DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 340

SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

EFFECTIVE JANUARY 1, 2016

411-340-0010 Statement of Purpose
(Amended 12/28/2013)

(1) The rules in OAR chapter 411, division 340 prescribe standards, responsibilities, and procedures for support services brokerages to assist adults with intellectual or developmental disabilities to identify and address support needs and for providers paid with support services funds, including resources available through the state plan and waiver, to provide services so that an adult with an intellectual or developmental disability may live in his or her own home or in the family home.

(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 intellectual or developmental disabilities so that an adult with an intellectual or developmental disability may exercise self-determination in the design and direction of his or her life.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0020 Definitions
(Temporary Effective 01/01/2016 to 06/28/2016)

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 340:

(1) "ADL" means "activities of daily living".

(2) "Brokerage" means an entity or distinct operating unit within an existing entity that uses the principles of self-determination to perform the functions associated with planning and implementation of support services for individuals with intellectual or developmental disabilities.

(3) "Brokerage Director" means the Director of a publicly or privately-operated brokerage, who is responsible for administration and provision of services according to these rules, or the designee of the Brokerage Director.

(4) "CDDP" means "Community Developmental Disability Program".

(5) "Certificate" means the 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 the provision of services.

(6) "Choice Advising" means the impartial sharing of information to individuals with intellectual or developmental disabilities provided by a person that meets the qualifications in OAR 411-340-0150(5) about:

(a) Case management;

(b) Service options;

(c) Service setting options; and

(d) Provider types.

(7) "Clinical Criteria" means the criteria used by the Department or the Medically Fragile Children's Unit as described in OAR 411-350-0055 to assess the private duty nursing support needs of an individual aged 18 through 20.

(8) "CPMS" means "Client Process Monitoring System".

(9) "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 the individual is in emergent status. Crisis diversion services include short-term residential placement services indicated on a Support Services Brokerage Crisis Addendum.

(10) "Department" means the Department of Human Services.

(11) "Director" means the Director of the Department of Human Services, Office of Developmental Disability Services or Office of Licensing and Regulatory Oversight, or the designee of the Director.

(12) "Direct Nursing Services" mean the nursing services described in OAR chapter 411, division 380 that are determined medically necessary to support an adult with complex health management support needs in his or her home and community. Direct nursing services are provided on a shift staffing basis.

(13) "Discovery and Career Exploration" means "discovery and career exploration" as defined in OAR 411-345-0020.

(14) "Employment Path Services" means "employment path services" as defined in OAR 411-345-0020.

(15) "Employment Services" means "employment services" as defined in OAR 411-345-0020.

(16) "Employment Specialist" means "employment specialist" as defined in OAR 411-345-0020.

(17) "Endorsement" means the authorization to provide program services issued by the Department to a certified agency that has met the qualification criteria outlined in these rules, the corresponding program rules, and the rules in OAR chapter 411, division 323.

(18) "Entity" means a person, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation of a state.

(19) "Family":

(a) Means a unit of two or more people that includes at least one individual with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the individual with an intellectual or developmental disability by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general, such as child-rearing, maintenance of the residence, and basic living expenses; and

(iii) Joint responsibility for supporting the individual with an intellectual or developmental disability when the individual is related to one of the partners by blood, marriage, or legal adoption.

(b) The term "family" is defined as described above for purposes of:

(A) Determining the eligibility of an individual for brokerage services as a resident in the family home;

(B) Identifying people who may apply, plan, and arrange for individual services; and

(C) Determining who may receive family training.

(20) "Functional Needs Assessment":

(a) Means the comprehensive assessment or re-assessment that:

(A) Documents physical, mental, and social functioning;

(B) Identifies risk factors and support needs; and

(C) Determines the service level.

(b) The functional needs assessment for an adult enrolled in a support services brokerage is known as the Adult Needs Assessment (ANA). The Department incorporates Version C of the ANA into these rules by this reference. The ANA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm/. A printed copy of a blank ANA may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

(21) "Home Delivered Meals" means "Home Delivered Meals" as defined in OAR 411-040-0010.

(22) "IADL" means "instrumental activities of daily living".

(23) "ICF/ID" means an intermediate care facility for individuals with intellectual disabilities.

(24) "In-Home Expenditure Guidelines" mean the guidelines published by the Department that describe allowable uses for support services funds. Effective January 1, 2016, the Department incorporates Version 4.0 of the In-home Expenditure Guidelines into these rules by this reference. The In-home Expenditure Guidelines are maintained by the Department at: (http://www.dhs.state.or.us/spd/tools/dd/cm/ss_exp_guide.pdf). A printed copy may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(25) "Incident of Ownership" means an ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interest.

(26) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in another entity. Indirect ownership interest includes an ownership interest in an entity that has an indirect ownership interest in another entity.

(27) "ISP" means "Individual Support Plan".

(28) "Job Coaching" means "job coaching" as defined in OAR 411-345-0020.

(29) "Job Development" means "job development" as defined in OAR 411-345-0020.

(30) "Level of Care" means an individual meets the following institutional level of care for an ICF/ID:

(a) The individual has a an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria in OAR 411-320-0080 for developmental disability services; and

(b) The individual has a significant impairment in one or more areas of adaptive behavior as determined in OAR 411-320-0080.

(31) "OHA" means the "Oregon Health Authority".

(32) "OHP Plus" means only the Medicaid benefit packages provided under OAR 410-120-1210(4)(a) and (b). This excludes individuals receiving Title XXI benefits.

(33) "OSIPM" means "Oregon Supplemental Income Program-Medical" as described in OAR 461-001-0030. OSIPM is Oregon Medicaid insurance coverage for individuals who meet the eligibility criteria described in OAR chapter 461.

(34) "Owner" means a person with an ownership interest.

(35) "Ownership Interest" means the possession of equity in the capital, stock, or profits of an entity.

(36) "Personal Agent" means a person who:

(a) Is a case manager for the provision of case management services;

(b) Is the person-centered plan coordinator for an individual as defined in the Community First Choice state plan amendment;

(c) Works directly with individuals and, if applicable, the legal or designated representatives and families of individuals to provide or arrange for support services as described in these rules;

(d) Meets the qualifications set forth in OAR 411-340-0150(5); and

(e) Is a trained employee of a brokerage or 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.

(37) "Plan Year" means 12 consecutive months that, unless otherwise set according to the conditions of OAR 411-340-0120, begins on the start date specified in the first authorized ISP for an individual after entry to a brokerage. Subsequent plan years begin on the anniversary of the start date of the initial ISP.

(38) "Policy Oversight Group" means the group that meets the requirements of OAR 411-340-0150(1) that is formed to provide individual-based leadership and advice to each brokerage regarding issues, such as development of policy, evaluation of services, and use of resources.
(39) "Private Duty Nursing Services" mean the State Plan nursing services described in OAR chapter 410, division 132 (OHA, Private Duty Nursing Services) and OAR 411-350-0055 that are determined medically necessary to support an individual aged 18 through 20.

(40) "Regional Crisis Diversion Program" means "Regional Crisis Diversion Program" as defined in OAR 411-320-0020.

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

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

(b) Are designed, selected, and managed by an individual;

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

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

(42) "Support Services Brokerage Crisis Addendum" means the short-term plan that is required by the Department to be added to an ISP to describe crisis diversion services an individual is to receive while the individual is in emergent status.

(43) "Support Services Funds" mean the public funds designated by the brokerage for assistance with the purchase of supports according to an ISP.

(44) "Supported Employment - Individual Employment Support" means "supported employment - individual employment support" as defined in OAR 411-345-0020.

(45) "Supported Employment - Small Group Employment Support" means "supported employment - small group employment support" as defined in OAR 411-345-0020.

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

(47) "Variance" means the temporary exception from a regulation or provision of these rules that may be granted by the Department as described in OAR 411-340-0090.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0030 Certification of Support Services Brokerages and Provider Organizations
(Temporary Effective 01/01/2016 to 06/28/2016)

(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 Department 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 OAR 411-340-0170.

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

(d) Certificates, including those issued before January 1, 2016 are effective for a maximum of two years.

(e) The Department shall conduct a review of the brokerage, or the provider organization granted certification under OAR 411-340-0170 or requiring certification and endorsement as set forth in OAR chapter 411 division 323, prior to the issuance of a certificate or endorsement.

(2) CERTIFICATION. A brokerage must apply for an initial certificate and for a certificate renewal. A provider organization requesting certification under these rules must apply before January 1, 2016.

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

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

(c) To renew certification, the brokerage must make application at least 30 days, but not more than 120 days, prior to the expiration date of the existing certificate. On renewal of brokerage certification, no increase in the maximum number of individuals to be served by the brokerage may be certified unless specifically approved by the Department. A certificate for a provider organization that was issued under these rules before January 1, 2016 may not be renewed. On

and after January 1, 2016, the provider organization must apply for certification and endorsement as set forth in OAR chapter 411, division 323.

(d) Application for renewal must be filed no more than 120 days prior to the expiration date of the existing certificate and extends the effective date of the existing certificate until the Department 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) Before issuance or renewal of the certificate, the applicant must demonstrate to the satisfaction of the Department that the applicant is capable of providing services identified in a manner consistent with the requirements of these rules.

(3) CERTIFICATION EXPIRATION, TERMINATION OF OPERATIONS, OR CERTIFICATE RETURN.

(a) Unless revoked, suspended, or terminated earlier, each certificate to operate a brokerage or provider organization expires on the expiration date specified on the certificate or two years from the date the certificate was issued, whichever is sooner.

(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, must notify the Department in writing of any pending action resulting in a five percent or more change in ownership and of any pending change in the legal entity, legal status, or management corporation of the brokerage or provider organization.

(5) NEW CERTIFICATE REQUIRED. A new certificate for a brokerage or provider organization is required upon change in the ownership, legal

entity, or legal status of a brokerage or provider organization. The brokerage or provider organization must apply for a certificate as described in section (2) of this rule at least 30 days before the change in ownership, legal entity, or legal status.

