Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

OREGON DEPARTMENT OF HUMAN SERVICES
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OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 450

COMMUNITY LIVING SUPPORTS

EFFECTIVE JANUARY 1, 2024

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411-450-0010 Statement of Purpose

(Adopted 06/29/2016)

(1) The rules in OAR chapter 411, division 450 prescribe standards, responsibilities, and procedures for the delivery of community living supports. Supports are intended to permit individuals to live independently in a community-based setting.

(2) Community living supports are designed to prevent out-of-home placement of a child, or to return a child to the family home from a residential setting other than the family home.

(3) These rules prescribe service eligibility requirements for individuals receiving community living supports, and standards and procedures for agency providers operating a community living supports program.

(4) The rules in OAR chapter 411, division 450 effectuate Oregon's Employment First policy under which the employment of individuals with developmental disabilities in competitive integrated employment is the highest priority over unemployment, segregated employment, or other non-work day activities. The delivery of services provided under these rules presumes all individuals eligible for services are capable of working in an integrated employment setting and earning minimum wage or better.

Statutory/Other Authority: ORS 409.050, 430.662
Statutes/Others Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

411-450-0020 Definitions and Acronyms
(Amended 01/01/2024)

In addition to the following definitions, OAR 411-317-0000 includes general definitions for words and terms frequently used in OAR chapter 411, division 450. If a word or term is defined differently in OAR 411-317-0000, the definition in this rule applies.

(1) "ADL" means "Activities of Daily Living" as defined in OAR 411-317-0000.

(2) "Alternative Resources" is defined in OAR 411-317-0000.

(3) "ANA-C" means the "Adult In-Home Support Needs Assessment, Version C". The Department incorporates the ANA-C into these rules by this reference. The ANA-C is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/ANA%20-%20Adult%20In-home%20-%20v_C.106r.xlsm.

(4) “Adult and Children In-Home Assessment Manual” and "ANA/CNA Manual" means the document that describes how to administer an ANA and CNA. The Department incorporates the ANA/CNA Manual, Version 3 into these rules by this reference. The ANA/CNA Manual is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/bpa/ana-cna-manual.pdf.

(5) "Assessor" is defined in OAR 411-317-0000.

(6) "Attendant Care" is defined in OAR 411-317-0000.

(7) "Authorized ISP" means an ISP that meets the criteria set forth in OAR 411-415-0070(8)(e).

(8) "CDDP" means "Community Developmental Disabilities Program" as defined in OAR 411-317-0000.

(9) "Class" means group attendant care that is regularly occurring, organized, and structured around specific ADL/IADL supports intended to maintain or enhance an individual’s skill level in the ADL/IADL.

(10) "CNA-C" means the "Child In-Home Support Needs Assessment, Version C". The Department incorporates the CNA-C into these rules by this reference. The CNA-C is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/CNA%20-%20Child%20In-home%20-%20v_C.106r.xlsm.

(11) "Community Living Supports Agency" means a provider agency certified under OAR chapter 411, division 323 and endorsed to these rules, excluding OAR 411-450-0090, to deliver community living supports.

(12) "Day Support Activities" means attendant care supports, delivered by a provider agency, that happen during scheduled, intentional, structured activities in a non-residential setting. Day support activities focus on maintaining or enhancing the skills an individual needs to engage with the community.

(13) "DSA" means "Day Support Activities" as defined in this rule.

(14) "Exception" means an approval granted by the Department, or the Department's designee, to alter a limit or condition on a service based on an individual’s demonstrated need.

(15) "Facility-Based" means a service operated at a fixed site owned, operated, or controlled by a service provider where an individual has few or no opportunities to interact with people who do not have a disability except for paid staff.

(16) "Family":

(a) Means a unit of two or more people that includes at least one individual, found to be eligible for developmental disabilities services, where the primary caregiver is:

(A) A family member as defined in OAR 411-317-0000; or

(B) In a domestic relationship where partners share the following:

(i) A permanent residence.

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

(iii) Joint responsibility for supporting the individual 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 determining the service eligibility of an individual for community living supports as a resident in the family home.

(17) "Group Activity" means an organized or impromptu DSA that involves more than one individual supported by the same provider agency.

(18) "Healthier Oregon" is defined in OAR 411-317-0000.

(19) "Hour Allocation" means the number of monthly hours authorized in an ISP for any combination of attendant care, day support activities, skills training services, private duty nursing as described in OAR 411-300-0150, direct nursing services as described in OAR chapter 411, division 380, and state plan personal care as described in OAR chapter 411, division 455.

(20) "HSD Medical Programs" is defined in OAR 411-317-0000.

(21) "IADL" means "Instrumental Activities of Daily Living" as defined in OAR 411-317-0000.

(22) "IDEA" means the Individuals with Disabilities Education Act, 20 U.S.C §1400.

(23) "Implementation Strategy" means a written description of the steps a provider agency will take to assist an individual to achieve the individual’s desired outcomes, increase independence, and build or maintain skills, as identified in the individual’s ISP or Service Agreement, and assigned to the provider agency to implement.

(24) "Informal Arrangement" means a paid or unpaid arrangement for shelter or utility costs that does not include the elements of a rental agreement.

(25) "ISP" means "Individual Support Plan" as defined in OAR 411-317-0000.

(26) "Natural Support" is defined in OAR 411-317-0000.

(27) "ODDS" means the Oregon Department of Human Services, Office of Developmental Disabilities Services.

(28) "ONA" means "Oregon Needs Assessment" as defined in OAR 411-317-0000 and described in OAR 411-425-0055.

(29) "OSIPM" means "Oregon Supplemental Income Program-Medical" as defined in OAR 411-317-0000.

(30) "Primary Caregiver" means the person identified in an ISP as providing the majority of services and support for an individual in the home of the individual.

(31) "Progress Report" means a written document that summarizes an individual’s progress, the evidence of the progress, and a provider agency’s activities undertaken towards achieving the individual's desired outcomes of increased independence and skill building or maintenance, as identified in the individual’s ISP or Service Agreement.

(32) "Provider-Owned Dwelling" means a dwelling that is owned by a provider or the provider's spouse, when the provider is proposing to be paid for delivering home and community-based services to an individual, and the provider or the provider’s spouse is not related to the individual by blood, marriage, or adoption. A provider-owned dwelling includes, but is not limited to:

(a) A house, apartment, and condominium.

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

(c) A trailer and mobile home.

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

(33) "Provider-Rented Dwelling" means a dwelling that is rented or leased by a provider or the provider's spouse, when the provider is proposing to be paid for delivering home and community-based services to an individual, and the provider or the provider's spouse is not related to the individual by blood, marriage, or adoption.

(34) "PSW" means "Personal Support Worker" as defined in OAR 411-317-0000.

(35) "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:

(a) The name and contact information for the property owner, property manager, or landlord.

(b) The period or term of the agreement and method for terminating the agreement.

(c) The number of tenants or occupants.

(d) The rental fee and any other charges, such as security deposits.

(e) The frequency of payments, such as monthly.

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

(g) The duties and responsibilities of the property owner, property manager, or landlord and the tenant, such as:

(A) The person responsible for maintenance;

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

(C) Advance notice requirements prior to an increase in rent.

(36) "Scheduled Support" means an attendant care or skills training support that a representative of a provider agency and an individual agree to at least 48 hours ahead of the anticipated service delivery.

(37) "Service Level" means the maximum number of hours available to an individual in a month for any combination of attendant care, day support activities, skills training services, private duty nursing as described in OAR 411-300-0150, direct nursing services as described in OAR chapter 411, division 380 or state plan personal care as described in OAR chapter 411, division 455, based on an assessment required by the Department.

(38) "Skills Training" is defined in OAR 411-317-0000.

(39) "Staffing Ratio" means the number of paid providers to the number of individuals in their care at the same time.

(40) "Standard Model Agency" means a provider agency certified under OAR chapter 411, division 323 and endorsed to these rules, including OAR 411-450-0090, to deliver community living supports.

(41) "These Rules" mean the rules in OAR chapter 411, division 450.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662, SB 1548 (2022 OR Law, Ch. 91)
Statutes/Others Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662, SB 1548 (2022 OR Law, Ch. 91)

411-450-0030 Eligibility for Community Living Supports
(Amended 01/01/2024)

(1) An individual may not be denied community living supports or otherwise discriminated against on the basis of race, color, religion, sex, gender identity, sexual orientation, national origin, marital status, age, disability, source of income, duration of Oregon residence, or other protected classes under federal and Oregon Civil Rights laws.

(2) To be eligible for community living supports, an individual must meet the following requirements:

(a) Be an Oregon resident who meets the residency requirements in OAR 461-120-0010.

(b) Be determined eligible for developmental disabilities services by the Community Developmental Disabilities Program (CDDP) of the county of origin as described in OAR 411-320-0080, except for those enrolled in the Medically Involved Children's Waiver or the Medically Fragile Children's Program as described in OAR chapter 411, division 300.

(A) A child enrolled in the Medically Involved Children's Waiver must be determined eligible for the waiver as described in OAR 411-300-0120(7).

(B) A child enrolled in the Medically Fragile Children's Program must meet the eligibility requirements described in OAR 411-300-0120(5).

(c) Choose to use a case management entity for assistance with the design and management of developmental disabilities services.

(d) Be receiving a Medicaid Title XIX benefit package through Oregon Supplemental Income Program-Medical (OSIPM) or Health Systems Division, Medical Assistance Programs (HSD) medical programs or a benefit package through Healthier Oregon.

(A) An adult is eligible for community living supports if the adult had been receiving community living supports as a child up to their 18th birthday and has not become ineligible due to section (2)(d)(B) of this rule.

(B) Eligibility for community living supports based on section (2)(d)(A) of this rule ends if:

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

(ii) The Social Security Administration or the Presumptive Medicaid Disability Determination Team of the

Department finds the individual does not have a qualifying disability; or

(iii) The individual is determined by the state of Oregon to be ineligible for a Medicaid Title XIX benefit package through OSIPM or HSD medical programs or a benefit package through Healthier Oregon.

(C) Individuals receiving Medicaid Title XIX through HSD medical programs for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(i) The transfer of assets as set forth in OAR 461-140-0210 through 461-140-0300.

