Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

NOTICE OF PROPOSED RULEMAKING

Oregon Department of Human Services (ODHS)
Office of Developmental Disabilities Services (ODDS) 411

Agency and Division Name | Administrative Rules Chapter Number

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FILING CAPTION

ODDS: Oregon Needs Assessment and Community Living Support Hours, Service Limits, and Exceptions (411-415, 450)

Last Date and Time for Public Comment: [December 1, 2023 at 11:00 p.m.]

November 29, 2023	2:00 p.m.	Rule Hearing - Zoom Register to provide comments: https://www.zoomgov.com/meeting/register/vJIsdemhpjktGItFcsqoFZRQ7qW5FCCsQPo Join by phone (audio only): 1-669-254-5252, 161 209 8272#	Staff

Hearing Date | Time | Address/Teleconference | Hearings Officer

RULE HEARING NOTES: A rule hearing is an opportunity for people to provide comments about proposed rule changes. If you wish to attend the rule hearing, please join no later than 15 minutes after the hearing has started.

Questions about the rule content or other developmental disabilities services are not answered during the rule hearing. If you need help or have questions, please email mike.r.parr@odhs.oregon.gov or call 503-508-4003.

WRITTEN COMMENTS: Comments about the proposed rule changes may also be made in writing. Written comments may be sent by email to ODDS.Rules@odhs.oregon.gov or mailed to ODDS Rules, 500 Summer Street NE, E-09, Salem, Oregon, 97301-1073. Written comments must be received by **11:00 p.m. on December 1, 2023**.

LANGUAGE ACCESS AND ACCOMODATIONS: We provide free help so everyone can use our services.

Español | اللغة العربية | 简体中文 | 繁體中文 | Foosun Chuuk | हिन्दी | Lus Hmoob | 한국어 | Kajin Majol | Português | Русский | Soomaali | Tiếng Việt

For people who speak or use a language other than English, people with disabilities or people who need additional support, we can provide free help. Some examples:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Real-time captioning (CART)
- Large print
- Audio and other formats

If you need accommodations, please email ODDS.Rules@odhs.oregon.gov or call 503-945-5811. We accept all relay calls.

RULEMAKING ACTION

List each rule number separately (000-000-0000) below. Attach proposed, tracked changed text for each rule at the end of the filing.

AMEND:
411-415-0050, 411-415-0060, 411-415-0070, 411-450-0020, 411-450-0030, 411-450-0040, 411-450-0050, 411-450-0060

ADOPT:
411-450-0065

RULE SUMMARY

Include a summary for each rule included in this filing.

The Oregon Department of Human Services (ODHS), Office of Developmental Disabilities Services (ODDS) is proposing to update the rules in:

- **OAR chapter 411, division 415 about case management services**. The rules in OAR chapter 411, division 415 prescribe standards, responsibilities, and procedures for the delivery of case management services to individuals with intellectual or developmental disabilities.
- **OAR chapter 411, division 450 about** c**ommunity living supports**. The rules in OAR chapter 411, division 450 prescribe standards, responsibilities, and procedures for the delivery of community living supports. Community living

supports are intended to permit individuals to live independently in a home and community-based setting.

ODDS is updating the following rules in **OAR chapter 411, divisions 415 and 450** to begin using the Oregon Needs Assessment (ONA) as the universal assessment tool to determine the amount of hourly attendant care (also known as in-home hours) available to individuals receiving community living supports in their own home or family home. The ONA is replacing the Adult Needs Assessment (ANA) and Child Needs Assessment (CNA). Starting with 2024 Individual Support Plans (ISP), an individual who has a completed ONA will be assigned to a service group for the purpose of determining their service level. The service level indicates the range of hours an individual may use for community living supports. Service groups are based on an individual's age and the amount of help needed. An individual may request an exception to the service level, for a staff ratio greater than 1:1, or when an individual's service needs are not being met after exhausting available resources. Full transition to using the ONA will be completed in 2025. Until then, no one will receive fewer hours than they have now according to their ANA or CNA.

OAR 411-415-0050 about standards for case management services is being amended to:

- Include the exception request process for individuals receiving community living supports.
- Specify when an ANA or CNA is used to establish an individual's service level.

OAR 411-415-0060 about assessment activities is being amended to specify:

- A response to an item in an ONA may only be changed by a person who meets the qualifications and training requirements of an assessor and is employed by a case management entity or ODDS as a certified assessor.
- An ONA must be completed within 45 calendar days from the date a case management entity identifies the support needs of an individual may have changed significantly and the change is expected to last at least 90 calendar days.
- When a case management entity must inform an individual of their service group and service level after the completion of an ONA.

OAR 411-415-0070 about service planning is being amended to specify:

- For community living supports, an ISP must include an hour allocation that is within the maximum service level or within the amount approved by an exception.
- An ISP must be reviewed no later than the end of the month following the month an ONA was conducted.
- An ISP must not be authorized that includes types or amounts of developmental disabilities services for which an individual is not eligible.

OAR 411-450-0020 about the definitions and acronyms for community living supports is being amended to reflect changes related to the ONA, in-home hours, service levels, and exceptions.

OAR 411-450-0030 about eligibility for community living supports is being amended to reflect changes related to the ONA.

OAR 411-450-0040 about community living supports entry and exit is being amended to:

- Specify an individual may not access community living supports unless they are included in the individual's current, authorized ISP.
- Reflect changes related to the ONA.

OAR 411-450-0050 about minimum standards for community living supports is being amended to reflect changes related to the ONA.

OAR 411-450-0060 about community living supports is being amended to:

- Specify ODDS funds may only be used to purchase community living supports when included in an authorized ISP.
- Clarify that cueing, hands-on, monitoring, set-up, or stand-by must be tied to assistance with activities of daily living, instrumental activities of daily living, or a health-related task.
- Update the section about service limits to reflect changes related to the ONA, include tables defining services groups and service levels, specify when in-home hour allocations may be reduced, and include hearing rights and the exception request process.
- Add a section about staff ratios and include hearing rights and the exception request process.

OAR 411-450-0065 about exceptions is being adopted to provide for when an individual may request an exception to the service level or staffing ratios.

Other technical changes may be made to these rules to make the rules easier to understand and implement, correct grammatical errors, ensure consistent terminology, address issues identified during the public comment period, and improve the accuracy, structure, and clarity of the rules. Technical rule changes will not affect services or introduce additional requirements or processes.

STATEMENT OF NEED

ODDS needs to update the rules in OAR chapter 411, divisions 415 and 450 to begin using the ONA as the universal assessment tool to determine the amount of hourly in-home hours available to individuals receiving community living supports. The ONA is

replacing the ANA and CNA. Starting in 2024, an individual who has a completed ONA will be assigned to a service group for the purpose of determining their service level. The service level indicates the range of hours an individual may use for community living supports. Service groups are based on an individual's age and the amount of help needed.

