, and mobility;

(B) Socialization, which includes development or maintenance of self-awareness and self-control, social responsiveness, social amenities, and interpersonal skills;

(C) Community participation, recreation, or leisure, which includes the development or maintenance of skills to use available community services, facilities, or businesses;

(D) Communication, which includes 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, which includes development or maintenance of skills such as planning and preparing meals, budgeting, laundry, and housecleaning.

(b) Community living and inclusion supports may or may not be work related.

(20) "Complaint" means a verbal or written expression of dissatisfaction with services or providers.

(21) "Comprehensive Services" mean a package of developmental disability services and supports that include 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) Twenty-four hour residential services including but not limited to services provided in a group home, foster home, or through a supported living program; or

(b) In-home supports provided to an individual in the individual or family home costing more than the individual cost limit.

(c) Comprehensive services do not include support services for adults enrolled in brokerages or for children enrolled in long-term supports or children's intensive in-home services.

(22) "Cost Effective" means being responsible and accountable with Department resources by offering less costly alternatives when providing choices that adequately meet an individual’s support needs. Less costly alternatives include other programs available from the Department, the utilization of assistive devices, natural supports, architectural modifications, and alternative resources. Less costly alternatives may include resources not paid for by the Department.

(23) "Crisis" means:

(a) A situation that may result in civil court commitment under ORS 427.215 to 427.306 and for which no appropriate alternative resources are available; or

(b) Risk factors described in OAR 411-320-0160 are present for which no appropriate alternative resources are available.

(24) "Crisis Diversion Services" mean the services authorized and provided according to OAR 411-320-0160 that are intended to maintain an individual at home or in the family home while an individual is in emergent status. Crisis diversion services may include short-term residential placement services indicated on an individual's Support Services Brokerage Plan of Care Crisis Addendum, as well as additional support as described in an Individual Support Plan.

(25) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Division (SPD)".

(26) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(27) "Emergent Status" means an individual has been determined to be eligible for crisis diversion services according to OAR 411-320-0160..

(28) "Employer-Related Supports" mean activities that assist individuals and, when applicable, their family members with fulfilling roles and obligations as employers as described in the Individual Support Plan. Supports to the employer include but are not limited to:

(a) Education about employer responsibilities;

(b) Orientation to basic wage and hour issues;

(c) Use of common employer-related tools such as job descriptions; and

(d) Fiscal intermediary services.

(29) "Entry" means admission to a Department-funded developmental disability service provider.

(30) "Environmental Accessibility Adaptations" mean 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) Environmental accessibility adaptations include but are not limited to:

(A) Environmental modification consultation to determine the appropriate type of adaptation;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke detectors, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for an individual whose temperature sensitivity issues create behaviors or medical conditions that put the individual or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual; or

(R) 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) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the home that 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.

(31) "Environmental Modification Consultant" means either an independent provider, provider organization, or general business 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.

(32) "Exit" means either termination from a Department-funded developmental disability service provider or transfer from one Department-funded service provider to another.

(33) "Family" for determining individual eligibility for 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 include at least one individual with developmental disabilities where the primary caregiver is:

(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 developmental disabilities and the individual with developmental disabilities is related to one of the partners by blood, marriage, or legal adoption.

(34) "Family Training" means training and counseling services for the family of an individual that increase the family's capacity to care for, support, and maintain the individual in the home. Family training includes:

(a) Instruction about treatment regimens and use of equipment specified in the Individual Support Plan;

(b) Information, education, and training about the individual's developmental disability, medical, and behavioral conditions; and

(c) Counseling for the family to relieve the stress associated with caring for an individual with developmental disabilities.

(35) "Fiscal Intermediary" means a person or entity that receives and distributes support services funds on behalf of an individual who employs persons to provide services, supervision, or training in the home or community according to the Individual Support Plan.

(36) "Founded Reports" means the Department's or Law Enforcement Authority's (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(37) "General Business Provider" means an organization or entity selected by an individual or the individual's legal representative, and paid with support services 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.

(38) "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. Habilitation services include supported employment and community living and inclusion supports.

(39) "Hearing" means the formal process following an action that would terminate, suspend, reduce, or deny a service. This is a formal process required by federal law (42 CFR 431.200-250). A hearing is also known as a Medicaid Fair Hearing and contested case hearing.

(40) "Home" means an individual's primary residence that is not under contract with the Department to provide services to an individual as a licensed or certified foster home, residential care facility, assisted living facility, nursing facility, or other residential support program site.

(41) "Homemaker Services" mean the general household activities such as meal preparation and routine household services required to maintain a clean, sanitary, and safe environment in an individual's home.

(42) "Incident Report" means a written report of any unusual incident involving an individual.

(43) "Independence" means the extent to which individuals with developmental disabilities exert control and choice over their own lives.

(44) "Independent Provider" means a person selected by an individual or the individual's legal representative and paid with support services funds that personally provide services to the individual.

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

(46) "Individual Cost Limit" means the maximum annual benefit level available under the Support Services Waiver.

(47) "Individual Support Plan (ISP)" means the written details of the supports, activities, and resources required for an individual to achieve personal goals. The type of service supports needed, how supports are delivered, and the frequency of provided supports are included in the ISP. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The ISP is the individual's plan of care for Medicaid purposes.

(48) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with developmental disabilities of the same community resources used by and available to other persons;

(b) Participation by individuals with developmental disabilities in the same community activities in which persons without a developmental disability participate, together with regular contact with persons without a developmental disability; and

(c) Individuals with developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with persons in their community.

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

(50) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who, while acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with

developmental disabilities has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused an adult with developmental disabilities. Nothing contained in ORS 40.225 to 40.295 shall affect the duty to report imposed by this section of this rule, except that a psychiatrist, psychologist, clergy, or attorney is not required to report if the communication is privileged under ORS 40.225 to 40.295.

(51) "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.

(52) "Natural Supports" or "Natural Support System" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(53) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse or licensed practical nurse pursuant to ORS chapter 678.

(54) "Nursing Care Plan" means a plan developed by a registered nurse that describes the medical, nursing, psychosocial, and other needs of the individual and how those needs shall be met. The Nursing Care Plan includes which tasks shall be taught, assigned, or delegated to the qualified provider or family.

(55) "Occupational Therapy" means the services provided by 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.

(56) "OSIP-M" means Oregon Supplemental Income Program Medical.

(57) "Personal Agent" means a person who works directly with individuals and families to provide or arrange for support services as described in the Support Services Waiver and these rules, is a case manager for the provision of targeted case management services, meets the qualifications set forth in OAR 411-340-0150(5), and is:

(a) A trained employee of a 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.

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

(59) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps an individual:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

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

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with individual needs and preferences.

(60) "Physical Therapy" means the 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.

(61) "Plan Year" means 12 consecutive months used to calculate an individual's annual benefit level. Unless otherwise set according to the conditions of OAR 411-340-0120, the initial plan year begins on the start date specified on the individual's first authorized Individual Support Plan (ISP) after entry to a brokerage. Subsequent plan years begin on the anniversary of the start date of the initial ISP.

(62) "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.

(63) "Prescription Medication" means any medication that requires a physician prescription before it may be obtained from a pharmacist.

(64) "Primary Caregiver" means the person identified in an Individual Support Plan as providing the majority of service and support for an individual in the individual's home.

(65) "Productivity" as defined in ORS 427.005 means:

(a) Engagement in income-producing work by an individual with developmental disabilities that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual with developmental disabilities in work contributing to a household or community.

(66) "Protection" and "Protective Services" mean necessary actions taken as soon as possible to prevent subsequent abuse or exploitation of an individual, to prevent self-destructive acts, and to safeguard an individual's person, property, and funds.

(67) "Provider Organization" means an entity selected by an individual or the individual's legal representative, and paid with support services 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.

(68) "Provider Organization Director" means the employee of a provider organization, or the employee's designee, responsible for administration and provision of services according to these rules.

(69) "Psychotropic Medication" means a medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior including but not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(70) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services.

(71) "Rate Ranges" mean the rates and limits paid for some support services. The Department's support services rate ranges as of April 1, 2013 are maintained on the Department's website (http://www.dhs.state.or.us/spd/tools/dd/bpa/rate-guidelines-040113.pdf). Printed copies may be obtained by contacting the Department of Human Services, Developmental Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-10, Salem, Oregon 97301.

(72) "Regional Crisis Diversion Program" means the regional coordination of the management of crisis diversion services for a group of designated counties that is responsible for the management of the following developmental disability services:

(a) Crisis intervention services;

(b) Evaluation of requests for new or enhanced services for certain groups of individuals eligible for developmental disability services; and

(c) Other developmental disability services that the counties comprising the region agree are more effectively or automatically delivered on a regional basis.

(73) "Respite" means intermittent services provided on a periodic basis for the relief of, or due to the temporary absence of, persons normally providing the supports to individuals unable to care for themselves.

(74) "Restraint" means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal functioning of an individual.

(75) "Self-Administration of Medication" means the individual manages and takes his or her own medication, identifies his or her medication and the times and methods of administration, places the medication internally in or externally on his or her own body without staff assistance upon written order of a physician, and safely maintains the medication without supervision.

(76) "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 an individual 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 shall 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 an individual'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 individuals with developmental disabilities.

(77) "Social Benefit" means a service or financial assistance solely intended to assist an individual with a developmental disability to function in society on a level comparable to that of a person who does not have such a developmental disability.

(a) Social benefits may not:

(A) Duplicate benefits and services otherwise available to persons regardless of developmental disability;

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

(C) Replace other governmental or community services available to an individual.

(b) Financial assistance provided as a social benefit may not exceed the actual cost of the support required by an individual to be supported in the individual's home and must be either:

(A) Reimbursement for an expense previously authorized in an Individual Support Plan (ISP); or

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

(78) "Special Diet" means specially prepared food or particular types of food, ordered by a physician and periodically monitored by a dietician, specific to an individual's medical condition or diagnosis that are needed to sustain an individual in the individual's home. Special diets are supplements and are not intended to meet an individual's complete daily nutritional requirements. Special diets may include:

(a) High caloric supplements;

(b) Gluten-free supplements; and

(c) Diabetic, ketogenic, or other metabolic supplements.

(79) "Specialized Medical Equipment and Supplies" mean devices, aids, controls, supplies, or appliances that 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. Specialized medical equipment and supplies include 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 State Medicaid Plan. Specialized medical equipment and supplies may not include items not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies must meet applicable standards of manufacture, design, and installation.

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

(d) Monitor implementation of the plan of support; and

(e) Revise the plan of support as needed.

(81) "Speech and Language Therapy" means the services provided by 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.

(82) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(83) "Support" means assistance that individuals require, solely because of the affects of developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is flexible and subject to change with time and circumstances.

(84) "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.

(85) "Support Services" mean the services of a brokerage listed in OAR 411-340-0120(1) as well as the uniquely determined activities and purchases arranged through the brokerage support services that:

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

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

(c) Are provided in accordance with an Individual Support Plan; 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.

(86) "Support Services Brokerage" or "Brokerage" means an entity, or distinct operating unit within an existing entity, that uses the principles of self-determination to perform the functions listed in OAR 411-340-0120(1) associated with planning and implementation of support services for individuals with developmental disabilities.

(87) "Support Services Brokerage Director" or "Brokerage Director" means the employee of a publicly or privately-operated brokerage, or that person's designee, who is responsible for administration and provision of services according to these rules.