(6) CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may deny, revoke, or refuse to renew a certificate when the Department finds the brokerage or provider organization, the brokerage or provider organization director, or any person holding five percent or greater financial interest in the brokerage or provider organization:

(a) Demonstrates substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized and 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 Department 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 Department 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 Office of Inspector General's list of excluded or debarred providers (http://exclusions.oig.hhs.gov/).

(7) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. Following a Department finding that there is a substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in section (6) of this rule has occurred, the Department may issue a notice of certificate revocation, denial, or refusal to renew.

(8) IMMEDIATE SUSPENSION OF CERTIFICATE. When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the certificate holder, immediately suspend a certificate without a pre-suspension hearing and the 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 Department 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 Department's 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 Department 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 Department 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 Department for an administrative review. The Department 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 is treated as a request for a 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, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0040 Abuse and Unusual Incidents in Support Services Brokerages and Provider Organizations
(Amended 12/28/2013)

(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 (as applicable); and

(B) In the case of a 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 Department;

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

(C) The CDDP; and

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

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0050 Inspections and Investigations in Support Services Brokerages and Provider Organizations
(Amended 12/28/2014)

(1) Support services brokerages and provider organizations 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, Oregon Health Authority, or proper authority performs 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 Department may review the brokerage implementation of these rules at least every two years or more frequently as needed to ensure compliance.

(10) Following a Department review, the Department shall issue a report to the brokerage identifying areas of compliance and areas in need of improvement.

(11) If, following a review, the brokerage is not in substantial compliance with these rules; the brokerage must respond to a plan of improvement within 45 days of the review report being issued, or in a time specified by the Department. The Department may conduct additional reviews as necessary to ensure improvement measures have been achieved. The Department may offer, or the brokerage may request, technical assistance or training.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0060 Complaints, Notification of Planned Action, and Hearings
(Amended 12/28/2014)

(1) COMPLAINTS.

(a) Complaints must be addressed in accordance with OAR 411-318-0015.

(b) The brokerages must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015.

(c) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual.

(2) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disability service is denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(3) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(b) An individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025.

(c) Upon entry and request and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0070 Support Services Brokerage and Provider Organization Personnel Policies and Practices
(Amended 12/28/2013)

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

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

(b) Written documentation of an approved background 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 intellectual or 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 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 407-007-0210, who has or will have contact with an eligible individual of support services, must have an approved background 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, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0080 Support Services Brokerage and Provider Organization Records
(Amended 12/28/2014)

(1) CONFIDENTIALITY. Brokerage and provider organization records of services to individuals must be kept confidential in accordance with ORS 179.505 and any Department rules or policies pertaining to individual service records.

(2) DISCLOSURE AND CONFIDENTIALITY. For the purpose of disclosure from individual medical records under these rules, brokerages, and provider organizations requiring certification under OAR 411-340-0170(2), are considered "providers" as defined in ORS 179.505(1) and ORS 179.505 is applicable.

(a) Access to records by the Department does not require authorization by an individual or the legal or designated representative or family of the individual.

(b) For the purpose of disclosure of 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 Medicaid funds may not exceed the customary charges to private individuals for any like item or services charged by the brokerage or provider organization; and

(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 at least three years after the close of the contract period.

(b) Individual records must be kept for at least seven years.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0090 Support Services Brokerage and Provider Organization Request for Variance
(Amended 12/28/2014)

(1) A variance that does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws 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 shall 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 a written application to the Department that contains the following:

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

(b) The reason for the proposed variance;

(c) A description of the alternative practice, service, method, concept, or procedure proposed, including how the health and safety of individuals receiving services shall be protected to the extent required by these rules;

(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 the services to an individual, evidence that the variance is consistent with the currently authorized ISP for the individual.

(4) The request for a variance is approved or denied by the Department. The decision of the Department is sent to the brokerage or provider organization and to all relevant Department programs or offices within 45 days from the receipt of the variance request.

(5) The brokerage or provider organization may request an administrator review of the denial of a variance request by sending a written request for review to the Director. The decision of the Director is the final response from the Department.

(6) The Department determines the duration of the variance.

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

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0100 Eligibility for Support Services
(Amended 12/28/2014)

(1) 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 of an individual for support services is determined by the CDDP of the county of origin according to OAR 411-320- 0110(8).

(3) Individuals are not eligible for services by more than one brokerage unless the concurrent eligibility:

(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, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0110 Standards for Support Services Brokerage Entry and Exit
(Amended 12/28/2014)

(1) The brokerage must make accurate, up-to-date, information about the brokerage available to individuals referred for services and the legal or designated representatives of individuals. 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 the individual rights in OAR 411-318-0010, including the right of an individual to:

(A) Choose a brokerage from among Department-contracted brokerages in the county of origin of an individual that is serving less than the total number of individuals specified in the current contract between the brokerage and 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 for the individual;

(D) Direct the services of providers; and

(E) Raise and resolve concerns about brokerage services, including specific rights to notification of planned action and hearings according to OAR 411-340-0060 and the rules in OAR chapter 411, division 318.

(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 organizational structure of the brokerage;

(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 Policy Oversight Group of the brokerage.

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

(3) ENTRY INTO BROKERAGE SERVICES.

(a) To enter brokerage services:

(A) An individual must be determined eligible according to OAR 411-320-0110; and

(B) The individual 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 current contract between the brokerage and the Department.

(4) EXIT FROM A BROKERAGE.

(a) An individual must exit a brokerage:

(A) At the oral or written request of an individual to end the service relationship;

(B) After an individual, either cannot be located or has not responded after 30 days of repeated attempts by brokerage staff to complete ISP development or monitoring activities;

(C) Upon the entry of an individual into CDDP case management services;

(D) When an individual is incarcerated or admitted to a medical hospital, psychiatric hospital, sub-acute facility, nursing facility, ICF/ID, or other 24-hour residential setting and it is determined that the individual is not returning home; or

(E) When an individual does not reside in Oregon or resides in an area outside the geographic service area of the brokerage.

(b) In the event an individual exits a brokerage, a written Notification of Planned Action must be provided as described in OAR 411-340-0060 and OAR chapter 411, division 318.

(c) Each brokerage must have policies and procedures for notifying the CDDP of the county of origin of an individual when the individual plans to exit, or exits, brokerage services. Notification method, timelines, and content must be based on agreements between the brokerage and the CDDP of each county in which the brokerage provides services.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0120 Support Service Brokerage Services
(Temporary Effective 01/01/2016 to 06/28/2016)

(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 and plan supports in response to needs;

(b) Case management;

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

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

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

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

(g) Employer-related supports; and

(h) 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 the provision of services required in section (1) 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 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 business 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 as applicable the legal or designated representative of the individual, within 10 business days from the date entry becomes known to the brokerage.

(D) Prior to implementation of the initial ISP for an individual, the brokerage must ask the individual to identify any family and other advocates to whom the brokerage must 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, and as applicable the legal or designated representative of the individual, and all current providers within 10 business 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) OSIPM/OHP PLUS ELIGIBILITY. If an individual loses OSIPM or OHP Plus eligibility, a personal agent must assist the individual in identifying why OSIPM or OHP Plus eligibility was lost. Whenever possible, the personal agent must assist the individual in becoming eligible for OSIPM or OHP Plus again. The personal agent must document efforts taken to assist the individual in becoming OSIPM or OHP Plus eligible.

(e) CASE MANAGEMENT CONTACT. Every individual who has an ISP must have a case management contact no less than once every three months. Individuals with significant health and safety risks as identified in the ISP must have more frequent case management contact. At least one case management contact per year must be face to face. If an individual agrees, other case management contacts may be made by telephone or by other interactive methods. The outcome of the case management contact must be recorded in the progress notes. The purpose of the case management contact is:

(A) To assure known health and safety risks are adequately addressed;

(B) To assure that the support needs of the individual have not significantly changed; and

(C) To assure that the individual is satisfied with the current supports.

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

(7) CHOICE ADVISING.

(a) Choice advising regarding the provision of case management and other services must be provided to individuals who are eligible for, and desire, developmental disability services. Choice advising must be provided at least annually. Documentation of the discussion must be included in the service record for the individual.

(b) Beginning no later than July 1, 2016, in accordance with the rules for home and community-based services and settings in OAR chapter 411, division 004, an individual, or as applicable the legal or designated representative of the individual, must be advised regarding the available residential and non-residential settings, including non-disability specific settings and an option for a private unit in a residential setting. The settings options must be:

(A) Identified and documented in the ISP as described in section (10) of this rule;

(B) Based on the needs and preferences of the individual;

(C) For residential settings, the available resources of the individual for room and board; and

(D) For employment and non-residential day services, a non-disability specific setting option must be presented and documented in the ISP.

(8) LEVEL OF CARE DETERMINATION.

(a) The brokerage must assure that an individual who is eligible for OHP Plus or OSIPM or who becomes eligible after entry into the brokerage:

(A) Receives a level of care determination prior to accessing services and prior to an initial functional needs assessment;

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

(C) Is provided a notice of fair hearing rights (Notification of Rights SDS 0948); and

(D) Has the level of care determination reviewed annually not more than 60 days prior to the renewal of the ISP, or at any time there is a significant change in a condition that qualified the individual for the level of care.

(b) A level of care determination may be made by a services coordinator or a personal agent.

(c) The level of care assessment must be documented in a progress note in the record for the individual.

(9) FUNCTIONAL NEEDS ASSESSMENT. The brokerage or CDDP must complete a functional needs assessment initially and at least annually for any individual who is enrolled in, or is expected to enroll in, waiver or Community First Choice state plan services.

(a) A functional needs assessment must be completed:

(A) Not more than 45 days from the date the individual submitted a completed application to the CDDP or the date the individual became eligible for OHP Plus or OSIPM;

(B) Prior to the development of an initial ISP;

(C) Within 60 days prior to the annual renewal of an ISP; and

(D) Within 45 days from the date an individual requests a functional needs re-assessment.

(b) The assessment must be conducted face to face.

(c) An individual, and as applicable the legal or designated representative of the individual, must participate in a functional needs assessment and provide information necessary to complete the functional needs assessment and reassessment within the time frame required by the Department.