The proposed rulemaking specifically addresses this need by:

Amending OAR 411-415-0050 about standards for case management services to:

- Include the exception request process for individuals receiving community living supports.
- Specify when an ANA or CNA is used to establish an individual's service level.

Amending OAR 411-415-0060 about assessment activities to specify:

- A response to an item in an ONA may only be changed by a person who meets the qualifications and training requirements of an assessor and is employed by a case management entity or ODDS as a certified assessor.
- An ONA must be completed within 45 calendar days from the date a case management entity identifies the support needs of an individual may have changed significantly and the change is expected to last at least 90 calendar days.
- When a case management entity must inform an individual of their service group and service level after the completion of an ONA.

Amending OAR 411-415-0070 about service planning to specify:

- For community living supports, an ISP must include an hour allocation that is within the maximum service level or within the amount approved by an exception.
- An ISP must be reviewed no later than the end of the month following the month an ONA was conducted.
- An ISP must not be authorized that includes types or amounts of developmental disabilities services for which an individual is not eligible.

Amending OAR 411-450-0020 about the definitions and acronyms for community living supports to reflect changes related to the ONA, in-home hours, service levels, and exceptions.

Amending OAR 411-450-0030 about eligibility for community living supports to reflect changes related to the ONA.

Amending OAR 411-450-0040 about community living supports entry and exit to:

- Specify an individual may not access community living supports unless they are included in the individual's current, authorized ISP.
- Reflect changes related to the ONA.

Amending OAR 411-450-0050 about minimum standards for community living supports to reflect changes related to the ONA.

Amending OAR 411-450-0060 about community living supports to:

- Specify ODDS funds may only be used to purchase community living supports when included in an authorized ISP.
- Clarify that cueing, hands-on, monitoring, set-up, or stand-by must be tied to assistance with activities of daily living, instrumental activities of daily living, or a health-related task.
- Update the section about service limits to reflect changes related to the ONA, include tables defining services groups and service levels, specify when in-home hour allocations may be reduced, and include hearing rights and the exception request process.
- Add a section about staff ratios and include hearing rights and the exception request process.

Adopting OAR 411-450-0065 about exceptions to provide for when an individual may request an exception to the service level or staffing ratios.

Documents Relied Upon, and where they are available:

1. Compass Project. Available at: https://www.oregon.gov/odhs/compass/pages/default.aspx
2. Compass Project: Oregon Needs Assessment (ONA). Available at: https://www.oregon.gov/odhs/compass/Pages/ona.aspx

RACIAL EQUITY IMPACT STATEMENT

Statement Identifying How Adoption of Rule(s) Will Affect Racial Equity in this state:

The proposed rule changes impact people with intellectual or developmental disabilities (I/DD). People with I/DD are often members of one or more of the following communities:

- Tribes.
- Racial, ethnic, and culturally-based communities.
- People who identify as LGBTQIA2S+.
- Religious minorities.
- People with limited English proficiency.
- Immigrants.
- Refugees.

Potential consequences or impacts of the proposed rule changes as identified the Rules Advisory Committee (RAC) are as follows:

- The Oregon needs assessment tool is easier to understand and more transparent than the previous assessment tool. This will make it easier for people with I/DD and their families to advocate for services.
- Reductions taking effect in as few as 30 days from an assessment may not allow enough time to plan for the reduction, especially for people with a primary language other than English.
- The rolling implementation as ISPs renew is a positive impact because translation and interpretation services will not be overwhelmed.
- The rule allows exception requests to be denied if it is due to a provider's inability to perform a task that most providers could. This could cause an inequity for workers who have physical or other impairments.

On whole, the proposed rule changes improve access to services for people with I/DD by distributing resources more equitably and introducing transparency into the in-home hour allocations.

To minimize adverse impacts and eliminate potential harm to people with I/DD, ODDS has made an agreement with the Centers for Medicare and Medicaid Services to not reduce in-home hour allocations for people who would otherwise see a reduction as a result of this rulemaking until the end of the American Rescue Plan Act Maintenance of Effort period. This provides an extended period (January 1, 2024 to at least March 31, 2025) for individuals to adjust to the hour ranges in these rules, identify additional resources, and/or request exceptions to mitigate or minimize reductions.

FISCAL IMPACT

Fiscal and Economic Impact:

The fiscal and economic impact is stated below in the cost of compliance statement. The fiscal and economic impact was evaluated as part of the RAC process and is based on data and information currently available to ODDS.

Cost of Compliance:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).

ODDS estimates the proposed rule changes will have the following fiscal and economic impact:

- ODDS: To meet American Rescue Plan Act Maintenance of Effort funding written into these rules is estimated to cost $127M.
- Other State Agencies: No impact is expected because these rules do not affect other state agencies.
- Case Management Entities (CME) (units of local government): There most likely will be a fiscal impact, though it is difficult to estimate. There will be an initial increase in workload to implement these rules, but over the long term should result in a decreased workload due to having to complete fewer assessments.

- Individuals Receiving Services: There will be no fiscal impact to people receiving services because there is no cost for developmental disabilities services. Introducing the ONA and an exceptions process will have no fiscal impact on people receiving services.
- Providers: As adopted, due to the American Rescue Plan Act Maintenance of Effort funding written into these rules, as a whole, providers will see a positive fiscal impact as the overall total number of hours people will receive paid support will increase, estimated to be $127M.
- Members of the Public: There will be no impact to members of the public because these rules do not affect members of the public.

(2) Effect on Small Businesses:
(a) Estimate the number and type of small businesses subject to the rule(s);
The proposed rule changes apply to agencies endorsed to provide community living supports. There are approximately 245 agencies endorsed to provide community living supports. Some agencies may meet the definition of a small business in ORS 183.310.

The proposed rule changes also apply to personal support workers. Personal support workers are not considered small businesses as defined in ORS 183.310.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);
The estimated impact to providers is described in the cost of compliance statement.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).
The estimated impact to providers is described in the cost of compliance statement.

Describe how small businesses were involved in the development of these rule(s)?
Small businesses as defined in ORS 183.310 were invited to participate in the RAC and are included in the public review and comment period.

Was an Administrative Rule Advisory Committee consulted? Yes or No?
If not, why not?
Yes. An invitation for RAC participants was posted to the ODDS Engagement and Innovation website. The RAC meetings were held on April 26, May 3, and May 9 and were open to the public.

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

CHAPTER 411
DIVISION 415

CASE MANAGEMENT SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

411-415-0050 Standards for Case Management Services

(1) A CME must apply the principles of self-determination, person-centered practices, diversity, equity, and inclusion to the provision of case management services.

(2) A CME must ensure that a case manager is available to provide case management services and other supports to an individual.

(a) Case management services include the activities related to:

(A) Assessment and periodic reassessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services including those assessments described in OAR 411-415-0060.