(88) "Support Services Brokerage Plan of Care Crisis Addendum" means the short-term plan that is required by the Department to be added to an Individual Support Plan to describe crisis diversion services an individual is to receive while the individual is in emergent status in a short-term residential placement.

(89) "Support Services Brokerage Policy Oversight Group" or "Policy Oversight Group" means the group that meets the requirements of OAR 411-340-0150(1) that is formed to provide consumer-based leadership and advice to each brokerage regarding issues such as development of policy, evaluation of services, and use of resources.

(90) "Support Services Expenditure Guideline" means a publication of the Department that describes allowable uses for support services funds.

(91) "Support Services Funds" mean public funds designated by the brokerage for assistance with the purchase of supports according to each Individual Support Plan.

(92) "These Rules" mean the rules in OAR chapter 411, division 340.

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

(94) "Unusual Incident" means 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, an act of physical aggression, or any incident requiring an abuse investigation.

(95) "Volunteer" means any person assisting a service provider without pay to support the services provided to an individual.

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**411-340-0030 Certification of Support Services Brokerages and Provider Organizations**
*(Amended 5/5/2011)*

(1) CERTIFICATE REQUIRED.

(a) No person or governmental unit acting individually or jointly with any other person or governmental unit may establish, conduct, maintain, manage, or operate a brokerage without being certified by the Division under this rule.

(b) 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 this rule or current Division license or certification as described in OAR 411-340-0170(1).

(c) Certificates are not transferable or assignable and are issued only for the brokerage, or for the provider organization requiring certification under OAR 411-340-0170(2), and persons or governmental units named in the application.

(d) Certificates issued on or after November 15, 2008 shall be in effect for a maximum of five years.

(e) The Division shall conduct a review of the brokerage, or the provider organization requiring certification under OAR 411-340-0170(2), prior to the issuance of a certificate.

(2) CERTIFICATION. A brokerage, or a provider organization requiring certification under OAR 411-340-0170(2), must apply for an initial certificate and for a certificate renewal.

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

(b) The applicant requesting certification as a brokerage must identify the maximum number of individuals to be served.

(c) To renew certification, the brokerage or provider organization 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 Division.

(d) Application for renewal must be filed no more than 120 days prior to the expiration date of the existing certificate and shall extend the effective date of the existing certificate until the Division takes action upon the application for renewal.

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

(f) Prior to issuance or renewal of the certificate, the applicant must demonstrate to the satisfaction of the Division 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, OR CERTIFICATE RETURN.

(a) Unless revoked, suspended, or terminated earlier, each certificate to operate a brokerage or provider organization shall expire on the expiration date specified on the certificate.

(b) If a certified brokerage or provider organization is discontinued, the certificate automatically terminates on the date operation is discontinued.

(4) CHANGE OF OWNERSHIP, LEGAL ENTITY, LEGAL STATUS, OR MANAGEMENT CORPORATION. The brokerage, or provider organization requiring certification under OAR 411-340-0170(2), must notify the Division in writing of any pending action resulting in a 5 percent 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 for a brokerage or provider organization is required upon change in a brokerage's or provider organization's ownership, legal entity, or legal status. The 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, OR REFUSAL TO RENEW. The Division may deny, revoke, or refuse to renew a certificate when the Division finds the brokerage or provider organization, the brokerage or provider organization director, or any person holding 5 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 the brokerage or provider organization fails to correct the noncompliance within 30 calendar days of receipt of written notice of non-compliance;

(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 rule, "inspection" means an on-site review of the service site by the Division for the purpose of investigation or certification);

(c) Has been convicted of a felony or any crime as described in OAR 407-007-0275;

(d) Has been convicted of a misdemeanor associated with the operation of a brokerage or provider organization;

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

(f) Has been found to have permitted, aided, or abetted any illegal act that 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 Division 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 (6) of this rule has occurred, the Division may issue a notice of certificate revocation, denial, or refusal to renew.

(8) IMMEDIATE SUSPENSION OF CERTIFICATE. When the Division finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Division may, by written notice to the certificate holder, immediately suspend a certificate without a pre-suspension hearing and the brokerage or provider organization may not continue operation.

(9) HEARING. An applicant for a certificate or a certificate holder may request a hearing pursuant to the contested case provisions of ORS chapter 183 upon written notice from the Division of denial, suspension, revocation, or refusal to renew a certificate. In addition to, or in lieu of a hearing, the applicant or certificate holder may request an administrative review by the Division's Assistant Director. An administrative review does not preclude the right of the applicant or certificate holder to a hearing.

(a) The applicant or certificate holder must request a hearing within 60 days of receipt of written notice by the Division of denial, suspension, revocation, or refusal to renew a certificate. The request for a hearing must include an admission or denial of each factual matter alleged by the Division and must affirmatively allege a short plain statement of each relevant, affirmative defense the applicant or certificate holder may have.

(b) In the event of a suspension pursuant to section (8) of this rule and during the first 30 days after the suspension of a certificate, the brokerage or provider organization may submit a written request to the Division for an administrative review. The Division shall conduct the review within 10 days after receipt of the request for an administrative review. Any review requested after the end of the 30-day period following certificate suspension shall be treated as a

request for hearing under subsection (a) of this section. If following the administrative review the suspension is upheld, the brokerage or provider organization may request a hearing pursuant to the contested case provisions of ORS chapter 183.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0040 Abuse and Unusual Incidents in Support Services Brokerages and Provider Organizations**
*(Amended 5/5/2011)*

(1) ABUSE PROHIBITED. No adult or individual as defined in OAR 411-340-0020 shall be abused nor shall any employee, staff, or volunteer of the brokerage or provider organization condone abuse.

(a) 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 accused person in an abuse investigation as well as when the allegation of abuse has been substantiated.

(b) All employees of a brokerage or provider organization are mandatory reporters. The brokerage or provider organization must:

(A) Notify all employees of mandatory reporting status at least annually on forms provided by the Department; and

(B) Provide all employees with a Department-produced card regarding abuse reporting status and abuse reporting.

(2) INCIDENT REPORTS.

(a) A brokerage or provider organization must prepare an incident report for instances of potential or suspected abuse or an unusual incident as defined in OAR 411-340-0020, involving an individual and a brokerage or provider organization employee. The incident report must be placed in the individual's record and must include:

(A) Conditions prior to or leading to the potential or suspected abuse or unusual incident;

(B) A description of the potential or suspected abuse or unusual incident;

(C) Staff response at the time; and

(D) Review by the brokerage administration and follow-up to be taken to prevent recurrence of the potential or suspected abuse or unusual incident.

(b) A brokerage or provider organization must send copies of all incident reports involving potential or suspected abuse that occurs while an individual is receiving brokerage or provider organization services to the CDDP.

(c) A provider organization must send copies of incident reports of all potential or suspected abuse or unusual incidents that occur while the individual is receiving services from a provider organization to the individual's brokerage within five working days of the potential or suspected abuse or unusual incident.

(3) IMMEDIATE NOTIFICATION

(a) The brokerage must immediately report to the CDDP, and the provider organization must immediately report to the CDDP with notification to the brokerage, any incident or allegation of potential or suspected abuse falling within the scope of OAR 407-045-0260.

(A) When an abuse investigation has been initiated, the CDDP must provide notice according to OAR 407-045-0290.

(B) When an abuse investigation has been completed, the CDDP must provide notice of the outcome of the investigation according to OAR 407-045-0320.

(b) In the case of emergency overnight hospitalization due to illness or injury to an individual, the brokerage or provider organization must immediately notify:

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

(B) In the case of the provider organization, the individual's brokerage.

(c) In the event of the death of an individual, the brokerage or provider organization must immediately notify:

(A) The Medical Director of the Division;

(B) The individual's legal representative, parent, next of kin, designated contact person, or other significant person;

(C) The CDDP; and

(D) In the case of a provider organization, the individual's brokerage.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0050 Inspections and Investigations in Support Services Brokerages and Provider Organizations**
*(Amended 7/1/2010)*

(1) Entities certified under these rules must allow the following types of investigations and inspections:

(a) Quality assurance and on-site inspections;

(b) Complaint investigations; and

(c) Abuse investigations.

(2) The Department, CDDP, or proper authority shall perform all inspections and investigations.

(3) Any inspection or investigation may be unannounced.

(4) 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) When abuse is alleged or death of an individual has occurred and a law enforcement agency, the Department, or CDDP has determined to initiate an investigation, the brokerage or provider organization may not conduct an internal investigation without prior authorization from the Department. For the purposes of this rule, an "internal investigation" is defined as:

(a) Conducting interviews with the alleged victim, witness, the accused person, or any other person who may have knowledge of the facts of the abuse allegation or related circumstances;

(b) Reviewing evidence relevant to the abuse allegation, other than the initial report; or

(c) Any other actions beyond the initial actions of determining:

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

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

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

(D) What, if any, immediate personnel actions must be taken.

(6) The Department or the CDDP shall conduct abuse investigations as set forth in OAR 407-045-0250 to OAR 407-045-0360 and shall complete an abuse investigation and protective services report according to OAR 407-045-0320.

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

(8) Upon completion of the abuse investigation and protective services report, in accordance with OAR 407-045-0330, the sections of the report that are public records and not exempt from disclosure under the public records law shall be provided to the appropriate brokerage or provider organization.

(9) The brokerage or provider organization may be required to submit to the Division a plan of improvement for any noncompliance found during an inspection pursuant to section (1)(a) of this rule.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0060 Complaints in Support Services Brokerages**
*(Amended 7/1/2009)*

(1) COMPLAINTS. Brokerages must develop and implement written policies and procedures regarding individual complaints and a formal complaint process. These policies and procedures must at minimum address:

(a) Receipt of complaints. If a complaint is associated in any way with abuse, the recipient of the complaint must immediately report the issue to the CDDP and notify the brokerage director and, if applicable, the provider organization director. The brokerage must maintain a log of all complaints regarding the brokerage, provider organization, or independent provider that the brokerage receives from individuals, others acting on the behalf of individuals, and from provider organizations acting in accordance with OAR 411-340-0170(2)(a)(C)(v).

(A) The complaint log must, at a minimum, include the following:

(i) The date the complaint was received;

(ii) The name of the person taking the complaint;

(iii) The nature of the complaint;

(iv) The name of the person making the complaint, if known; and

(v) The disposition of the complaint.

(B) Brokerage personnel issues and allegations of abuse may be maintained separately from a central complaint log. If a complaint results in disciplinary action against a staff member, the documentation on the complaint must include a statement that disciplinary action was taken.

(b) Informal complaint resolution. An individual or someone acting on behalf of the individual must have an opportunity to informally discuss

and resolve any allegation that a brokerage, provider organization, or independent provider has taken action that is contrary to law, rule, policy, or that is otherwise contrary to the interest of the individual and that does not meet the criteria for an abuse investigation. Choosing an informal resolution does not preclude an individual or someone acting on behalf of the individual from pursuit of resolution through formal complaint processes.

(c) Investigation of the facts supporting or disproving the complaint.

(d) Taking appropriate actions. The brokerage must take steps to resolve the complaint within five working days following receipt of the complaint. If the complaint cannot be resolved informally, or if the individual making the complaint so chooses at any time, the individual may request a formal resolution of the complaint and, if needed, must be assisted by the brokerage with initiating the formal complaint process.