(A) Failure to participate in the functional needs assessment or provide information necessary to complete the functional needs assessment or reassessment within the applicable time frame results in the denial of service eligibility. In the event service eligibility is denied, a written Notification of Planned Action must be provided as described in OAR 411-340-0060 and OAR chapter 411, division 318.

(B) The Department may allow additional time if circumstances beyond the control of the individual prevent timely participation in the functional needs assessment or reassessment or timely submission of information necessary to complete the functional needs assessment or reassessment.

(d) No fewer than 14 days prior to conducting a functional needs assessment, the brokerage must mail a notice of the assessment process to the individual to be assessed. The notice must include a description and explanation of the assessment process and an explanation of the process for appealing the results of the assessment.

(10) INDIVIDUAL SUPPORT PLANS.

(a) An individual who is accessing waiver or Community First Choice state plan services must have an authorized ISP.

(A) The personal agent must facilitate and develop an ISP through a person-centered service planning process.

(B) The initial ISP must be authorized by the personal agent --

(i) No more than 90 days from the date a competed application is submitted to the CDDP according to OAR 411-320-0080; or

(ii) No later than the end of the month following the month in which the level of care determination was made or no more than 45 days from the date the level of care determination was made.

(C) The personal agent must review and revise the ISP for an individual --

(i) Upon reassessment of functional needs as required every 12 months;

(ii) When the circumstances or needs of the individual change; or

(iii) At the request of the individual or legal representative of the individual. The revision of the ISP must be completed within 30 days from the date of the request.

(D) The brokerage must provide a written copy of the most current ISP to the individual and the legal or designated representative of the individual (as applicable).

(b) PERSON-CENTERED ISP REQUIREMENTS. The person-centered ISP must reflect the services and supports that are important for the individual to meet the needs of the individual identified through a Department approved assessment, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. The written ISP must include, but not be limited to, the following:

(A) The name of the individual and the name of the legal or designated representative of the individual (as applicable);

(B) The projected dates of when specific supports are to begin and end;

(C) Home and community-based service and setting options --

(i) Based on the needs and preferences of the individual, and for residential settings, the available resources of the individual for room and board;

(ii) Chosen by the individual; and

(iii) Integrated in and support full access to the greater community;

(D) Opportunities to seek employment and work in competitive integrated employment settings for those individuals who desire to work.

(i) If the individual wishes to pursue employment, a non-disability specific setting option must be presented and documented in the ISP.

(ii) Individuals working in sheltered workshops shall be encouraged to use services in integrated settings.

(E) Opportunities to engage in community life, control personal resources, and receive services in the community to the same degree of access as people not receiving home and community-based services;

(F) The strengths and preferences of the individual;

(G) The service and support needs of the individual;

(H) The goals and desired outcomes of the individual;

(I) The providers of services and supports, including unpaid supports provided voluntarily;

(J) Risk factors and measures in place to minimize risk;

(K) Individualized backup plans and strategies, when needed;

(L) People important in supporting the individual;

(M) The person responsible for monitoring the ISP;

(N) Language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual receiving services and the people important in supporting the individual;

(O) The written informed consent of the individual or, if applicable, the legal or designated representative of the individual;

(P) Signatures of the individual, or if applicable the legal or designated representative of the individual, and all people and

providers with whom the ISP was shared in its entirety, or as described below in subsection (d) of this section;

(Q) Self-directed supports; and

(R) Provisions to prevent unnecessary or inappropriate services and supports.

(c) The individual, or if applicable the legal or designated representative of the individual, decides on the level of information in the ISP that is shared with providers. To effectively provide services, providers must have access to necessary information from the ISP that the provider is responsible for implementing. A provider identified to deliver a service or support included in an ISP must acknowledge through a signature on a written agreement receipt of the necessary information.

(d) ISP SCHEDULE. The schedule of the support services ISP, developed in compliance with this rule after an individual enters a brokerage, may be adjusted with the consent of, or at the request of, an individual.

(A) An adjustment may only occur one time per individual upon ISP renewal.

(B) An ISP date adjustment must be clearly documented in the ISP.

(e) After September 1, 2018, the brokerage must only authorize services delivered in a home and community-based setting that meets the qualities described in OAR 411-004-0020 and non-residential employment service and day service settings that are consistent with OAR 411-004-0020(1), as implemented in OAR chapter 411, division 345:

(A) The setting must be integrated in and support the same degree of access to the greater community as people not receiving home and community-based services, including opportunities for individuals enrolled in or utilizing home and community-based services to:

(i) Seek employment and work in competitive integrated employment settings. Employment service settings must, at minimum, provide interaction with the general public (including opportunities to work with customers and coworkers who do not have disabilities or use home and community-based services). Non-residential day service settings must, at minimum, be used to facilitate going out into the broader community and away from a provider site;

(ii) Engage in community life;

(iii) Control personal resources; and

(iv) Receive services in the community.

(B) The setting must ensure individual rights of privacy, dignity, respect, and freedom from coercion and restraint;

(C) The setting must optimize but not regiment individual initiative, autonomy, self-direction, and independence in making life choices including, but not limited to, daily activities, physical environment, and with whom to interact; and

(D) The setting must facilitate individual choice regarding services and supports, and who provides the services and supports.

(f) An ISP must not authorize any single personal support worker to be paid for more than 50 hours in a work week per individual unless --

(A) The personal support worker is delivering daily relief care; or

(B) An exception has been granted by the brokerage or Department.

(g) ISP AUTHORIZATION.

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

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

(C) A revision to an initial or annual ISP that does not involve the types of support purchased with support services funds does not require authorization. Documented oral agreement to the revision by the individual, or as applicable the legal or designated representative of the individual, is required prior to implementation of the revision.

(D) An ISP is authorized when:

(i) The signature of the individual, or as applicable the legal or designated representative of the individual, is present on the ISP or documentation is present explaining the reason an individual who does not have a legal or designated representative may be unable to sign the ISP.

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

(II) Unavailability is not an acceptable reason for an individual, or as applicable the legal or designated representative of an individual, not to sign the ISP.

(III) In the case of a revision to an 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 oral agreement may substitute for a signature for no more than 10 business days.

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

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

(E) For an individual transferring from in-home comprehensive services to a brokerage, the CDDP ISP may be used as authorization for available support services for up to 90 days.

(h) PERIODIC REVIEW OF ISP AND RESOURCES.

(A) A personal agent must facilitate and document reviews of the ISP and resources for an individual with the individual and the legal or designated representative of the individual (as applicable).

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

(i) Evaluate the progress of the individual toward achieving the purposes of the ISP and assess and revise goals as needed;

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

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

(11) ANNUAL PLANS. An Annual Plan must be completed for individuals who do not access waiver or Community First Choice state plan services.

(a) A personal agent must complete an Annual Plan within 60 days of the entry of an individual into support services, and annually thereafter if the individual is not enrolled in any waiver or Community First Choice state plan services.

(b) A written Annual Plan must be documented as an Annual Plan or as a comprehensive progress note in the record for the individual and consist of:

(A) A review of the current living situation of the individual;

(B) A review of any personal health, safety, or behavioral concerns;

(C) A summary of the support needs of the individual; and

(D) Actions to be taken by the personal agent and others.

(12) PROFESSIONAL OR OTHER SERVICE PLANS.

(a) A Nursing Service Plan must be present when support services are authorized for the provision of the following:

(A) Community nursing services as described in OAR chapter 411, division 048;

(B) Private duty nursing services as described in OAR 411-350-0055; and

(C) Direct nursing services as described in OAR chapter 411, division 380.

(b) A Support Services Brokerage 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 crisis diversion services for the individual.

(c) As of July 1, 2014, a Career Development Plan must be attached to the ISP of an adult in accordance with OAR 411-345-0160. Employment service providers, including Vocational Rehabilitation, must have a copy of the Career Development Plan.

(13) TRANSITION TO ANOTHER BROKERAGE OR TO A CDDP. At the request of an individual enrolled in brokerage services who has selected another brokerage or CDDP to provide case management and to arrange services, the brokerage must collaborate with the receiving brokerage or CDDP of the county of origin of the individual to transition case management and other authorized services.

(a) If an individual requests case management services from a CDDP, the brokerage must notify the local CDDP of the request within five business days. Planning for a transfer of case management services must begin within 10 business days of the request unless a later date is mutually agreed upon by the individual, the brokerage, and the CDDP.

(b) An individual may request case management services from another brokerage when the selected brokerage has capacity available within the limits of the contract between the brokerage and the Department.

(c) If an individual requests case management services from an available brokerage, the brokerage must notify the local CDDP of the request within five business days. Planning for a transfer of case management services to the available brokerage must begin within 10 business days of the request unless a later date is mutually agreed upon by the individual, the brokerage, and the CDDP of the county of origin of the individual.

(d) 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.

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

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0125 Crisis Supports in Support Services
(Amended 12/28/2014)

(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 section (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 primary caregiver due to the inability of the primary caregiver 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; and

(C) The ISP for the individual 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) A functional needs assessment must be completed for any individual determined to be in crisis as described in this section of this 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 personal agent of the individual must:

(A) Participate with the Regional Crisis Diversion Program staff in efforts to stabilize supports and return costs to the service 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 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 providers, and the legal or designated representative and family of the individual (as applicable).

(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 subparagraph (ii) of this paragraph in the record for the individual and report to the Regional Crisis Diversion Program or CDDP as required.

(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 county of origin of the individual;

(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, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0130 Using Support Services Funds to Purchase Supports
(Temporary Effective 01/01/2016 to 06/28/2016)

(1) Support services funds may be used to assist individuals to purchase supports described in section (8) of this rule, in accordance with an ISP when the following conditions are met:

(a) The supports are necessary for an individual to live in his or her own home or in the family home or meet individual support needs;

(b) For Community First Choice state plan services, the support addresses a need that has been determined to be necessary by a functional needs assessment;

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

(d) The individual is eligible for the services as described in section (8) of this rule;

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

(A) Support services funds are not intended to replace the resources available to an individual from the voluntarily provided natural supports of the individual.

(B) Support services funds are not available when the support needs of an individual 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) The ISP has been authorized for implementation; and

(g) After September 1, 2018, the supports are delivered in a home and community-based setting that meets the qualities described in OAR 411-004-0020.