(B) Development and periodic revision of an ISP or Annual Plan based on the information collected through an assessment or reassessment that specifies the desired outcomes, goals, and actions to address the medical, employment, social, educational, and other services needed by an eligible individual as described in OAR 411-415-0070.

(C) Support to access available services, including referral and related activities to help an individual obtain needed services as described in OAR 411-415-0080.

(D) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure an ISP or Annual Plan is effectively implemented and adequately addresses the needs of an eligible individual as described in OAR 411-415-0090.

(b) Other supports provided by a CME may include, but are not limited to:

(A) Authorizing services in the Department's electronic payment and reporting system.

(B) Arranging employer-related supports that may include, but are not limited to:

(i) Education about employer responsibilities.

(ii) Orientation to basic wage and hour issues.

(iii) Use of common employer-related tools, such as service agreements.

(C) Assisting the Department with establishing provider credentials.

(D) Assistance with understanding and accessing financial, medical, and other benefits.

(3) Prior to an initial ISP, at least annually, and at the request of an individual, or as applicable the legal representative of the individual, a CME must provide a Notification of Rights (form 0948), ~~and~~ an explanation of the individual rights described in OAR 411-318-0010, and the complaint process described in OAR 411-318-0015, to the individual and if applicable the legal representative of the individual.

(4) A CME may not authorize services that are delivered by an affiliated entity.

(5) Developmental disabilities services must be authorized in accordance with OAR 411-415-0070. A case manager must authorize any

developmental disabilities services and delivery of those services by an available, qualified provider chosen by an individual, or as applicable the legal or designated representative of the individual, for which the individual is eligible as described in the relevant program rules. A provider is considered available when the provider has the capacity and willingness to deliver services chosen by an individual.

(a) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disabilities service is denied, reduced, suspended, or terminated, or a chosen qualified provider is not authorized to deliver a chosen service to an individual, a written advance Notification of Planned Action (form 0947) must be provided as described in OAR 411-318-0020.

(b) HEARINGS.

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

(B) Hearings are addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(c) Upon entry into case management, upon request, and annually thereafter, a notice of hearing rights and the policy and procedures for hearings as described in OAR chapter 411, division 318 must be explained and provided to an individual, and as applicable the legal or designated representative of the individual.

(6) Services authorized in an ISP must be entered into the Department's electronic payment and reporting system prior to the authorized start date of the services being delivered by a provider.

(7) If an individual loses eligibility for a medical assistance program delivered by the Oregon Health Authority, a case manager must assist the individual to identify why the eligibility was lost. Whenever possible, the case manager must assist the individual in reestablishing the eligibility. The case manager must document the assistance given in the service record for the individual.

(8) CHOICE ADVISING. Through choice advising, a CME must assure that case management and other developmental disabilities service options, provider options, and setting options, including non-disability specific settings and an option for a private or shared unit in a residential program, are described to an individual receiving case management services from the CME, or to the legal representative of the individual.

(a) Within 10 business days of an individual being found eligible for developmental disabilities services, the individual must receive choice advising, including all of the following:

(A) The choice of institutional or home and community-based services.

(B) Options for developmental disabilities services available to the individual.

(C) For an adult, information about all CMEs operating in the county of origin, using materials provided by each CME when the materials are made available.

(b) Choice advising occurs as part of the person-centered planning process and must be conducted prior to an initial ISP and prior to a review of the ISP when required according to OAR 411-415-0070.

(c) Prior to an individual's 18th birthday, the individual must be offered the choice of institutional or home and community-based services.

(d) Prior to an individual's 17th birthday, the individual must be informed about all CMEs operating in the county of origin that will be available to the individual as an adult, using materials provided by each CME when the materials are made available.

(e) Prior to entry into a 1915(c) Home and Community-Based Services waiver, an individual, or as applicable the individual's legal representative, must be informed of the individual's choice to receive home and community-based or institutional services and verify the individual's choice using the Freedom of Choice form (ODHS 2808).

(f) A CME must present to an adult at least three types of community living settings as defined in ORS 427.101, including an option for services in the adult's own or family home, annually and when an adult is moving from one community living setting to another community living setting unless:

(A) The adult is at imminent risk to health or safety in the adult's current placement setting; or

(B) The adult is moving from one non-residential program setting to another non-residential program setting.

(g) If a CME is affiliated with an agency provider of developmental disabilities services in addition to case management services, the CME must disclose the relationship and inform the individual, or as applicable the legal or designated representative of the individual, that the CME cannot authorize the affiliated provider. The CME must discuss other case management provider options when the individual, or as applicable the legal or designated representative of the individual, expresses interest in receiving services from the affiliated provider.

(9) A case manager must coordinate services with the Child Welfare caseworker assigned to a child to ensure the provision of required supports from the Department, CDDP, and Child Welfare.

(10) A case manager must participate in transition planning by attending IEP meetings or other transition planning meetings for a student 16 years of age or older to discuss the transition of the student to adult living and work situations, unless the attendance of the case manager is refused by the parent or guardian of the student or the student if the student is 18 years of age or older. A case manager must participate in transition planning for a student as young as 14 years of age if transition planning is deemed appropriate by the student's IEP team, unless the attendance of the case manager is refused by the parent or guardian of the student.

(11) When appropriate, a case manager must coordinate with Vocational Rehabilitation regarding employment services. When appropriate, a case manager must facilitate referrals to Vocational Rehabilitation.

(12) HEALTH CARE ADVOCATES.

(a) For an individual determined to be incapable as defined in OAR 411-390-0120, and who does not have a guardian with medical decision-making authority or a health care representative, a case manager must have a documented discussion with the individual's ISP team regarding the appointment of a health care advocate as described in OAR chapter 411, division 390 when a significant medical procedure or treatment is being considered. The case manager must assure the individual is informed of all of the following:

(A) The ISP team’s decision to seek a health care advocate, prior to the appointment of the health care advocate.

(B) The name of the appointed health care advocate.

(C) The proposed decision about any significant medical procedure or treatment.

(b) A case manager must give an individual's health care advocate appointed according to OAR chapter 411, division 390 a copy of OAR chapter 411, division 390 and document this in the individual's service record.

(c) A case management entity must provide health care advocate training materials to a potential health care advocate prior to appointment and any health care decision-making.

(13) A case manager who becomes aware that a health care representative is considering withholding or withdrawing life-sustaining procedures for an individual, must provide the health care representative with any information in the case manager’s possession that is related to the individual’s values, beliefs, and preferences with respect to the withholding or withdrawing of life-sustaining procedures.

(14) EXCEPTIONS.

(a) If an individual eligible for community living supports as described in OAR chapter 411, division 450, or the individual's legal or designated representative, requests an exception to the service level, for a staff ratio greater than 1:1, or expresses concerns that the individual's service needs are not being met after exhausting available resources, the case manager must help the individual apply for an exception as described in OAR 411-450-0065, including completing a funding review and exception request, and gathering documentation required by the Department.