(ii) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(e) Be determined to meet the level of care as defined in OAR 411-317-0000.

(f) POST ELIGIBILITY TREATMENT OF INCOME Individuals with excess income must contribute to the cost of services in accordance with OAR 461-160-0610 and OAR 461-160-0620.

(g) Participate in an Oregon Needs Assessment and provide information necessary to complete the Oregon Needs Assessment prior to receiving community living supports, annually, and as required by the Department.

(A) Failure to participate in the Oregon Needs Assessment or to provide information necessary to complete the Oregon Needs Assessment within the required time frame results in the denial or termination of service eligibility. In the event service eligibility is denied or terminated, a written Notification of Planned Action must be provided as described in OAR 411-318-0020.

(B) The Department may allow additional time if circumstances beyond the control of the individual prevents timely participation in the Oregon Needs Assessment or timely submission of information necessary to complete the Oregon Needs Assessment.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662
Statutes/Others Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662

411-450-0040 Community Living Supports Entry and Exit
(Amended 01/01/2024)

(1) An individual may not access community living supports unless community living supports are included in the individual's current, authorized Individual Support Plan (ISP).

(2) A provider of community living supports must agree in writing to deliver the supports identified in an individual's ISP. Agreement may be shown by the provider's signature on a Service Agreement. The agreement must include acknowledgement of limits and scope of service that may be provided.

(3) Community living supports must be terminated:

(a) At the end of a service period agreed upon by all parties and specified in an individual's ISP.

(b) At the oral or written request of an individual or their legal representative to end the service relationship.

(c) When an individual has been determined to no longer meet eligibility for community living supports as described in OAR 411-450-0030.

(d) When a case management entity has sufficient evidence to believe that an individual has engaged in fraud or misrepresentation, failed to use resources consistent with the services as agreed upon in the individual's ISP, refused to cooperate with documenting use of

Department funds, or otherwise knowingly misused public funds associated with community living supports.

(e) When an individual either cannot be located or has not responded following 30 calendar days of repeated attempts by staff of the case management entity to complete ISP development or monitoring activities, including participation in an Oregon Needs Assessment. An individual, and as applicable the legal or designated representative of the individual, must participate in an Oregon Needs Assessment and provide information necessary to complete the Oregon Needs Assessment within the time frame required by the Department.

(A) Failure to participate in the Oregon Needs Assessment or provide information necessary to complete the assessment or reassessment within the applicable time frame results in the denial of service eligibility.

(B) The Department may allow additional time if circumstances beyond the control of the individual prevent timely participation in the Oregon Needs Assessment or timely submission of information necessary to complete the Oregon Needs Assessment.

(4) INVOLUNTARY REDUCTIONS AND EXITS.

(a) A provider agency must only reduce or exit an individual involuntarily for one or more of the following reasons:

(A) The behavior of the individual poses an imminent risk of danger to self or others.

(B) The individual experiences a medical emergency.

(C) The provider agency is no longer able to meet the service needs of the individual.

(D) The provider agency cannot provide the services needed to meet the individual’s goals associated with the service.

(E) The individual is no longer eligible for the service or the provider agency is not paid for the service.

(F) The site closes or the provider agency makes a programmatic change.

(G) The certification or endorsement for the provider agency described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) A provider agency may give less than 30 calendar days advance written notice only in a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others. The notice must be provided to the individual, the legal or designated representative of the individual (as applicable), and the individual's case manager immediately upon determination of the need for a reduction, transfer, or exit.

(c) A Notice of Involuntary Reduction or Exit is not required when:

(A) An individual requests the reduction or exit.

(B) The end date of the service identified on the ISP or Service Agreement is reached, if the provider has given at least 30 calendar days written notification to the individual and the individual's case manager of the intent to reduce or terminate services.

(d) PROVIDER AGENCY NOTICE OF INVOLUNTARY REDUCTION OR EXIT. A provider agency must not reduce services, transfer, or exit an individual involuntarily without 30 calendar days advance written notice to the individual, the legal or designated representative of the individual (as applicable), and the individuals' case manager, except in the case of a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others as described in subsection (b) of this section. The written notice must be provided on the Notice of Involuntary Reduction or Exit form approved by the Department and include all of the following:

(A) The reason for the reduction or exit.

(B) The right of individuals receiving Day Support Activities (DSA) to submit a complaint to the Department and have the Department review the matter.

(C) The right of the individual to request a hearing as described in subsection (f) of this section. For DSA services, the individual has a right to a hearing if the individual is not satisfied with the outcome of the complaint process and Department review of the matter.

(e) NOTICE OF INVOLUNTARY GROUP REDUCTION, TRANSFER, OR EXIT. If a provider agency reduces or transfers more than 10 individuals within any 30 calendar day period, the provider agency must provide 60 calendar days advance written notice to each individual, the Department, the legal or designated representative of each individual (as applicable), and each individual's case manager.

(A) The written notice must be provided on the Notice of Involuntary Group Reduction, Transfer, or Exit form approved by the Department and include all of the following:

(i) The reason for the reduction, transfer, or exit.

(ii) The right of individuals receiving DSA to submit a complaint to the Department and have the Department review the matter.

(iii) The right of the individual to request a hearing as described in subsection (f) of this section. For DSA services, the individual has a right to a hearing if the individual is not satisfied with the outcome of the complaint and Department review of the matter.

(B) A Notice of Involuntary Group Reduction, Transfer, or Exit is not required when an individual requests the reduction, transfer, or exit.

(f) HEARING RIGHTS. An individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0030 to

dispute an involuntary reduction or exit if the individual is not satisfied with the complaint resolution and Department review. If an individual requests a hearing, the individual must receive the same services until the hearing is resolved, unless the provider is no longer delivering that service to any individual. When an individual has been given less than 30 calendar days advance written notice of a reduction, transfer, or exit as described in subsection (b) of this section and the individual has requested a hearing, the provider must reserve service availability for the individual until receipt of the Final Order.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662
Statutes/Others Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662

411-450-0050 Minimum Standards for Community Living Supports
(Amended 01/01/2024)

(1) Abuse of an individual is prohibited. Abuse is not tolerated by any employee, staff, or volunteer of an individual, provider agency, or case management entity.

(2) Community living supports, purchased with Department funds, must be provided only as a social benefit.

(3) Community living supports must be delivered in a manner consistent with positive behavioral theory and practice, and where behavior intervention is not undertaken unless a behavior:

(a) Represents a risk to the health and safety of an 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.

(4) Community living supports must be delivered in accordance with applicable state and federal wage and hour regulations.

(5) For a child, community living supports are considered to be for supports that are not typical for a parent or guardian to provide to a child of the same age.

(6) Community living supports are reimbursed in accordance with the Expenditure Guidelines.

(7) Community living supports must be delivered as identified in an individual's Individual Support Plan (ISP) or Service Agreement.

(8) Department funds may not be used for:

(a) A reimbursement to an individual, or the legal or designated representative or family member of the individual, for expenses related to community living supports.

(b) An advance payment of funds to an individual, or the legal or designated representative or family member of the individual, to obtain community living supports.

(c) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 411-317-0000.

(d) Services that restrict the freedom of movement of an individual by seclusion in a locked room under any condition.

(e) Vacation costs that are normally incurred by a person on vacation, regardless of disability, and are not strictly required by the need of an individual for Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), or health-related tasks in a home and community-based setting.

(f) Rate enhancements to existing employment services under OAR chapter 411, division 345.

(g) Services or supports that are not necessary to meet support needs identified by the Oregon Needs Assessment (ONA) or are not cost-effective.

(h) Services that do not meet:

(A) The description of community living supports as described in these rules; or

(B) The definition of a social benefit in OAR 411-317-0000.

(i) DSA when an individual does not have a goal related to community participation as described in OAR 411-450-0060(2)(b)(D).

(j) Educational services for school-age individuals, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills.

(k) Services, activities, materials, or equipment that may be obtained by an individual through other available means, such as private or public insurance, philanthropic organizations, or other governmental or public services.

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

(m) Services in circumstances where a case management entity has sufficient evidence to believe that an individual, a legal or designated representative of an individual (as applicable), or a provider, has engaged in fraud, misrepresentation, failed to use resources as agreed upon in an ISP, refused to cooperate with documenting use of Department funds, or otherwise knowingly misused public funds associated with community living supports.

(n) Services provided in a nursing facility, correctional institution, or mental health facility.

(o) Services provided in an acute care hospital unless an individual's ISP authorizes attendant care for the individual in an acute care hospital. An ISP may only authorize attendant care for an individual

who has been admitted to an acute care hospital when the support is not a duplication of service that the hospital provides and the individual has one of the following:

(A) Challenging behavior that interferes with getting medical care. The challenging behavior must require specific training or experience to support and must be able to be mitigated by a developmental disability service provider to an extent that medical care is improved.

(B) An inability to independently communicate with hospital staff that interferes with getting medical care. This must not be solely due to limited or emerging English proficiency.

(C) Support with one or more ADL that may only be adequately met by someone familiar with the individual.

(p) Unless under certain conditions and limits specified in Department guidelines, employee wages or provider agency charges for time or services when an individual is not present or available to receive services including, but not limited to, hourly "no show" charge and provider travel and preparation hours.

(q) Costs associated with training a Personal Support Worker (PSW), other independent provider, or provider agency staff to deliver services.

(r) Services that are not delivered in a home and community-based setting.

(s) Services available to an individual under Vocational Rehabilitation and Other Rehabilitation Services, 29 U.S.C. § 701-796l, as amended.

(t) Services available to an individual under the Individuals with Disabilities Education Act (IDEA).

(u) Notwithstanding abuse as defined in OAR 411-317-0000, services that a case management entity determines are characterized by failure to act or neglect that leads to, or is in imminent danger of

causing, physical injury through negligent omission, treatment, or maltreatment of an individual.

(v) Support generally provided for a child of similar age without disabilities by a child's parent, guardian, or other family members.

(w) Supports and services that are funded by child welfare in the family home.

(x) Educational and supportive services provided by schools as part of a free and appropriate public education for children and young adults under the IDEA.