(2) A brokerage may use support services funds to assist individuals that do not meet the criteria in section (1)(d) of this rule when, up to the 18th birthday of the individual, the individual was receiving children's intensive in-home services as described in OAR chapter 411, division 300 or in-home supports as described in OAR chapter 411, division 308.

(3) An individual is no longer eligible to access support services funds when the individual is eligible for support services funds based on section (2)of this rule and --

(a) The individual does not apply for a disability determination and Medicaid within 10 business days of the 18th birthday of the individual;

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

(c) The individual is determined by the state of Oregon to be ineligible for OHP Plus and OSIPM.

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

(5) POST ELIGIBILITY TREATMENT OF INCOME. Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(6) SERVICE LIMITS. The use of support services funds to purchase individual supports is limited to:

(a) The service level for an individual as determined by a functional needs assessment. The functional needs assessment determines the total number of hours available to meet identified needs. The total number of hours may not be exceeded without prior approval from the Department. The types of services that contribute to the total of hours used include:

(A) Attendant care;

(B) Hourly relief care;

(C) Skills training; and

(D) State plan personal care services as described in OAR chapter 411, division 034.

(b) Other services and supports determined by a personal agent to be necessary to meet the support needs identified through a person-centered planning process and consistent with the In-home Expenditure Guidelines; and

(c) Employment services and payment for employment services are limited to:

(A) An average of 25 hours per week for any combination of job coaching, small group employment support, and employment path services; and

(B) 40 hours in any one week for job coaching if job coaching is the only service utilized.

(d) Payment for no more than 50 hours in a work week by a single personal support worker per individual unless --

(A) The personal support worker is delivering daily relief care; or

(B) An exception has been granted by the brokerage or Department.

(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 families of individuals for expenses related to services and from advancing funds to individuals or families of individuals to obtain services.

(b) The method and schedule of payment must be specified in written agreements between the brokerage and the individual or the legal or designated representative of the individual (as applicable).

(8) TYPES OF SUPPORTS. Supports eligible for purchase with support services funds must be consistent with the In-home Expenditure Guidelines and are limited to:

(a) Community First Choice state plan services. An individual who is eligible for OHP Plus and meets the Level of Care may access Community First Choice state plan services when supported by an assessed need.

(b) Transfer of Assets.

(A) As of October 1, 2014, an individual receiving medical benefits under OAR chapter 410, division 200 requesting Medicaid coverage for services in a nonstandard living arrangement (see OAR 461-001-0000) is subject to the requirements of the rules regarding transfer of assets (see OAR 461-140-0210 to 461-140-0300) in the same manner as if the individual was requesting these services under OSIPM. This includes, but is not limited to, the following assets:

(i) An annuity evaluated according to OAR 461-145-0022;

(ii) A transfer of property when an individual retains a life estate evaluated according to OAR 461-145-0310;

(iii) A loan made evaluated according to OAR 461-145-0330; or

(iv) An irrevocable trust evaluated according to OAR 461-145-0540.

(B) When an individual is considered ineligible due to a disqualifying transfer of assets, the individual must receive a notice meeting the requirements of OAR 461-175-0310 in the same manner as if the individual was requesting services under OSIPM.

(c) Community First Choice state plan services include:

(A) Behavior support services as described in section (9) of this rule;

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

(C) Environmental modifications as described in section (11) of this rule; and

(D) Attendant care as described in section (12) of this rule;

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

(F) Relief care as described in section (14) of this rule;

(G) Assistive devices as described in section (15) of this rule;

(H) Assistive technology as described in section (16) of this rule;

(I) Chore services as described in section (17) of this rule;

(J) Community transportation as described in section (18) of this rule;

(K) Transition costs as described in section (19) of this rule; and

(L) Home delivered meals as described in OAR chapter 411, division 040.

(d) Individuals who are eligible for OSIPM and meet the Level of Care may access Community First Choice state plan services and the following home and community-based waiver services:

(A) Case management as defined in OAR 411-340-0020;

(B) Employment services as described in section (20) of this rule that include:

(i) Supported employment - individual employment support;

(ii) Supported employment - small group employment support;

(iii) Employment path services; and

(iv) Discovery and career exploration services.

(C) Family training as described in section (21) of this rule;

(D) Special diets as described in section (22) of this rule;

(E) Environmental safety modifications as described in section (23) of this rule;

(F) Vehicle modifications as described in section (24) of this rule;

(G) Specialized medical supplies as described in section (25) of this rule; and

(H) Direct nursing services for individuals 21 years of age and over as described in OAR chapter 411, division 380.

(e) State Plan private duty nursing services under OAR chapter 410, division 132 (OHA, Private Duty Nursing Services), for individuals aged 18 through 20 that meet the clinical criteria described in OAR 411-350-0055.

(f) State Plan personal care as described in OAR chapter 411, division 034.

(9) BEHAVIOR SUPPORT SERVICES.

(a) Behavior support services consist of:

(A) Assessing an individual or the needs of the family of the individual and the environment;

(B) Developing positive behavior support strategies, including a Behavior Support Plan, by a qualified behavior consultant as described in OAR 411-340-0160, if needed;

(C) Implementing the Behavior Support Plan with the provider or family; and

(D) Revising and monitoring the Behavior Support Plan as needed.

(b) Behavior support services may include:

(A) Training, modeling, and mentoring the family of an individual;

(B) Developing a visual communication system as a strategy for behavior support; and

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

(c) Behavior support services exclude:

(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 the needs of an individual at school;

(E) An assessment in a school setting;

(F) Attendant care;

(G) Skills training; or

(H) Relief care.

(10) COMMUNITY NURSING SERVICES.

(a) Community nursing services include:

(A) Nursing assessments, including medication reviews;

(B) Care coordination;

(C) Monitoring;

(D) Development of a Nursing Service Plan;

(E) Delegation and training of nursing tasks to a provider and primary caregiver;

(F) Teaching and education of the provider and primary caregiver and identifying supports that minimize health risks while promoting the autonomy of an individual and self-management of healthcare; and

(G) Collateral contact with a services coordinator regarding the community health status of an individual to assist in monitoring safety and well-being and to address needed changes to the ISP for the individual.

(b) Community nursing services exclude direct nursing care.

(c) A Nursing Service Plan must be present when support services funds are used for community nursing services. A personal agent must authorize the provision of community nursing services as identified in an ISP.

(d) After an initial nursing assessment, a nursing re-assessment must be completed every six months or sooner if a change in a medical condition requires an update to the Nursing Service Plan.

(11) ENVIRONMENTAL MODIFICATIONS.

(a) Environmental modifications 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 alarms, light fixtures, and appliances;

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

(H) Adaptation of kitchen cabinets and sinks;

(I) Widening of doorways;

(J) Handrails;

(K) Modification of bathroom facilities;

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

(M) Installation of non-skid surfaces;

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

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

(P) Adaptations to control lights, heat, and stove.

(b) Environmental modifications exclude:

(A) Adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, and central air conditioning, unless directly related to the assessed health and safety needs of the individual and identified in the ISP for the individual;

(B) Adaptations that add to the total square footage of the home except for ramps that attach to the home for the purpose of entry or exit;

(C) Adaptations outside of the home; and

(D) General repair or maintenance and upkeep required for the home.

(c) Environmental modifications must be tied to supporting assessed ADL, IADL, and health-related tasks as identified in the needs assessment and ISP for an individual.

(d) Environmental modifications are limited to $5,000 per modification. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-effectiveness. In addition, separate environmental modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(e) Environmental modifications must be completed by a state licensed contractor with a minimum of $1,000,000 liability insurance. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the file for the contractor 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.

(h) A scope of work as defined in OAR 411-340-0020 must be completed for each identified environmental modification project. All contractors submitting bids must be given the same scope of work.

(i) Personal agents must follow the processes outlined in the In-home Expenditure Guidelines for contractor bids and the awarding of work.

(j) All dwellings must be in good repair and have the appearance of sound structure.

(k) The identified home may not be in foreclosure or be the subject of legal proceedings regarding ownership.

(l) Environmental modifications must only be completed to the primary residence of the individual.

(m) Upgrades in materials that are not directly related to the health and safety needs of the individual are not paid for or permitted.

(n) Environmental modifications are subject to Department requirements regarding materials and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials, manuals, and industry and risk management publications.

(o) RENTAL PROPERTY.

(A) Environmental modifications to rental property may not substitute or duplicate services otherwise the responsibility of the landlord under the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.

(B) Environmental modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.

(C) The Department does not fund work to restore the rental structure to the former condition of the rental structure.

(12) ATTENDANT CARE SERVICES. Attendant care services include direct support provided to an individual in the home of the individual or community by a qualified personal support worker or provider organization. ADL and IADL services provided through attendant care must support the individual to live as independently as possible, and be based on the identified goals, preferences, and needs of the individual. Assistance with ADLs, IADLs, and health-related tasks may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete any IADL tasks.

(a) "Cueing" means giving verbal, audio, 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 assistance 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 the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment 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 if the individual is unable to complete the task independently.

(13) SKILLS TRAINING. Skills training is specifically tied to accomplishing ADL, IADL, and other health-related tasks as identified by the functional needs assessment and ISP and is a means for an individual to acquire, maintain, or enhance independence.

(a) Skills training may be applied to the use and care of assistive devices and technologies.

(b) Skills training is authorized when:

(A) The anticipated outcome of the skills training, as documented in the ISP, is measurable;

(B) Timelines for measuring progress towards the anticipated outcome are established in the ISP; and

(C) Progress towards the anticipated outcome are measured and the measurements are evaluated by a personal agent no less frequently than every six months, based on the start date of the initiation of the skills training.

(c) When anticipated outcomes are not achieved within the timeframe outlined in the ISP, the personal agent must reassess or redefine the use of skills training with the individual for that particular goal.

(14) RELIEF CARE.

(a) Relief care may not be characterized as daily or periodic services provided solely to allow the primary caregiver to attend school or work. Daily relief care may be provided in segments that are sequential but may not exceed seven consecutive days without permission from the Department. No more than 14 days of relief care in a plan year are allowed without approval from the Department.

