CHAPTER 411
DIVISION 30

IN-HOME SERVICES

411-030-0001
(Renumbered to OAR 411-030-0040 6/1/1993)

411-030-0002 Purpose
(Amended 6/7/2004)

These Administrative Rules are established to ensure that in-home support services will maximize independence, empowerment, dignity, and human potential through provision of flexible, efficient, and suitable services to each eligible client. Such services fill the role of complementing and supplementing the client's own personal abilities to continue to live in his/her own home.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070

411-030-0020 Definitions
(Amended 9/24/2008)

As used in these rules:

(1) "Activities of Daily Living (ADL)" means those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities consist of eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel and bladder management), and cognition/behavior as defined in OAR 411-015-0006.

(2) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet a specific service need of the eligible individual.

(3) "Area Agency on Aging (AAA)" means the Department of Human Services designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors or people with disabilities in a planning and service area. For purposes of these rules, the term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 through 410.300.

(4) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. This definition includes the use of service animals, general household items or furniture to assist the individual.

(5) "Business Days" means Monday through Friday and excludes Saturdays, Sundays and state or federal holidays.

(6) "Case Manager" means a Department of Human Services or Area Agency on Aging employee who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements the service plan, and monitors the services delivered.

(7) "Client" or "Client-Employer" means the individual eligible for in-home services. “Individual” is synonymous with client.

(8) "Client Assessment and Planning System (CA/PS)” is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental and social functioning, and identifying risk factors, individual choices and preferences, and the status of service needs. The CA/PS documents the level of need and calculates the individual's service priority level in accordance with OAR chapter 411, division 015, calculates the service payment rates, and accommodates individual participation in service planning.

(9) "Client-Employed Provider Program (CEP)" refers to the program wherein the provider is directly employed by the client and provides either hourly or live-in services. In some aspects of the employer and employee relationship, the Department of Human Services acts as an agent for the

client-employer. These functions are clearly described in OAR 411-031-0040.

(10) "Contingency Fund" a monetary amount set aside in the Independent Choices Program service budget that continues month to month if approved by the case manager, to purchase identified items that substitute for personal assistance.

(11) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR chapter 333, division 536 that provides hourly contracted in-home services to individuals served by the Department of Human Services or Area Agency on Aging.

(12) "Cost Effective" means being responsible and accountable with Department of Human Services resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices include other programs available from the Department, the utilization of assistive devices, natural supports, architectural modifications and alternative service resources (defined in OAR 411-015-0005). Less costly alternatives may include resources not paid for by the Department.

(13) "Department" or "DHS" means the Department of Human Services.

(14) "Discretionary Fund" means a monetary amount set aside in the Independent Choices Program service budget to purchase items not otherwise delineated in the monthly service budget or agreed to be savings for items not traditionally covered under waivered services. Discretionary funds must be expended at the end of each month.

(15) "Disenrollment" means either voluntary or involuntary termination of the participant from the Independent Choices Program.

(16) "Employee Provider" means a worker who provides services to, and is a paid provider for, a participant in the Independent Choices Program.

(17) "Employment Relationship" means the relationship involving the employee provider and the participant as employee and employer.

(18) "Exception" means an approval for payment of a service plan granted to a specific individual in their current residence (or in the proposed residence identified in the exception request) that exceeds the CA/PS assessed service payment levels for individuals residing in community-based care facilities or the maximum hours of service as described in OAR 411-030-0070 for individuals residing in their own homes. The approval is based on the service needs of the individual and is contingent upon the service plan meeting the requirements in OAR 411-027-0020, OAR 411-027-0025 and OAR 411-027-0050. The term "exception" is synonymous with "exceptional rate" or "exceptional payment."

(19) "FICA" is the acronym for the Social Security payroll taxes collected under authority of the Federal Insurance Contributions Act.

(20) "Financial Accountability" refers to guidance and oversight which act as fiscal safeguards to identify budget problems on a timely basis and allow corrective action to be taken to protect health and welfare of individuals.

(21) "FUTA" is the acronym for Federal Unemployment Tax Assessment which is a United States payroll (or employment) tax imposed by the federal government on both employees and employers.

(22) "Homecare Worker (HCW)" means a provider, as described in OAR 411-031-0040, that provides either hourly or live-in services to eligible individuals and is employed by the individual. The term homecare worker includes client-employed providers in the Spousal Pay and Oregon Project Independence Programs. It also includes client-employed providers that provide state plan personal care services to seniors and people with physical disabilities. The term does not include Independent Choices Program providers or personal care attendants enrolled through Developmental Disability Services or the Addictions and Mental Health Division.

(23) "Hourly Services" means the in-home services, including activities of daily living and self-management tasks, that are provided at regularly scheduled times.

(24) "Independent Choices Program (ICP)" means a self directed in-home services program in which the participant is given a cash benefit to purchase goods and services identified in a service plan and prior

approved by the Seniors and People with Disabilities Division or Area Agency on Aging case manager.

