

CHAPTER IV – ALLOWABLE SERVICES AND PROVIDER REQUIREMENTS

4.01 Introduction

This chapter defines the services covered by the Medicaid Waivers and describes the state expectations for waiver service providers. It outlines certain policy requirements that apply to all services or to the program as a whole. The chapter contains a description and definition of each of the allowable services, including specific requirements and exclusions, the applicable standards for providers and documentation requirements. The service definitions include descriptions of the items and services allowable. When examples are used in a service definition the examples are intended to be illustrative and do not limit the specific items or services that may be covered by the waiver(s).

The waiver programs, CIP 1A, CIP 1B, BIW, COP-W, CIP II, the three CLTS Waivers and the COR Waiver cover many of the same items and services. Some variation occurs due to the target group and/or the individual federal waiver requirements. For example, the CLTS waivers cover many of the same services available from the other waivers as well as certain services specific to serving children. In addition, there are some distinctions specific to federal Medicaid requirements for children. Similarly, the COR waiver covers many of the same services available in the other waivers serving adults, as well as other services specific to meeting the needs of the COR target population. The table in Section 4.09 lists the services covered by the applicable waiver program.

The chapter also addresses **new requirements** that apply to the providers of waiver services and the responsibility of the waiver agency to monitor these providers. It describes the expectations for providers to meet the standards for the service they provide, mandates that waiver agencies evaluate providers against these requirements and requires all waivers service providers to execute a provider agreement with the State Medicaid Agency (DHS.)

4.02 Ensuring Providers are Qualified

A. Provider Standards Certification

County waiver agencies are responsible for assuring that all Medicaid waiver service providers meet the standards established in this chapter for the specific service for which they claim payment. Provider standards certification is a local waiver agency function, whereby not less than every four years - or more frequently if specified in the standards for a particular service - the agency must assess and ensure that each waiver service provider continues to meet all applicable waiver service standards, as

well as the general provider standards found in Sections 4.02 through 4.06 of this chapter.

Local waiver agencies must document that they have completed these certification reviews showing that the provider meets standards required by the waiver as well as any other applicable federal, state and local standards that apply. This may require evidence of or the presence of a license or certification, as applicable. Waiver agencies must also document that providers have been monitored within the required time frames for the specific service and conduct periodic reviews to determine that they meet any applicable screening requirements (Section 4.05)

If a deficiency is discovered by the county waiver agency during a review of the provider against standards for the waiver service as provided in this section, the county waiver agency may condition the provider's continued participation in the waiver on the completion of corrective actions that will bring the provider into full compliance with the standards for the service.

B. Provider Agreements

To meet federal requirements, the Medicaid waiver programs now require providers to have an agreement directly with the State Medicaid Agency (DHS). The role of the local waiver agency is to ensure all service providers complete this agreement. This agreement, along with this Manual, contains or references all requirements providers must address to qualify them for participation. No additional requirements, conditions or specifications may be added or imposed by the local waiver agency.

The Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation (the [F-00180](#) form) must be completed by all waiver service providers. While county agencies are responsible for notifying local providers of the requirement, it is the provider's obligation to ensure signed, completed agreements are submitted to the Department. Upon full implementation of the requirement in 2010, payment for waiver services will not be available to any service provider that has not completed and submitted the agreement document. (See also the DLTC numbered memo at [DLTC N Memo2009_12.](#))

Unless terminated sooner, the provider agreements will remain in force for one year. At that point, in the absence of a notice of termination by either party, the agreement shall automatically be renewed and extended for a period of one year. Automatic annual extensions may not continue for more than four years or extend the agreement beyond the due date of the next provider standards certification. DHS will monitor compliance with this requirement in the ongoing waiver quality management systems for all waiver programs and in the State Single Audit process.

Three program provider agreement forms have been developed, each designed for a specific provider type:

- The F-00180 is for Medicaid waiver service provider entities. *Entities* here means Medicaid-certified providers (pharmacies, clinics therapists, etc.) or Medicaid waiver service providers including, but not limited to, substitute care providers, adult day care providers, supportive home care providers, transportation providers and other entities or agencies that have been specifically identified as covered service providers in this Manual.
- The F-00180A is for providers who are individuals, unaffiliated with an agency or service entity. It is also to be used for a company or organization that provides waiver funded services but who are not typically Medicaid program providers and who may not be specifically listed in the Medicaid Waivers Manual. Examples include carpenters and other skilled trades providing home modifications or those doing specialty work like vehicle modifications.
- The F-00180B is used for provider agencies or individuals who are employed by the waiver participant under a self-directed supports plan and paid via a fiscal agent.

The provider agreement forms are available from the DHS Forms Library at: [forms/F0/f00180.doc](#), [forms/F0/f00180a.doc](#) or [forms/F0/f00180b.doc](#).

C. State Medicaid Agency Authority

Except as provided in Section D below, local waiver agencies **may not** execute additional or supplemental agreements that impose any additional policies, conditions or requirements on waiver service providers beyond those established by the State Medicaid Agency (DHS). The State Medicaid Agency is solely responsible for waiver service provider agreement content, policies and requirements.