(e) Review by the brokerage director. If a complaint involves brokerage staff or services and if the complaint is not resolved according to section (1)(b) through (1)(d) of this rule, or if the person making the complaint requests one, a formal review must be completed by the brokerage director and a written response must be provided to the complainant within 30 days following receipt of the complaint.

(f) Agreement to resolve the complaint. Any agreement to resolve a complaint that has been formally reviewed by the brokerage director must be in writing and must be specifically approved by the complainant. The brokerage must provide the complainant with a copy of the agreement.

(g) Administrative review. Unless the complainant is a Medicaid recipient who has elected to initiate the hearing process according to section (3) of this rule, the complaint may be submitted to SPD for administrative review when the complaint cannot be resolved by the brokerage and the complaint involves the provision of service or a provider.

(A) Following a decision by the brokerage director regarding a complaint, the complainant may request an administrative review by the SPD Assistant Director.

(B) The complainant must submit to SPD a request for an administrative review within 15 days from the date of the decision by the brokerage director.

(C) Upon receipt of a request for an administrative review, the SPD Assistant Director shall appoint an Administrative Review Committee and name the chairperson. The Administrative Review Committee shall be comprised of a representative of SPD, a CDDP representative, and a brokerage representative. Committee representatives may not have any direct involvement in the provision of services to the complainant or have a conflict of interest in the specific case being reviewed.

(D) The Administrative Review Committee must review the complaint and the decision by the brokerage director and make a recommendation to the SPD Assistant Director within 45 days of receipt of the complaint unless the complainant and the Administrative Review Committee mutually agree to an extension.

(E) The SPD Assistant Director shall consider the report and recommendations of the Administrative Review Committee and make a final decision. The decision must be in writing and issued within 10 days of receipt of the recommendation by the Administrative Review Committee. The written decision must contain the rationale for the decision.

(F) The decision of the SPD Assistant Director is final. Any further review is pursuant to the provision of ORS 183.484 for judicial review.

(h) Documentation of complaint. Documentation of each complaint and its resolution must be filed or noted in the complainant's record.

(2) NOTIFICATION. Upon enrollment and annually thereafter, and when a complaint is not resolved according to section (1)(b) through (1)(d) of this

rule, the brokerage must inform each individual, or the individual's legal representative, orally and in writing, using language, format, and methods of communication appropriate to the individual's needs and abilities, of the following:

(a) Brokerage grievance policy and procedures, including the right to an administrative review and the method to obtain an administrative review; and

(b) The right of a Medicaid recipient to a hearing as pursuant to section (3) of this rule and the procedure to request a hearing.

(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 of the right to a hearing and the method to request a hearing. The brokerage must mail the notice by certified mail, or personally serve the notice to the individual or the individual's legal representative 10 days or more prior to the effective date of an action.

(A) The brokerage must use form SDS 0947, Notification of Planned Action, or a comparable SPD-approved form for such notification.

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

(b) A notice required by section (3)(a) of this rule must include:

(A) The action the brokerage intends to take;

(B) The reasons for the intended action;

(C) The specific Oregon Administrative Rules that support, or the change in federal or state law that requires, the action;

(D) The appealing party's right to request a hearing in accordance with OAR chapter 137, ORS chapter 183, and 42 CFR Part 431, Subpart E;

(E) A statement that the brokerage files on the subject of the hearing automatically becoming part of the hearing record upon default for the purpose of making a prima facie case;

(F) A statement that the actions specified in the notice shall take effect by default if the DHS representative does not receive a request for hearing from the party within 45 days from the date that the brokerage mails the notice of action;

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

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

(c) If the individual or the individual's legal representative disagrees with a decision or proposed action by the brokerage to deny, terminate, suspend, or reduce an individual's access to services covered under Medicaid, the party may request a hearing as provided in ORS chapter 183. The request for a hearing must be in writing on form DHS 443 and signed by the individual or the individual's legal representative. The signed form (DHS 443) must be received by DHS within 45 days from the date the brokerage mailed the notice of action.

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

(e) If the individual or the individual's legal representative requests a hearing before the effective date of the proposed action and requests

that the existing services be continued, DHS shall continue the services.

(A) DHS must continue the services until whichever of the following occurs first:

(i) The current authorization expires;

(ii) The administrative law judge issues a proposed order and DHS issues a final order; or

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

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

(f) DHS may reinstate services if:

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

(B) DHS fails to provide the notice in the time required in this rule and the individual or the individual's legal representative requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the individual or the 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.

(g) DHS 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 DHS decides in the individual's favor before the hearing.

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

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

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

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

(D) Inform the individual or the 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 DHS 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 DHS an opportunity to review its action or the action of the brokerage.

(i) The individual or the individual's legal representative may, at any time prior to the hearing date, request an additional conference with the DHS representative. At the DHS representative's discretion, the DHS representative may grant an additional conference if it facilitates the hearing process.

(j) DHS may provide the individual or the individual's legal representative the relief sought at any time before the final order is issued.

(k) An individual or the individual's legal representative may withdraw a hearing request at any time prior to the issuance of a final order. The withdrawal shall be effective on the date DHS or the Office of Administrative Hearings receives it. DHS must issue a final order confirming the withdrawal to the last known address of the individual or the individual's legal representative. The individual or the individual's legal representative may cancel the withdrawal up to 10 working days following the date the final order is issued.

(l) Proposed and final orders.

(A) In a contested case, the administrative law judge must serve a proposed order on the individual and DHS.

(B) If the administrative law judge 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 DHS. The exception must be in writing and must be received by DHS no later than 10 days after service of the proposed order. The individual or the individual's legal representative may not submit additional evidence after this period unless DHS grants prior approval.

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

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0070 Support Services Brokerage and Provider Organization Personnel Policies and Practices**
*(Amended 7/1/2010)*

(1) Brokerages and provider organizations must maintain up-to-date written position descriptions for all staff as well as a file available to the Division or CDDP for inspection that includes written documentation of the following for each staff:

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

(b) Written documentation of an approved criminal records check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370;

(c) Satisfactory completion of basic orientation, including instructions for mandatory 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 reporter status;

(e) Written documentation of any founded report of child abuse or substantiated abuse;

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

(g) Legal eligibility to work in the United States.

(2) 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) An application for employment at the brokerage or provider organization must inquire whether an applicant has had any founded reports of child abuse or substantiated abuse.

(4) Any employee of the brokerage or provider organization, or any subject individual defined by OAR 407-007-0200 to 407-007-0370, who has or will have contact with an eligible individual of support services, must have an approved criminal records check in accordance with OAR 407-007-0200 to 407-007-0370 and under ORS 181.534.

(5) Effective July 28, 2009, a person may not be authorized as a provider or meet qualifications as described in this rule if the person has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(6) Section (5) of this rule does not apply to employees of the brokerage or provider organization who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(7) Each brokerage and provider organization regulated by these rules must be a drug-free workplace.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0080 Support Services Brokerage and Provider Organization Records**
*(Amended 7/1/2010)*

(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 rules or policies pertaining to individual service records.

(2) DISCLOSURE AND CONFIDENTIALITY.

> (a) For the purpose of disclosure from individual medical records under these rules, brokerages, and provider organizations requiring certification under OAR 411-340-0170(2), shall be considered "providers" as defined in ORS 179.505(1), and 179.505 shall be applicable.
>
> (b) Access to records by the Department does not require authorization by the individual or family.

(c) For the purpose of disclosure from non-medical individual records, all or portions of the information contained in the non-medical individual 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 brokerage or provider organization must:

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

(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 may not exceed the customary charges to private individuals 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 rule pertaining to fraud and embezzlement.

(4) RECORDS RETENTION. Records must be retained in accordance with OAR chapter 166, division 150, Secretary of State, Archives Division.

(a) 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.

(b) Individual records must be kept for a minimum of seven years.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0090 Support Services Brokerage and Provider Organization Request for Variance**
*(Amended 7/1/2009)*

(1) Variances may be granted to a brokerage or provider organization:

(a) If the brokerage or provider organization lacks the resources needed to implement the standards required in these rules;

(b) 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

(c) If there are other extenuating circumstances.

(2) Variances may not be granted to OAR 411-340-0130 and OAR 411-340-0140.

(3) The brokerage or provider organization requesting a variance must submit to SPD, in writing, an application 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 proposed alternative practice, service, method, concept, or procedure;

(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 an individual's currently authorized ISP.

(4) SPD may approve or deny the variance request. SPD's decision shall be sent to the brokerage or provider organization and to all relevant SPD programs or offices within 45 calendar days of the receipt of the variance request.

(5) The brokerage or provider organization may appeal the denial of a variance request by sending a written request for review to the SPD Assistant Director, whose decision is final.

(6) SPD shall determine the duration of the variance.

(7) The brokerage or the provider organization may implement a variance only after written approval from SPD.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0100 Eligibility for Support Services Brokerage Services**
*(Temporary Effective 7/1/2013 - 12/28/2013)*

(1) NON-DISCRIMINATION. Individuals determined eligible according to this rule may not be denied brokerage services or otherwise discriminated against on the basis of age, diagnostic or disability category, 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 brokerage when:

(a) The individual is an Oregon resident who has been determined eligible for developmental disability services by the CDDP; AND

(b) The individual is an adult living in the individual's own home or family home; AND

(c) At the time of initial entry to the brokerage, the individual is not enrolled in comprehensive services; AND

(d) At the time of initial entry to the brokerage, the individual is not receiving short-term services from the Department because the individual is eligible for, and at imminent risk of, civil commitment under ORS chapter 427.215 through 427.306; AND

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

(3) CONCURRENT SERVICES. Individuals are not eligible for service by more than one brokerage unless the concurrent service:

(a) Is necessary to affect transition from one brokerage to another;

(b) Is part of a collaborative plan between the affected brokerages; and

(c) Does not duplicate services and expenditures.

Stat. Auth.: ORS 409.050 and 410.070
Stats. Implemented: ORS 427.005, 427.007, and 430.610 to 430.695

**411-340-0110 Standards for Support Services Brokerage Entry and Exit**
*(Temporary Effective 7/1/2013 - 12/28/2013)*

(1) The brokerage must make accurate, up-to-date information about the brokerage available to individuals referred for services. This information must include:

(a) A declaration of brokerage philosophy;

(b) A brief description of the services provided by the brokerage, 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 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 an individual’s right to:

(A) Choose a brokerage from among Department contracted brokerages in an individual's county of residence that is serving less than the total number of individuals specified in the brokerage's current contract with the Department;

(B) Choose a personal agent among those available in the selected brokerage;

(C) Select providers among those willing, available, and 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 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 when services covered under Medicaid are denied, terminated, suspended, or reduced.

(g) Indication that additional information about the brokerage is available on request. The additional information must include but not be limited to:

(A) A description of the brokerage's organizational structure;

(B) A description of any contractual relationships the brokerage has in place or may establish to accomplish the brokerage functions required by rule; and

(C) A description of the relationship between the brokerage and the brokerage's Policy Oversight Group.

(2) The brokerage must make information required in OAR 411-340-0110(1) of this rule available using language, format, and presentation methods appropriate for effective communication according to individuals' needs and abilities.

(3) ENTRY INTO BROKERAGE SERVICES.

(a) To enter brokerage services:

(A) An individual must be determined by the CDDP to be eligible for brokerage services according to OAR 411-340-0100; and

(B) The individual or the individual's representative must choose to receive services from a selected brokerage.