(y) Home schooling.

(z) Services delivered outside of the United States or the territories of the United States.

(aa) Services, supports, materials, or activities that are illegal or in support of illegal conduct.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662
Statutes/Others Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662

411-450-0060 Community Living Supports
(Amended 01/01/2024)

(1) Department funds may be used to purchase the following community living supports available through the Community First Choice state plan when included in an authorized Individual Support Plan (ISP):

(a) Attendant care as described in section (2) of this rule.

(b) Skills training as described in section (3) of this rule.

(c) Relief care as described in section (4) of this rule.

(2) ATTENDANT CARE SERVICES. Attendant care services include direct support provided to an individual in the home or community of the individual

by a qualified provider. Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) services provided through attendant care must be necessary to permit an individual to live independently in a community-based setting.

(a) ADL services include, but are not limited to, the following:

(A) Basic personal hygiene. Providing or assisting with needs such as bathing (tub, bed, bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene.

(B) Toileting, bowel, and bladder care.

(i) Assisting to and from the bathroom or on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting.

(ii) Changing incontinence supplies.

(iii) Following a toileting schedule.

(iv) Managing menses.

(v) Cleansing an individual or adjusting clothing related to toileting.

(vi) Emptying a catheter, drainage bag, or assistive device.

(vii) Ostomy care.

(viii) Bowel care.

(C) Mobility, transfers, and repositioning.

(i) Assisting with ambulation or transfers with or without assistive devices.

(ii) Turning an individual or adjusting padding for physical comfort or pressure relief.

(iii) Encouraging or assisting with range-of-motion exercises.

(D) Eating.

(i) Assisting with adequate fluid intake or adequate nutrition.

(ii) Assisting with food intake (feeding).

(iii) Monitoring to prevent choking or aspiration.

(iv) Assisting with adaptive utensils, cutting food.

(iv) Placing food, dishes, and utensils within reach for eating.

(E) Cognitive assistance or emotional support provided to an individual due to an intellectual or developmental disability.

(i) Helping the individual cope with change.

(ii) Assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive functions.

(b) IADL services include, but are not limited to, the following:

(A) Light housekeeping tasks necessary to maintain an individual in a healthy and safe environment.

(i) Cleaning surfaces and floors.

(ii) Making the individual's bed.

(iii) Cleaning dishes.

(iv) Taking out the garbage.

(v) Dusting.

(vi) Laundry.

(B) Grocery and other shopping necessary for the completion of other ADL and IADL tasks.

(C) Meal preparation and special diets.

(D) Support with participation in the community:

(i) Support with community participation. Assisting an individual in acquiring, retaining, and improving skills to use available community resources, facilities, or businesses, and improving self-awareness and self-control.

(ii) Support with communication. Assisting an individual in acquiring, retaining, and improving expressive and receptive skills in verbal and non-verbal language, social responsiveness, social amenities, and interpersonal skills, and the functional application of acquired reading and writing skills.

(c) Assistance with ADL, IADL, 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 of the IADL tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal, audio, or visual clues during an ADL, IADL, or health-related task to help an individual complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an ADL, IADL, or health-related task because an individual is unable to do so.

(C) "Monitoring" means a provider observes an individual to determine if assistance is needed during the completion of an ADL, IADL, or health-related task.

(D) "Reassurance" means to offer an individual encouragement and support to complete an ADL, IADL, or health-related task.

(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 an individual may perform an ADL, IADL, or health-related task.

(G) "Stand-by" means a provider is at the side of an individual ready to step in and take over the ADL, IADL, or health-related task if the individual is unable to complete it independently.

(d) For a child, the child's primary caregiver is expected to be present or available during the provision of attendant care. ADL and IADL services provided through attendant care must support the child to live as independently as appropriate for the age of the child and support, but not supplant, the child's family in their primary caregiver role.

(e) DAY SUPPORT ACTIVITIES (DSA).

(A) DSA must include a focus on competencies around the IADLs identified in section (2)(b)(D) of this rule or be a class.

(B) DSA requires that an individual have a measurable goal documented in the individual's ISP that is related to developing or maintaining skills for participating in the community.

(C) DSA may only be delivered by a provider qualified to deliver community living supports according to OAR 411-450-0070(2) or (4).

(D) DSA must meet staffing requirements specified in an individual's ISP or Service Agreement. Direct service staff must be present in sufficient number to meet health, safety, and service needs. DSA may not be delivered at the same time to more than eight individuals per agency staff member.

(E) Department approval is required to authorize DSA for individuals under age 18. DSA is only possible when IDEA services are not available.

(F) Facility-based DSA must, at minimum, provide on-going opportunities and encouragement to individuals for going out into the broader community.

(G) An individual may access DSA at a 1:1 (or greater) staffing ratio if any of the following apply:

(i) The individual does not want to participate in a group activity, the DSA is authorized in the individual's ISP, and the individual has a desired outcome to support the DSA.

(ii) The support needs of the individual require a 1:1 (or greater) staffing ratio in a group activity.

(iii) The DSA occur without other individuals receiving paid services at the same time from the same provider agency and the individual has a desired outcome to support the DSA.

(H) A provider agency may not design or allow a group activity where 1:1 is provided but not necessary to support an individual.

(3) SKILLS TRAINING. Skills training is specifically tied to accomplishing ADL, IADL, and other health-related tasks as identified by a functional needs assessment and an ISP and permitting an individual to live independently in a community-based setting.

(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.

(C) Progress towards the anticipated outcomes are measured and the measurements are evaluated by a case manager 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 an individual's ISP, the individual's case manager must reassess or redefine the use of skills training with the individual for that particular goal.

(d) For a child, the child's primary caregiver is expected to be present or available during the provision of skills training. ADL and IADL services provided through skills training must support the child to live as independently as appropriate for the age of the child and support, but not supplant, the child's family in their primary caregiver role.

(e) Skills training may not replace or supplant the services of the educational system in fulfilling its obligation to educate an individual.

(4) RELIEF CARE.

(a) Relief care may not be characterized as daily or periodic services provided solely to allow a primary caregiver to attend school or work. Daily relief care may be provided in segments that are sequential.

(b) Relief care may be provided in any of the following:

(A) The home of an individual.

(B) A licensed or certified setting.

(C) The home of a qualified provider, chosen by an individual or their legal or designated representative, that is a safe setting for the individual.

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

(c) No other community living supports may be provided to an individual during a 24-hour unit of daily relief care.

(5) Community living supports may be delivered:

(a) Individually or in a group as indicated by the outcome of the person-centered planning process for an individual.

(b) In an individual's home, community, or a facility.

(A) Community living supports are facility-based if delivered outside of an individual's home at a fixed site operated, owned, or controlled by a provider.

(B) DSA may not be provided in a residential setting.

(6) SETTING LIMITATIONS.

(a) An individual may receive community living supports if the individual:

(A) Resides in a setting the individual owns, leases, or rents or is on the property deed, mortgage, or title.

(B) Resides in a setting, either through an informal arrangement or rental agreement, owned, leased, or rented by a family member.

(C) Has no permanent residence.

(b) An individual is not eligible for community living supports, other than DSA, if the individual resides in one of the following:

(A) A provider-owned dwelling or a provider-rented dwelling through an informal or formal arrangement.

(B) A provider owned, controlled, or operated setting, including a setting owned, controlled, or operated by an employee of a provider agency.

(c) An individual is not eligible for community living supports in a specific setting if:

(A) The Department determines the health and safety of the individual may not be reasonably maintained in the setting; or

(B) Dangerous conditions in the setting jeopardize the health or safety of the individual or provider, and the individual, or their legal or designated representative, is unable or unwilling to implement necessary safeguards to minimize the dangers.

(d) An individual enrolled in a residential program, an adult foster home for older adults or adults with physical disabilities licensed in accordance with OAR chapter 411, division 049, or a residential care or assisted living facility licensed in accordance with OAR chapter 411, division 054, is not eligible for the following:

(A) Community living supports provided by a personal support worker.

(B) Community living supports delivered in the home of the individual, whether the home is a licensed setting or not.

(C) Relief care.

(e) A child living in a Behavior Rehabilitation Services (BRS) Program as described in OAR chapter 410, division 170, or Psychiatric Residential Treatment Facility (PRTF) as defined in OAR 309-022-0105, is not eligible for community living supports.

(7) SERVICE LIMITS.

(a) All hour allocations, and staffing ratios greater than 1:1, for community living supports must be included in an authorized ISP.

(b) An individual who has had a completed Oregon Needs Assessment (ONA) is assigned to a service group (SG) for the purpose of determining a service level upon the individual's initial ISP or the first annual ISP renewal following the adoption of this rule, and annually thereafter. An individual may only be assigned to one service group. The service groups are:

(A) Very Low.

(B) Low.

(C) Moderate.

(D) High.

(E) Very High.

(F) Infant/Toddler.

(c) Service groups are determined by applying a numeric value based on the responses to specific items being assessed in the ONA and using the values to calculate scores (the value of each item by response may be found in table 4). This is done for seven areas of the ONA, generating the following seven scores:

(A) General Support Need (GSN) score.

(B) The Medical Support Need (MSN) score.

(C) The Support Person Performs score.

(D) The Behavior Support Need (BSN) score.

(E) The Behavior Intervention/Management Frequency score.

(F) The Positive Behavior Support Plan (PBSP) score.

(G) Emergency/Crisis Services score.

(d) The scores described in subsection (c) of this section are used to assign an individual a service group number according to table 1.

(e) The service group number identified in subsection (d) of this section assigns an individual to a service group based on the individual's age at the time the ONA was submitted, as shown in table 2.