(25) "Individualized Back-Up Plan" means a plan incorporated into the Independent Choices Program service plan to address critical contingencies or incidents that pose a risk or harm to the participant's health and welfare.

(26) "In-Home Services" means those activities of daily living and self-management tasks that assist an individual to stay in his or her own home.

(27) “Liability” refers to the dollar amount individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(28) "Live-In Services" means those Client-Employed Provider Program services provided when an individual requires activities of daily living, self-management tasks and twenty-four hour availability. Time spent by any live-in employee doing self-management and twenty-four hour availability are exempt from federal and state minimum wage and overtime requirements. To ensure continuity of service for the individual, live-in service plans must include at least one homecare worker providing twenty-four hour availability for a minimum of five days in a calendar week.

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

(30) "Oregon Project Independence (OPI)" means the program of in-home services described in OAR chapter 411, division 032.

(31) "Participant" means an individual eligible for Independent Choices Program services.

(32) "Provider" means the individual who actually renders the service.

(33) "Rate Schedule" means the rate schedule published by the Seniors and People with Disabilities Division at http://www.oregon.gov/DHS/spd/provtools/rateschedule.pdf.

(34) "Representative" is a person either appointed by the individual to participate in service planning on their behalf or the individual's natural support with longstanding involvement in assuring the individual's health, safety and welfare. There are additional responsibilities for the Independent Choices Program representatives as described in OAR 411-030-0100. An ICP representative cannot be a paid employee provider regardless of relationship to the participant.

(35) "Self-Management" or "Instrumental Activities of Daily Living (IADL)" means those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in self-management tasks are identified in OAR 411-015-0007.

(36) "Service Budget" means the participant's plan for the distribution of authorized funds that are under the control and direction of the participant within the Independent Choices Program. The service budget is a required component of the service plan.

(37) "Service Need" means the assistance an individual requires from another person for those functions or activities identified in OAR 411-015-0006 and OAR 411-015-0007.

(38) "SPD" or "Division" means the Seniors and People with Disabilities Division, within the Department of Human Services.

(39) "SUTA" is the acronym for State Unemployment Tax Assessment. State unemployment taxes are paid by employers to finance the unemployment benefit system that exists in each state.

(40) "Twenty-Four Hour Availability" means the availability and responsibility of an employee to meet activities of daily living and self-management needs of an eligible individual as required by that person over a 24 hour period. These services are provided by a live-in employee and are exempt from federal and state minimum wage and overtime requirements.

(41) "Waivered Services" means services provided through Oregon's Medicaid Home and Community-Based Services Waiver under the authority of section 1915 (c) of the Social Security Act, that allows the state to provide home and community-based services to eligible individuals in place of nursing facility services. Waivered services include in-home services, residential care facility services, assisted living facility services, adult foster care services, home-delivered meals (when provided in conjunction with in-home services), specialized living services, Spousal Pay Program services and adult day services.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0022
(Renumbered to OAR 411-030-0050 6/1/1993)

411-030-0027
(Renumbered to OAR 411-030-0080 6/1/1993)

411-030-0033 Program Scope
(Amended 6/1/2006)

(1) In-Home Support Services are designed to provide essential supportive services that enable an individual to remain in his or her own home. The services range from assistance with household tasks to assistance with activities of daily living. The extent of the services may vary from a few hours per week to full-time. Live-in services may be an option depending on the program.

(2) In-home support services may be provided through the Home and Community-Based Services waivered In-Home Services Program, Independent Choices Program, the State-funded Spousal Pay Program, or Oregon Project Independence Program.

(3) Permissible In-Home Services Program Living Arrangements

(a) The following terms are used in this rule:

(A) "Informal arrangement" means a paid or unpaid arrangement for shelter or utility costs that does not include the elements of a "property manager's rental agreement" as defined in this rule.

(B) "Property manager's rental agreement" means a payment arrangement for shelter or utility costs with a property owner, property manager or landlord that includes all of the following elements:

(i) The name and contact information for the property manager, landlord, or leaser;

(ii) The period or term of the agreement and method for terminating the agreement;

(iii) The number of tenants or occupants;

(iv) The rental fee and any other charges (such as security deposits);

(v) The frequency of payments (such as monthly);

(vi) What costs are covered by the amount of rent charged (such as shelter, utilities or other expenses); and

(vii) The duties and responsibilities of the property manager and the tenant, such as:

(I) The person responsible for maintenance;

(II) If the property is furnished or unfurnished; and

(III) Advance notice requirements prior to an increase rent

(C) "Provider-owned dwelling" means a dwelling that is owned by the provider or his or her spouse when the provider is

proposing to be paid through waivered services. The dwelling does not include the client's name on the property deed, mortgage or title. Such dwellings include, but are not limited to:

(i) Houses, apartments and condominiums;

(ii) A portion of a house such as basement or a garage even when remodeled to be used as a separate dwelling;

(iii) Trailers and mobile homes; or

(iv) Duplexes, unless the structure displays a separate address from the other residential unit and was originally built as a duplex.