(b) If the individual's case manager assesses that the individual's needs exceed the available resources or require a staffing ratio greater than 1:1, the case manager must work with the individual to determine the appropriate hour allocation and staffing ratio and submit a Funding Review and Exception Request Form, or other form designated by the Department to request an exception, if necessary. The form is submitted to the Department or the Department's designee.

(c) When required by the Department, an individual's case manager must complete a Funding Review and Exception Request Form, or other form designated by the Department to request an exception, to inform an exception request.

(d) A CME has 14 calendar days, or a later time determined by the Department, from the date of a request from the Department for information related to an exception request to provide the information or inform the Department the information is not available.

(15) SERVICE LEVEL SETTING. A CME must use the Adult In-Home Support Needs Assessment, Version C (ANA-C), for an adult, or the Child In-Home Support Needs Assessment, Version C (CNA-C), for a child, to establish an ANA-C or CNA-C service level for a person intending to access in-home, hourly attendant care who:

(a) Is newly eligible for development disabilities services;

(b) Is going to access in-home, hourly attendant care following a period of more than one year when hourly in-home attendant care was not authorized for the individual; or

(c) Is leaving a residential service.

(~~14~~16) A CME must implement procedures to address individual, designated representative, or family complaints regarding service delivery that have not been resolved using the complaint procedures of a provider agency. The complaint procedures must be consistent with the requirements in OAR 411-318-0015.

(~~15~~17) A case manager must coordinate with other state, public, and private agencies regarding services to individuals.

(~~16~~18) When appropriate, a case manager must facilitate referrals to nursing facilities as described in OAR 411-070-0043.

(~~17~~19) A case manager must coordinate and monitor the services provided to an eligible individual living in a nursing facility.

(~~18~~20) A Department case manager must make referrals for entry and participate in all entry meetings for children in residential programs, CIIS, and the Stabilization and Crisis Unit.

(~~19~~21) A CME must provide case management services to individuals who are eligible for and desire them. If an individual receiving case management services from a CDDP is receiving other developmental disabilities services in more than one county, the county of origin must be responsible for case management services unless otherwise negotiated and documented in writing with the mutually agreed upon conditions.

(~~20~~22) CHANGE OF CASE MANAGER.

(a) If a CME changes the assignment of an individual's case manager for any reason, the CME must notify the individual, the legal and designated representative of the individual (as applicable), and all providers within 10 business days of the change. The notification

must be in writing and include the name, telephone number, email address, and mailing address of the new case manager.

(b) An individual receiving services, or as applicable the legal or designated representative of the individual, may request a new case manager within the same CME or request a change of CME.

(~~21~~23) FAMILY RECONNECTION. A CME and a case manager must provide assistance to the Department when a family member is attempting to reconnect with an individual who was previously discharged from Fairview Training Center or Eastern Oregon Training Center or an individual who is currently receiving developmental disabilities services.

(a) If a family member contacts a CME for assistance in locating an individual, the CME must refer the family member to the Department. A family member may contact the Department directly.

(b) The Department shall send the family member a Department form requesting further information to be used in providing notification to the individual. The form shall include the following information:

(A) Name of requestor.

(B) Address of requestor and other contact information.

(C) Relationship to individual.

(D) Reason for wanting to reconnect.

(E) Last time the family had contact.

(c) The Department shall determine:

(A) If the individual was previously a resident of Fairview Training Center or Eastern Oregon Training Center.

(B) If the individual is deceased or living.

(C) Whether the individual is currently or previously enrolled in Department services.

(D) The county in which services are being provided, if applicable.

(d) With permission from the individual, the Department shall notify the family member if the individual is enrolled or no longer enrolled in Department services within 10 business days from the receipt of the request.

(e) If the individual is enrolled in Department services, the Department shall send the completed family information form to the individual and the case manager.

(f) If the individual is deceased, the Department shall follow the process for identifying the personal representative of the individual in accordance with ORS 192.573.

(A) If the personal representative and the requesting family member are the same, the Department shall inform the personal representative that the individual is deceased.

(B) If the personal representative is different from the requesting family member, the Department shall contact the personal representative for permission before sharing information about the individual with the requesting family member. The Department must make a good faith effort to find the personal representative and obtain a decision concerning the sharing of information as soon as practicable.

(g) When an individual is located, the CME must facilitate a meeting with the individual to discuss and determine if the individual wishes to have contact with the family member.

(A) The case manager must assist the individual in evaluating the information to make a decision regarding initiating contact, including providing the information from the form and any

relevant history with the family member that may support contact or present a risk to the individual.

(B) If the individual does not have a legal representative or is unable to express their wishes, the ISP team of the individual must be convened to review factors and choose the best response for the individual after evaluating the situation.

(h) If the individual wishes to have contact, the individual or ISP team designee may directly contact the family member to make arrangements for the contact.

(i) If the individual does not wish to have contact, the CME must notify the Department. The Department shall inform the family member in writing that no contact is requested.

(j) The notification to the family member regarding the decision of the individual must be within 60 business days from the receipt of the information form from the family member.

(k) The decision by the individual is not appealable.

Statutory/Other Authority: ORS 127.765, 409.050, 427.104, 427.105, 427.115, 427.154, 430.212, 430.662, 430.731
Statutes/Other Implemented: ORS 127.765, 409.010, 427.005-427.154, 430.212, 430.215, 430.610, 430.620, 430.662, 430.664, 430.731-430.768

411-415-0060 Assessment Activities

For the purpose of this rule, "supervisor" means an employee of a CME who provides management level oversight of an assessor and is trained and qualified to conduct an ONA according to OAR chapter 411, division 425.

(1) An ONA must be conducted according to the standards described in OAR chapter 411, division 425.

(2) A CME must assure an individual has an initial ONA from an assessor or supervisor prior to receiving Community First Choice state plan or waiver services.

(3) The Department may require an ONA to be completed by an assessor employed or identified by the Department.

(4) For each individual who has an authorized ISP, a CME must assure an ONA is conducted by:

(a) An assessor or supervisor:

(A) For each individual who has not had a functional needs assessment using the ONA when a functional needs assessment or ICF/IID Level of Care determination is required.

(B) Any time there may be a significant change in an individual's support needs.

(C) At a frequency or at specific ages as determined by the Department.

(D) Upon a request for reassessment by an individual or the individual's legal or designated representative.

(E) When a child who has been determined to be eligible for developmental disabilities services according to OAR 411-320-0080 and is enrolled to the Medically Involved Children's Program or Medically Fragile Children's Program and will be turning 18 in the next year and expects to receive Community First Choice state plan or waiver services as an adult.

(b) A case manager, an assessor, or a supervisor, when none of the conditions in subsection (a) of this section are present.

(5) Only a person who meets the qualification and training requirements for an assessor described in OAR 411-425-0035 and is employed by a CME or the Department as a certified assessor may change a response to an item

in an ONA that contributes to any of the scores identified in OAR 411-450-0060(7)(c).