(b) Relief care may include both day and overnight services that may be provided in:

(A) The home of the individual;

(B) A licensed or certified setting;

(C) The home of a qualified provider, chosen by the individual or the representative of the individual, that is a safe setting for the individual; or

(D) The community, during the provision of ADL, IADL, health-related tasks, and other supports identified in the ISP for the individual.

(15) ASSISTIVE DEVICES. Assistive devices are primarily and customarily used to meet an ADL, IADL, or health-related support need. The purchase, rental, or repair of assistive devices with support service funds must be limited to the types of equipment and supplies that are not excluded under OAR 410-122-0080.

(a) Assistive devices may include the purchase of devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the ability of the individual to perform and support ADLs and IADLs or to perceive, control, or communicate

within the home and community environment in which the individual lives.

(b) Assistive devices may be purchased with support service funds when the intellectual or developmental disability of an individual otherwise prevents or limits the independence of the individual in areas identified in a functional needs assessment.

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

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

(B) Assistive devices, not provided by any other funding source, to assist and enhance the independence of an individual in performing ADLs or IADLs, such as durable medical equipment, mechanical apparatus, or electronic devices.

(d) Expenditures for assistive devices are limited to $5,000 per plan year without Department approval. Any single purchase costing more than $500 must be approved by the Department prior to expenditure. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and a determination by the Department of appropriateness and cost-effectiveness.

(e) Devices must be limited to the least costly option necessary to meet assessed need of an individual.

(f) Assistive devices must meet applicable standards of manufacture, design, and installation.

(g) To be authorized by a personal agent, assistive devices must be:

(A) In addition to any assistive devices, medical equipment, and supplies furnished under OHP, the state plan, private insurance, or alternative resources;

(B) Determined necessary to the daily functions of the individual; and

(C) Directly related to the disability of the individual.

(h) Assistive devices exclude:

(A) Items that are not necessary or of direct medical benefit to the individual or do not address the underlying need for the device;

(B) Items intended to supplant similar items furnished under OHP, private insurance, or alternative resources;

(C) Items that are considered unsafe for an individual;

(D) Toys or outdoor play equipment; and

(E) Equipment and furnishings of general household use.

(16) ASSISTIVE TECHNOLOGY Assistive technology is primarily and customarily used to provide additional safety and support and replace the need for direct interventions, to enable self-direction of care, and maximize independence. Assistive technology includes, but is not limited to, motion or sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinence and fall sensors, or other electronic backup systems, including the expense necessary for the continued operation of the assistive technology;

(a) Expenditures for assistive technology are limited to $5,000 per plan year without Department approval. Any single purchase costing more than $500 must be approved by the Department prior to expenditure. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual

and a determination by the Department of appropriateness and cost-effectiveness.

(b) Payment for on-going electronic back-up systems or assistive technology costs must be paid to providers each month after services are received.

(A) Ongoing costs do not include electricity or batteries.

(B) Ongoing costs may include minimally necessary data plans and the services of a company to monitor emergency response systems.

(17) CHORE SERVICES. Chore services may be provided only in situations where no one else is responsible or able to perform or pay for the services.

(a) Chore services include heavy household chores, such as:

(A) Washing floors, windows, and walls;

(B) Tacking down loose rugs and tiles; and

(C) Moving heavy items of furniture for safe access and egress.

(b) Chore services may include yard hazard abatement to ensure the outside of the home is safe for the individual to traverse and enter and exit the home.

(18) COMMUNITY TRANSPORTATION.

(a) Community transportation includes, but is not limited to:

(A) Community transportation provided by a common carrier, taxicab, or bus in accordance with standards established for these entities;

(B) Reimbursement on a per-mile basis for transporting an individual to accomplish ADL, IADL, a health-related task, or employment goal identified in an ISP; or

(C) Assistance with the purchase of a bus pass.

(b) Community transportation may only be authorized when natural supports or volunteer services are not available and one of the following is identified in the ISP of the individual:

(A) The individual has an assessed need for ADL, IADL, or health-related task during transportation; or

(B) The individual has either an assessed need for ADL, IADL, or health-related task at the destination or a need for waiver funded services at the destination;

(c) Community transportation must be provided in the most cost effective manner, which meets the needs identified in the ISP for the individual.

(d) Community transportation expenses exceeding $500 per month must be approved by the Department.

(e) Community transportation must be prior authorized by a personal agent and documented in an ISP. The Department does not pay any provider under any circumstances for more than the total number of hours, miles, or rides prior authorized by the brokerage and documented in the ISP. Personal support workers who use their own personal vehicles for community transportation are reimbursed as described in OAR chapter 411, division 375.

(f) Community transportation services exclude:

(A) Medical transportation;

(B) Purchase or lease of a vehicle;

(C) Routine vehicle maintenance and repair, insurance, and fuel;

(D) Ambulance services;

(E) Costs for transporting a person other than the individual;

(F) Transportation for a provider to travel to and from the workplace of the provider;

(G) Transportation that is not for the sole benefit of the individual;

(H) Transportation to vacation destinations or trips for relaxation purposes;

(I) Transportation provided by family members who are not personal support workers and are not simultaneously providing other paid supports at the time of the transportation;

(J) Payment to the spouse of an individual receiving support services;

(K) Reimbursement for out-of-state travel expenses; and

(L) Mileage reimbursement for the vehicle of the supported individual.

(19) TRANSITION COSTS.

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

(b) Transition costs are based on the assessed need of an individual 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 transition costs must be through the Department prior to expenditure. The approval of the Department is based on the need of an individual and the determination by the Department of appropriateness and cost-effectiveness.

(c) Financial assistance for transition costs is limited to:

(A) Moving and move-in costs, including movers, cleaning and security deposits, payment for background or credit checks (related to housing), or 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, such as a bed; and

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

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

(e) Transitions costs for basic household furnishings and other items are limited to one time per year.

(20) EMPLOYMENT SERVICES. Employment services must be:

(a) Delivered according to OAR 411-345-0025; and

(b) Provided by an employment specialist meeting the requirements described in OAR 411-345-0030.

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

(a) Family training services include:

(A) Instruction about treatment regimens and use of equipment specified in an ISP;

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

(C) Registration fees for organized conferences and workshops specifically related to the intellectual or developmental disability of the individual or the identified, specialized, medical, or behavioral support needs of the individual.

(i) Conferences and workshops must be prior authorized by a personal agent, directly relate to the intellectual or developmental disability of the individual, and increase the knowledge and skills of the family to care for and maintain the individual in the home of the individual.

(ii) Conference and workshop costs exclude:

(I) Travel, food, and lodging expenses;

(II) Services otherwise provided under OHP or available through other resources; or

(III) Costs for a family member who is a paid provider.

(b) Family training services exclude:

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

(B) Training for a paid provider;

(C) Legal fees;

(D) Training for a family 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.

(c) Prior authorization by the brokerage is required for attendance by family members at organized conferences and workshops funded with support services funds.

(22) SPECIAL DIET. Special diets are specially prepared food or particular types of food, ordered by a physician and periodically monitored by a dietician, specific to the medical condition or diagnosis of an individual that are needed to sustain the individual in the home of the individual. Special

diets are supplements and are not intended to meet the complete daily nutritional requirements of the individual. Special diet supplies must be supported by an evidence-based treatment regimen.

(23) ENVIRONMENTAL SAFETY MODIFICATIONS.

(a) Environmental safety modifications must be made from materials of the most cost effective type and may not include decorative additions.

(b) Fencing may not exceed 200 linear feet without approval from the Department.

(c) Environmental safety modifications exclude:

(A) Large gates, such as automobile gates;

(B) Costs for paint and stain;

(C) Adaptations or improvements to the home that are of general utility and are not for the direct safety or long-term benefit to the individual or do not address the underlying environmental need for the modification; and

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

(d) Environmental safety modifications must be tied to supporting ADL, IADL, and health-related tasks as identified in the ISP.

(e) Environmental safety modifications are limited to $5,000 per modification. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-effectiveness. In addition, separate environmental safety modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(f) Environmental safety modifications must be completed by a state licensed contractor with a minimum of $1,000,000 liability insurance. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the file for the contractor prior to payment.

(g) Environmental safety modifications must be made within the existing square footage of the home and may not add to the square footage of the home.

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

(i) A scope of work as defined in OAR 411-340-0020 must be completed for each identified environmental safety modification project. All contractors submitting bids must be given the same scope of work.

(j) A personal agent must follow the processes outlined in the In-home Expenditure Guidelines for contractor bids and the awarding of work.

(k) All dwellings must be in good repair and have the appearance of sound structure.

(l) The identified home may not be in foreclosure or the subject of legal proceedings regarding ownership.

(m) Environmental safety modifications must only be completed to the primary residence of the individual.

(n) Upgrades in materials that are not directly related to the health and safety needs of the individual are not paid for or permitted.

(o) Environmental safety modifications are subject to Department requirements regarding material and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials manuals, and industry and risk management publications.

(p) RENTAL PROPERTY.

(A) Environmental safety modifications to rental property may not substitute or duplicate services otherwise the responsibility of the landlord under the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.

(B) Environmental safety modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.

(C) The Department does not fund work to restore the rental structure to the former condition of the rental structure.

(24) VEHICLE MODIFICATIONS.

(a) Vehicle modifications may only be made to the vehicle primarily used by an individual to meet the unique needs of the individual. Vehicle modifications may include a lift, interior alterations to seats, head and leg rests, belts, special safety harnesses, other unique modifications to keep the individual safe in the vehicle, and the upkeep and maintenance of a modification made to the vehicle.

(b) Vehicle modifications exclude:

(A) Adaptations or improvements to a vehicle that are of general utility and are not of direct medical benefit to the individual or do not address the underlying need for the modification;

(B) The purchase or lease of a vehicle; or

(C) Routine vehicle maintenance and repair.

(c) Vehicle modifications are limited to $5,000 per modification. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-

effectiveness. In addition, separate vehicle modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(d) Vehicle modifications must meet applicable standards of manufacture, design, and installation.