(D) "Provider-rented dwelling" means a dwelling that is rented or leased by the provider or his or her spouse when the provider is proposing to be paid through waivered services. The dwelling does not include the name of the client on the property manager's rental agreement.

(b) A client residing in any of the following living arrangements will not be eligible for the Home and Community-Based Services waivered In-Home Services Program:

(A) The client resides in a provider-owned dwelling. Such a setting may meet the requirements for relative adult foster care or limited license adult foster care as described in OAR 411-050-0405.

(B) The client resides in a provider-rented dwelling through an informal arrangement.

(c) If the client's name is added to the property deed, mortgage, title, or property manager's rental agreement (as defined in paragraph (3)(a)(B) of this rule), the client may be considered for waivered in-home services.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0040 Eligibility Criteria
(Amended 9/24/2008)

(1) In-home services may be provided to those individuals who meet the established priorities for service as described in OAR chapter 411, division 015 and have been assessed to be in need of a service provided in OAR chapter 411, division 030. Payments for in-home services are not intended to replace the resources available to an individual from their natural support system. Payment by the Department can be considered or authorized only when such resources are not available, not sufficient, or cannot be developed to adequately meet the needs of the individual. An individual whose service needs are met by their natural supports shall not be eligible for in-home services. Service plans must be based upon the least costly means of providing adequate care.

(2) Individuals served under the Home and Community-Based Services Waivered In-Home Services Program or the Independent Choices Program must meet the established priorities for service as described in OAR chapter 411, division 015 and must:

(a) Be current recipients of OSIPM;

(b) Reside in a living arrangement in which in-home services may be provided as described in OAR 411-030-0033; and

(c) Be eighteen years of age or older.

(3) To be eligible for the Home and Community-Based Services Waivered In-Home Services Program, an individual must employ an enrolled homecare worker or contracted in-home care agency to provide those services prior authorized and paid by the Department. Participants of the Independent Choices Program must employ an employee provider or contracted in-home care agency.

(a) Initial eligibility for waivered in-home services or the Independent Choices Program does not begin until a service plan has been

authorized. The service plan must identify the provider who delivers the authorized services, and must include the date when the provision of services begins and the maximum number of hours authorized.

(b) If, for any reason, the employment relationship between the individual and provider is discontinued, an enrolled homecare worker or contracted in-home care agency must be employed within 14 business days for the individual to remain eligible for the program. Participants of the Independent Choices Program must employ an employee provider within 14 business days.

(c) An eligible individual who has been receiving waivered in-home services and temporarily enters a nursing facility or medical institution must employ an enrolled homecare worker or contracted in-home care agency within 14 business days of discharge from the facility or institution. Participants of the Independent Choices Program must employ an employee provider within 14 business days of discharge.

(4) Additional eligibility criteria for in-home services exist for persons eligible for:

(a) Oregon Project Independence as described in OAR chapter 411, division 032;

(b) Independent Choices Program as described in OAR 411-030-0100; or

(c) Spousal Pay Program as described in OAR 411-030-0080.

(5) Residents of licensed community-based care facilities, nursing facilities, prisons, hospitals and other institutions that provide assistance with activities of daily living are not eligible for in-home services.

(6) Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0050 Case Management
(Amended 9/24/2008)

(1) ASSESSMENT.

(a) The assessment process must identify the individual's ability to perform activities of daily living, self-management tasks, and determine the individual's ability to address health and safety concerns. The case manager must conduct this assessment in accordance with standards of practices established by SPD in OAR 411-015-0008.

(b) The assessment must be conducted by a case manager or other qualified SPD or Area Agency on Aging representative in the home of the eligible individual, no less than annually, with a standardized assessment tool approved by SPD.

(2) CONTRACT RN ASSESSMENT.

(a) Contract RN services are prior authorized by a SPD or Area Agency on Aging case manager to provide:

(A) Nursing assessment and reassessment as appropriate;

(B) Medication review;

(C) Assignment of basic care tasks to a homecare worker or employee provider; and

(D) Delegation of special tasks of nursing care to a homecare worker or employee provider.

(b) Indicators of the need for RN assessment and monitoring include:

(A) Full assistance in cognition;

(B) Medical instability;

(C) Potential for skin breakdown or decubitus ulcer;

(D) Multiple health problems or frailty with a strong probability of deterioration; or

(E) Potential for increased self-care, but instruction and support for the individual are needed to reach goals.

(c) Maximum hours for each contracted RN service shall be established by SPD.

(3) SERVICE PLAN.

(a) The client and case manager, with the assistance of other involved individuals, must consider in-home service options as well as assistive devices, architectural modifications, and other community-based care resources to meet the service needs identified in the assessment process.

(b) The case manager has responsibility for determining eligibility for specific services, presenting alternatives to the individual, identifying risks, and assessing the cost effectiveness of the plan. The case manager must monitor the plan and make adjustments as needed.

(c) The client, or their representative, has the responsibility to choose and assist in developing less costly service alternatives, including the Client-Employed Provider Program and contracted in-home care agency services.