(~~5~~6) Each individual whose services are authorized in an ISP must have a completed ONA ~~by June 30, 2019~~.

(~~6~~7) An ONA must be completed:

(a) Not more than 12 months from a previously completed ONA, ICF/IID Level of Care determination, or functional needs assessment.

(b) Within 45 calendar days from the date an individual, or as applicable their legal or designated representative, requests a new ONA.

(c) Within 45 calendar days from the date the CME ~~acquires information~~identifies that the support needs of an individual may have changed significantly, and the change is expected to last at least 90 calendar days.

(~~7~~8) No fewer than 14 calendar days prior to conducting an ONA, the CME must mail a notice of the assessment process to the individual to be assessed. The notice must include a description and explanation of the assessment process and an explanation of the process for appealing the results of the assessment.

(9) No fewer than 14 calendar days from the completion of an ONA for an individual, the CME must inform the individual of their service group and the hour allocation for in-home services.

(~~8~~10) An assessment for State Plan Personal Care must be completed by a case manager as described in OAR chapter 411, division 455.

Statutory/Other Authority: ORS 409.050, 427.104, 427.105, 427.115, 427.154, 430.212, 430.662
Statutes/Other Implemented: ORS 409.010, ~~427.007, 427.104, 427.105, 427.115, 427.121,~~ 427.005-427.154, ~~427.160,~~ 430.212, 430.215, 430.610, 430.620, 430.662, 430.664

411-415-0070 Service Planning

This rule prescribes standards for the development and implementation of an ISP or Annual Plan.

(1) An ISP must meet the following requirements:

(a) Be developed using a person-centered planning process consistent with OAR 411-004-0030 and in a manner that addresses issues of independence, integration, and provides opportunities to seek employment and work in competitive integrated employment settings, in order to assist with establishing outcomes, planning for supports, and reviewing and redesigning support strategies.

(b) Be designed to enhance an individual's quality of life.

(c) Be consistent with the following principles:

(A) Adult individuals have the right to make informed choices about the level of family member participation.

(B) The preferences of an individual, and when applicable a child's legal representative or family, must serve to guide the ISP team. A case manager must facilitate active participation of an individual throughout the planning process.

(C) The planning process is designed to identify the types of services and supports necessary to achieve an individual's preferences, and when applicable a child's legal representative or family, identify the barriers to providing those preferred services, and develop strategies for reducing the barriers.

(D) Specify cost-effective arrangements for obtaining the required supports and applying public, private, formal, and alternative resources available to an eligible individual.

(E) When planning for a child in a 24-hour residential program, foster home, or host home, the following must apply:

(i) Unless contraindicated, there must be a goal for family reunification.

(ii) The number of moves or transfers must be kept to a minimum.

(iii) Unless contraindicated, if the placement of a child is distant from their family, the child's case manager must continue to seek a placement that brings the child closer to their family.

(d) Be developed based on assessed need.

(e) For community living supports, the ISP must include an hour allocation that is ~~be developed~~ within the maximum service level for the individual as ~~service level as defined~~ described in OAR 411-450-~~0020~~ 0060(7)(f) or (h) or within the amount approved by an exception as described in OAR 411-450-0065~~and as determined by a functional needs assessment~~.

(2) An individual enrolled in waiver or Community First Choice state plan services must have an ISP, completed on a Department approved document, consistent with the outcome of the person-centered planning process and OAR 411-004-0030.

(a) An initial ISP may begin a transition period as defined in OAR 411-415-0020. During a transition period, the ISP must include the minimum necessary services and supports for an individual upon entry to a new program type, setting, or CME. The ISP during a transition period must include, at a minimum, the following:

(A) An authorization of necessary services.

(B) The supports needed to facilitate adjustment to the services offered.

(C) The supports necessary to ensure health and safety.

(D) The assessments and consultations necessary for further ISP development.

(b) An initial ISP has a duration of 12 full months, beginning the month following the authorization of the ISP.

(c) The duration of an annual ISP is 12 months. With an individual's consent, or as applicable the consent of the individual's legal or designated representative, a start date for an initial ISP may be established within the 12 months when the individual enters or exits any of the following:

(A) A 24-hour residential program as described in OAR chapter 411, division 325. A transfer to a new setting within the same 24-hour residential program may not cause a new start date for an ISP.

(B) A host home program as described in OAR chapter 411, division 348. A transfer to a new setting within the same host home program may not cause a new start date for an ISP.

(C) A supported living program as described in OAR chapter 411, division 328. A transfer to a new setting within the same supported living program may not cause a new start date for an ISP.

(D) Foster care as described in OAR chapter 411, division 346 for children or OAR chapter 411, division 360 for adults.

(E) A CIIS program.

(d) All Department-funded developmental disabilities services included in an ISP must be consistent with the ISP manual, Department policy, and the Expenditure Guidelines, when applicable.

(e) For Community First Choice state plan and waiver services, the supports included in an ISP must reflect the services and supports that are important for an individual to meet the needs identified through an assessment of functional need, as well as what is

important to the individual with regard to preferences for the delivery of such services and supports.

(3) INDIVIDUALLY-BASED LIMITATIONS.

(a) An initial or annual ISP for an individual receiving services in a residential setting must include any applicable individually-based limitations to the following freedoms:

(A) Support and freedom to access the individual’s personal food at any time.

(B) Visitors of the individual's choosing at any time.

(C) A lock on the individual's bedroom, lockable by the individual.

(D) Choice of a roommate, if sharing a bedroom.

(E) Freedom to furnish and decorate the individual's bedroom as the individual chooses in accordance with a Residency Agreement.

(F) Freedom and support to control the individual's schedule and activities.

(b) An individually-based limitation must be in accordance with OAR 411-004-0040 and be supported by an individual's specific assessed need due to threats to the health and safety of the individual or others.

(c) An initial or annual ISP for an individual receiving services in any setting must include any applicable individually-based limitations to the individual’s freedom from restraint.

(d) An individually-based limitation must only include a safeguarding intervention that:

(A) Meets the definition found in OAR 411-317-0000 and complies with OAR 411-304-0150, OAR 411-304-0160, and applicable program rules.

(B) When used to address a challenging behavior, is directed in a Positive Behavior Support Plan written by a behavior professional qualified to author the safeguarding intervention according to ODDS-approved behavior intervention curriculum and certification as described in OAR 411-304-0150.

(C) When used to address a medical condition or medical support need, is included in a medical order written by an individual's licensed health care provider. The medical order may only indicate the use of a safeguarding intervention to address a medical condition and must include all of the following:

(i) The medical need for the use of the safeguarding intervention.

(ii) Situations for when to use the safeguarding intervention.

(iii) The length of time or situations permitted for the use of the safeguarding intervention.