(b) The Department may implement guidelines that govern entries when the Department has determined that such guidelines are prudent and necessary for the continued development and implementation of support services.

(c) The brokerage may not accept individuals for entry beyond the total number of individuals specified in the brokerage's current contract with the Department.

(4) EXIT FROM A BROKERAGE.

(a) An individual must exit a brokerage:

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

(B) Effective July 1, 2013, if an individual requests case management services from a CDDP, the brokerage must refer the individual to the local CDDP for case management within 10 working days of the request.

(C) No fewer than 30 days after the brokerage has served written notice of intent to exit from brokerage services, when the individual either cannot be located or has not responded to repeated attempts by brokerage staff to complete ISP development or monitoring activities, and does not respond to the notice of intent to terminate;

(D) Upon entry into a comprehensive service; (b) Any individual being exited from a brokerage shall be given written notice of

the intent to terminate service at least 10 days prior to the termination.

(c) Each 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 and 410.070
Stats. Implemented: ORS 427.005, 427.007, and 430.610 to 430.695

**411-340-0120 Support Service Brokerage Services**
*(Temporary Effective 7/1/2013 - 12/28/2013)*

(1) Each 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, for individuals whose entry into support services occurred prior to October 1, 2013 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 providers;

(e) Fiscal intermediary services in the receipt and accounting of support services funds on behalf of an individual in addition to making payment to providers with the authorization of the individual;

(f) Employer-related supports; 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.

(2) SELF-DETERMINATION. Brokerages must apply the principles of self-determination to provision of services required in OAR 411-340-0120 of this rule.

(3) PERSON-CENTERED PLANNING. A 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.

(4) 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.

(5) PERSONAL AGENT SERVICES.

(a) An individual entered into brokerage services must be assigned a personal agent for case management services.

(b) INITIAL DESIGNATION OF PERSONAL AGENT.

(A) The brokerage must designate a personal agent for individuals newly entered in support services within 10 working days from the date entry becomes known to the brokerage.

(B) In the instance of an individual transferring into a brokerage from another brokerage, the brokerage must designate a personal agent within 10 days of entry to the new brokerage.

(C) The brokerage must send a written notice that includes the name, telephone number, and location of the personal agent or brokerage to the individual and the individual's legal representative within 10 working days from the date entry becomes known to the brokerage.

(D) Prior to implementation of the initial ISP, the brokerage shall ask the individual or the individual's legal representative to identify any family and other advocates to whom the brokerage shall provide the name, telephone number, and location of the personal agent.

(c) CHANGE OF PERSONAL AGENT. Changes of personal agents initiated by the brokerage must be kept to a minimum. If the brokerage must change personal agent assignments, the brokerage must notify the individual, the individual's legal representative, and all current service providers within 10 working days of the change. The notification must be in writing and include the name, telephone number, and address of the new personal agent, if known, or of a contact person at the brokerage.

(d) If an individual loses OSIP-M eligibility, the personal agent must assist the individual in identifying why OSIP-M eligibility was lost. Whenever possible, the personal agent must assist the individual in becoming eligible for OSIP-M again. The personal agent must document efforts taken to assist the individual in becoming eligible OSIP-M eligible.

(6) PARTICIPATION IN PROTECTIVE SERVICES. The brokerage and personal agent are responsible for the delivery of protective services, in cooperation with the CDDP, through the completion of activities necessary to address immediate health and safety concerns.

(7) LEVEL OF CARE ASSESSMENT. The brokerage must assure that individuals who are eligible or become eligible for OSIP-M after entry into the brokerage receive a level of care assessment. These individuals must:

(a) Be offered the choice between home and community-based services or institutional care;

(b) Be provided a notice of fair hearing rights; and

(c) Have the level of care assessment reviewed annually or at any time there is a significant change in the criteria that qualified the individual for institutional level of care. The level of care assessment must be documented in a case note in the individual's record. The level of care assessment must be completed no more than 60 days prior to the authorization of the initial plan Individual Support Plan and the annual reauthorization.

(8) FUNCTIONAL NEEDS ASSESSMENT.

(a) The brokerage must complete a functional needs assessment at least annually. The FNAT must be completed:

(A) Within 30 days of entry into a brokerage;

(B) Within 60 days prior to the authorization of a plan renewal;

(C) For an individual whose initial or annual plan was authorized on or after October 1, 2013, within 45 days from the time the individual requests a functional needs assessment.

(b) After July 1, 2013, an individual who has not yet had an annual plan renewal may not request a FNAT unless the individual meets crisis criteria according to OAR 411-340-0125.

(9) WRITTEN PLAN REQUIRED.

(a) Unless circumstances allow exception under section (8)(c) of this section, an individual who meets the level of care and is OSIP-M eligible, must have an authorized ISP.

(A) The ISP must be written by a personal agent.

(B) The ISP must be dated within 60 days of the completion of an FNAT and at least annually thereafter.

(C)The brokerage must provide a written copy of the most current ISP to the individual and the individual’s legal representative.

(b) For an initial ISP that is authorized on or after July 1, 2013, and for an annual ISP that is authorized on or after October 1, 2013, the ISP must address all the support needs identified on the FNAT. The ISP or attached documents must include:

(A) The individual's name;

(B) A description of the supports required, including the reason the support is necessary. For an initial ISP that is authorized on or after July 1, 2013, and for an annual ISP that is authorized on or after October 1, 2013, the description must be consistent with the FNAT;

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

(D) For an initial or annual ISP that is authorized prior to October 1, 2013 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 shall be applied to provide the required supports. Sources of support may include waivered and state plan services, state general funds, or natural 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 business provider), of supports to be purchased with support services funds;

(G) Schedule of ISP reviews; and

(H) Any revisions to OAR 411-340-0120(8)(a)(A) to (G) of this section that may alter:

(i) The amount of support services funds required;

(ii) The amount of support services required;

(iii) Types of support purchased with support services funds; and

(iv) The type of support provider.

(I) For individuals whose entry into support services occurred prior to October 1, 2013, and for an annual ISP that is authorized on or after October 1, 2013, the ISP must reflect any changes in support needs identified on a FNAT.

(c) The schedule of the support services ISP, developed in compliance with OAR 411-340-0120(3) of this rule after an individual enters a brokerage, may be adjusted one time for any individual entering a brokerage in certain circumstances. Such an adjustment shall interrupt any plan year in progress and establish a new plan year for the individual beginning on the date the first new ISP is authorized. Circumstances where this adjustment is permitted include:

(A) Brokerages, with the consent of the individual, may designate a new ISP start date.

(i) This adjustment may only occur one time per individual upon ISP renewal.

(ii) ISP date adjustments must be clearly documented on the ISP.

(B) Transition of individuals receiving family support services for children with intellectual or 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 411, division 350, when those individuals are 18 years of age. The date of the individual's first new support services ISP after entry to the brokerage may be adjusted to correspond

to the expiration date of the individual's Annual Plan of Care in place at the time the individual turns 18 years of age when the Annual Plan of Care, developed while the individual is still receiving family support, CIIS, or MFC services, has been authorized for implementation prior to or upon the individual's entry to the brokerage.

(C) 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 when the plan for services:

(i) Has been developed according to regulations governing Department-paid services the individual receives prior to transition;

(ii) Is current at the time designated by the Department for transition to support services; and

(iii) Is authorized for implementation prior to or upon the individual's entry to the brokerage.

(d) An Annual Plan must be completed for an individual who does not meet the level of care or is not eligible for OSIP-M.

(10) PROFESSIONAL OR OTHER SERVICE PLANS.

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

(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 to the ISP when an individual enrolled in a brokerage is in emergent status in a short-term, out-of-home, residential placement as part of the individual's crisis diversion services.

(11) ISP AUTHORIZATION.

(a) An initial and annual ISP must be authorized prior to implementation.

(b) A revision to the annual or initial ISP that involves the types of support purchased with support services funds must be authorized prior to implementation.

(c) A revision to the annual or initial ISP that does not involve the types of support purchased with support services funds does not require authorization. Documented verbal agreement to the revision by the individual or the individual’s legal representative is required prior to implementation of the revision.

(d) An ISP is authorized when:

(A) The signature of the individual or the individual's legal representative is present on the ISP or documentation is present explaining the reason an individual who does not have a legal representative may be unable to sign the ISP.

(i) Acceptable reasons for an individual without a legal representative not to sign the ISP include physical or behavioral inability to sign the ISP.

(ii) Unavailability of the individual is not an acceptable reason for the individual or the individual's legal representative not to sign the ISP.

(iii) In the case of a revision to the initial or annual ISP that is in response to immediate, unexpected change in circumstance, and is necessary to prevent injury or harm to the individual, documented verbal agreement may substitute for a signature for no more than 10 working days.

(B) The signature of the personal agent involved in the development of, or revision to, the ISP is present on the ISP; and

(C) A designated brokerage representative has reviewed the ISP for compliance with Department rules and policy.

(12) PERIODIC REVIEW OF PLAN AND RESOURCES.

(a) The personal agent must conduct and document reviews of plans and resources with the individual and the individual's legal representative.

(b) At least annually as part of preparation for a new ISP, the personal agent must:

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

(B) Note effectiveness of the use of support services funds based on personal agent observation as well as individual satisfaction;

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

(D) Record final support services fund costs.

(13) TRANSITION TO ANOTHER BROKERAGE. At the request of an individual enrolled in brokerage services who has selected another brokerage, the brokerage must collaborate with the receiving brokerage and the CDDP of the individual's county of residence to transition support services.

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

(b) The ISP in place at the time of request for transfer may remain in effect 90 days after entry to the new brokerage while a new ISP is negotiated and authorized.

Stat. Auth.: ORS 409.050 and 410.070
Stats. Implemented: ORS 427.005, 427.007, and 430.610 to 430.695

**411-340-0125 Crisis Supports in Support Services**
*(Temporary Effective 7/1/2013 - 12/28/2013)*

(1) The brokerage must, in conjunction with its Regional Crisis Diversion Program, attempt to provide supports that mediate a crisis risk factor for adults who are:

(a) Entered in support services; and

(b) Determined to be in crisis as described in OAR 411-340-0125(2) of this rule.

(2) CRISIS DETERMINATION.

(a) An individual enrolled in support services is eligible for crisis diversion services when:

(A) A brokerage has referred an individual to the Regional Crisis Diversion Program because the brokerage has determined that one or more of the following crisis risk factors, not primarily related to a significant mental or emotional disorder or substance abuse, are present and for which no appropriate alternative resources are available:

(i) An individual is not receiving necessary supports to address life-threatening safety skill deficits;

(ii) An individual is not receiving necessary supports to address life-threatening issues resulting from behavioral or medical conditions;

(iii) An individual currently engages in self-injurious behavior serious enough to cause injury that requires professional medical attention;

(iv) An individual undergoes, or is at imminent risk of undergoing, loss of caregiver due to caregiver inability to provide supports;

(v) An individual experiences a loss of home due to a protective service action; or

(vi) An individual is not receiving the necessary supports to address significant safety risks to others, including but not limited to:

(I) A pattern of physical aggression serious enough to cause injury;

(II) Fire-setting behaviors; or

(III) Sexually aggressive behaviors or a pattern of sexually inappropriate behaviors.

(B) The Regional Crisis Diversion Program has determined crisis eligibility according to OAR 411-320-0160.