(25) SPECIALIZED MEDICAL SUPPLIES. Specialized medical supplies do not cover services that are otherwise available to an individual under Vocational Rehabilitation and Other Rehabilitation Services, 29 U.S.C. 701-7961, as amended, or the Individuals with Disabilities Education Act, 20 U.S.C. 1400 as amended. Specialized medical supplies may not overlap with, supplant, or duplicate other services provided through a waiver, OHP, or Medicaid state plan services.

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

(27) CONDITIONS OF PURCHASE. The brokerage must arrange for supports purchased with support services funds to be --

(a) Provided in settings and under purchasing arrangements and conditions that enable 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 may not be used to purchase existing, or create new, comprehensive services;

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

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

(b) After September 1, 2018, delivered in a home and community-based setting that meets the qualities described in OAR 411-004-0020;

(c) Provided 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.

(d) Provided in accordance with the following:

(A) Applicable state and federal wage and hour regulations in the case of personal services, training, and supervision;

(B) Applicable state or local building codes in the case of environmental modifications to the home;

(C) Oregon Board of Nursing rules in OAR chapter 851 when services involve performance of nursing services or delegation, teaching, and assignment of nursing tasks;

(D) OAR 411-340-0160 through 411-340-0180 governing provider qualifications and responsibilities; and

(E) The In-home Expenditure Guidelines.

(28) 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 people, if any, specified by the individual 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 family of the individual, 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 for an individual.

(d) The provisions of section (29) of this rule regarding sanctions that may be imposed on providers; and

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

(29) PROVIDER TERMINATION.

(a) The provider enrollment for a personal support worker is terminated as described in OAR chapter 411, division 375.

(b) An independent provider who is not a personal support worker may have their provider enrollment terminated in the following circumstances:

(A) The provider has not provided any paid in-home services to an individual within the last previous 12 months;

(B) The provider informs the Department, CDDP, CIIS, or brokerage that the personal support worker is no longer providing in-home services in Oregon;

(C) The background check for a provider results in a closed case pursuant to OAR 407-007-0325;

(D) Services to an individual, is being investigated by adult or child protective services for suspected abuse that poses imminent danger to current or future individuals; or

(E) Provider payments, all or in part, for the provider have been suspended based on a credible allegation of fraud or has a conviction of for fraud pursuant to federal law under 42 CFR 455.23.

(c) Provider enrollment may be terminated when the brokerage or Department determines that, at some point after the initial qualification and authorization of the provider to provide supports purchased with support services funds, the provider has:

(A) Been convicted of any crime that would have resulted in an unacceptable background 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) Notwithstanding abuse as defined in OAR 407-045-0260, failed to safely and adequately provide the authorized services;

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

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

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

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

(I) Falsified required documentation;

(J) Failed to comply with the provisions of section (28) of this rule or OAR 411-340-0140;

(K) Been suspended or terminated as a provider by the Department or Oregon Health Authority;

(L) Violated the requirement to maintain a drug-free work place;

(M) Failed to provide services as required;

(N) Failed to provide a tax identification number or social security number that matches the legal name of the independent provider, as verified by the Internal Revenue Service or Social Security Administration; or

(O) Has been excluded or debarred by the Office of the Inspector General.

(d) If the brokerage or Department makes a decision to terminate provider enrollment, the Department must issue a written notice that includes:

(A) An explanation of the reason for termination of the provider enrollment;

(B) The alleged violation as listed in subsection (b) and (c) of this section;

(C) The appeal rights of the individual, including where to file the appeal;

(D) For terminations based on substantiated abuse allegations, only the limited information allowed by law. In accordance with ORS 124.075, 124.085, 124.090, and OAR 411-020-0030, complainants, witnesses, the name of the alleged victim, and protected health information may not be disclosed; and

(E) The effective date of the termination.

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

(A) A provider of Medicaid services may appeal a termination by requesting an administrator review by the Director of the Department.

(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 from the date the termination notice was mailed to the provider.

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

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0135 Standards for Employers
(Adopted 12/28/2014)

(1) EMPLOYER OF RECORD. An employer of record is required when a personal support worker who is not an independent contractor is selected by an individual to provide supports. The Department may not act as the employer of record.

(2) SERVICE AGREEMENT. The employer must create and maintain a service agreement for a personal support worker that is in coordination with the services authorized in the ISP. The service agreement serves as a written job description for the employed personal support worker.

(3) BENEFITS. Only personal support workers qualify for benefits. The benefits provided to personal support workers are described in OAR chapter 411, division 375.

(4) INTERVENTION. For the purpose of this rule, "intervention" means the action the Department or the designee of the Department requires when an employer fails to meet the employer responsibilities described in this rule. Intervention includes, but is not limited to:

(a) A documented review of the employer responsibilities described in section (5) of this rule;

(b) Training related to employer responsibilities;

(c) Corrective action taken as a result of a personal support worker filing a complaint with the Department, the designee of the Department, or other agency who may receive labor related complaints;

(d) Identifying an employer representative if an individual is not able to meet the employer responsibilities described in section (5) of this rule; or

(e) Identifying another representative if the current employer representative is not able to meet the employer responsibilities described in section (5) of this rule.

(5) EMPLOYER RESPONSIBILITIES.

(a) For an individual to be eligible for support provided by a personal support worker, an employer must demonstrate the ability to:

(A) Locate, screen, and hire a qualified personal support worker;

(B) Supervise and train the personal support worker;

(C) Schedule work, leave, and coverage;

(D) Track the hours worked and verify the authorized hours completed by the personal support worker;

(E) Recognize, discuss, and attempt to correct, with the personal support worker, any performance deficiencies and provide appropriate, progressive, disciplinary action as needed; and

(F) Discharge an unsatisfactory personal support worker.

(b) Indicators that an employer may not be meeting the employer responsibilities described in subsection (a) of this section include, but are not limited to:

(A) Personal support worker complaints;

(B) Multiple complaints from a personal support worker requiring intervention from the Department or Brokerage as defined in section (4) of this rule;

(C) Frequent errors on timesheets, mileage logs, or other required documents submitted for payment that results in repeated coaching from the Department or Brokerage;

(D) Complaints to Medicaid Fraud involving the employer; or

(E) Documented observation by the Department or Brokerage of services not being delivered as identified in an ISP.

(c) The Department or the Brokerage may require intervention as defined in section (4) of this rule when an employer has demonstrated difficulty meeting the employer responsibilities described in subsection (a) of this section.

(d) An individual may not receive support provided by a personal support worker if, after appropriate intervention and assistance, an employer is not able to meet the employer responsibilities described in subsection (a) of this section.

(A) An individual determined ineligible to be an employer of a personal support worker and unable to designate an employer representative, may not request support provided by a personal support worker until the next annual ISP. Improvements in health and cognitive functioning may be factors in demonstrating the ability of the individual to meet the employer responsibilities described in subsection (a) of this section. If an individual is able to demonstrate the ability to meet the employer responsibilities sooner than the next annual ISP, the individual may request the waiting period be shortened.

(B) An individual determined ineligible to be an employer of a personal support worker is offered other available service options that meet the service needs of the individual, including support through a contracted qualified provider organization or general business provider when available. As an alternative to in-home support, the Department or the designee of the Department may offer other available services through the Home and Community Based Services Waiver or State Plan.

(6) DESIGNATION OF EMPLOYER RESPONSIBLITIES.

(a) An individual not able to meet all of the employer responsibilities described in section (5)(a) of this rule must:

(A) Designate an employer representative in order for the individual to receive or continue to receive in home support provided by a personal support worker; or

(B) Select a provider organization or general business provider to provide support for the individual.

(b) An individual able to demonstrate the ability to meet some of the employer responsibilities described in section (5)(a) of this rule must:

(A) Designate an employer representative to fulfill the responsibilities the individual is not able to meet in order for the individual to receive or continue to receive support provided by a personal support worker; and

(B) On a Department approved form, document the specific employer responsibilities performed by the individual and the employer responsibilities performed by the employer representative of the individual.

(c) When the employer representative of an individual is not able to meet the employer responsibilities described in section (5)(a) or the qualifications in section (7)(c) of this rule, an individual must:

(A) Designate a different employer representative in order for the individual to receive or continue to receive in home support provided by a personal support worker; or

(B) Select a provider organization or general business provider to provide in-home support for the individual.

(7) EMPLOYER REPRESENTATIVE.

(a) An individual, or the legal representative of an individual, may designate an employer representative to act on behalf of the individual, to meet the employer responsibilities described in section (5)(a) of this rule. The legal or designated representative of an individual may be the employer.

(b) An employer who is also the personal support worker of support must seek an alternate employer for purposes of the employment of the personal support worker. The alternate employer must:

(A) Track the hours worked and verify the authorized hours completed by the personal support worker; and

(B) Document the specific employer responsibilities performed by the employer on a Department approved form.

(c) The Department or the Brokerage may suspend, terminate, or deny a request for an employer representative if the requested employer representative has:

(A) A history of substantiated abuse of an adult as described in OAR 411-045-0250 to 411-045-0370;

(B) A history of founded abuse of a child as described in ORS 419B.005;

(C) Participated in billing excessive or fraudulent charges; or

(D) Failed to meet the employer responsibilities in section (5)(a) or (7)(b) of this rule, including previous termination as a result of failing to meet the employer responsibilities in section (5)(a) or (7)(b).

(d) If the Department or Brokerage suspends, terminates, or denies a request for an employer representative for the reasons described in subsection (c) of this section, an individual may select another employer representative.

(8) NOTICE.

(a) The Department or the Brokerage, respectively, shall mail a notice identifying the individual, and if applicable the employer representative and legal or designated representative of the individual, when:

(A) The Department or the Brokerage denies, suspends, or terminates an employer from performing the employer responsibilities described in sections (5)(a) or (7)(b) of this rule; and

(B) The Department or the Brokerage denies, suspends, or terminates an employer representative from performing the employer responsibilities described in section (5)(a) or (7)(b) of this rule because the employer representative does not meet the qualifications in section (7)(c) of this rule.