(f) For an individual not enrolled to a residential program who has been assigned to a service group as described in subsection (b) of this section, the maximum monthly hour allocation that may be included in an authorized ISP for the assigned service group, by the age of the individual on the submission date of the ONA, is the greater of:

(A) Without an approved exception as described in OAR 411-450-0065, the service level shown in table 3;

(B) With an approved exception as described in OAR 411-450-0065, an amount up to the amount approved by the Department, no earlier than the date of the exception approval;

(C) The service level for the individual on the last day of an ISP that expires between December 2023 and December 2024, as determined by an Adult Needs Assessment, Version C (ANA-C) for an adult, or a Child Needs Assessment, Version C (CNA-C) for a child. This does not include hours that have been included for the purpose of increasing a staff ratio;

(D) An amount up to the number of private duty nursing hours determined as described in OAR 411-300-0150 for a child in the Medically Fragile Children's program; or

(E) For an individual initially accessing hourly attendant care services, the greater of an amount:

(i) Determined by an ANA-C for an adult, or a CNA-C for a child. This does not include hours that have been included for the purpose of increasing a staff ratio; or

(ii) A condition described in (A), (B), (C), or (D) of this subsection.

(g) A change to the score of an Oregon Needs Assessment must only result from an assessment conducted by an assessor who meets the qualification and training requirements identified in OAR 411-425-0035 and is employed by a case management entity or the Department.

(h) The ANA-C or CNA-C determines the following for an individual who has not been assigned to a service group under subsection (b) of this section:

(A) Without an approved exception as described in OAR 411-450-0065, the service level. The service level may not be exceeded without prior approval from the Department.

(B) Without an approved exception as described in OAR 411-450-0065 and when such a need is identified, the ANA-C or CNA-C determines the maximum number of hours two staff may be simultaneously available.

(i) An hour allocation included in an authorized ISP may not exceed the number of hours of community living supports that are determined by the person-centered planning process and informed by the ISP team to be necessary to meet identified support needs after consideration and assignment of voluntary natural supports and alternative resources.

(j) An increase to an hour allocation must be based on:

(A) An increase in support needs identified following a completed reassessment using an ONA conducted by an assessor;

(B) A short-term increase in support needs based on a change in the support needs expected to last no more than 90 calendar days, documented in the service record;

(C) The loss of a natural support or alternative resource identified in the ISP as the means of meeting an identified need;

(D) A choice not to continue the use of a natural support; or

(E) A choice to meet a previously unmet, identified need.

(k) When an ONA assigns an individual to a service group with a lower service level than the hour allocation authorized in an ISP at the time of the ONA, the individual may have access to the amount authorized in the ISP for no longer than the end of the month that follows the month in which the ONA was conducted. (The example used in this subsection of this rule is illustrative only and limited to the facts it contains.) Example: An ONA completed on April 10th assigned an adult to service group 2. The previous ONA had assigned the adult to service group 3. The hour allocation within the service level for service group 3 is available to the adult through May 31st.

(l) When an ONA assigns an individual to a service group with a higher service level than the hour allocation authorized in an ISP at the time of the ONA, the individual may have access to an hour allocation within the new service level when it has been included in the authorized ISP.

(m) Unless an hour allocation below the service level is agreed to in advance and included in the individual's ISP, an individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0025 for any reduction in the authorized hour allocation.

(n) An hour allocation may not be reduced for anyone who has not been assigned to a service group as described in subsection (b) of this section.

(o) An hour allocation may not be reduced below the service level for the individual on the last day of an ISP that expires between December 2023 and December 2024, as determined by an ANA-C for an adult, or a CNA-C for a child. This does not include hours that have been included for the purpose of increasing a staff ratio.

(p) Any individual who is denied a requested hour allocation in an authorized ISP:

(A) Must be provided a Notice of Planned Action and given the opportunity for a hearing as described in ORS chapter 183 and OAR 411-318-0025; and

(B) May request an exception as described in OAR 411-450-0065.

(8) STAFF RATIOS.

(a) Community living supports are delivered by a staffing ratio of one provider (agency employee, personal support worker, etc.) to one or more individuals, unless the need for two or more providers to be available simultaneously to provide community living supports to an individual has been determined to be necessary following a person centered planning process and, except as noted in section (7)(e)(B) of this rule, confirmed by review of an exception request as described in OAR 411-450-0065.

(b) The number of hours allocated for a staffing ratio of greater than 1:1 may not exceed the number of hours required to meet the need that requires the higher ratio.

(c) Unless agreed to in advance and included in the individual's authorized ISP, an individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0025 for any reduction in the authorized staffing ratio.

(d) Any individual who is denied a requested staffing ratio in an authorized ISP:

(A) Must be provided a Notice of Planned Action and given the opportunity for a hearing as described in ORS chapter 183 and OAR 411-318-0025; and

(B) May request an exception as described in OAR 411-450-0065.

(9) The Department may put limits on how Department funds and resources are used, as long as those limited funds and resources are adequate to meet the needs of an individual.

(10) For an individual enrolled in a residential program, an adult foster home for older adults or adults with physical disabilities licensed in accordance with OAR chapter 411, division 049, or a residential care or assisted living facility licensed in accordance with OAR chapter 411, division 054, receipt of any combination of job coaching, supported employment - small group employment support, employment path services, and DSA may not exceed 25 hours per week. Individuals residing in these settings, who do not receive employment services, may receive up to 25 hours of DSA per week.

(11) No more than 14 days of relief care in a plan year are allowed without approval from the Department. Each day of respite care described in and provided according to OAR 411-070-0043(5) contributes to the 14 day limit for relief care.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662
Statutes/Others Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662

Table 1	
Score	Service Group Number
GSN score 14-22	1
GSN score 23-33	2
GSN score 34-53	3
GSN score 54-73	4
GSN score 74-84	5
Any GSN score with an MSN score of 5 or more And: A Support Person Performs score of 1 or more	5
Any GSN score with a BSN score of 2 or more And: PBSP score of 2 And: Behavior Intervention/Management Frequency score of 1 or more Or: Emergency/Crisis Services score of 1	5

Table 2

Adult (18 and older) and Adolescent (12-17 years old)	Service Group Number	Service Group
	1	Very Low
	2	Low
	3	Moderate
	4	High
	5	Very High

Child (4-11 years old)	Service Group Number	Service Group
	3	Very Low to Low
	4	Moderate
	5	High to Very High

Infant/Toddler (0-3)	Service Group Number	Service Group
	5	Infant/Toddler

Table 3

	Service Group	Service Level
Adult (18 and older)	Very Low	70
	Low	100
	Moderate	183
	High	369
	Very High	513

	Service Group	Service Level (School Year)	Service Level (Summer)
Adolescent (12-17 years old)	Very Low	56	74
	Low	87	104
	Moderate	104	122
	High	169	200
	Very High	239	282

	Service Group	Service Level (School Year)	Service Level (Summer)
Child (4-11 years old)	Very Low/ Low	83	91
	Moderate	96	109
	High/ Very High	152	174

	Service Group	Service Level
Infant/Toddler (0-3 years old)	Infant/Toddler	61

Table 4

General Support Need (GSN) Score

Below are the items that are used to create the GSN Score. The table includes the item number in the ONA, the item, notes on how to combine items when applicable (dressing and mobility items only), followed by the scores that are assigned to all possible responses. The area of general support need for each item in the ONA is indicated in the row above each item in that area. Responses range from 1 (independent) to 6 (dependent). Since some skills are not expected to be present for children under certain ages, skip patterns exist for items based on age. The highlighted column indicates that if a person is under the indicated age, their response is automatically recoded to a 6 (dependent). The next 3 columns are rules for coding “non-responses” or responses that are not on the scale from 1 (independent) to 6 (dependent). “Non-responses” are coded because to calculate a sum score that is consistent across all service recipients, all items must have a value. In the unlikely event of an item that has no response or is left blank, that item is not coded, and a service group is not assigned until the blank response is changed to a valid response.

Once all items are recoded to the specifications below, they are summed to become the GSN score.

Item #	Item	Combined items notes	Independent	Setup or Clean-up Assistance	Supervision or Touching	Partial/ Moderate Assistance	Substantial/ Maximal Assistance	Dependent	If Under (age), = 6	Not Applicable	Not Attempted	If Refused	If Not answered/blank
Area: Dressing													
3a	Upper Body Dressing - The ability to put on and remove shirt or pajama top. Includes buttoning, if applicable. *	Only use the least independent score out of the upper (3a) and lower	1	2	3	4	5	6	4	1	6	1	
3b	Lower Body Dressing - The ability to dress and undress below the waist, including fasteners. Does not include footwear.*		1	2	3	4	5	6	4	1	6	1	

		(3b) dressing											
3c	Putting on/taking off footwear - The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility.*		1	2	3	4	5	6	4	1	6	1	
Area: Mobility													
5b	Walks 150 feet - Once standing, the ability to walk at least 150 feet in a corridor or similar space.*	Calculate by using score for wheels 150 feet and if that is null, then use walks 150 feet If both 5a and 5e are answered “no,” , score mobility as Dependent (6).	1	2	3	4	5	6	3	1	6	1	
5f	Wheels 150 feet - Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space*		1	2	3	4	5	6	3	1	6	1	
Area: Eating and Tube Feeding													
6b	Eating - The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. *		1	2	3	4	5	6	4	1	6	1	
Area: Elimination													
7a	Toilet hygiene - The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. *		1	2	3	4	5	6	4	1	6	1	
Area: Showering and Bathing													
8a	Shower/bathe self - The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Include transferring in/out of tub/shower. *		1	2	3	4	5	6	5	1	6	1	
Area: Oral Hygiene													
9a	Oral Hygiene - The ability to use suitable items to clean teeth. [Dentures (if applicable) - The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] *		1	2	3	4	5	6	5	1	6	1	
Area: General Hygiene													
10a	General Hygiene - The ability to perform other hygiene maintenance tasks, such as hair brushing, shaving, nail care, and applying deodorant. Note: Excludes toilet, and oral hygiene. *		1	2	3	4	5	6	5	1	6	1	

Area: Housework													
12a	Housework - The ability to safely and effectively maintain cleanliness of the living environment by washing cooking and eating utensils; changing bed linens; dusting; cleaning the stove, sinks, toilets, tubs/showers, and counters; sweeping, vacuuming, and washing floors; and taking out garbage. *		1	2	3	4	5	6	12	1	6	1	
Area: Meal preparation													
13a	Make a light meal - The ability to plan and prepare all aspects of a light meal such as a bowl of cereal or a sandwich and cold drink, or reheat a prepared meal. *		1	2	3	4	5	6	12	1	6	1	
Area: Laundry													
14a	Laundry - Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, adding laundry detergent, and folding laundry. *		1	2	3	4	5	6	12	1	6	1	
Area: Transportation													
15a	Use public transportation: The ability to plan and use public transportation. Includes boarding, riding, and disembarking from transportation. *		1	2	3	4	5	6	12	1		1	
Area: Money management													
16a	Money Management - The ability to manage finances for basic necessities (food, clothing, shelter), including counting money and making change, paying bills/writing checks, making budgeting and other financial decisions, and balancing checkbook. *		1	2	3	4	5	6	12	1	6	1	
Area: Light shopping													
17a	Light shopping - Once at store, can locate and select up to five groceries and personal care items, take to check out, and complete purchasing transaction. *		1	2	3	4	5	6	12	1	6	1	

Medical Support Need Score

Below are the items that are used to create the Medical support need score. The table includes the item number in the ONA and the item, followed by the scores that are assigned to all possible responses. Responses are recoded to 0 (does not receive), 1 (receives less than weekly), 2 (receives weekly or more but not daily), or 3 (receives daily or more).