(d) The service plan payment must be considered full payment for the services rendered under Title XIX. Under no circumstances is the employee to demand or receive additional payment for these Title XIX-covered services from the client-employer or any other source. Additional payment to homecare workers or Independent Choices Program employee providers for the same services covered by Oregon's Title XIX Home and Community-Based Services Waiver or Spousal Pay Programs is prohibited.

(e) For the Independent Choices Program, the service plan must include the service budget as per OAR 411-030-0100.

(f) SPD may not authorize a hardship shelter allowance associated with employing a live-in provider on or after June 1, 2006.

(g) Individuals eligible for and authorized to receive a hardship shelter allowance before June 1, 2006 may continue to receive a hardship shelter allowance on or after June 1, 2006 at the rate established by SPD if one of the following conditions is met:

(A) The individual shall be forced to move from their current dwelling and the individual's current average monthly rent or mortgage costs exceed current OSIP and OSIPM standards for a one-person need group as outlined in OAR 461-155-0250; or

(B) Service costs significantly increase as a result of the individual being unable to provide living quarters for a necessary live-in provider.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0055 Service Plan-Related Transportation
(Adopted 6/1/2006)

(1) Service-related transportation (non-medical) may be prior-authorized for reasons related to an eligible individual's safety or health, in accordance with a plan of care. Such services will be offered through contracted transportation providers or by Homecare workers.

(2) Service-related transportation may be authorized to assist an eligible individual in getting to and from his or her place of employment when that individual is approved for the Employed Persons with Disabilities Program (OSIPM-EPD).

(3) Natural supports, volunteer transportation, and other transportation services available to the eligible individual will be considered a prior resource and must not be replaced with transportation paid by the Department.

(a) DMAP is a prior resource for medical transportation to a physician, hospital, clinic or other medical service provider. Medical transportation costs cannot be reimbursed through service-related transportation.

(b) The Department will not provide service-related transportation to obtain medical or non-medical items that can be delivered by a supplier or sent by mail order without cost to the eligible individual.

(4) Transportation must be prior authorized by the Case Manager and documented in the case record. Under no circumstances will any provider receive payment from the Department for more than the total number of hours, miles or rides authorized by the Department in the Service Plan.

(a) Contracted transportation providers will be reimbursed according to the terms of their contract with the Department. Service transportation services provided through contracted transportation providers must be authorized by the Case Manager based on an estimate of a total count of one way rides per month.

(b) Homecare Workers will be reimbursed according to the terms defined in their collective bargaining agreement when they use their own personal vehicle for service-related transportation. Any mileage reimbursement authorized to a Homecare Worker must be based on an estimate of the monthly maximum miles required to drive to and from the destination(s) authorized in the Service Plan. Transportation hours are authorized in accordance with OAR 411-030-0070.

(c) SPD/AAA will not authorize reimbursement for travel to or from the residence of the Homecare Worker. Transportation and mileage may only be authorized from the home of the eligible individual to the destination(s) authorized in the Service Plan and back to the eligible individual's home.

(5) The Department is not responsible for any vehicle damage or personal injury sustained while using a personal motor vehicle for service-related transportation.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0060 Client Employed Provider Program
(Repealed 6/7/2004 – Moved to OAR chapter 411, division 031)

411-030-065 Administrative Review and Hearing Rights
(Repealed 6/7/2004 – Moved to OAR chapter 411, division 031)

411-030-0070 Maximum Hours of Service
(Amended 9/24/2008)

(1) LEVELS OF ASSISTANCE FOR DETERMINING SERVICE PLAN HOURS.

(a) "Minimal Assistance" means the individual is able to perform the majority of an activity, but requires some assistance from another person.

(b) "Substantial Assistance" means the individual can perform only a small portion of the tasks that comprise the activity without assistance from another person.

(c) "Full Assistance" means the individual needs assistance from another person through all phases of the activity, every time the activity is attempted.

(2) MAXIMUM MONTHLY HOURS FOR ACTIVITIES OF DAILY LIVING.

(a) The planning process uses the following limitations for time allotments for ADL tasks. Hours authorized are based on the service needs of the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial or full).

(A) Eating:

(i) Minimal assistance -- 5 hours;

(ii) Substantial assistance -- 20 hours;

(iii) Full assistance -- 30 hours;

(B) Dressing/Grooming:

(i) Minimal assistance -- 5 hours;

(ii) Substantial assistance -- 15 hours;

(iii) Full assistance -- 20 hours;

(C) Bathing and Personal Hygiene:

(i) Minimal assistance -- 10 hours;

(ii) Substantial assistance -- 15 hours;

(iii) Full assistance -- 25 hours;

(D) Mobility:

(i) Minimal assistance -- 10 hours;

(ii) Substantial assistance -- 15 hours;

(iii) Full assistance -- 25 hours;

(E) Elimination (Toileting, Bowel and Bladder):

(i) Minimal assistance -- 10 hours;

(ii) Substantial assistance -- 20 hours;

(iii) Full assistance -- 25 hours;

(F) Cognition/Behavior:

(i) Minimal assistance -- 5 hours;

(ii) Substantial assistance -- 10 hours;

(iii) Full assistance -- 20 hours.