(C) The individual's ISP has been revised to address the identified crisis risk factors and the revisions:

(i) May resolve the crisis; and

(ii) May not contribute to new or additional crisis risk factors.

(b) On or after October 1, 2013, an FNAT must be completed for any individual determined to be in crisis as described in this section of the rule.

(3) CRISIS SUPPORTS.

(a) An ISP for an individual in emergent status may authorize short-term, out-of-home, residential placement. Residential placement does not exit an individual from support services.

(b) The individual's personal agent must:

(A) Participate with the Regional Crisis Diversion Program staff in efforts to stabilize supports and return costs to the individual's benefit level;

(B) Assist with the identification of qualified providers who may be paid in whole or in part using crisis diversion funding except in the case of short-term, out-of-home, residential placements with a licensed or certified provider;

(C) Complete and coordinate the Support Services Brokerage Plan of Care Crisis Addendum when an individual in emergent status requires a short-term, out-of-home, residential placement; and

(D) Monitor the delivery of supports provided, including those provided through crisis funding.

(i) Monitoring is done through contact with the individual, any service providers, and the individual's family.

(ii) Monitoring is done to collect information regarding supports provided and progress toward outcomes that are identified as necessary to resolve the crisis.

(iii) The personal agent must document the information described in OAR 411-340-0125(3)(b)(D)(ii) of this section in the individual's case file and report to the Regional Crisis Diversion Program or CDDP as required.

(E) For an individual accessing support services who is not OSIP-M eligible, the personal agent must assist the individual in identifying why OSIP-M eligibility was lost. Whenever possible, the personal agent must assist the individual in becoming eligible for OSIP-M again. The personal agent must document efforts taken to assist the individual in becoming eligible OSIP-M eligible.

(c) Support services provided during emergent status are subject to all requirements of this rule.

(d) All supports authorized in an ISP continue during the crisis unless prohibited by other rule, policy, or the supports contribute to new or additional crisis risk factors.

(4) TRANSITION TO COMPREHENSIVE SERVICES. When an individual eligible for crisis supports may have long-term support needs that may not be met through support services:

(a) The brokerage must immediately notify the CDDP of the individual’s county of residence;

(b) The brokerage must coordinate with the CDDP and the Regional Crisis Diversion Program to facilitate a timely exit from support services and entry into appropriate, alternative services; and

(c) The brokerage must assure that information required for a potential provider of comprehensive services is available as needed for a referral to be made.

Stat. Auth.: ORS 409.050 and 410.070
Stats. Implemented: ORS 427.005, 427.007, and 430.610 to 430.695

**411-340-0130 Using Support Services Funds to Purchase Supports**
*(Temporary Effective 7/1/2013 - 12/28/2013)*

(1) A brokerage may use support services funds to assist individuals to purchase supports in accordance with an ISP when:

(a) Supports are necessary for an individual to live in the individual's own home or in the family home;

(b) For an initial ISP that is authorized on or after July 1, 2013, and for an annual ISP that is authorized on or after October 1, 2013 an FNAT has determined the supports to be necessary;

(c) An enrolled individual meets the criteria for level of care;

(d) An enrolled individual is eligible for OSIP-M;

(e) Cost-effective arrangements for obtaining the required supports, applying public, private, formal, and informal resources available to the eligible individual are specified in the ISP;

(A) Support services funds are not intended to replace the resources available to an individual from their natural support system. Support services funds may be authorized only when the natural support system is unavailable, insufficient, or inadequate to meet the needs of the individual.

(B) Support services funds are not available when an individual's support needs may be met by alternative resources. Support services funds may be authorized only when alternative resources are unavailable, insufficient, or inadequate to meet the needs of the individual.

(f) For individuals whose entry into support services occurred prior to October 1, 2013, or whose annual ISP is authorized prior to October 1, 2013, the ISP projects the amount of support services funds, if any, that may be required to purchase the remainder of necessary supports ; and

(g) The ISP has been authorized for implementation.

(2) A brokerage may use support services funds to assist individuals that do not meet the criteria in subsection (c) or (d) in the following circumstances:

(a) An individual meets the crisis criteria listed in 411-340-0125; or

(b) Up to the individual's 18th birthday the individual was enrolled in the Children's Intensive In-home Services (CIIS) Program as described in OAR chapter 411, division 300 or Long Term Supports as described in OAR chapter 411, division 308.

(3) The individual may no longer access support services after 10 days when an individual is eligible for support services based on section (1)(f) and --

(a) The individual does not apply for a disability determination and OSIP-M within 10 business days of the individual’s 18th birthday; OR

(b) The Social Security Administration or the Department's Presumptive Medicaid Disability Determination Team finds that an individual does not have a qualifying disability; OR

(c) The individual is determined by the State of Oregon to be ineligible for OSIP-M. ;.

(4) Goods and services purchased with support services funds on behalf of individuals are provided only as social benefits.

(5) LIMITS OF FINANCIAL ASSISTANCE. For individuals whose entry into support services occurred prior to October 1, 2013, the use of support services funds to purchase individual supports in any plan year is limited to the individual's annual benefit level.

(a) Individuals must have access throughout the plan year to the total annual amount of support services for which they are eligible that are determined to be necessary to implement an authorized ISP, even if there is a delay in implementation of the ISP, unless otherwise agreed to in writing by the individual or the individual's legal representative.

(b) The Department may require that annual benefit level amounts be calculated and applied on a monthly basis when an individual's eligibility for Medicaid changes during a plan year, an individual's benefit level changes, or when an individual's ISP is developed and written to be in effect for less than 12 months.

(A) Except in the case of an individual whose benefit level changes as the result of a change in eligibility for the Support Services Waiver, when an individual's benefit level changes, the monthly benefit level shall be 1/12 of the annual benefit level for which the individual would be eligible should the change in benefit level remain in effect for 12 calendar months. The monthly benefit level shall be applied each month for the

remainder of the plan year in which the individual's change in benefit level 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 benefit level shall be 1/12 of the annual benefit level for which the individual would be eligible should the individual's ISP be in effect for 12 calendar months. The monthly benefit level shall be applied each month during which the ISP of less than 12 months' duration is in effect.

(c) Estimates of the cost for each unique support service purchased with support services funds must be based on the Department's Support Services Rate Guidelines for costs of frequently used services.

(A) Notwithstanding the Department's Support Services Rate Guidelines, final costs for any support service purchased with support services funds may not exceed local usual and customary charges for these services as evidenced by the brokerage's own documentation.

(B) The brokerage must establish a process for review and approval of all cost estimates exceeding the Department's Support Services Rate Guidelines and must monitor the authorized ISP involved for continued cost effectiveness.

(6) EXCEPTIONS TO BASIC BENEFIT FINANCIAL LIMITS.

(a) Exceptions to the basic benefit annual support services fund limits do not apply to individuals whose entry into support services occurs on or after October 1, 2013 or whose annual ISP is authorized on or after October 1, 2013.

(b) Exceptions to the basic benefit annual support services fund limit for individuals whose entry into support services occurs prior to October 1, 2013 or whose annual ISP is authorized prior to October 1, 2013 may be only as follows:

(A) Individuals with extraordinary long-term need as demonstrated by a score of 60 or greater on the Basic

Supplement Criteria Inventory (Form DHS 0203) may have access to a basic supplement in order to purchase necessary supports.

(B) For Medicaid recipients choosing services under the Support Services Waiver, the basic supplement must result in a plan year cost that is not greater than the individual cost limit.

(C) The brokerage director, or a designee from brokerage management and administration, must administer the Basic Supplement Criteria Inventory 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 a designee from a brokerage’s management or administration must administer the Basic Supplement Criteria Inventory within 30 calendar days of the documented 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 basic supplement to the individual and the individual's legal representative within 45 calendar days of the documented request for a basic supplement. This written notice must include:

(i) An offer for the individual and the individual's legal representative to discuss the findings in person with the director and with the individual's personal agent in attendance if desired;

(ii) A notice of the complaint process under OAR 411-340-0060; and

(iii) A notice of planned action.

(F) Annual ISP reviews for recipients of the basic supplement must include a review of circumstances and resources to

confirm continued need according to the instructions included with the Basic Supplement Criteria Inventory.

(G) The basic supplement must be used to address the conditions and caregiver circumstances identified in the Basic Supplement Criteria Inventory as contributing to the extraordinary long-term need.

(c) An individual in emergent status may receive crisis diversion services that may cause an individual’s benefit level to be exceeded.

(A) Use of crisis diversion services and length of emergent status may be authorized only by the CDDP of the individual's county of residence, or the Regional Crisis Diversion Program responsible for the individual's county of residence, depending on the source of the funds for crisis diversion services.

(B) Funds associated with crisis diversion services may be used to pay the difference in cost between the authorized ISP and the supports authorized by either the CDDP of the individual's county of residence or the Regional Crisis Diversion Program responsible for crisis diversion services in the individual's county of residence, depending on the source of crisis diversion services funds required to meet the short-term need.

(C) Although costs for crisis diversion services may bring the individual's total plan year cost temporarily above the individual cost limit, the individual's costs may not exceed the cost of the state's current ICF/IDD daily cost per individual. Plan year expenses at or above the individual cost limit do not make the individual eligible for comprehensive services.

(D) 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 brokerage while both crisis diversion services and support services are required to stabilize and maintain the individual at home or in the family home..

(d) Individuals whose source of support funds are, in whole or in part, an individual-specific redirection of funds through a 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 entry to a 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.

(A) Individual plan year costs must always be less than the individual cost limit; and

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

(e) Individuals whose support funds were specifically assigned through a 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 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 individual cost limit; and

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

(f) 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), shall have limited access to support services funds as described in these rules. The amount of support services funds available shall be

equal to the Department's previous service costs for the individual for no more than 365 calendar days. The 365 calendar days begins the date the individual starts receiving support services exclusively through a brokerage.

(g) For Medicaid recipients eligible for and choosing services under the Support Services Waiver, individuals may have access to a basic supplement for ADLs to purchase needed support services under the following conditions:

(A) The individual must have additional assistance needs with ADLs after development of their ISP within the basic benefit, extraordinary long-term need fund limit, or other exceptions provided in this rule. ADLs include:

(i) Basic personal hygiene -- providing or assisting an individual with such needs as bathing (tub, bed bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(ii) Toileting, bowel, and bladder care -- assisting to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing the individual or adjusting clothing related to toileting, emptying catheter drainage bag or assistive device, ostomy care, or bowel care;

(iii) Mobility, transfers, and repositioning -- assisting the individual with ambulation or transfers with or without assistive devices, turning the individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(iv) Nutrition -- preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(v) Medication and oxygen management -- assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply; and

(vi) Delegated nursing tasks.

(B) Assistance means the individual requires help from another person with ADLs. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may also require verbal reminding to complete one of the tasks described in OAR 411-340-0130(4)(f)(A) of this section.

(i) "Cueing" means giving verbal or visual clues during the activity to help the individual complete activities without hands-on assistance.

(ii) "Hands-on" means a provider physically performs all or parts of an activity because the individual is unable to do so.

(iii) "Monitoring" means a provider observes the individual to determine if intervention is needed.

(iv) "Reassurance" means to offer encouragement and support.

(v) "Redirection" means to divert the individual to another more appropriate activity.

(vi) "Set-up" means getting personal effects, supplies, or equipment ready so that an individual may perform an activity.