Once all items are recoded to the specifications below, they are summed to become the MSN score.

Item #	Item	Has never needed	Does not currently need but has needed in the past	Needs but does not receive	Receives less than weekly	Receives weekly, fewer than 5 days per week	Receive weekly, 5 or more days per week	Receives daily	Receives 5 or more times per day
46b	Respiratory therapy	0	0	0	1	2	2	3	3
46b	Chest percussion (including percussion vest)	0	0	0	1	2	2	3	3
46b	Postural drainage	0	0	0	1	2	2	3	3
46b	Nebulizer	0	0	0	1	2	2	3	3
46b	Tracheal aerosol therapy	0	0	0	1	2	2	3	3
46b	Oral suctioning that does not extend beyond the oral cavity	0	0	0	1	2	2	3	3
46b	Airway suctioning	0	0	0	1	2	2	3	3
46b	Tracheal suctioning	0	0	0	1	2	2	3	3
46b	Nasopharyngeal suctioning	0	0	0	1	2	2	3	3
46b	Other suctioning	0	0	0	1	2	2	3	3
46b	Tracheostomy care	0	0	0	1	2	2	3	3
46b	Care for central line	0	0	0	1	2	2	3	3
46b	Intravenous (IV) injections/ infusions	0	0	0	1	2	2	3	3
46b	Subcutaneous injections	0	0	0	1	2	2	3	3
46b	Jejunostomy tube	0	0	0	1	2	2	3	3
46b	Nasogastric or abdominal feeding tube (e.g., g-tube, NG tube)	0	0	0	1	2	2	3	3
46b	Indwelling or suprapubic catheter monitoring	0	0	0	1	2	2	3	3
46b	Insertion of catheter (intermittent catheterization)	0	0	0	1	2	2	3	3
46b	CPAP/BiPAP	0	0	0	1	2	2	3	3
46b	Mechanical ventilator other than CPAP/BiPAP	0	0	0	1	2	2	3	3
46b	Oxygen therapy	0	0	0	1	2	2	3	3
46b	Colostomy, urostomy, and/or other ostomy	0	0	0	1	2	2	3	3
46b	Peritoneal dialysis	0	0	0	1	2	2	3	3
46b	Hemodialysis	0	0	0	1	2	2	3	3
46b	Active cerebral shunt monitoring	0	0	0	1	2	2	3	3
46b	Baclofen pump	0	0	0	1	2	2	3	3

46b	Wound care, excluding stage III or IV ulcers	0	0	0	1	2	2	3	3
46b	Treatment for stage III or IV ulcers (full loss of skin and tissue, may extend into muscle or bone)	0	0	0	1	2	2	3	3

Support Person Performs Score

For all of the same items in the previous section, the ONA also asks whether a support person performs the treatment/monitoring/therapy. These items are only scored when the same item is scored a 3 (receives daily or more) in the above MSN score section. For any items that have a 3 (receives daily or more), the support person item responses are coded as 0 (support person performs – no) or 1 (support person performs – yes).

Once all items are recoded to the specifications below, they are summed to become the Support Person Performs Score.

Item #	Item	If receives less than daily or support person performs - no	If receives daily or more and support person performs - yes
46b	Respiratory therapy	0	1
46b	Chest percussion (including percussion vest)	0	1
46b	Postural drainage	0	1
46b	Nebulizer	0	1
46b	Tracheal aerosol therapy	0	1
46b	Oral suctioning that does not extend beyond the oral cavity	0	1
46b	Airway suctioning	0	1
46b	Tracheal suctioning	0	1
46b	Nasopharyngeal suctioning	0	1
46b	Other suctioning	0	1
46b	Tracheostomy care	0	1
46b	Care for central line	0	1
46b	Intravenous (IV) injections/ infusions	0	1
46b	Subcutaneous injections	0	1
46b	Jejunostomy tube	0	1
46b	Nasogastric or abdominal feeding tube (e.g., g-tube, NG tube)	0	1

46b	Indwelling or suprapubic catheter monitoring	0	1
46b	Insertion of catheter (intermittent catheterization)	0	1
46b	CPAP/BiPAP	0	1
46b	Mechanical ventilator other than CPAP/BiPAP	0	1
46b	Oxygen therapy	0	1
46b	Colostomy, urostomy, and/or other ostomy	0	1
46b	Peritoneal dialysis	0	1
46b	Hemodialysis	0	1
46b	Active cerebral shunt monitoring	0	1
46b	Baclofen pump	0	1
46b	Wound care, excluding stage III or IV ulcers	0	1
46b	Treatment for stage III or IV ulcers (full loss of skin and tissue, may extend into muscle or bone)	0	1
46b	Behavioral health therapies, including mental health	0	1
46b	Psychiatric therapies/ services	0	1

Behavior Support Need Score

Below are the items that are used to create the Behavior support need score. The table includes the item number in the ONA and the item, followed by the scores that are assigned to all possible responses. The area of behavior support need for each item in the ONA is indicated in the row above each item in that area. Responses are recoded to 1 (Yes, present in past year) or 0 (all other responses).

Once all items are recoded to the specifications below, they are summed to become the BSN score.

Item #	Item	No history	Has history, no concern	Has history, concerns	No History, concerns	Yes, present in past year
Area: Injurious to self						
18a	Individual displays, or would without intervention, disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs). *	0	0	0	0	1
Area: Aggressive or combative						

19a	Individual displays physical behavior symptoms, or would without intervention, directed toward others (e.g., hits, kicks, pushes, or punches others, throws objects, spitting). *	0	0	0	0	1
Area: Sexual aggression/assault						
23a	Individual displays, or would without intervention, behaviors that are sexually aggressive (e.g., grabbing, thrusting) or assaultive (e.g., pushing up against wall and groping) towards others. *	0	0	0	0	1
Area: Property destruction						
24a	Individual engages in behavior, or would without intervention, that disassembles or damages public or private property or possessions. The individual is intentionally engaging in an act that leads to damage, though may not have the intent to cause damage. *	0	0	0	0	1

Behavior Intervention/Management Frequency Score

Below are the items that are used to create the Behavior intervention/management frequency score. The table below shows how both of the items are recoded. For the item on proactive strategies and physical prompts, a response of daily or more is coded to 1 and a response of less frequently than daily is recoded to 0. For the item on safeguarding interventions (also known as PPIs), a response of monthly or more is coded to 1 and a response of less frequently than monthly is coded to a 0.

Once all items are recoded to the specifications below, they are summed to become the Behavior intervention/management frequency score.

Item #	Item	None	Less than once per month	Once per month	More than once per month	1 – 3 times per week	4 or more times per week, but less than daily	Less than 5 times per day	More than 5 times per day
36b	How often does the individual require intervention and/or environment management due to any behavior issue (not specifically to each	0	0	0	0	0	0	1	1

	presenting behavior)? Proactive strategies and physical prompts								
36c	How often does the individual require intervention and/or environment management due to any behavior issue (not specifically to each presenting behavior)? Safeguarding interventions (also known as PPIs)	0	0	1	1	1	1	1	1

Positive Behavior Support Plan Score

Below are the items about the Positive Behavior Support Plan (PBSP) that are used in the criteria for service group numbers. For both items, a response of “No” is recoded to 0 and a response of “Yes” is recoded to 1.

Once all items are recoded to the specifications below, they are summed to become the Positive Behavior Support Plan score.

Item #	Item	No	Yes
39a	Has a Positive Behavior Support Plan (PBSP) (also known as Behavior Support Plan or BSP) been created for the individual?	0	1
39b	Is the PBSP currently being implemented by support persons? (Support persons have been trained on the PBSP.)	0	1

Emergency/Crisis Services Score

Below is the item about emergency/crisis services that is used in the criteria for service group numbers. A response of “No” is recoded to 0 and a response of “Yes” is recoded to 1 for this item.

Once the item is recoded to the specifications below, it is the Emergency/crisis services score.

Item #	Item	No	Yes
39f	Has the individual required emergency services, crisis intervention services, or protective services to address a dangerous behavior 2 or more times in the past 12 months?	0	1

411-450-0065 Exceptions
(Adopted 01/01/2024)

(1) An hour allocation or staffing ratio that requires approval under this rule may not be included in an authorized Individual Support Plan (ISP) prior to the date of the approval.

(2) HOUR ALLOCATION EXCEPTIONS. The Department or the Department's designee shall review and approve a request for an hour allocation greater than the service level to the extent the individual is unable to have their support needs met within the service level because the individual has one of the following circumstances described in (a), (b), (c), or (d) below:

(a) Intermittent needs that cannot be scheduled that must be met throughout the day to keep the individual healthy and safe. The need must be related to a physical, behavioral, or medical condition that may reasonably be expected to cause physical harm to the individual or other person if left unmet. The need must arise multiple times in a typical week, or must be a need that is known to occur less frequently but if unmet would likely result in hospitalization or death.

(A) The reviewing entity may approve a request for an exceptional hourly allocation when the individual requires support in at least one of the following:

(i) Toileting.

(ii) Transfers.

(iii) Mobility.

(iv) Managing a recurring behavior described in section (3)(a)(A) of this rule.