(e) An individually-based limitation must only include safeguarding equipment that:

(A) Meets the definition found in OAR 411-317-0000 and complies with OAR 411-304-0150 and applicable program rules.

(B) When used to address a challenging behavior, is directed in a Positive Behavior Support Plan written by a behavior professional as described in OAR 411-304-0150.

(C) When used to address a medical condition or medical support need, is included in a medical order written by an

individual’s licensed health care provider. The medical order may only indicate the use of safeguarding equipment to address a medical condition and must include all of the following:

(i) The medical condition the safeguarding equipment addresses.

(ii) The type of safeguarding equipment.

(iii) Situations for when to use the safeguarding equipment.

(iv) The length of time or situations permitted for the use of the safeguarding equipment.

(4) TEMPORARY EMERGENCY SAFETY PLAN. A Temporary Emergency Safety Plan described in OAR 411-304-0150 may be in effect for up to 90 calendar days. The date may be extended up to an additional 90 calendar days with approval from an individual and the individual's case manager to allow additional time for the completion of a Functional Behavior Assessment and Positive Behavior Support Plan.

(5) CAREER DEVELOPMENT PLAN.

(a) A Career Development Plan must be completed as part of an ISP:

(A) When an individual is working age; or

(B) Prior to the expected exit from school for students eligible for services under the Individuals with Disabilities Education Act (I.D.E.A.). If a student leaves school prior to the expected exit, the student must have the opportunity to have a Career Development Plan within one year of the unexpected exit.

(b) A Career Development Plan must meet the following requirements:

(A) For an individual who uses employment services as described in OAR chapter 411, division 345, include goals and objectives related to obtaining, maintaining, or advancing in competitive integrated employment, or at minimum, exploring competitive integrated employment or developing skills that may be used in competitive integrated employment.

(B) Be developed based on a presumption that, with the right support and job match, an individual may succeed and advance in an integrated employment setting and earn minimum wage or better.

(C) Prioritize competitive integrated employment in the general workforce.

(D) For an individual who has competitive integrated employment, person-centered planning must focus on maintaining employment, maximizing the number of hours the individual works consistent with their preferences and interests, improving wages and benefits, and promoting additional career or advancement opportunities.

(E) For an individual using job coaching or job development services, the Career Development Plan must document either a goal or discussion regarding opportunities for maximizing work hours and other career advancement opportunities. The recommended standard for planning job coaching and job development is the opportunity to work at least 20 hours per week. Individualized planning should ultimately be based on individual choice, preferences, and circumstances, and recognize that an individual may choose to pursue working full-time, part-time, or another goal identified by the individual.

(F) Document all employment service options presented, including the option to use employment services in a non-disability specific setting, meaning a setting that is not owned, operated, or controlled by a provider of home and community-based services.

(G) For an individual who uses employment services in a sheltered workshop setting, the Career Development Plan must document the individual has been encouraged to choose a community-based employment service option and not a sheltered workshop setting option.

(6) ISP REVIEWS.

(a) An ISP must be reviewed, and as needed, revised~~,~~ and re-authorized ~~as needed~~:

(A) No ~~more~~ later than the end of the month following the month in which the ONA was conducted~~30 calendar days following a functional needs assessment conducted pursuant to OAR 411-415-0060~~.

(B) Prior to the expiration of the ISP.

(C) No later than the end of a transition period.

(D) When the circumstances or needs of an individual change significantly.

(E) At the request of an individual or as applicable the individual's legal or designated representative.

(b) For an individual who changes CME, but remains in an in-home setting, the ISP authorized by the previous CME may be used as authorization for available services when the services in the new setting remain appropriate.

(7) TEAM PROCESS IN PERSON-CENTERED PLANNING. This section applies to an ISP developed for an individual receiving services in a residential program.

(a) The ISP is developed by the individual, the individual's legal or designated representative (as applicable), and the services coordinator. Others may be included as a part of the ISP team at the invitation of the individual and as applicable the individual's legal or

designated representative. In order to assure adequate planning, provider representatives are necessary informants to the ISP team even when not ISP team members.

(b) In circumstances where an individual is unable to express their opinion or choice using words, behaviors, or other means of communication and the individual does not have a legal or designated representative, the following apply:

(A) On behalf of the individual, the ISP team is empowered to make a decision the ISP team feels best meets the health, safety, and assessed needs of the individual.

(B) Consensus amongst ISP team members is prioritized. When consensus may not be reached, majority agreement is used. For purposes of reaching a majority agreement each interested party, which may be represented by more than one person, is considered as one member of the ISP team. Interested parties may include, but are not limited to, the individual's provider, family, and services coordinator.

(C) No one member of an ISP team has the authority to make decisions for the ISP team.

(c) Any objections to the decisions of an ISP team by a member of the ISP team must be documented in the ISP.

(d) A services coordinator must track the ISP timelines and coordinate the resolution of complaints and conflicts arising from ISP discussions.

(8) ISP AUTHORIZATION.

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

(b) Unless noted otherwise in these or program rules, an initial ISP must include the Medicaid funded developmental disabilities services for which an individual is eligible and desires. An initial ISP must be

authorized no more than 90 calendar days from the date of the request for the services when the individual making the request is enrolled in a Medicaid Title XIX benefit package or a benefit package through the Healthier Oregon medical program. A completed application, as defined in OAR 411-320-0020 and submitted to the CDDP, is a request for services if the individual is enrolled in a Medicaid Title XIX benefit package or a benefit package through the Healthier Oregon medical program at the time the completed application is submitted.

(c) A revision to an initial or annual ISP that ~~involves the~~begins or ends ~~types of~~a developmental disabilities service~~s~~ paid using Department funds must be authorized prior to implementation.

(d) A revision to an initial or annual ISP that does not ~~involve the types of~~begin or end a developmental disabilities service~~s~~ paid using Department funds does not require authorization. The CME must provide written notification of~~Documented agreement to~~ the revision ~~by~~ to the individual, or as applicable their legal or designated representative, ~~is required~~ prior to implementation of the revision.

(e) An initial ISP, and a revision to an initial or annual ISP requiring authorization, is authorized on the date:

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

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

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

(iii) Documented oral agreement may substitute for a signature for up to 10 business days when a revision to an initial or annual ISP is in response to an immediate, unexpected change in circumstance, and the revision is necessary to prevent injury or harm to the individual.

(B) The signature of the case manager involved in the development of, or revision to, the ISP is present on the ISP.

(f) A renewing ISP signed as described in this section, is authorized to begin the first calendar day after the previous ISP expired.

(g) All authorized developmental disabilities services funded through the Community First Choice state plan or home and community-based services waivers must occur in a setting consistent with OAR 411-004-0020.

(h) Community First Choice state plan and waiver services are only funded by the Department when the services are authorized in an ISP developed in a manner consistent with this rule.

(i) A legal or designated representative responsible for directing the development of an ISP on behalf of an individual (as applicable) may not be authorized to be a paid provider for the individual.