(b) BROKERAGE ISSUED NOTICES. An individual receiving support from a personal support worker, or as applicable the legal or designated representative or employer representative of the individual, may appeal a notice issued by the Brokerage by requesting a review by Director of the Brokerage.

(A) For an appeal regarding denial, suspension, or termination of an employer to be valid, written notice of the appeal and request for review must be received by the Brokerage within 45 days from the date of the notice.

(B) The Brokerage Director shall complete a review and issue a decision within 30 days of the date the written appeal was received by the Brokerage.

(C) If an individual, or as applicable the legal or designated representative or employer representative of the individual, is dissatisfied with the decision of the Brokerage Director, the individual, or as applicable the legal or designated representative or employer representative of the individual, may request an administrator review by the Director of the Department.

(D) For an appeal of the decision of the Brokerage to be valid, written notice of the appeal and request for an administrator review must be received by the Department within 15 days from the date of the decision of the Brokerage.

(E) The Director shall complete an administrator review within 30 days from the date the written appeal was received by the Department.

(F) The determination of the Director is the final response from the Department.

(c) DEPARTMENT ISSUED NOTICES. An individual receiving support from a personal support worker, or as applicable the legal or designated representative of the individual, may appeal a notice issued by the Department by requesting an administrator review by the Director of the Department.

(A) For an appeal regarding denial, suspension, or termination of an employer to be valid, written notice of the appeal and request for an administrator review must be received by the Department within 45 days of the date of the notice.

(B) The Director shall complete an administrator review and issue a decision within 30 days from the date the written appeal was received by the Department.

(C) The determination of the Director is the final response from the Department.

(d) When a denial, suspension, or termination of an employer results in the Department denying, suspending, or terminating an individual from in-home support, the hearing rights in OAR chapter 411, division 318 apply.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0140 Using Support Services Funds for Certain Purchases Is Prohibited
(Temporary Effective 01/01/2016 to 06/28/2016)

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

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

(a) After September 1, 2018, services delivered in a home and community-based setting that is not in compliance with the qualities of a home and community based setting described in OAR 411-004-0020;

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

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

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

(e) Individual or family vehicles;

(f) Health and medical costs that the general public normally must pay, including but not limited to:

(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.

(g) Ambulance services;

(h) Legal fees;

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

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

(k) 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;

(l) Educational services for school-age individuals over the age of 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;

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

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

(o) 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;

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

(q) Notwithstanding abuse as defined in OAR 407-045-0260, services when there is sufficient evidence to believe that an individual, or as applicable the legal or designated representative of the individual, 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;

(r) Any purchase that is not generally accepted by the relevant mainstream professional or academic community as an effective means to address an identified support need;

(s) Services, supplies, or supports that are illegal, experimental, or determined unsafe for the general public by recognized consumer safety agencies; or

(t) After June 30, 2016, services provided by an entity affiliated with the brokerage authorizing services.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0150 Standards for Support Services Brokerage Administration and Operations
(Temporary Effective 01/01/2016 to 06/28/2016)

(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 the daily operations of the brokerage in compliance with these rules and who 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) and (2), the brokerage director must have:

(a) A minimum of a bachelor's degree and two years' experience, including supervision, in the field of 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 the individuals' ISPs.

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

(c) FISCAL INTERMEDIARY QUALIFICATIONS.

(A) A fiscal intermediary may not:

(i) Be a provider of support services paid using support services 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 at least:

(A) A bachelor's degree in a behavioral science, social science, or a closely related field;

(B) A bachelor's degree in any field and one year of human services related experience, such as work providing assistance to individuals and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing;

(C) An associate's degree in a behavioral science, social science, or a closely related field and two years of human services related experience, such as work providing assistance to individuals and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or

(D) Three years of human services related experience.

(b) A brokerage must submit a written variance request to the Department prior to employing 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.

(i) The proposal must specify activities, timelines, and responsibility for costs incurred in completing the alternative plan.

(ii) A person who fails to complete the alternative plan for education and training to correct the 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 plans; 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 receiving services and must make these records available to the Department upon request. The individual or the individual’s legal representative may access any portion of the individual's record 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 or designated representative (if applicable), address, telephone number, date of entry into the program, date of birth, gender, marital status, individual financial resource information, and plan year anniversary date;

(c) Documents related to determining eligibility for brokerage services;

(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 as applicable the individual's legal or designated representative, that the individual, or as applicable the individual's legal or designated representative, has been informed of responsibilities associated with the use of support services funds;

(f) Incident reports;

(g) The completed functional needs assessment and other assessments used to determine supports required, preferences, and resources;

(h) ISP and reviews. If an individual is unable to sign the ISP, the individual's 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 an individual was not able to participate in the development of the ISP, the individual's 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 a 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 the individual is missing while in the community under the service of a contractor or provider organization.

(k) Personal agent correspondence and notes related to resource development and plan outcomes;

(l) Progress notes. Progress notes must include documentation of the delivery of services 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 individual receiving services;

(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.

(m) Information about individual satisfaction with personal supports and the brokerage's 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 an individual's authorized ISP.

(B) Procedures for confirming the receipt, and securing the use of, assistive devices, environmental safety modifications, and environmental modifications.

(i) When an assistive device 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 if the item is lost, damaged, or sold within that time period.

(iii) The brokerage must ensure that projects for environmental modifications and environmental safety modifications involving renovation or new construction in an individual's home or property 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; and

(II) Are completed or supervised by a contractor licensed and bonded in Oregon.

(b) Any goods purchased with support services funds that are not used according to an individual's ISP or according to an agreement securing the state's use may be immediately recovered.

(c) Failure to furnish written documentation upon the 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 the 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 individuals, legal or designated representatives, professionals, and other sources to determine community support needs and preferences;

(B) Involves individuals in ongoing evaluation of the quality of his or her 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 the 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. When a brokerage is part of, or otherwise directly affiliated with, an entity that also provides services that 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. An affiliated entity may not be authorized by a brokerage to provide services. If an individual served by the brokerage was receiving services from an affiliated entity on December 31, 2015, the individual may continue to have those services provided by the affiliated entity until June 30, 2016, at which time the individual must either receive services from another service

provider or receive case management from another brokerage or a CDDP. An entity is affiliated with the brokerage when the entity or the brokerage has an incident of ownership in the other.

(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 the brokerage's objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0160 Standards for Independent Providers Paid with Support Services Funds
(Temporary Effective 01/01/2016 to 06/28/2016)

(1) PERSONAL SUPPORT WORKER QUALIFICATIONS. Each personal support worker must meet the qualifications described in OAR chapter 411, division 375.

(2) INDEPENDENT PROVIDER QUALIFICATIONS. Each independent provider who is not a personal support worker who is paid as a contractor or a self-employed person that is selected to provide the services and supports in OAR 411-340-0130 must:

(a) Be at least 18 years of age;

(b) Have approval to work based on current Department policy and a background check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370. A subject individual as defined in OAR 407-007-0210 may be approved for one position to work with multiple individuals statewide when the subject individual is working in the same employment role. The Department Background Check Request form must be completed by the subject individual to show intent to work statewide;

(A) Prior background check approval for another Department provider type is inadequate to meet background check requirements for independent provider enrollment.

(B) Background check approval is effective for two years from the date an independent provider is contracted with to provide in-home support, except in the following circumstances:

(i) Based on possible criminal activity or other allegations against the independent provider, a new fitness determination is conducted resulting in a change in approval status; or

(ii) The background check approval has ended because the Department has inactivated or terminated the provider enrollment for the independent provider.

(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 the spouse of an individual receiving services;

(f) Demonstrate by background, education, references, skills, and abilities that he or she is capable of safely and adequately performing the tasks specified the ISP, with such demonstration confirmed in writing by the individual, or as applicable the individual's legal or designated 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.

(g) Hold a 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 list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/);

(j) If transporting an individual, have a valid license to drive and proof of insurance, as well as any other license or certification that may be required under state and local law, depending on the nature and scope of the transportation; and

(k) Sign a Medicaid provider agreement and be enrolled as a Medicaid provider prior to delivery of any services.

(3) Section (2)(c) of this rule does not apply to employees of individuals, legal or designated representatives, employees of general business providers, or employees of provider organizations, who were hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(4) 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 the designee of the Department within 24 hours.

(5) Independent providers, including personal support workers, are not employees of the state, CDDP, or Brokerage.

(6) BEHAVIOR CONSULTANTS. Behavior consultants are not personal support workers. Behavior consultants may include, but are not limited to, autism specialists, licensed psychologists, or other behavioral specialists. Behavior consultants providing specialized supports must:

(a) Have education, skills, and abilities necessary to provide behavior support services as described in OAR 411-340-0130;

(b) Have received current certification demonstrating completion of OIS training; and

(c) Submit a resume or the equivalent 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 includes providing the services of a behavior consultant as described in OAR 411-340-0130.

(7) NURSE. A nurse is not a personal support worker.

(a) A nurse providing community nursing services must:

(A) Be enrolled in the Long Term Care Community Nursing Program as described in OAR chapter 411, division 048;

(B) Meet the qualifications described in OAR 411-048-0210; and

(C) Submit a resume to the CDDP indicating the education, skills, and abilities necessary to provide nursing services in accordance with Oregon law, including at least one year of experience with individuals with intellectual or developmental disabilities.

(b) A nurse providing direct nursing services must be an enrolled Medicaid Provider and meet the qualifications described in OAR 411-380-0080.

(c) A nurse providing private duty nursing services must be an enrolled Medicaid Provider as described in OAR 410-132-0200 (OHA, Provider Enrollment).

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

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0170 Standards for Provider Organizations Paid with Support Services Funds
(Temporary Effective 01/01/2016 to 06/28/2016)

(1) PROVIDER ORGANIZATIONS WITH CURRENT LICENSE OR CERTIFICATION. A provider organization certified or applying for certification prior to January 1, 2016 according to OAR 411-340-0030, certified and endorsed as set forth in OAR chapter 411, division 323, or licensed under OAR chapter 411, division 360 for an adult foster home, does not require additional certification or endorsement as an organization to provide relief care, attendant care, skills training, community transportation, or behavior consultation.