(vii) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

(C) The supplement for ADLs must be used to meet identified support needs related to ADLs. The supplement for ADLs may also be used for the following services if they are incidental to the provision of ADLs, essential for the health and welfare of the individual, and provided solely for the individual receiving support services:

(i) Housekeeping tasks necessary to maintain the eligible individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens. Only the housekeeping activities related to the eligible individual’s needs may be considered in housekeeping;

(ii) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services, assistance with mobility, and transfers or cognition in getting to and from appointments;

(iii) Observation of an individual's status and reporting of significant changes to physicians, health care professionals, or other appropriate persons;

(iv) First aid and handling emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another person, or responding to an individual’s call for help during an emergent situation or for unscheduled needs requiring immediate response ; and

(v) Cognitive assistance or emotional support provided to an individual by another person due to intellectual or

developmental disability. This support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(D) The supplement for ADL support may not be used for any of the following services:

(i) Shopping;

(ii) Transportation;

(iii) Money management;

(iv) Mileage reimbursement;

(v) Social companionship; or

(vi) Respite

(E) Activities and goals related to the provision of ADL services must be sufficiently documented in the individual's ISP.

(F) Planned expenses must be based upon the least costly means of providing adequate services and must only be to the extent necessary to meet the documented ADL needs.

(G) The supplement for ADLs may not cause the cost per any plan year to exceed the individual cost limit. There is an exception for individuals receiving both support services under these rules who had a benefit level at the individual cost limit and state plan personal care services under OAR chapter 411, division 034, as of June 30, 2005. These individuals may continue to access the basic supplement and the supplement for ADLs until the individual terminates their receipt of support services or becomes ineligible for one of the supplements. The combined basic benefit, the basic supplement, and supplement for ADLs must remain above the individual cost limit to remain eligible for this exception.

(H) For Medicaid recipients receiving state plan personal care services under OAR chapter 411, division 034 entering support services after June 30, 2005, the Medicaid Personal Care Assessment (Form SDS 0531A) shall serve as the individual's authorized ISP for a period not to exceed 90 days.

(I) The supplemental ADL services are not intended to replace the resources available to an individual receiving support services under these rules from their natural support system of relatives, friends, neighbors, or other available sources of support.

(7) 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 in the amount required to implement an authorized ISP. 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 the brokerage and the individual or the individual's legal representative.

(8) TYPES OF SUPPORTS PURCHASED PRIOR TO JULY 1, 2013. For ISPs authorized for implementation prior to July 1, 2013, supports eligible for purchase with support services funds are:

(a) Chore services. Chore services may be provided only in situations where no one else in the household is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer agency, or third-party payer is capable of or responsible for providing these services;

(b) Community living and inclusion supports;

(c) Environmental accessibility adaptation;

(d) Family training;

(A) Family training must be provided:

(i) By licensed psychologists, medical professionals, clinical social workers, or counselors as described in OAR 411-340-0160(9); or

(ii) In organized conferences and workshops that are limited to topics related to the individual's intellectual or developmental disability, identified support needs, or specialized medical or habilitative support needs.

(B) Family training may not be provided to paid caregivers.

(e) Homemaker services. Homemaker services may be provided only when the person regularly responsible for general housekeeping 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;

(f) Occupational therapy services;

(g) Personal emergency response systems;

(h) Physical therapy services;

(i) Respite;

(A) 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.

(B) Respite includes two types of care, neither of which may be characterized as eight-hours-a-day, five-days-a-week services or provided to allow caregivers to attend school or work.

(i) Temporary respite must be provided on less than a 24-hour basis.

(ii) Twenty-four hour overnight care must be provided in segments of 24-hour units that may be sequential but may not exceed 14 consecutive days without permission from the Department.

(j) Special diets. Special diets may not provide or replace the nutritional equivalent of meals and snacks normally required regardless of intellectual or developmental disability.

(k) Specialized medical equipment and supplies as well as the following provisions:

(A) When specialized medical equipment and supplies are primarily and customarily used to serve a medical purpose, the purchase, rental, or repair of specialized medical equipment and supplies 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.

(B) 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 the State Medicaid Plan or private insurance, and the denial has been upheld in an applicable hearing or private insurance benefit appeals process.

(C) Devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the individual's abilities to perform ADLs or to perceive, control, or communicate with the environment in which the individual lives, may be purchased with support services funds when the individual's intellectual or developmental disability otherwise prevents or limits the individual's independence in these areas. Equipment and supplies that may 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 or herself);

(ii) Positioning devices;

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

(iv) Assistive technology items;

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

(vi) Augmentative communication devices;

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

(viii) 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);

(l) Specialized supports;

(m) Speech and language therapy services;

(n) Supported employment; and

(o) Transportation.

(9) TYPES OF SUPPORTS PURCHASED ON OR AFTER JULY 1, 2013. For an initial or annual ISP that is authorized after July 1, 2013, supports eligible for purchase with support services funds are:

(a) Community First Choice state plan services:

(A) Community nursing services as described in section (10) of this rule;

(B) Chore services as described in section (11) of this rule;

(C) Personal care as described in section (12) of this rule;

(D) Skills training as described in section (13) of this rule;

(E) Transportation as described in section (14) of this rule;

(F) Specialized medical equipment and supplies as described in section (15) of this rule;

(G) Respite as described in section (16) of this rule;

(H) Behavior support services as described in section (17) of this rule;

(I) Environmental accessibility adaptations as described in section (18) of this rule; and

(J) Transition costs as described in section (19) of this rule.

(b) Home and Community Based Waiver Services:

(A) Alternatives to employment - habilitation as described in section (20) of this rule;

(B) Pre-vocational services as described in section (21) of this rule;

(C) Supported employment as described in section (22) of this rule;

(D) Family training as described in section (23) of this rule;

(E) Occupational therapy as described in section (24) of this rule;

(F) Physical therapy as described in section (25) of this rule; and

(G) Speech, hearing, and language services as described in section (26) of this rule.

(10) COMMUNITY NURSING SERVICES. Community nursing services includes:

(a) Evaluation and identification of supports that minimize health risks while promoting an individual's autonomy and self-management of healthcare;

(b) Medication reviews;

(c) Collateral contact with a services coordinator regarding an individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered Individual Support Plan; and

(d) Delegation of nursing tasks to an individual’s provider so the provider may safely perform health related tasks.

(11) CHORE SERVICES. Chore services may be provided only in situations where no one else in the home is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer. agency, or third-party payer is capable of, or responsible for, providing these services;

(12) PERSONAL CARE SERVICES (ADL/IADL).

(a) Personal care services include but are not limited to:

(A) Basic personal hygiene -- providing or assisting an individual with such needs as bathing (tub, bed, bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(B) Toileting, bowel, and bladder care -- assisting an individual to and from bathroom, on and off toilet, commode, bedpan,

urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing an individual or adjusting clothing related to toileting, emptying catheter drainage bag or assistive device, ostomy care, or bowel care;

(C) Mobility, transfers, and repositioning -- assisting an individual with ambulation or transfers with or without assistive devices, turning the individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(D) Nutrition -- preparing meals and special diets, assisting an individual with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(E) Medication and oxygen management -- assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring an individual for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply;

(F) Delegated nursing tasks;

(G) Housekeeping -- tasks necessary to maintain an individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens.

(H) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services, assistance with mobility, and transfers or cognition in getting to and from appointments;

(I) Observation of an individual's status and reporting of significant changes to physicians, health care professionals, or other appropriate persons;

(J) First aid and handling emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another person, or responding to an individual’s call for help during an emergent situation or for unscheduled needs requiring immediate response ; and

(K) Cognitive assistance or emotional support provided to an individual by another person due to developmental disability. This support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(b) Personal care assistance means an individual requires help from another person with ADLs. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may also require verbal reminding to complete one of the tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal or visual clues during an activity to help an individual complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an activity because an individual is unable to do so.

(C) "Monitoring" means a provider observes an individual to determine if intervention is needed.

(D) "Reassurance" means to offer an individual encouragement and support.

(E) "Redirection" means to divert an individual to another more appropriate activity.

(F) "Set-up" means getting personal effects, supplies, or equipment ready so that an individual may perform an activity.

(G) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

(13) SKILLS TRAINING. Skills training are specifically tied to the FNAT and IHS Plan and are a means to increase independence, preserve functioning, and reduce dependency of an individual.

(14) TRANSPORTATION.

(a) Transportation services include but are not limited to --

(A) Transportation provided by common carriers, taxicab, or bus in accordance with standards established for these entities;

(B) Reimbursement on a per-mile basis for transporting an individual in a rural area into the nearest town once a week for shopping and recreational opportunities;

(C) Assistance with the purchase of a bus pass; and

(D) Reimbursement of operational expenses of agency or staff vehicles used for transporting individuals not to exceed established rates.

(b) Transportation services do not include medical transportation, purchase of individual or family vehicles, routine vehicle maintenance and repair, ambulance services, payment to the spouse of an individual receiving IHS services, and costs for transporting a person other than the individual.

(15) SPECIALIZED EQUIPMENT AND SUPPLIES. When specialized equipment and supplies are primarily and customarily used to serve a medical purpose, the purchase, rental, or repair of specialized equipment and supplies with IHS funds must be limited to the types of equipment and supplies that are not excluded under OAR 410-122-0080.

(a) Specialized equipment and supplies may include devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the individual's abilities to perform and support activities of daily living or to perceive, control, or communicate with the environment in which the individual lives.

(b) Specialized equipment and supplies may be purchased with IHS funds when an individual's intellectual or developmental disability otherwise prevents or limits the individual's independence in the areas described in section (5) of this rule

(c) Specialized equipment and supplies that may be purchased for the purpose described in subsection (b) of this section must be of direct benefit to the individual and include:

(A) Supplies needed to assist with incontinence care such as gloves, pads, wipes, or incontinence garments;

(B) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders and alert systems for ADL or IADL supports, or mobile electronic devices;

(C) Assistive technology to provide additional security and replace the need for direct interventions to allow self direction of care and maximize independence such as motion/sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems;

(i) Limit of $5000 per year without Department approval.

(ii) Any single device or assistance costing more than $500 in a plan year must be approved by the Department.

(D) Assistive devices. Examples include durable medical equipment, mechanical apparatus, electrical appliance or information technology device to assist and enhance an individual's independence in performing ADL/IADLs, not covered by other Medicaid programs.

(i) Limit of $5000 per year without Department approval.

(ii) Any single device or assistance costing more than $500 must be approved by the department.

(16) RESPITE.

(a) Respite may be provided in an 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.

(b) Respite includes two types of care, neither of which may be characterized as eight-hours-a-day, five-days-a-week services or provided to allow an individual's provider to attend school or work.

(c) Temporary respite must be provided on less than a 24-hour basis.

(d) Twenty-four hour overnight services must be provided in segments of 24-hour units that may be sequential but may not exceed 14 consecutive days without permission from the Department.

(17) BEHAVIOR SUPPORT SERVICES.

(a) Behavior support services consist of:

(A) Assessment of an individual or the needs of the individual's family and the environment;

(B) Development of positive behavior support strategies including a Behavior Support Plan if needed;

(C) Implementation of a positive Behavior Support Plan with the provider or family; and

(D) Revision and monitoring of the plan as needed.

(b) Behavior support services may include:

(A) Training, modeling, and mentoring the family;

(B) Development of visual communication systems as behavior support strategies; and

(C) Communicating as authorized by the individual or their legal representative with school, medical, or other professionals about the strategies and outcomes of the Behavior Support Plan.