(j) An ISP may only have services authorized for personal support workers when the services are consistent with the payment limitations described in OAR 411-375-0040.

(k) An hour allocation or staffing ratio that requires approval from the Department may not be included in an authorized ISP prior to the date of the approval unless there is an imminent threat to an individual’s health and safety that may be mitigated by additional supports. A request for the Department to approve additional supports intended to mitigate an imminent threat to an individual’s health and safety must be submitted to the Department by a CME within five calendar days of the authorization of the additional supports.

(l) An ISP for an adult enrolled in a foster home, as described in OAR chapter 411, division 360, must include at least six hours of activities each week that are of interest to the individual that do not include television or movies made available by the provider. Activities are those available in the community and made available or offered by the provider or the CDDP.

(A) Activities may include the following:

(i) Recreational and leisure activities.

(ii) Other activities required to meet the needs of an individual as described in the ISP for the individual.

(B) Activities that contribute to the six hours may not include any of the following:

(i) Rehabilitation.

(ii) Educational services.

(iii) Employment services.

(m) Not more than two weeks after authorization, a CME must provide a copy of an individual's most current ISP to the individual, the individual's legal and designated representative (as applicable), and others as identified by the individual. An ISP must be made available using language, format, and presentation methods appropriate for effective communication according to the needs and abilities of an individual receiving services and the people important in supporting the individual. When an authorized ISP must be translated from English, translation must be initiated within two weeks of authorization and the translated document must be provided to the individual by the CME upon receipt.

(n) A case manager may not knowingly authorize a community living supports agency or a standard model agency to utilize an agency employee to deliver community living supports skills training or attendant care services, other than day support activities as defined

in OAR 411-450-0020, to an individual that also engages the same person for services as the individual's personal support worker.

(9) DEVELOPMENTAL DISABILITIES SERVICE AUTHORIZATION~~S~~ LIMITS.

(a) Developmental disabilities services may not be authorized or must be terminated in the following circumstances:

(A) An individual does not meet the service eligibility requirements in the program rule corresponding to the service.

(B) A case manager is not permitted to conduct a monitoring visit to an individual's home as required in OAR 411-415-0090 if services can be expected to occur in the home.

(C) An individual fails to participate in, or be available for, the conducting of the components of an ONA within the timeframes identified in OAR 411-415-0060.

(b) A CME may deny, or must terminate, services from a provider, services in a setting, or a combination of services, selected by an eligible individual or the legal or designated representative of the individual in the following circumstances:

(A) The setting has dangerous conditions that jeopardize the health or safety of the individual and necessary safeguards are not available to improve the setting.

(B) Services may not be provided safely or adequately by the provider based on:

(i) The extent of the service needs of the individual; or

(ii) The choices or preferences of the eligible individual or as applicable the individual's legal or designated representative.

(C) Dangerous conditions in the setting jeopardize the health or safety of the provider authorized and paid for by the Department, and necessary safeguards are not available to minimize the dangers.

(D) The individual does not have the ability to express their informed decision, does not have a designated representative to make decisions on their behalf, and the Department or CME are unable to take necessary safeguards to protect the safety, health, and welfare of the individual.

(c) An ISP must not be authorized that includes types or amounts of developmental disabilities services for which the individual is not eligible.

(~~c~~d) A case manager must present an individual, or as applicable the individual's legal or designated representative, with information on service alternatives and provide assistance to assess other choices when a provider or setting selected by the individual, or as applicable the individual's legal or designated representative, is not authorized.

(~~d~~e) A services coordinator employed by a CDDP, or a sub-contractor of a CDDP contracted to deliver case management, may authorize an eligible individual to receive the following developmental disabilities services:

(A) Community First Choice 1915(k) state plan services.

(B) Services described in the Adults' and Children's 1915(c) Home and Community-Based Services waivers.

(C) State Plan Personal Care as described in OAR chapter 411, division 455.

(D) Private duty nursing as described in OAR chapter 410, division 132.

(E) Family support services as described in OAR chapter 411, division 305.

(~~e~~f) A personal agent may authorize an eligible individual to receive the following developmental disabilities services:

(A) Community First Choice 1915(k) state plan services, except services delivered as part of a residential program.

(B) Services described in the Adults' 1915(c) Home and Community-Based Services Waiver.

(C) State Plan Personal Care as described in OAR chapter 411, division 455.

(D) Private duty nursing as described in OAR chapter 410, division 132.

(~~f~~g) A CIIS services coordinator may authorize an eligible individual to receive the following developmental disabilities services:

(A) Community First Choice 1915(k) state plan services.

(B) Services described in the following 1915(c) waivers:

(i) Medically Involved Children's Waiver.

(ii) Medically Fragile (Hospital) Model Waiver.

(iii) Behavioral (ICF/IDD) Model Waiver.

(C) State Plan Personal Care as described in OAR chapter 411, division 455.

(D) Private duty nursing as described in OAR chapter 410, division 132 and OAR 411-300-0150.

(~~g~~h) The Department authorizes entry for children into residential programs, CIIS, and the Stabilization and Crisis Unit.

(10) ANNUAL PLANS. An individual enrolled in case management services, but not accessing Community First Choice state plan or waiver services, must have an Annual Plan.

(a) A case manager must develop an Annual Plan within 90 calendar days from the date of the enrollment of an individual into case management services, and annually thereafter if the individual is not enrolled in any Community First Choice state plan or waiver services.

(b) An Annual Plan must be developed as follows:

(A) For an adult, a written Annual Plan must be documented as an Annual Plan or as a comprehensive progress note in the service record for the individual and include all of the following:

(i) A review of the current living situation of the individual.

(ii) A review of the employment status of the individual and a summary of any related support needs.

(iii) A review of any personal health, safety, or behavioral concerns.

(iv) A summary of the support needs of the individual.

(v) Actions to be taken by the case manager and others.

(B) For a child receiving family support services, a services coordinator must coordinate with the child and the child's parent or legal representative in the development of an Annual Plan. The Annual Plan for a child receiving family support services must be in accordance with OAR 411-305-0225.

(c) An Annual Plan must be kept current. A case manager must ensure that a current Annual Plan is maintained for each individual receiving services.

Statutory/Other Authority: ORS 409.050, 427.104, 427.105, 427.115, 427.154, 430.212, 430.662

Statutes/Other Implemented: ORS 409.010, 427.005-427.154, 430.212, 430.215, 430.610, 430.620, 430.662, 430.664

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

CHAPTER 411
DIVISION 450

COMMUNITY LIVING SUPPORTS

411-450-0020 Definitions and Acronyms

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.

(~~2~~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.

(~~3~~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).

(~~4~~8) "CDDP" means "Community Developmental Disabilities Program" as defined in OAR 411-317-0000.

(~~5~~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.

(~~6~~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.

(~~7~~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.