(b) Service plan hours for activities of daily living may only be authorized for an individual if the individual requires assistance (minimal, substantial or full assist) from another person in that activity of daily living as determined by a service assessment applying the parameters in OAR 411-015-0006.

(c) For households with two or more eligible individuals, each person's ADL service needs are considered separately. In accordance with section (3)(c) of this rule, authorization of self-management hours is limited for each additional individual in the home.

(d) Hours authorized for activities of daily living are paid at hourly rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for ADLs paid at the hourly rates. Participants of the Independent Choices Program may determine their own employee provider pay rates.

(3) MAXIMUM HOURS FOR SELF MANAGEMENT TASKS.

(a) The planning process uses the following limitations for time allotments for all services. Hours authorized are based on the service needs of the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial or full).

(A) Medication and Oxygen Management:

(i) Minimal assistance -- 2 hours;

(ii) Substantial assistance -- 4 hours;

(iii) Full assistance -- 6 hours;

(B) Transportation or Escort Assistance:

(i) Minimal assistance -- 2 hours;

(ii) Substantial assistance -- 3 hours;

(iii) Full assistance -- 5 hours;

(C) Meal Preparation:

(i) Minimal assistance--breakfast -- 4 hours, lunch -- 4 hours, supper -- 8 hours;

(ii) Substantial assistance--breakfast -- 8 hours, lunch -- 8 hours, supper -- 16 hours;

(iii) Full assistance--breakfast -- 12 hours, lunch -- 12 hours, supper -- 24 hours;

(D) Shopping:

(i) Minimal assistance -- 2 hours;

(ii) Substantial assistance -- 4 hours;

(iii) Full assistance -- 6 hours;

(E) Housecleaning:

(i) Minimal assistance -- 5 hours;

(ii) Substantial assistance -- 10 hours;

(iii) Full assistance -- 20 hours.

(b) Rates shall be paid in accordance with the rate schedule. When a live-in employee is present, these hours may be paid at less than minimum wage according to the Fair Labor Standards Act. The Independent Choices Program cash benefit is based on the hours authorized for self management tasks paid at the hourly rates.

Participants of the Independent Choices Program may determine their own employee provider pay rates.

(c) When two or more individuals eligible for self-management task hours live in the same household, the assessed self-management need of each individual must be calculated. Payment shall be made for the highest of the allotments and a total of four additional self-management hours per month for each additional individual to allow for the specific self-management needs of the other individuals.

(d) Service plan hours for self-management tasks may only be authorized for an individual if the individual requires assistance (minimal, substantial or full assist) from another person in that self-management task as determined by a service assessment applying the parameters in OAR 411-015-0007.

(4) TWENTY-FOUR HOUR AVAILABILITY.

(a) Payment for twenty-four hour availability shall be authorized only when the client employs a live-in homecare worker or Independent Choices Program employee provider and requires this availability due to the following:

(A) The individual requires assistance with activities of daily living or self-management tasks at unpredictable times throughout most 24 hour periods; and

(B) The individual requires minimal, substantial, or full assistance with ambulation and requires assistance with transfer (as defined in OAR 411-015-0006); or

(C) The individual requires full assistance in transfer or elimination (as defined in OAR 411-015-0006); or

(D) The individual requires full assist in at least three of the eight components of cognition/behavior (as defined in OAR 411-015-0006).

(b) The number of hours allowed per month shall have the following maximums. Hours authorized are based on the service needs of the

individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial or full).

(A) Minimal assistance -- 60 hours. Minimal assistance hours may be authorized when an individual requires one of these assessed needs as defined in OAR 411-015-0006:

(i) Full assist in cognition; or

(ii) Full assist in toileting or bowel or bladder.

(B) Substantial assistance -- 110 hours. Substantial assistance hours may be authorized when an individual requires these assessed needs as defined in OAR 411-015-0006:

(i) Assist in transfer; and

(ii) Assist in ambulation; and

(iii) Full assist in cognition; or

(iv) Full assist in toileting or bowel or bladder.

(C) Full assistance -- 159 hours. Full assistance hours may be authorized when:

(i) The authorized provider cannot get at least five continuous hours of sleep in an eight hour period during a 24-hour work period; and

(ii) The eligible individual requires these assessed needs as defined in OAR 411-015-0006:

(I) Full assist in transfer; and

(II) Assist in mobility; or

(III) Full assist in toileting or bowel or bladder; or

(IV) Full assist in cognition.

(c) Service plans that include full-time live-in homecare workers or Independent Choices Program employee providers must include a minimum of 60 hours per month of twenty-four hour availability. When a live-in homecare worker or Independent Choices Program employee provider is employed less than full time, the hours must be pro-rated. Full-time means the live-in homecare worker is providing services to the client-employer seven days per week throughout a calendar month.