(c) Behavior support services does not include:

(A) Mental health therapy or counseling;

(B) Health or mental health plan coverage;

(C) Educational services, including, but not limited to, consultation and training for classroom staff;

(D) Adaptations to meet needs of the individual at school; or

(E) Assessment in the school setting.

(18) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke detectors, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for an individual whose temperature sensitivity issues create behaviors or medical conditions that put the individual or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual;

(R) Modifications for the primary vehicle used by the individual that are necessary to meet the unique needs of the individual (lift or 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); and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the home that 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,

(c) Environmental modifications are limited to $5,000 per modification. A services coordinator may request approval for additional expenditures through the Department's prior to expenditure. Approval is based on the individual’s need and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental modifications must be tied to supporting activities of daily living, instrumental activities of daily living, and health-related tasks as identified in the IHS Plan.

(e) Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by a local inspector. Certification of compliance must be filed in the provider's file prior to payment.

(f) Environmental modifications must be made within the existing square footage of the home, except for external ramps, and may not add to the square footage of the home.

(g) Payment to the contractor is to be withheld until the work meets specifications.

(19) TRANSITION COSTS.

(a) Transition costs are limited to individuals transitioning from a nursing facility, ICF/IDD, or acute care hospital to a home or community-based setting where the individual resides.

(b) Services are based on an individual's assessed need, determined during the person-centered service planning process and must support the desires and goals of the individual receiving services and supports. Final approval for expenditures must be through the

Department prior to expenditure. Approval is based on the individual's need and the Department's determination of appropriateness and cost-effectiveness.

(c) Financial assistance is limited to:

(A) Moving and move-in costs including movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for heating, lighting, and phone;

(B) Payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishings (i.e. bed); and

(C) Other items necessary to re-establish a home.

(d) Transition costs are provided no more than twice annually

(e) Basic household furnishings and other items are limited to one time per year.

(20) ALTERNATIVES TO EMPLOYMENT - HABILITATION is assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home in which an individual with an intellectual or developmental disability resides.

(21) PRE-VOCATIONAL SERVICES. The IHS Plan must reflect that prevocational services are directed to habilitative rather than explicit employment objectives.

(22) SUPPORTED EMPLOYMENT SERVICES. Supported employment services assist an individual to choose, get, and keep a paid job in an integrated community business setting.

(a) Supported employment services includes job development, training, and on-going supervision to obtain paid employment.

(b) Training may focus on the individual and the individual's co-workers without disabilities capable of providing natural support.

(c) Supported employment services must not replace services available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

(d) Supported employment services under this rule may not replace or duplicate services that the individual currently receives through the Department-contracted employment and alternative to employment services governed by OAR chapter 411, division 345.

(23) FAMILY TRAINING. Family training services are training and counseling services provided to the family of an individual to increase their capabilities to care for, support, and maintain the individual in the home.

(a) Family training services include but are not limited to:

(A) Instruction about treatment regimens and use of equipment specified in the IHS Plan;

(B) Information, education, and training about the individual's disability, medical, and behavioral conditions; and

(C) Organized conferences and workshops specifically related to the individual's disability, identified support needs, or specialized medical or behavioral support needs.

(b) Family training services may be provided in various settings by various means, including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under ORS 677.100 or nursing under ORS 678.040, social workers licensed under ORS 675.530, or counselors licensed under ORS 675.715;

(c) Examples of what family training services do not provide include, but are not limited to:

(A) Mental health counseling, treatment, or therapy;

(B) Training for paid caregivers;

(C) Legal fees;

(D) Training for families to carry out educational activities in lieu of school;

(E) Vocational training for family members; and

(F) Paying for training to carry out activities that constitute abuse of an adult.

(d) Prior authorization by the CDDP is required for attendance by family members at organized conferences and workshops funded with IHS funds.

(e) Family training may not be provided to paid caregivers.

(24) OCCUPATIONAL THERAPY. Occupational therapy services are the services of a professional licensed under ORS 675.240 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Occupational therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified occupational therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Occupational therapy services do not include:

(A) Goods and services available through other public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(25) PHYSICAL THERAPY. Physical therapy services are the services of a professional licensed under ORS 688.020 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Physical therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified physical therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Physical therapy services do not include:

(A) Goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(26) SPEECH, HEARING, AND LANGUAGE SERVICES. Speech, hearing, and language services are the services of a professional licensed under

ORS 681.250 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope specified in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Speech, hearing, and language services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified speech therapy professional when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Speech, hearing, and language services do not include:

(A) Goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible, or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(27) Educational services for school age individuals, such as professional instruction, formal training, and tutoring in communication, socialization, and academic skills are not allowable expenses covered by support services funds.

(28) 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 choose to receive supports and services from another qualified provider;

(A) Individuals who choose to combine support services funds to purchase group services must receive written instruction from the brokerage 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) A provider organization resulting from the combined arrangements for community living and inclusion supports or supported employment services must be certified according to these rules; 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 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 and 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 services, 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 Oregon Board of Nursing rules in OAR chapter 851 when services involve performance of nursing services or delegation, teaching, and assignment of nursing tasks;

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

(g) In accordance with the Department's Support Services Expenditure Guidelines.

(29) INDEPENDENT PROVIDER, PROVIDER ORGANIZATION, AND GENERAL BUSINESS PROVIDER AGREEMENTS AND RESPONSIBILITIES. When support services funds are used to purchase services, training, supervision, or other personal assistance for individuals, the brokerage must require and document that providers are informed of:

(a) Mandatory reporter responsibility to report suspected abuse;

(b) Responsibility to immediately notify the person or persons, if any, specified by the individual or the individual's legal representative of any injury, illness, accident, or unusual circumstance that occurs when the provider is providing individual services, training, or supervision that 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 services 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 individual’s 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 services funds unless another arrangement is agreed upon by the brokerage and described in the ISP.

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

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

(30) SANCTIONS FOR INDEPENDENT PROVIDERS, PROVIDER ORGANIZATIONS, AND GENERAL BUSINESS PROVIDERS.

(a) A sanction 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 records check upon hiring or authorization of service;

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

(C) Surrendered his or her professional license or had his or her professional license suspended, revoked, or otherwise limited;

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

(E) Had a founded report of child abuse or substantiated abuse;

(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) Failed to comply with the provisions of OAR 411-340-0130(8) of this rule or OAR 411-340-0140; or

(K) Been suspended or terminated as a provider by another division within the Department or Oregon Health Authority.

(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 the Department, as applicable; or

(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.

(d) The provider may appeal a sanction within 30 days of the date the sanction notice was mailed to the provider. The provider must appeal a sanction separately from any appeal of audit findings and overpayments.

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

(B) 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.

(e) At the discretion of the Department, providers who have previously been terminated or suspended by any Department division or by the Oregon Health Authority may not be authorized as providers of Medicaid services.

Stat. Auth.: ORS 409.050 and 410.070
Stats. Implemented: ORS 427.005, 427.007, and 430.610 to 430.695

**411-340-0140 Using Support Services Funds for Certain Purchases Is Prohibited**
*(Amended 12/28/2011)*

(1) Effective July 28, 2009, support services funds may not be used to support, in whole or in part, a provider in any capacity who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(2) OAR 411-340-0140(1) of this rule does not apply to employees of individuals, individual's legal representatives, employees of general business providers, or employees of provider organizations who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(3) Support services funds may not be used to pay for:

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

(b) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 407-045-0260;

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

(d) Individual or family vehicles;

(e) Health and medical costs that the general public normally must pay including:

(A) Medications;

(B) Health insurance co-payments;

(C) Dental treatments and appliances;

(D) Medical treatments;

(E) Dietary supplements including but not limited to vitamins and experimental herbal and dietary treatments; or

(F) Treatment supplies not related to nutrition, incontinence, or infection control.

(f) Ambulance services;

(g) Legal fees;

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

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

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

(k) 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;

(l) Services provided in a nursing facility, correctional institution, or hospital;

(m) Services, activities, materials, or equipment that may be obtained by the individual or family through alternative resources or natural supports;

(n) Unless under certain conditions and limits specified in Department guidelines, 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;

(o) Services or activities for which the legislative or executive branch of Oregon government has prohibited use of public funds; or

(p) Notwithstanding abuse as defined in OAR 407-045-0260, services when there is sufficient evidence to believe that the individual or the individual's legal 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 brokerage resources, or otherwise knowingly misused public funds associated with brokerage services

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0150 Standards for Support Services Brokerage Administration and Operations**
*(Temporary Effective 7/1/2013 - 12/28/2013)*

(1) POLICY OVERSIGHT GROUP. 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 brokerage must establish and utilize a Policy Oversight Group, of which the membership majority must be individuals with intellectual or developmental disabilities and family members of individuals with intellectual or 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, and complaint resolution.

(c) If the Policy Oversight Group is not also the governing body of the 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 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 the general staff qualifications of OAR 411-340-0070(1) through (2), the brokerage director must have:

(a) A minimum of a bachelor's degree and two years experience, including supervision, in intellectual or developmental disabilities, social services, mental health, or a related field; or

(b) Six years of experience, including supervision, in the field of intellectual or developmental disabilities, social services, or mental health.

(4) FISCAL INTERMEDIARY REQUIREMENTS.

(a) A fiscal intermediary 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) A fiscal intermediary may not recruit, hire, supervise, evaluate, dismiss, or otherwise discipline those employed to provide services described in an authorized ISP.

(c) Fiscal intermediary qualifications.

(A) A fiscal intermediary may not:

(i) Be a provider of support services paid using support funds; or

(ii) Be a family member or other representative of an individual for whom they provide fiscal intermediary services.

(B) The brokerage must obtain and maintain written evidence that:

(i) Contractors providing fiscal intermediary services have sufficient education, training, or work experience to

effectively and efficiently perform all required activities; and

(ii) 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.

(a) Each personal agent must have knowledge of the public service system for developmental disability services in Oregon and --

(A) Bachelor's degree in a Behavioral Science, Social Science, or a closely related field; OR

(B) Bachelor's degree in any field and one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house); OR

(C) Associate's degree in a Behavioral Science, Social Science or a closely related field AND two years of human services related experience (i.e. work providing assistance to individuals and groups with issues such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing); OR

(D) Three years of human services related experience

(b) A brokerage must submit a written variance request to the Department prior to employment of a person not meeting the minimum qualifications for a personal agent set forth in subsection (a) of this section. The variance request must include:

(A) An acceptable rationale for the need to employ a person who does not meet the qualifications; and

(B) A proposed alternative plan for education and training to correct the deficiencies. The proposal must specify activities, timelines, and responsibility for costs incurred in completing the plan. A person who fails to complete a plan for education and training to correct deficiencies may not fulfill the requirements for the qualifications.

(6) 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:

(a) Principles of self-determination;

(b) Person-centered planning processes;

(c) Identification and use of alternative support resources;

(d) Fiscal intermediary services;

(e) Basic employer and employee roles and responsibilities;

(f) Developing new resources;

(g) Major public health and welfare benefits;

(h) Constructing and adjusting individualized support budgets; and

(i) Assisting individuals to judge and improve quality of personal supports.