(v) Uncontrolled seizures.

(vi) Diabetes management that includes administration of sliding scale insulin.

(vii) Airway, tracheal, or nasopharyngeal suctioning.

(viii) Use of a CPAP/BiPAP or mechanical ventilator.

(B) When the conditions of (A) are met, the reviewing entity shall determine an hour allocation to approve. When considering the hour allocation, the reviewing entity must consider:

(i) Usual parental supports provided to a minor child based on the age of the child; and

(ii) Whether denying any portion of the requested allocation would put the individual at risk of moving out of a preferred setting.

(C) The reviewing entity may approve an increase to the hour allocation by 30 hours per month until the allocation is able to meet the assessed Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), or health-related task.

(b) At least one ADL need or health-related task that reasonably requires substantially more time to meet than other individuals with a similarly assessed need and that causes the time it takes to meet the total amount of support for the individual to exceed the individual's service level.

(A) To determine the need for an hour allocation greater than the individual's service level, the Department or designee shall consider:

(i) Frequency of the care needs that require additional time in the relevant ADLs or health-related task.

(ii) Duration of the care needs that require additional time in the relevant ADLs or health-related task.

(iii) The reasons driving the increased duration and frequency.

(iv) The number and duration of other ADL, IADL support needs and health-related tasks.

(v) The complexity of the individual's care need.

(vi) The chosen provider's ability to complete the task in a reasonable time.

(vii) Whether denying any portion of the requested allocation would put the individual at risk of moving out of a preferred setting.

(B) When the reviewing entity determines that an hour allocation greater than the individual's service level is required, the hour allocation may be increased by increments of 30 hours per month until the allocation is able to meet the assessed need.

(c) EXCEPTIONS FOR COMMUNITY INCLUSION. The Department or the Department's designee may approve an exception to service level for an adult when approval is necessary for the adult to be able to have reasonable access, outside of their home, for inclusion in the community where they live.

(A) An individual or the individual's representative must demonstrate that the individual's service level is inadequate to meet the identified need for support with ADL, IADL, or health-related tasks, including those supports that are necessary to have reasonable access for inclusion in the community where the individual lives.

(B) An inadequate hour allocation may be demonstrated by evidence of isolation due to an inadequate amount of support for community inclusion. An individual may be considered isolated when unable to engage in at least 20 hours of community inclusion activities in a week when so desired, after having other identified ADL, IADL, health-related tasks met. Community inclusion activities are activities that take place away from the home, including travel time, but do not include

employment services. Community inclusion activities do include activities such as:

(i) IADLs that occur away from the home.

(ii) Entertainment out.

(iii) Dining out.

(iv) Attending religious services.

(v) Errands.

(vi) Day support activities.

(d) Support needs that must be met in order to prevent a serious risk of institutionalization. The Department shall review and approve an hour allocation or staffing ratio that is adequate to meet the unmet support needs. An institution includes the following:

(A) A nursing facility;

(B) An institution as outlined in ORS 426.010;

(C) An intermediate care facility for individuals with intellectual disabilities;

(D) A hospital providing long-term care services; or

(E) Any other setting that has the following qualities of an institution.

(i) A setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

(ii) A setting that is located in a building on the grounds of, or immediately adjacent to, a public institution; or

(iii) A setting that has the effect of isolating individuals receiving home and community-based services from the greater community.

(3) STAFFING RATIO EXCEPTIONS.

(a) Indicators of the possible need for a staffing ratio of greater than 1:1 are:

(A) Presence of a Professional Behavior Support Plan that includes safeguarding interventions and the Oregon Needs Assessment (ONA) identifies at least one of the following behaviors that are:

(i) Self-injurious behavior that may lead to a serious injury.

(ii) Aggressive or combative.

(iii) Injurious to animals.

(iv) Sexual aggression or assault.

(v) Property destruction.

(vi) Leaving the supervised area.

(vii) A diagnosis of Pica.

(B) The medical section of the ONA identifies that the individual is receiving or needs special treatments five or more times per day from a provider.

(C) Two-person assist is selected in an individual’s ONA for at least one ADL activity.

(D) Individual requires intensive focus from a paid provider to assure the individual’s health and safety and it is necessary for a different provider to complete an IADL that would otherwise detract from the intensive focus.

(b) To determine the need for a higher staffing ratio, the Department or the Department's designee shall review:

(A) The necessity for more than one attendant at a time to address an identified support need.

(B) Frequency of the care needs that require additional staffing for the relevant ADLs and IADLs.

(C) Duration of the care needs that require additional staffing for the relevant ADLs and IADLs.

(D) The reasons driving the increased staffing ratio.

(E) The complexity of the individual's support needs.

(F) The chosen provider's ability to support the individual alone.

(G) When a higher staffing ratio is the most cost-effective way for providers to receive instruction on the implementation of a Positive Behavior Support Plan from a behavior professional or to be delegated a nursing task by a Long Term Care Community Nurse.

(c) A staffing ratio of greater than 1:1 must be necessary to provide support. It may not be approved:

(A) For the purpose of training providers without an approved exception as described in this rule.

(B) For convenience.

(C) Due to a specific provider's inability to do the task alone when another provider reasonably could.

(D) If none of the indicators identified in subsection (a) of this section are present.

(4) EXCEPTION REQUESTS AND SUPPORTING DOCUMENTATION.

(a) A service level or staffing ratio exception may be requested by the individual or the individual's representative, as defined in OAR 411-318-0005, by completing a form designated for that purpose. The form may be submitted to the case management entity or to the Department.

(b) Except for an individual's case manager, a paid provider may not submit an exception request.

(c) Documentation from sources that are free from a conflict of interest shall be given precedence in decision making when contradictory documentation exists. The opinion of a qualified professional shall be given precedence over a lay opinion regarding support needs within the area of expertise of the professional.

(d) To evaluate the request, the Department or designee may require the individual, or their representative, to provide further documentation during the exception decision making process. This documentation may include, but is not limited to:

(A) Care provider time logs detailing the support needs of the individual throughout the day.

(B) Daily, weekly, or monthly schedules that show the individual's actual use of support for ADL, IADL, or health-related tasks.

(C) Relevant medical, behavioral, and mental health records to support the specific exception request.

(D) Data tracking of challenging behavior.

(e) When the Department or the Department's designee determines that additional information is needed to complete a review, it will notify the individual, and the case manager or case management entity, in writing within ten business days of receipt of the Funding Review and Exception Request Form, or other form designated by the Department to request an exception, by sending a Notification of Pending Status (form 2853).

(f) The request for additional information shall specify the due date and explain how to submit the required information. If the requested documentation is not provided to the reviewing entity, a denial of the request may be issued.

(A) If the individual or individual's representative fails to timely provide the requested information, the reviewing entity shall complete the review based on the documentation in its possession.

(B) If the individual or the individual's representative responds to the request for additional information after the exception application has been denied, the individual's response shall be considered a new request for an exception, with a new submission date.

(C) If the individual submits the required documentation after the 14 calendar day timeframe, the individual may request an extension for good cause and request that reviewing entity issue a revised decision.

(D) The individual may request a good cause extension prior to the expiration of 14 calendar day timeframe by requesting it via their case manager.

(E) Good cause exists when an action, delay, or failure to act arises from an excusable mistake or from factors beyond an individual's reasonable control.

(5) The reviewing entity shall issue a Funding Decision notice which approves or disapproves the request for exception, in whole or in part, within 45 calendar days of receipt of the Funding Review and Exception Request Form, or other form designated by the Department to request an exception. The Funding Decision notice must include an approval date.

(a) If the reviewing entity determines that the documentation supports the requested hour allocation or staffing ratio, the exception request shall be approved and the hour allocation or staffing ratio may become part of the individual's authorized ISP.

(b) If the reviewing entity determines that the documentation supports additional hours but not as many hours as requested or for the timeframe requested, the exception request shall be approved for only those additional hours supported by the documentation.

(c) If the reviewing entity determines that the documentation does not support any additional hours over the service level or staffing ratio, the exception request shall be denied.

(d) The reviewing entity may deny an exception if the request is:

(A) Unable to be approved because a circumstance required for approval in section (2) or (3) is not present.

(B) For supports that a parent would be expected to provide to a child of a similar age who would not be eligible for developmental disabilities services.

(C) Based on the needs or abilities of a chosen service provider when another qualified provider could reasonably meet identified needs within the available hour allocation.

(D) Based on a desire for services outside of assessed service needs.

(E) Submitted prior to ruling out reasonable alternatives to meet the need.

(F) Not medically or behaviorally appropriate.

(G) For services not covered in the Community First Choice 1915(k) State Plan.

(H) For tasks that are not consistent with the definition of community living supports.

(I) For service that would meet any one of the conditions listed in OAR 411-450-0050(8).

(6) The Department or designee may revoke an approved exception if:

(a) The documentation supporting the approval is determined to have been inaccurate or falsified.

(b) The individual no longer meets the criteria in this rule for an approved exception.

(7) A revoked exception is treated as a reduction for which the individual must be given the opportunity for a hearing as described in ORS chapter 183 and OAR 411-318-0025. The individual may have access to the approved exceptional hour allocation or staffing ratio for no longer than the end of the month that follows the month in which the approval was revoked.

(8) An individual must be given Notice of Planned Action and the opportunity for a hearing as described in ORS chapter 183 and OAR 411-318-0025 when an exception requested under this rule is denied in whole or in part.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662
Statutes/Others Implemented: 427.104, 430.662, ORS 409.010, 427.007, 430.215, 430.610

411-450-0070 Community Living Supports Providers and Provider Requirements
(Amended 12/20/2022)

Delivery of community living supports is limited to the following provider types:

(1) A PSW who meets the standards described in OAR chapter 411, division 375.

(a) A PSW is not an available provider type when there is not a common law employer as described in OAR 411-375-0055.

(b) A PSW may not provide community living supports to an individual when the PSW and individual reside together unless:

(A) The PSW is a family member;

(B) The PSW does not own or control the property; or

(C) The individual and the PSW have equal homeowner or rental property rights.