(a) Current license, certification, or endorsement is 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 all people directed by the provider organization as employees, contractors, or volunteers to provide services paid for with support services funds meet the

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 ORGANIZATION CERTIFICATION. A provider organization without a current license, certification, or endorsement as described in section (1) of this rule must be certified, or applied for certification, as a provider organization according to OAR 411-340-0030 before January 1, 2016, and must be granted a certificate prior to selection for providing the services listed in OAR 411-340-0130(12), (13), (14) or (18) and paid for with support services funds. A provider organization that was certified or had applied for certification according to OAR 411-340-0030 before January 1, 2016 may also provide employment services when the organization also meets the requirements in OAR 411-345-0030. When granted after January 1, 2016, certification as set forth in OAR chapter 411 division 323, with an endorsement to these rules, is not sufficient qualification for a provider organization to deliver employment services. To be certified or to receive an endorsement under these rule:

(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 protect the individual rights described in OAR 411-318-0010 and that:

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

(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 name of the staff member or provider organization to the bank account or other personal property of the individual without approval of the individual or the legal representative of the individual (as applicable).

(C) Complaints.

(i) Complaints must be addressed in accordance with OAR 411-318-0015.

(ii) The provider organization must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015.

(iii) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual.

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

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

(c) The provider organization must maintain a current record for each individual receiving services. The record must include:

(A) The name, current home address, and home phone number of the individual;

(B) A current written service agreement signed and dated by the individual;

(C) Contact information for the legal or designated representative of the individual (as applicable) and any other people designated by the individual 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 people 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 the individuals 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 or designated representative (as applicable), 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, including 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 Department; and

(IV) The Oregon Health Authority, Public Health Division, when necessary.

(iii) The inspection must cover:

(I) Hazardous material handling and storage;

(II) Machinery and equipment used at the service site;

(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 an 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 a 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 or the individual's legal or designated representative (as applicable); and

(iii) Prohibiting the use of one individual's medications by another individual or person.

(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 a first aid kit in each vehicle; 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's or another individual's funds, or the provider organization becoming an individual's legal or designated 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 business 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 as applicable the individual's legal or designated representative, of the behavior intervention policy and procedures prior to finalizing the individual's 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 or designated representative (as applicable); and

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

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

(i) Prescribed by a 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 protective physical intervention.

(A) The provider organization must only employ protective physical intervention:

(i) As part of an individual's 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 protective physical intervention under an individual's service agreement must be trained by a Department-approved trainer and documentation of the training must be maintained in the staff members' personnel file.

(C) Protective physical intervention in emergency situations must:

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

(ii) Be authorized by the provider organization director or the physician of the individual within one hour of application of the protective physical intervention;

(iii) Result in the immediate notification of the individual's legal or designated representative (as applicable); and

(iv) Prompt a review of the individual's written service agreement, initiated by the provider organization, if protective physical intervention is used more than three times in a six month period.

(D) Protective physical intervention must be designed to avoid physical injury to an individual or others and to minimize physical and psychological discomfort.

(E) All use of protective physical intervention 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 protective physical intervention is applied;

(ii) The date, type, and length of time of the application of protective physical intervention;

(iii) The name and position of the person authorizing the use of the protective physical intervention;

(iv) The name of the staff member applying the protective physical intervention; and

(v) Description of the incident.

(l) Additional standards for supports that involve employment services are found in OAR 411-345-0160.

(3) CERTIFICATE ADMINISTRATIVE SANCTION. An administrative sanction may be imposed for non-compliance with these rules. An administrative sanction includes one or more of the following actions:

(a) Conditions;

(b) Denial, revocation, or refusal to renew a certificate; or

(c) Immediate suspension of a certificate.

(4) CERTIFICATE CONDITIONS.

(a) The Department may attach conditions to a certificate that limit, restrict, or specify other criteria for operation of the provider organization. The type of condition attached to a certificate must directly relate to the risk of harm or potential risk of harm to individuals.

(b) The Department may attach a condition to a certificate upon a finding that:

(A) Information on the application or initial inspection requires a condition to protect the health, safety, or welfare of individuals;

(B) A threat to the health, safety, or welfare of an individual exists;

(C) There is reliable evidence of abuse, neglect, or exploitation; or

(D) The provider organization is not being operated in compliance with these rules.

(c) Conditions that the Department may impose on a certificate include, but are not limited to:

(A) Restricting the total number of individuals to whom a provider organization may provide services;

(B) Restricting the total number of individuals to whom a provider organization may provide services based upon the capability and capacity of the provider organization and staff to meet the health and safety needs of all individuals;

(C) Restricting the type of support and services the provider organization may provide to individuals based upon the capability and capacity of the provider organization and staff to meet the health and safety needs of all individuals;

(D) Requiring additional staff or staff qualifications;

(E) Requiring additional training;

(F) Restricting the provider organization from allowing a person on the premises who may be a threat to the health, safety, or welfare of an individual;

(G) Requiring additional documentation; or

(H) Restricting admissions.

(d) NOTICE OF CERTIFICATE CONDITIONS. The Department issues a written notice to the provider organization when the Department imposes conditions on the certificate of the provider organization. The written notice of certificate conditions includes the conditions imposed by the Department, the reason for the conditions, and the opportunity to request a hearing under ORS chapter 183. Conditions take effect immediately upon issuance of the written notice of certificate conditions or at a later date as indicated on the notice and are a Final Order of the Department unless later rescinded through the hearing process. The conditions imposed remain in effect until the Department has sufficient cause to believe the situation that warranted the condition has been remedied.

(e) HEARING. The provider organization may request a hearing in accordance with ORS chapter 183 and this rule upon receipt of written notice of certificate conditions. The request for a hearing must be in writing.

(A) The provider organization must request a hearing within 21 days of receipt of the written notice of certificate conditions.

(B) In addition to, or in-lieu of a hearing, a provider organization may request an administrative review as described in section (7) of this rule. The administrative review does not diminish a provider organization's right to a hearing.

(f) The provider organization may send a written request to the Department to remove a condition if the provider organization believes the situation that warranted the condition has been remedied.

(5) CERTIFICATE DENIAL, REFUSAL TO RENEW, OR REVOCATION.

(a) The Department may deny, refuse to renew, or revoke a certificate when the Department finds the provider organization, or any person holding five percent or greater ownership interest in the provider organization:

(A) Demonstrates substantial failure to comply with these rules or the corresponding program rules such that the health, safety,

or welfare of individuals is jeopardized and the provider organization fails to correct the non-compliance within 30 days from the receipt of written notice of non-compliance;

(B) Has demonstrated a substantial failure to comply with these rules or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized;

(C) Has been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of services;

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

(E) Falsifies information required by the Department to be maintained or submitted regarding individual services, provider organization finances, or funds belonging to the individuals;

(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 maintained by the Office of the Inspector General.

(b) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may issue a notice of denial, refusal to renew, or revocation of a certificate following a Department finding that there is a substantial failure to comply with these rules or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in subsection (a) of this section has occurred.

(c) HEARING. An applicant for a certificate or a certified provider organization, as applicable, may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential setting, upon written notice from the Department of denial,

refusal to renew, or revocation of the certificate. The request for a hearing must be in writing.

(A) DENIAL. The applicant must request a hearing within 60 days from the receipt of the written notice of denial.

(B) REFUSAL TO RENEW. The provider organization must request a hearing within 60 days from the receipt of the written notice of refusal to renew.

(C) REVOCATION. The provider organization must request a hearing within 21 days from the receipt of the written notice of revocation.

(i) In addition to, or in-lieu of a hearing, the provider organization may request an administrative review as described in section (7) of this rule.

(ii)The administrative review does not diminish the right of the provider organization to a hearing.

(6) IMMEDIATE SUSPENSION OF CERTIFICATE.

(a) When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the provider organization, immediately suspend a certificate without a pre-suspension hearing and the provider organization may not continue operating.

(b) HEARING. The provider organization may request a hearing in accordance with ORS chapter 183 and this rule upon written notice from the Department of the immediate suspension of the certificate. The request for a hearing must be in writing.

(A) The provider organization must request a hearing within 21 days from the receipt of the written notice of suspension.

(B) In addition to, or in-lieu of a hearing, the provider organization may request an administrative review as described

in section (7) of this rule. The request for an administrative review must be in writing. The administrative review does not diminish right of the provider organization to a hearing.

(7) ADMINISTRATIVE REVIEW.

(a) The provider organization, in addition to the right to a hearing, may request an administrative review. The request for an administrative review must be in writing.

(b) The Department must receive a written request for an administrative review within 10 business days from the receipt of the notice of suspension, revocation, or imposition of conditions. The provider organization may submit, along with the written request for an administrative review, any additional written materials the provider organization wishes to have considered during the administrative review.

(c) The determination of the administrative review is issued in writing within 10 business days from the receipt of the written request for an administrative review, or by a later date as agreed to by the provider organization.

(d) The provider organization may request a hearing if the decision of the Department is to affirm the suspension, revocation, or condition. The request for a hearing must be in writing. The Department must receive the written request for a hearing within 21 days from the receipt of the original written notice of suspension, revocation, or imposition of conditions.

(8) INFORMAL CONFERENCE. Unless an administrative review has been completed as described in section (7) of this rule, a provider organization requesting a hearing may have an informal conference with the Department.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0180 Standards for General Business Providers Paid with Support Services Funds
(Amended 12/28/2014)

(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) For a home health agency, a license under ORS 443.015;

(b) For an in-home care agency, a license under ORS 443.315;

(c) For providers of environmental modifications involving building modifications or new construction, 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);

(d) For environmental accessibility consultants, a current license as a general contractor as required by OAR chapter 812, including experience evaluating homes, assessing the needs of an individual, and developing cost-effective plans to make homes safe and accessible;

(e) For public transportation providers, the established standards;

(f) For private transportation providers, a business license and drivers licensed to drive in Oregon;

(g) For vendors and medical supply companies assistive devices or specialized medical supplies, a current retail business license, including enrollment as Medicaid providers through the Division of Medical Assistance Programs if vending medical equipment;

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

(i) 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 the services within the scope of the license of the general business provider.

Stat. Auth.: ORS 409.050, 427.402, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695