(~~8~~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.

(~~9~~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.

(~~10~~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.

(~~11~~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.

(~~12~~17) "Group Activity" means an organized or impromptu DSA that involves more than one individual supported by the same provider agency.

(~~13~~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.

(~~14~~20) "HSD Medical Programs" is defined in OAR 411-317-0000.

(~~15~~21) "IADL" means "Instrumental Activities of Daily Living" as defined in OAR 411-317-0000.

(~~16~~22) "IDEA" means the Individuals with Disabilities Education Act, 20 U.S.C §1400.

(~~17~~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.

(~~18~~24) "Informal Arrangement" means a paid or unpaid arrangement for shelter or utility costs that does not include the elements of a rental agreement.

(~~19~~25) "ISP" means "Individual Support Plan" as defined in OAR 411-317-0000.

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

(~~20~~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.

(~~21~~29) "OSIPM" means "Oregon Supplemental Income Program-Medical" as defined in OAR 411-317-0000.

(~~22~~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.

(~~23~~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.

(~~24~~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.

(~~25~~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.

(~~26~~34) "PSW" means "Personal Support Worker" as defined in OAR 411-317-0000.

(~~27~~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.

(~~28~~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.

(~~29~~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, or state plan personal care~~, available under~~ as described in OAR chapter 411, division 455, based on an assessment required by the Department. ~~The service level is determined by a formula embedded in the ANA-C and CNA-C. The formula uses the individual items within the areas measured by the assessment to generate the service level.~~

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

(~~30~~39) "Staffing Ratio" means the number of paid providers to the number of individuals ~~receiving services~~in their care at the same time.

(~~31~~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.

(~~32~~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/Other 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

(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 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 OSIPM or HSD medical programs or a benefit package through ~~the~~ Healthier Oregon ~~medical program~~.

(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 ~~the~~ Healthier Oregon ~~medical program~~.

(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 ~~a functional~~an Oregon ~~n~~Needs ~~a~~Assessment and provide information necessary to complete the ~~functional~~ Oregon Nneeds Aassessment ~~and reassessment~~prior to receiving community living supports, annually, and as required by the Department.

(A) Failure to participate in the ~~functional~~ Oregon Nneeds Aassessment or to provide information necessary to complete the ~~functional~~ Oregon Nneeds Aassessment ~~or reassessment~~ within the ~~applicable~~ 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 ~~functional~~ Oregon ~~n~~Needs ~~a~~Assessment or timely submission of information necessary to complete the ~~functional~~ Oregon ~~needs~~ Needs ~~a~~Assessment ~~or reassessment~~.

(h) A child receiving supports and services under the family support program as described in OAR 411-305-0235 is not eligible to receive community living supports.

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

411-450-0040 Community Living Supports Entry and Exit

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

(~~1~~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.

(~~2~~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 ~~functional~~ Oregon N~~n~~eeds A~~a~~ssessment. An individual, and as applicable the legal or designated representative of the individual, must participate in an ~~functional~~ Oregon ~~n~~Needs Assessment and provide information necessary to complete the ~~functional needs assessment and~~ Oregon Needs Assessment ~~reassessment~~ within the time frame required by the Department.

(A) Failure to participate in the ~~functional~~ Oregon ~~n~~Needs A~~a~~ssessment or provide information necessary to complete the ~~functional needs~~ 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 ~~functional~~ Oregon~~n~~ Needs A~~a~~ssessment ~~or reassessment~~ or timely submission of information necessary to complete the ~~functional needs assessment~~Oregon Needs Assessment.~~ or reassessment~~

(~~3~~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 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/Other Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662

411-450-0050 Minimum Standards for Community Living Supports

(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 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 ADL, 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 ~~as determined by a functional needs assessment~~to meet support needs identified by the Oregon Needs Assessment 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 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 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/Other Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662

411-450-0060 Community Living Supports

(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 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. ADL and 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 ~~activity~~ to help an individual complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an ADL, IADL, or health-related task ~~activity~~ 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 taskactivity.

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

(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 ~~All~~ community living supports must be included in an authorized ~~in an~~ ISP ~~as described in OAR 411-415-0070~~.

(b) An individual who has had a completed 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 Oregon Needs Assessment (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 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;

(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.

~~(b) For an individual residing in their own home or family home, the amount of community living supports in any plan year is limited to the service level determined by an ANA-C for an adult, or CNA-C for a child, when conducted as described in the ANA/CNA Manual.~~

~~(c) If an individual was receiving community living supports on October 31, 2016, the service level for that individual is the higher service level of:~~

~~(A) The service level in place on October 31, 2016; or~~

~~(B) The highest service level determined by an ANA or CNA after October 31, 2016.~~

(g~~d~~) A~~n~~ change~~increase~~ ~~in service level must be based on~~ to the score of an Oregon Needs ~~rea~~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.

~~(e) The Department may approve a request for a temporary increased service level when an individual requires an additional number of hours to respond to the Coronavirus (COVID-19) pandemic. When the federally declared public health emergency is ended, service levels must be reduced to the number of hours available immediately prior to the increase granted under this subsection. The Department shall provide individuals with a Notification of Planned Action as described in OAR 411-318-0020, including the opportunity for a hearing according to ORS chapter 183 and OAR 411-318-0025.~~

~~(f) An individual's service level may not be reduced below the service level in place on October 31, 2016.~~

(h~~g~~) 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, ~~T~~the service level. The service level may not be exceeded without prior approval from the Department. ~~The service level applies to hours used for the following:~~

~~(i) Attendant care as described in this rule.~~

~~(ii) Skills training as described in this rule.~~

~~(iii) State plan personal care service hours as described in OAR chapter 411, division 455.~~

(B) Without an approved exception as described in OAR 411-450-0065 ~~The staffing level. The need for two staff to be available simultaneously to provide community living supports to an individual. W~~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; or

(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; or

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

(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.

~~(h) The Department may approve a service level or staffing level greater than was determined by the ANA-C or CNA-C if the individual is unable to have their support needs met within the assessed service level because the individual has:~~

~~(A) Intermittent needs that cannot be scheduled that must be met throughout the day to keep the individual healthy and safe;~~

~~(B) A specific support that takes an exceptional amount of time and there is justification of the amount of time needed; or~~

~~(C) Support needs that must be met in order to prevent a serious risk of institutionalization.~~

(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~~i~~) 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.

(~~j~~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~~k~~) 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/Other 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 Assistance	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	1/2	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	1/2	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	1/2	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	1/2	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	1/2	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	1/2	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,	0	0	0	0	1

	including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs). *					
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 presenting behavior)? Proactive strategies and physical prompts	0	0	0	0	0	0	1	1
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

(1) An hour allocation or staffing ratio that requires approval under this rule may not be included in an authorized 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 ADL, 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 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/Other Implemented: ORS 409.010, 427.007, 427.104, 430.215, 430.610, 430.662