(2) A provider agency certified in accordance with OAR chapter 411, division 323 with an endorsement to operate as either a community living supports agency or a standard model agency. A provider agency cannot simultaneously be a community living supports agency and a standard model agency.

(3) A home health agency with a current license issued in accordance with ORS 443.015.

(4) An in-home care agency with a current license issued in accordance with ORS 443.315.

(5) An adult foster home licensed in accordance with OAR chapter 411, division 360. This provider type may only deliver community living supports, excluding DSA:

(a) When the community living supports are delivered in, or based out of, the licensed adult foster home. An adult foster home provider may not provide community living supports to an individual in, or based out of, the home of the individual.

(b) To an adult.

(6) A child foster home licensed in accordance with OAR chapter 411, division 346. This provider type may only deliver community living supports, excluding DSA:

(a) When the community living supports are delivered in, or based out of, the licensed child foster home. A child foster home provider may not provide community living supports to a child in, or based out of, the home of the child.

(b) To a child.

(7) An agency certified in accordance with OAR chapter 411, division 323 and endorsed to OAR chapter 411, division 325 for 24-hour residential programs does not require endorsement to these rules to deliver community living supports, excluding DSA, when the community living supports are delivered in, or based out of, the licensed setting. A provider of a 24-hour residential program may not provide community living supports to an individual in, or based out, of the home of the individual.

(8) Providers qualified to deliver community living supports as described in sections (5) though (7) of this rule are subject to OARs 411-450-0040, 411-450-0050, 411-450-0060, and sections (6) through (28) of OAR 411-450-0080 when delivering community living supports.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662, SB 1548 (2022 OR Law, Ch. 91)
Statutes/Others Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662, SB 1548 (2022 OR Law, Ch. 91)

411-450-0080 Minimum Standards for Provider Agencies Delivering Community Living Supports
(Amended 12/20/2022)

(1) CERTIFICATION, ENDORSEMENT, AND ENROLLMENT. To be endorsed to operate a community living support program, a provider agency must have all of the following:

> (a) A certificate and an endorsement, in accordance with OAR chapter 411, division 323, to deliver community living supports as a community living supports agency or a standard model agency.
>
> (b) A Medicaid Agency Identification Number assigned by the Department as described in OAR chapter 411, division 370.

(2) INSPECTIONS AND INVESTIGATIONS. A provider agency must allow inspections and investigations in accordance with OAR 411-323-0040.

(3) MANAGEMENT AND PERSONNEL PRACTICES. A provider agency must comply with the management and personnel practices described in OAR 411-323-0050.

(4) PRE-SERVICE TRAINING. A provider agency must maintain written documentation of six hours of pre-service training prior to staff supporting individuals that includes mandatory abuse reporting, ISPs, and Service Agreements.

(5) CONFIDENTIALITY OF RECORDS. A provider agency must ensure the confidentiality of individuals' records in accordance with OAR 411-323-0060.

(6) DOCUMENTATION REQUIREMENTS. Unless stated otherwise, all entries required by these rules must comply with the agency documentation requirements described in OAR 411-323-0060.

(7) For DSA, a provider agency must develop and share the following information with an individual and the individual's case manager:

(a) A written plan or implementation strategies. The written strategies for service implementation must be given to an individual and the individual’s case manager within 60 calendar days of providing services for the ISP year.

(b) A risk mitigation strategy or protocol that addresses each identified relevant risk. The risk mitigation strategy or protocol must be given to an individual and the individual’s case manager before services begin for the ISP year.

(c) Other documents requested by the ISP team.

(8) A provider agency must maintain progress notes regarding the delivery of community living supports. A progress note must include, at minimum, all of the following information regarding the supports rendered:

(a) The date and time the support was delivered.

(b) The staff involved.

(c) Information regarding the nature of the support provided and how the support met an identified ADL or IADL support need or was a health-related task.

(9) Progress notes must be made available monthly and upon request by a case management entity.

(10) 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 payment.

(11) 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 a contract period.

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

(12) ABUSE AND INCIDENT HANDLING AND REPORTING. Complaints of abuse and the occurrence of serious incidents must be treated as described in OAR 411-323-0063.

(13) A provider agency must develop and implement policies and procedures required for administration and operation in compliance with these rules including, but not limited to, all of the following:

(a) INDIVIDUAL RIGHTS. A provider agency must have, and implement, written policies and procedures protecting the individual rights described in OAR 411-318-0010 and that:

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

(B) Protect individuals during hours of service from financial exploitation that may include, but is not limited to, any of the following:

(i) Staff borrowing from, or loaning money to, an individual.

(ii) Witnessing wills in which staff or the provider agency may benefit directly or indirectly.

(iii) Adding the name of a staff member or provider agency to the bank account or other personal property of an individual without the approval of the individual or their legal representative (as applicable).

(b) Policies and procedures appropriate to the scope of service including, but not limited to, those required to meet the minimum standards set forth in sections (17) through (31) of this rule and consistent with the ISPs or written Service Agreements for individuals currently receiving services.

(14) A provider agency must deliver services according to an individual's ISP or written Service Agreement.

(15) Service rates, as authorized in the Department's electronic payment and reporting system for individuals authorized to receive community living supports and paid to a provider agency for delivering services as described in these rules, shall be reimbursed at the rate for a community living supports agency identified in the Expenditure Guidelines unless the provider agency is endorsed to operate a standard model agency in accordance with OAR 411-450-0090.

(16) For a provider agency offering services to the general public, billings for Medicaid funds may not exceed the customary charges to private individuals for any like item or services charged by the provider agency.

(17) SERVICE RECORD. A provider agency must maintain a current service record for each individual receiving services. The individual's service record must include all of the following:

(a) The individual's name, current home address, and home phone number.

(b) The individual's current ISP or written Service Agreement.

(c) Contact information for the individual's legal or designated representative (as applicable) and any other people designated by the individual to be contacted in case of incident or emergency.

(d) Contact information for the case management entity assisting the individual to obtain services.

(e) Records of service provided, including type of services, dates, hours, and staff involved.

(f) For skills training, relief care services, and attendant care that does not meet the definition of DSA, an electronic system must record all of the following for a service provided at the time of service:

(A) Type of service provided.

(B) Individual receiving service.

(C) Date of service provided.

(D) Location of service.

(E) Staff member providing the service.

(F) Start time of the service.

(G) End time of the service.

(18) A provider agency must ensure staff, contractors, and volunteers receive appropriate and necessary training.

(19) A provider agency regulated by these rules must be a drug-free workplace.

(20) A provider agency that owns or leases a site, delivers services to individuals at the site, and regularly has individuals present and receiving services at the site, must meet all of 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 receiving services.

(b) Posting of emergency information including, but not limited to, posting the following telephone numbers by designated telephones:

(A) Local fire, police department, and ambulance service, or "911".

(B) The executive director of the provider agency and other people to be contacted in case of emergency.

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

(d) When an individual begins receiving services at a service site, a provider agency must deliver training to the individual to leave the site in response to an alarm or other emergency signal and to cooperate with assistance to exit the site.

(e) A provider agency must conduct an unannounced evacuation drill each month when individuals are present.

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

(B) 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.

(C) Written documentation must be made at the time of the drill and kept by the provider agency for at least two years following the drill. The written documentation must include all of the following:

(i) Date and time of the drill.

(ii) Location of the simulated fire.

(iii) Last names of all individuals and staff present at the time of the drill.

(iv) Amount of time required by each individual to evacuate if the individual needs more than the established time limit.

(v) Signature of the staff conducting the drill.

(D) In sites delivering services to an individual who is medically fragile or has 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 agency's executive director; and

(ii) Be submitted as a variance request according to OAR 411-450-0100.

(f) A provider agency must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(g) At least once every five years, a provider agency must conduct a health and safety inspection.

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

(B) The inspection must be performed by:

(i) The Oregon Occupational Safety and Health Division;

(ii) The provider agency's worker's compensation insurance carrier;

(iii) An appropriate expert, such as a licensed safety engineer or consultant as approved by the Department; or

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

(C) The inspection must cover all of the following:

(i) Hazardous material handling and storage.

(ii) Machinery and equipment used at the service site.

(iii) Safety equipment.

(iv) Physical environment.

(v) Food handling, when necessary.

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

(h) A provider agency must ensure 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 agency for five years.

(i) Direct service staff must be present in sufficient number to meet health, safety, and service needs specified in the individual ISP or Service Agreement for each individual present. When individuals are present, at least one staff member on duty must have the following minimum skills and training:

(A) CPR certification.

(B) Current First Aid certification.

(C) Training to meet other specific medical needs identified in individual ISPs or Service Agreements.

(D) Training to meet other specific behavior support needs identified in individual ISPs or Service Agreements.

(21) A provider agency delivering services to individuals that involve assistance with meeting health and medical needs must:

(a) Develop and implement written policies and procedures addressing all of the following:

(A) Emergency medical intervention.

(B) Treatment and documentation of illness and health care concerns.

(C) Administering, storing, and disposing of prescription and non-prescription drugs, including self-administration.

(D) Emergency medical procedures, including the handling of bodily fluids.

(E) Confidentiality of medical records.

(b) Maintain a current written record for each individual receiving assistance with meeting health and medical needs that includes all of the following:

(A) Health status as known.

(B) Changes in health status observed during hours of service.

(C) Any remedial and corrective action required and when such actions were taken if occurring during hours of service.

(D) A description of any known 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 agency must:

(A) 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.

(B) Administer medications per written orders.

(C) Administer medications from containers labeled as specified per physician written order.

(D) Keep medications secure and unavailable to any other individual and stored as prescribed.

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

(F) Not administer unused, discontinued, outdated, or recalled medication.

(G) Not administer PRN psychotropic medication. PRN orders may not be accepted for psychotropic medication.

(d) Maintain a MAR (if required). The MAR must include all of the following:

(A) The name of the individual.

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

(C) Times and dates the administration or self-administration of the medication occurs.

(D) The signature of the staff administering the medication or monitoring the self-administration of the medication.

(E) Method of administration.

(F) Documentation of any known allergies or adverse reactions to a medication.

(G) Documentation and an explanation of why a PRN, or "as needed", medication was administered and the results of such administration.