(d) Rates for this availability shall be in accordance with the rate schedule and paid at less than minimum wage according to the Fair Labor Standards Act and ORS 653.020(2).

(e) Twenty-four hour availability assumes the homecare worker is available to address the service needs of an individual as they arise throughout a 24 hour period. A homecare worker who engages in employment outside the eligible individual's home or building during the work periods he or she is on duty as a homecare worker, is not considered available to meet the service needs of the individual.

(5) Under no circumstances shall any provider receive payment from SPD for more than the total amount authorized by SPD on the service plan authorization form. All service payments must be prior-authorized by SPD or AAA.

(6) AUTHORIZED HOURS ARE SUBJECT TO THE AVAILABILITY OF FUNDS. Case managers must assess and utilize as appropriate, natural supports, cost-effective assistive devices, durable medical equipment, housing accommodations, and alternative service resources (as defined in OAR 411-015-0005) which could reduce the individual's reliance on paid in-home services hours.

(7) SPD may authorize paid in-home services only to the extent necessary to supplement potential or existing resources within the individual's natural support system.

(8) Payment by SPD for waivered in-home services can only be made for those tasks described in this rule as activities of daily living, self-management tasks and twenty-four hour availability. Services must be

authorized to meet the needs of the eligible individual and cannot be provided to benefit the entire household.

(9) EXCEPTIONS TO MAXIMUM HOURS OF SERVICE.

(a) To meet an extraordinary ADL service need that has been documented, the hours authorized for activities of daily living can exceed the full assistance hours (defined in section (2) of this rule) as long as the total number of ADL hours in the service plan does not exceed 145 hours per month.

(b) Monthly service payments that exceed 145 ADL hours per month may be approved by SPD central office when the exceptional payment criteria identified in OAR 411-027-0000 and OAR 411-027-0050 are met.

(c) Monthly service plans that exceed 389 hours per month for a live-in homecare worker or Independent Choices Program employee provider, or that exceed the equivalent monthly service payment for an hourly services plan, may be approved by SPD central office when the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050 are met.

(d) As long as the total number of self-management task hours in the service plan does not exceed 85 hours per month and the service need is documented, the hours authorized for self-management tasks can exceed the hours for full assistance (as defined in section (3) of this rule) for the following tasks and circumstances:

(A) Housekeeping based on medical need (such as immune deficiency);

(B) Short-term extraordinary housekeeping services necessary to reverse unsanitary conditions that jeopardize the health of the individual; or

(C) Extraordinary self-management needs in medication management or service-related transportation.

(e) Monthly service plans that exceed 85 hours per month in self-management tasks may be approved by SPD central office when the individual meets the exceptional payment criteria identified in OAR 411-027-0000 and OAR 411-027-0050.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0080 Spousal Pay Program
(Amended 10/28/2007)

(1) The Spousal Pay Program is one of the live-in service options under the In-Home Support Services Program (defined in chapter 411, division 030) for those who qualify.

(2) For the purposes of this program, a spouse is defined as a person who is legally married per OAR 461-001-0000 to an individual eligible for the In-Home Support Services Program.

(3) An individual may be eligible for the Spousal Pay Program when all of the following conditions are met:

(a) The individual has met all program requirements of the In-Home Support Services Program; and

(b) As determined by an assessment described in chapter 411, division 015 rules, the individual requires full assistance in at least four of the six activities of daily living described in OAR 411-015-0006; and

(c) The individual would otherwise require nursing facility services without in-home support services; and

(d) The individual has a medically-diagnosed, progressive, debilitating condition that will limit additional activities of daily living, or has experienced a spinal cord injury or similar disability with permanent impairment of the ability to perform activities of daily living; and

(e) At the time of requesting enrollment in the Spousal Pay Program, the individual is determined, through a Pre-Admission Screening (PAS) assessment (as defined in OAR 411-070-0040) to meet the requirements described in sections (3)(b), (3)(c) and (3)(d) of this rule. The PAS assessment is a second, independent assessment, conducted by a Department or AAA representative using the Client Assessment and Planning System (CA/PS); and

(f) The individual's service needs exceed in both extent and duration the usual and customary services rendered by one spouse to another; and

(g) The spouse demonstrates the capability and health to provide the services and actually provides the principal services, including the majority of service plan hours, for which payment has been authorized; and

(h) The spouse meets all requirements for enrollment as a Homecare Worker in the Client-Employed Provider Program as described in OAR 411-031-0040; and

(i) DHS Central Office has reviewed the request and approved program eligibility at enrollment and annually upon re-assessment.

(4) Payments:

(a) All payments must be prior authorized by the Department or its designee.

(b) The hours authorized in the service plan must consist of one-half of the assessed hours for 24-hour availability, one-half of the assessed hours for self-management tasks, plus all of the hours for specific activities of daily living based on the service needs of the individual.

(c) Spousal Pay Providers are paid at live-in Homecare Worker rates as bargained in the 2007-2009 Collective Bargaining Agreement between the Home Care Commission and Service Employees International Union, Local 503, OPEU for activities of daily living,

self-management tasks and 24 hour availability, except as described otherwise in section (4)(d) of this rule.