(7) INDIVIDUAL RECORD REQUIREMENTS. The brokerage must maintain current, up-to-date records for each individual served and must make these records available to the Department upon request. Individual records must include at minimum:

(a) Application and eligibility information received from the referring CDDP.

(b) An easily-accessed summary of basic information, including the individual's name, family name (if applicable), individual's legal representative (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, for individuals whose entry into support services occurred prior to October 1, 2013 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, and verification that providers meet the requirements of OAR 411-340-0160 through 411-340-0180.

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

(f) Incident reports.

(g) The FNAT once completed and other assessments used to determine supports required, preferences, and resources.

(h) ISP and reviews. If the individual is unable to sign the ISP, the individual record must document that the individual was informed of the contents of the ISP and that the individual's agreement to the ISP was obtained to the extent possible.

(i) Names of those who participated in the development of the ISP. If the individual was not able to participate in the development of the ISP, the individual record must document the reason.

(j) Written service agreements. A 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 the individual's own safety and is missing while in the community under the service of the contractor or provider organization.

(k) A written job description for all services to be delivered by an employee of the individual or the individual's legal representative. The written job description must be consistent with the individual's ISP and must describe at minimum:

(A) Type of service to be provided;

(B) Hours, rates, location, duration 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 the individual's own safety and is missing while in the community under the service of the employee of the individual.

(l) Personal agent correspondence and notes related to resource development and plan outcomes.

(m) Progress notes. Progress notes must include documentation of the delivery of service by a personal agent to support each case service provided. Progress notes must be recorded chronologically and documented consistent with brokerage policies and procedures. All late entries must be appropriately documented. Progress notes must at a minimum include:

(A) The month, day, and year the services were rendered and the month, day, and year the entry was made if different from the date service was rendered;

(B) The name of the person receiving service;

(C) The name of the brokerage, the person providing the service (i.e., the personal agent's signature and title), and the date the entry was recorded and signed;

(D) The specific services provided and actions taken or planned, if any;

(E) Place of service. Place of service means the name of the brokerage and where the brokerage is located, including the address. The place of service may be a standard heading on each page of the progress notes; and

(F) The names of other participants (including titles and agency representation, if any) in notes pertaining to meetings with or discussions about the individual.

(n) Information about individual satisfaction with personal supports and the brokerage services.

(8) SPECIAL RECORD REQUIREMENTS FOR SUPPORT SERVICES FUND EXPENDITURES.

(a) 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:

(i) Itemized invoices and receipts to record purchase of any single item;

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

(iii) Itemized invoices for any services purchased from independent contractors, provider organizations, and professionals. Itemized invoices must include:

(I) The name of the individual to whom services were provided;

(II) The date of the services; and

(III) A description of the services.

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

(v) Documentation that services provided were consistent with the authorized ISP.

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

(i) When equipment is obtained for the exclusive use of an individual, the brokerage must record the purpose, final cost, and date of receipt.

(ii) The brokerage must secure use of equipment or furnishings costing more than $500 through a written agreement between the brokerage and the individual or the individual's legal representative that 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.

(iii) The brokerage must ensure that projects for environmental accessibility adaptations involving renovation or new construction in an individual's home costing $5,000 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 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.

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

(b) 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 Unit, 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.

(9) QUALITY ASSURANCE.

(a) The Policy Oversight Group must develop a Quality Assurance Plan and review this plan at least twice a year. The Quality Assurance 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.

(10) BROKERAGE REFFERRAL TO AFFILIATED ENTITIES.

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

(A) The brokerage conducts a review of provider options that demonstrates that the entity's services shall 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 provider;

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

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

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

(E) Collection and review of data on services, purchased by an 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 providers.

(11) GENERAL OPERATING POLICIES AND PRACTICES. The 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 brokerage to accomplish its objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 409.050 and 410.070
Stats. Implemented: ORS 427.005, 427.007, and 430.610 and 430.695

**411-340-0160 Standards for Independent Providers Paid with Support Services Funds**
*(Amended 7/1/2010)*

(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 the 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 Division policy and a criminal records check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370. Any individual meeting the definition of subject individual as defined in OAR 407-007-0200 to

407-007-0370 may be approved for one position to work in multiple homes within the jurisdiction of the qualified entity as defined in OAR 407-007-0200 to 407-007-0370. The Department's Background Check Request form must be completed by the subject individual to show intent to work at various homes;

(c) Effective July 28, 2009, not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275;

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

(e) Not be a spouse of the individual;

(f) 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 the 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; and

(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.

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

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

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

(j) 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) Section (1)(c) of this rule does not apply to employees of individuals or individual's legal representatives, employees of general business providers, or employees of provider organizations who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(3) All providers must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and OAR 407-007-0290. The provider must notify the Department or its designee within 24 hours.

(4) BEHAVIOR CONSULTANTS. 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 individuals who present difficult or dangerous behaviors; or

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

(5) SOCIAL OR SEXUAL CONSULTANTS. Social or sexual consultants providing specialized supports must:

(a) Have the education, skills, and abilities necessary to provide social or 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 individuals; or

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

(6) NURSING CONSULTANTS. 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 individuals.

(7) ENVIRONMENTAL MODIFICATION CONSULTANTS. 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 shall make the home safe and accessible for the individual.

(8) ENVIRONMENTAL ACCESSIBILITY ADAPTATION PROVIDERS. 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 Board.

(9) FAMILY TRAINING PROVIDERS. 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.

(10) DIETICIANS. Dieticians providing special diets must be licensed according to ORS 691.415 through 691.465.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0170 Standards for Provider Organizations Paid with Support Services Funds**
*(Amended 7/1/2009)*

(1) PROVIDER ORGANIZATIONS WITH CURRENT LICENSE OR CERTIFICATION. A provider organization's license under OAR chapter 411, division 325 for 24-hour residential services, OAR chapter 411, division 360 for adult foster homes, certified under OAR chapter 411, division 345 for employment and alternatives to employment services, or OAR 309-041-0550 through 309-041-0830 for supported living services, may not require additional certification as an organization to provide respite, supported employment, community living and inclusion supports, transportation, specialized supports, chore services, family training, or emergent services.

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

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

(B) Provide services according to ISPs; 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 persons 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 described 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 section (2)(f) of this rule in each such site.

(2) PROVIDER ORGANIZATIONS REQUIRING CERTIFICATION. A provider organization without a current license or certification as described in section (1) of this rule must be certified as a provider organization according to OAR 411-340-0030 prior to selection for providing services listed in OAR 411-340-0130(6) and paid for with support services funds.

(a) 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, OAR 411-340-0050, OAR 411-340-0070, OAR 411-340-0080, and OAR 411-340-0090 related to abuse and unusual incidents, inspections and investigations, personnel policies and practices, records, and variances.

(B) Individual rights. The provider organization must have and implement written policies and procedures that:

(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 that may include but is not limited to:

(I) Staff borrowing from or loaning money to individuals;

(II) Witnessing wills in which the staff or provider organization is beneficiary; or

(III) Adding the staff member or provider organization name to the individual's bank account or other personal property without approval of the individual or the individual's legal representative.

(C) Complaints. The provider organization must implement written policies and procedures for individuals' complaints. These policies and procedures must, at a minimum, provide for:

(i) Receipt of complaints from an individual or others acting on the individual's behalf. If the complaint is associated in any way with abuse or the violation of the individual's rights, the recipient of the complaint must immediately report the issue to the provider organization director and the CDDP;

(ii) Investigation of the facts supporting or disproving the complaint;

(iii) Taking appropriate actions on complaints within five working days following receipt of the complaints;

(iv) Submission to the provider organization director. If the complaint is not resolved, the complaint must be submitted to the provider organization director for review. The provider organization director must complete a review and provide a written response to the complainant within 15 days of request for review;

(v) Submission to the brokerage. All complaints received from an individual or others acting on the individual's behalf must be reported to the appropriate brokerage; and

(vi) Notification. Upon entry into the program and annually thereafter, the provider organization must inform each individual, or the individual's legal representative, orally and in writing, using language, format, and methods of communication appropriate for the individual's needs and abilities, of the provider organization's complaint policy and procedures.

(D) Policies and procedures appropriate to scope of service including but not limited to those required to meet minimum standards set forth in sections (2)(f) through (2)(k) of this rule and consistent with written service agreements for individuals currently receiving services.

(b) The provider organization must deliver services according to the written service agreement.

(c) The provider organization 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 the individual's legal representative;

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

(D) Contact information for the 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 current CPR and first aid certification obtained from a recognized training agency prior to working alone with an individual.

(e) The provider organization must ensure that employees, contractors, and volunteers receive appropriate and necessary training.

(f) 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) 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" must be posted by designated telephones; 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 telephones.

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

(D) The provider organization 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 provider organization 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 provider organization for at least two years following the drill. The written documentation 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 the individual's legal representative, and the provider organization director; and

(II) Be submitted as a variance request according to OAR 411-340-0090.

(E) The provider organization must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(F) At least once every three years, the provider organization must conduct a health and safety inspection.

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

(ii) The inspection must be performed by:

(I) The Oregon Occupational Safety and Health Division;

(II) The provider organization's worker's compensation insurance carrier; or

(III) An appropriate expert such as a licensed safety engineer or consultant as approved by the SPD; and

(IV) The DHS Public Health Division, when necessary.

(iii) The inspection 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) The provider organization 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) 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. 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 needs identified in the individual service agreement; and

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

(g) 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:

(i) Emergency medical intervention;

(ii) Treatment and documentation of illness and health care concerns;

(iii) Administering, storing, and disposing of prescription and non-prescription drugs including self administration;

(iv) Emergency medical procedures including the handling of bodily fluids; and

(v) Confidentiality of medical records;

(B) Maintain a current written record for each individual receiving assistance with meeting health and medical needs that includes:

(i) Health status;

(ii) Changes in health status observed during hours of service;

(iii) Any remedial and corrective action required and when such actions were taken if occurring during hours of service; and

(iv) 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 may 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;

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

(vi) Not administer unused, discontinued, outdated, or recalled drugs; and

(vii) Not administer PRN psychotropic medication. PRN orders may not be accepted for psychotropic medication.

(D) Maintain a MAR (if required). 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.

(E) Provide safeguards to prevent adverse medication reactions including:

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

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

(iii) Prohibiting the use of one individual's medications by another.

(F) Maintain a record of visits to medical professionals, consultants, or therapists if facilitated or provided by the provider organization.

(h) 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;

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

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

(i) 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 the provider organization or another individual's funds, or the provider organization becoming an individual's legal representative; and

(B) The provider organization's reimbursement to the individual of any funds that are missing due to theft or mismanagement on the part of any staff of the provider organization, or of any funds within the custody of the provider organization 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) The provider organization must have and implement a written policy concerning behavior intervention procedures. The provider organization must inform the individual and the 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 and must be:

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

(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.

(k) Additional standards for supports that involve restraints.

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

(i) As part of an ISP;

(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) Provider organization staff members who need to apply restraint under an individual's service agreement must be trained by a SPD-approved trainer and documentation of the training must be maintained in the staff members' personnel file.

(C) 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 provider organization director or the individual's physician;

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

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

(v) Prompt a review of the written service agreement, initiated by the provider organization, 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) 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 applying the restraint; and

(v) Description of the incident.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

**411-340-0180 Standards for General Business Providers Paid with Support Services Funds**
*(Amended 7/1/2009)*

(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 Board, 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 licenses 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 Division of Medical Assistance Programs 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 special 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 & 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695