(H) An explanation of any medication administration irregularity with documentation of a review by the provider agency's executive director or their designee.

(e) Provide safeguards to prevent adverse medication reactions including, but not limited to, all of the following:

(A) Maintaining information about the effects and side-effects of medications the provider agency has agreed to administer.

(B) Communicating any concerns regarding any medication usage, effectiveness, or effects to an individual or the individual's legal or designated representative (as applicable).

(C) 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 delivered by the provider agency.

(22) A provider agency that owns or operates vehicles that transport individuals must:

(a) Maintain the vehicles in safe operating condition.

(b) Comply with the laws of the Oregon Driver and Motor Vehicles Division (DMV).

(c) Maintain insurance coverage on the vehicles and all authorized drivers.

(d) Carry a first aid kit in each vehicle.

(e) Assign drivers who meet the applicable DMV requirements to operate vehicles that transport individuals.

(23) If assisting with management of funds, a provider agency must have and implement written policies and procedures related to the oversight of an individual's financial resources that includes the following:

(a) Procedures that prohibit inappropriately expending an individual's personal funds, theft of an individual's personal funds, using an individual's funds for the benefit of staff, commingling an individual's personal funds with the provider agency's or another individual's funds, or the provider agency becoming an individual's legal or designated representative.

(b) The provider agency's reimbursement to an individual of any funds that are missing due to theft or mismanagement on the part of any staff of the provider agency, or of any funds within the custody of the provider agency that are missing. Such reimbursement must be made within 10 business days of the verification that funds are missing.

(24) PROFESSIONAL BEHAVIOR SERVICES. A provider agency must have and implement written policies and procedures to assure professional behavior services are delivered by a qualified behavior professional in accordance with OAR chapter 411, division 304.

(25) BEHAVIOR SUPPORTS. A provider agency must have and implement written policies and procedures for the delivery of behavior supports that prohibits abusive practices and assures behavior supports are included in a Positive Behavior Support Plan.

(a) A provider agency must inform each individual, and as applicable their legal or designated representative, of the behavior support policies and procedures at the time of entry and as changes occur.

(b) A decision to alter an individual's behavior must be made by the individual or their legal or designated representative.

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

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

(B) Monitored by the prescribing physician for desired responses and adverse consequences.

(26) ADDITIONAL STANDARDS FOR BEHAVIOR SUPPORTS. For the purpose of this section, a designated person is the person implementing the behavior supports identified in an individual's Positive Behavior Support Plan.

(a) SAFEGUARDING INTERVENTIONS AND SAFEGUARDING EQUIPMENT.

(A) A designated person must only utilize a safeguarding intervention or safeguarding equipment when:

(i) BEHAVIOR. Used to address an individual's challenging behavior, the safeguarding intervention or safeguarding equipment is included in the individual's Positive Behavior Support Plan written by a qualified behavior professional as described in OAR 411-304-0150 and implemented consistent with the individual's Positive Behavior Support Plan.

(ii) MEDICAL. Used to address an individual's medical condition or medical support need, the safeguarding intervention or safeguarding equipment is included in a medical order written by the individual's licensed health care provider and implemented consistent with the medical order.

(B) An individual, or as applicable their legal representative, must provide consent for a safeguarding intervention or safeguarding equipment through an individually-based limitation in accordance with OAR 411-004-0040.

(C) Prior to utilizing a safeguarding intervention or safeguarding equipment, a designated person must be trained.

(i) For a safeguarding intervention, the designated person must be trained in intervention techniques using an ODDS-approved behavior intervention curriculum and trained to an individual's specific needs. Training must be conducted by a person who is appropriately certified in an ODDS-approved behavior intervention curriculum.

(ii) For safeguarding equipment, the designated person must be trained on the use of the identified safeguarding equipment.

(D) A designated person must not utilize any safeguarding intervention or safeguarding equipment not meeting the standards set forth in this rule even when the use is directed by an individual or their legal or designated representative, regardless of the individual's age.

(b) EMERGENCY PHYSICAL RESTRAINTS.

(A) The use of an emergency physical restraint when not written into a Positive Behavior Support Plan, not authorized in an individual’s ISP, and not consented to by the individual in an individually-based limitation, must only be used when all of the following conditions are met:

(i) In situations when there is imminent risk of harm to the individual or others or when the individual’s behavior has a probability of leading to engagement with the legal or justice system.

(ii) Only as a measure of last resort.

(iii) Only for as long as the situation presents imminent danger to the health or safety of the individual or others.

(B) The use of an emergency physical restraint must not include any of the following characteristics:

(i) Abusive.

(ii) Aversive.

(iii) Coercive.

(iv) For convenience.

(v) Disciplinary.

(vi) Demeaning.

(vii) Mechanical.

(viii) Prone or supine restraint.

(ix) Pain compliance.

(x) Punishment.

(xi) Retaliatory.

(27) A provider agency may not knowingly allow an agency employee to provide community living supports skills training or attendant care services, other than DSA or employment services, to an individual that also engages the agency employee's services as a personal support worker.

(28) A provider agency may not allow:

(a) The parent of a minor child to provide services as an employee of the agency to the employee’s own child unless, for the duration of the COVID-19 public health emergency, the child:

(A) Meets the enrollment criteria for any of the Children's Intensive In-Home Services programs; or

(B) Has a service level of at least 240 hours per month.

(b) The spouse of an individual receiving services to provide services as an employee of the agency to the employee's spouse.

(29) No later than January 1, 2023, a provider agency must only deliver community living supports through employees of the agency. Contracted direct support professionals are prohibited.

(30) A provider agency must maintain an average wage for direct support professionals who deliver hourly attendant care, not including DSA, that is equal to or greater than the hourly rate stated in the Department's approved published rate model.

(31) A provider agency must submit annual data to the nationally standardized reporting survey organization specified by the Department using the instructions provided by the organization and the Department.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662, SB 1548 (2022 OR Law, Ch. 91)
Statutes/Others Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662, SB 1548 (2022 OR Law, Ch. 91)

411-450-0090 Standard Model Agency Requirements
(Adopted 12/20/2022)

(1) For a provider agency to be endorsed to deliver community living supports as a standard model agency, the provider agency must meet the additional requirements in this rule. The requirements of this rule do not apply to a provider agency endorsed as a community living supports agency.

(2) A standard model agency must develop and implement policies and procedures that minimize:

(a) The loss of supports to an individual when an agency employee is unavailable to deliver a scheduled support; and

(b) The loss of agency employee income when an individual cancels a scheduled support.

(3) While a standard model agency employee is delivering a scheduled support, the agency employee must have timely access to a supervisor.

(4) INTEGRATED SUPPORT COORDINATION. When an ISP or Service Agreement identifies activities that are necessary for an individual to live in the community but are not directly related to the completion of an ADL, IADL, or health-related task, a standard model agency must assist in the completion of that activity when identified as the entity to do so in the ISP or Service Agreement. These activities may include, but are not limited to:

(a) Scheduling medical appointments and medical transportation.

(b) Assuring medications and treatments are ordered and reordered as needed.

(c) Assisting with additional documentation necessary to:

(A) Demonstrate progress towards desired outcomes.

(B) Record data related to challenging behaviors.

(C) Record data for review by a medical professional.

(d) Evaluating and implementing strategies to mitigate risks in the individual’s environment, including safe storage practices of medication and harmful chemicals.

(e) Maintaining a schedule of activities for the individual when needed to make progress toward a desired outcome.

(f) Facilitating communication among agency employees who support the individual.

(5) When directed by an individual's ISP or Service Agreement, a standard model agency must develop or acquire, maintain, and follow written protocols, specific to the individual, designed to mitigate known risks identified in the individual's ISP or Service Agreement.

(a) The standard model agency must provide training on the protocols to each agency employee who supports the individual.

(b) The protocols must be available to an agency employee when the agency employee is supporting the individual.

(6) A standard model agency must allow an agency employee who is familiar with an individual’s support needs and preferences to participate in meetings related to the development of the individual's ISP when the individual requests the employee's participation and the employee is available.

(7) IMPLEMENTATION STRATEGY. Beginning January 1, 2023, when an individual has a new annual ISP or when an individual begins receiving services from a standard model agency:

(a) The standard model agency must develop, and update as needed, an individualized implementation strategy and provide the individual's implementation strategy to the individual’s case manager no later than:

(A) Sixty calendar days from the start of the individual's ISP; or

(B) If later than the start of the individual's ISP, sixty calendar days from agreeing to deliver hourly attendant care supports as shown by the dated signature of an agency representative on the individual's ISP or Service Agreement.

(b) The standard model agency must provide each agency employee who supports the individual an orientation to the individual's implementation strategy.

(c) An implementation strategy must be added to the individual's service record described in OAR 411-450-0080(17).

(8) Beginning January 1, 2023, when an individual has a new annual ISP or when an individual begins receiving services from a standard model agency, the agency must submit a quarterly, written progress report to each individual’s case management entity.

(9) Employees of a standard model agency who deliver hourly attendant care or skills training supports must have 12 hours per year of training related to the delivery of attendant care or skills training supports in addition to the requirements in OAR 411-323-0050(8)(f). At least two hours per year must be on subjects related to diversity, equity, and inclusion.

(10) A standard model agency may not require an individual or the individual's family to coordinate the schedules of the agency's employees who support the individual.

Statutory/Other Authority: ORS 409.050, 427.104, 430.662, SB 1548 (2022 OR Law, Ch. 91)
Statutes/Others Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662, SB 1548 (2022 OR Law, Ch. 91)

411-450-0100 Variances
(Adopted 06/29/2016)

(1) The Department may grant a variance to these rules based upon a demonstration by an agency that an alternative method or different approach provides equal or greater agency effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws.

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

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

(e) If the variance applies to an individual's service, evidence that the variance is consistent with the individual's current ISP.

(3) The Department's director may approve or deny the request for a variance. The director's decision is final.

(4) The Department must notify the agency of the Department's decision. The decision notice must be sent within 45 calendar days of the receipt of the request by the Department with a copy sent to all relevant Department programs or offices.

(5) The agency may implement a variance only after written approval from the Department.

Statutory/Other Authority: ORS 409.050, 430.662
Statutes/Others Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670