(d) Homecare Workers who marry their client-employer retain the same standard of compensation, if their employer meets the spousal pay eligibility criteria as described in section (3) of this rule. Additional self-management task hours may be authorized in the service plan when necessary to prevent a loss of compensation to the Homecare Worker following marriage to the client-employer.

(e) Spousal Pay Providers must not claim payment from the Department for:

(A) Hours that the Spousal Pay Provider did not work; or

(B) Time spent arranging coverage to meet the client-employer's needs; or

(C) Services provided to the client by substitute providers.

(f) DHS is not responsible for payment of a substitute provider during interim absences while the Spousal Pay Provider is taking leave without pay. As used in this rule, leave without pay means time that is not covered by the Spousal Pay Homecare Worker's live in paid leave benefit. During these interim absences when the spouse needs to secure a substitute provider to perform the authorized duties normally performed by the Spousal Pay Provider, the spouse must arrange for adequate coverage to meet the service needs and pay the substitute provider for periods of leave without pay.

(5) Individuals receiving Spousal Pay Program services who have excess income must contribute to the cost of services pursuant to OAR 461-160-0610 and OAR 461-160-0620.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070, 411.802 & 411.803

411-030-0090 Contracted In-Home Care Agency Services
(Amended 9/4/2007)

(1) Contracted In-Home Care Agency services are one of the in-home support service options for individuals eligible for Oregon's Home and Community-Based Services Waiver.

(2) In-Home Care Agencies must be licensed in accordance with OAR 333-536-0000 through OAR 333-536-0100. The geographic service area in which the agency provides services must comply with OAR 333-536-0050. The specific services provided will be described in each contract's statement of work.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0100 Independent Choices Program
(Adopted 9/24/2008)

(1) The Independent Choices Program (ICP) is an in-home services program that empowers participants to self-direct their own service plans and purchase goods and services that enhance independence, dignity, choice and well-being.

(2) The ICP is limited to a maximum of 2,600 participants.

(a) SPD shall establish and maintain a waiting list for individuals eligible for in-home services requesting ICP after the ICP has reached its maximum.

(b) SPD shall enter names on the waiting list according to the date submitted by the SPD/AAA office.

(c) As vacancies occur, eligible individuals on the waiting list shall be offered the ICP in order according to their place on the waiting list.

(d) Individuals on the waiting list may receive services through other appropriate DHS programs for which they are eligible.

(3) INITIAL ELIGIBILITY REQUIREMENTS.

(a) To be eligible for the ICP an individual must:

(A) Meet all program requirements of the in-home services program in OAR chapter 411, division 030;

(B) Develop a service plan and budget to meet the needs identified in the CA/PS assessment;

(C) Sign the ICP participation agreement;

(D) Have or be able to establish a checking account;

(E) Provide evidence of a stable living situation for the past three months; and

(F) Demonstrate the ability to manage money as evidenced by timely and current utility and housing payments.

(b) If the participant is unable to direct and purchase his or her own in-home services, the participant must have a representative to act on the participant's behalf. The "representative" is the person assigned by the participant to act as the participant's decision maker in matters pertaining to the ICP service plan and service budget. A representative must:

(A) Complete a criminal history check pursuant to OAR chapter 407, division 007 and receive a final fitness determination of approval; and

(B) Sign and adhere to the "Independent Choices Program Representative Agreement" on behalf of the participant.

(c) If the participant is unable to manage ICP cash payment accounting, tax or payroll responsibilities and does not have a representative, the participant must arrange and purchase the ongoing services of a fiscal intermediary, such as an accountant, bookkeeper or equivalent financial services. Participants, or their representative who have met the eligibility criteria in section (3)(b) of this rule, may also choose to use a fiscal intermediary. The participant is responsible for any fees or payment to the fiscal

intermediary and may allocate the fees or payment from their discretionary funds or other non ICP funds.

(4) DISENROLLMENT CRITERIA. Participants may be disenrolled from the ICP voluntarily or involuntarily.

(a) Voluntary disenrollment. Participants or representatives must provide notice to SPD of intent to discontinue participation. The participant or the representative must meet with SPD to reconcile remaining ICP cash payment either within 30 days of the date of disenrollment or before the termination date, whichever is sooner.

(b) Involuntary disenrollment.

(A) The participant may be involuntarily disenrolled from the ICP when the participant, representative or employee provider does not adequately meet the participant's service needs or carry out the following ICP responsibilities:

(i) Non-payment of employee’s wages, as stated in the service budget.

(ii) Failure to maintain health and well-being by obtaining personal care as evidenced by:

(I) Decline in functional status due to the failure to meet the participant’s needs; or

(II) Substantiated complaints of self-neglect or neglect or other abuse on the part of the employee provider or representative.

(iii) Failure to purchase goods and services according to the service plan;

(iv) Failure to comply with the legal or financial obligations as an employer;

(v) Failure to maintain a separate ICP checking account or commingling ICP cash benefit with other assets;

(vi) Inability to manage the cash benefit as evidenced by two or more incidents of overdrafts of the participant's ICP checking account during the last cash benefit review period;

(vii) Failure to deposit monthly service liability payment into the ICP checking account;

(viii) Failure to maintain an individualized back-up plan (as part of the service plan) resulting in a negative consequence;

(ix) Failure to sign or follow the ICP Participation Agreement; and

(x) Failure to select a representative within 30 days if a participant needs a representative and does not have one.

(B) Participants who are disenrolled from the ICP may not reapply for six months. After the six month disenrollment period, an individual may re-enroll and must meet all ICP eligibility requirements. If the ICP enrollment cap has been reached, participants who were disenrolled shall be added to the waiting list.

(5) INTERRUPTION OF SERVICES. When a participant is absent from the home for longer than 30 days due to illness or medical treatment, the ICP cash benefit shall be terminated. The cash benefit may resume upon return to the home, providing ICP eligibility criteria is met.

(6) SELECTION OF EMPLOYEE PROVIDERS.

(a) The participant or representative carries full responsibility for locating, screening, interviewing, hiring, training, paying, and terminating employee providers. The participant or representative must comply with Immigration and Customs Enforcement laws and policies.

(b) The participant or representative must assure the employee provider's ability to perform or assist with activities of daily living, self-management and twenty-four hour availability needs.

(c) Employee providers must complete a criminal history check pursuant to OAR chapter 407, division 007. If a record of a potentially disqualifying crime is revealed, the participant or representative may employ the provider at the participant's or representative's discretion.

(d) A representative cannot be an employee provider regardless of relationship to the participant.

(e) Participant's relatives may be employed as employee providers.

(7) CASH BENEFIT.

(a) The cash benefit is determined based on the CA/PS assessment of need, the service plan, the level of assistance standards in OAR 411-030-0070 and natural supports.

(b) The cash benefit is calculated by adding the activities of daily living task hours, the self-management task hours and the 24-hour availability hours that the participant is eligible for as determined in the CA/PS assessment, at the rates according to the SPD rate schedule.

(c) The following services, which are approved by the case manager and paid for by SPD, are excluded from ICP cash benefit:

(A) Community health supports;

(B) Contracted non-medical waiver service transportation;

(C) Home delivered meals; and

(D) Emergency response systems.

(d) The cash benefit shall include the employer’s portion of required FICA, FUTA, and SUTA.

(e) The cash benefit shall be directly deposited into the participant's ICP designated checking account.

(8) SERVICE BUDGET.

(a) The service budget must identify the cash benefit, the discretionary and contingency funds if applicable, the reimbursement to an employee provider and all other expenditures. The service budget must be initially approved by SPD/AAA staff.

(b) The participant may amend the service budget as long as the amendments relate to meeting the service needs and are within ICP program guidelines.

(c) A budget review to assure financial accountability and review service budget amendments must be completed at least every six months.

(9) CONTINGENCY FUND.

(a) The participant may establish a contingency fund in the service budget to purchase identified items that are not otherwise covered by Medicaid or food stamps that substitute for personal assistance and allow for greater independence.

(b) The contingency fund must be approved by the case manager, identified in the service budget and related to service plan needs.

(c) Contingency funds may be carried over into the next month's budget until the item is purchased.

(10) DISCRETIONARY FUND.

(a) The participant may establish a monthly discretionary fund in the service budget to purchase items that directly relate to the health, safety and independence of the participant and are not otherwise covered under waivered services or delineated in the monthly service budget.

(b) The maximum amount of discretionary funds may be up to 10 percent of the participant's cash benefit not including employee taxes.

(c) The discretionary fund must be approved by the case manager, identified in the service budget and related to service plan needs.

(d) Discretionary funds must be used by the end of the month.

(11) ISSUING BENEFITS.

(a) The service plan and service budget must be prior approved by the case manager before the first ICP cash benefit is paid.

(b) A cash benefit is considered issued and received by the participant when the direct deposit is made to the participant's ICP bank account or a benefit check is received by the participant.

(c) The cash benefit is exempt from resource calculations for other DHS programs only while in the ICP bank account and not commingled with other personal funds.

(d) The cash benefit is not subject to assignment, transfer, garnishment, or levy as long as it can be identified as a program benefit and is separate from other money in the participant's possession.

(12) CASE MANAGER RESPONSIBILITIES.

(a) The case manager is responsible to review and authorize service plans and service budgets that meet the ICP program criteria.

(b) If a participant is disenrolled, the case manager must review eligibility for other Medicaid long term care and community based service options and offer other alternatives if the participant is eligible.

(c) At least every six months, SPD/AAA staff must complete a service budget review to assure financial accountability and review service budget amendments.

(13) HEARING RIGHTS. ICP participants have contested case hearing rights as described in OAR chapter 461, division 025.

Stat. Auth.: ORS 410.090
Stats. Implemented: ORS 410.070