D. Local Agency Authority

Local waiver agencies may enter into a purchase of service (POS) contract with providers that conforms to s. 46.036 Wis. stats., as long as that contract does not impose any additional local policies or requirements. Any POS contract used must be approved by the department and is limited to projected fiscal and claiming information including details that cover estimated total claims for all participants expected to be served, rates for covered services and projected units of service. These terms must be considered estimates of anticipated claims and be based on current and projected participant utilization. (See also the DLTC Numbered Memo 2009-10 at [DLTC N -Memo2009-10](#).)

4.03 Ensuring Access - Provider Choice

A. Supporting Participant Choice: Provider Registration

All Medicaid waiver participants must be given a choice of qualified service providers when the person first applies for waiver services and upon request, at any time while the participant is receiving waiver services. Waiver participants must be informed of their right to choose from any willing and qualified providers during any review of the individual service plan. Information provided to waiver applicants and participants must include a description of all qualified providers available for the waiver-covered services they are authorized to receive.

The Department supports the consumer's right to choose between qualified providers. To ensure this choice is available, the Department has developed a statewide Medicaid Waiver Provider Registry. All Medicaid waiver service providers are required to complete this **one-time** registration. The registration information will be compiled at the DHS Central Office and made available to county waiver agencies and to waiver participants and their guardians. Registration is accomplished in one of the following ways:

1. **Providers currently serving waiver participants:**

These providers must have a completed Medicaid Waiver Provider Agreement on file (See [Appendix P](#) and see also [DLTC N Memo2009 12](#). Current service providers are expected to register on the Department's provider registry. The registry is located on line at [Medicaid Waivers Provider Registry](#). Registration information entered will consist of contact information; a designation of specific waiver program(s) for which the provider is an approved, qualified provider; the target group or groups they currently serve; the waiver agency with which they are currently involved and a brief program statement describing their services.

- Registration may be completed by the provider or by the waiver agency that utilizes the provider.

2. **Prospective providers not currently serving waiver participant(s):**

For agencies or individuals who are interested in becoming waiver service providers, the registry provides a means to inform participants of their availability. Prospective, willing providers may register on the DHS on line registry at [Medicaid Waivers Provider Registry](#). Registration information to be entered includes contact information; a designation of the target group or groups they wish to serve; the region of the state, by county, where they are available to serve and a brief program statement describing their services.

Note: Local agencies will need to assure that providers not currently serving a participant meet the appropriate standards for the service(s) they offer, prior to utilization.

Important: Placement on the provider registry described above does not establish provider qualification. Nor does any such placement obligate the state or the local agency to provide services that are not needed by an individual participant or to provide any service that is not program or statutorily allowable.

B. Local Agency Responsibilities

Local waiver agencies have the obligation to assist, facilitate and support participant and guardian choice through continuous provider registration and development practices. The standards established by state and Medicaid waiver regulations must be met by all providers before the provider may begin waiver service provision. Local waiver agencies **may not** supplement standards established by the Department pursuant to the approved waiver and detailed by standard program category in Section 4.10 of this Chapter. This does not bar the waiver agency from seeking excellence by employing quality improvement strategies as part of an organized quality improvement program.

To build a pool of service providers, waiver agencies may solicit requests for proposals (RFP) from all willing and qualified providers. Counties may not limit the pool of qualified providers by offering an exclusive agency contract to a provider even if that provider presents the lowest cost alternative. County agencies may establish a countywide rate or rate band that recognizes the complexity of care for a particular service, based on an actual bid or estimate they receive from a qualified provider. The rate must be specific to each of the services to be provided and consider the capacity of the lowest bid.

Other providers, including those selected by the participant, must be given the opportunity to meet the countywide rate or a higher rate if the capacity of low bid provider cannot meet demand or need. On an individual basis, base rates may be adjusted to address the specific assessed needs of specific program participants. Rates may be established for specific individuals when the individual presents with highly complex medical or behavioral needs requiring greater resources. Agencies may establish a higher threshold, such as an additional percentage above the countywide rate. Such a percentage must be uniformly applied to all providers seeking to provide the specific service. The wider threshold enhances choice of provider and allows additional provider participation in the waiver.

C. Program Access: The Provision of Translator Services

To meet federal waiver requirements and to improve program access, waiver agencies and all service providers must provide access to qualified interpreters for waiver

participants who have hearing or vision impairments or a language barrier. Translator services may take the form of qualified language translation provided in person and/or the provision of documents (e.g., statements of client/participant rights, service agreements, worker schedules, contact/emergency information, and the like) to program participants in Braille format or, to the extent possible, in the primary language of the participant.

If such assistance is needed, the agency may provide service under Communication Aids (SPC 112.47). Providers shall meet the applicable service standards specified in Section 4.10, pages 52 – 54 of this chapter.

4.04 Conflict of Interest

A. Conflict of Interest: Definition and Policy

The Medicaid Waivers will be operated in a manner, such that they are free of conflict of interest, to the greatest extent possible. Where conflicts cannot be eliminated, they must be identified and their impact must be minimized by the intervention of the waiver agency. Conflict of interest situations that must be addressed include both those that are present and those that may be perceived. Each waiver agency must have a written description of how the agency will identify, resolve or mitigate conflicts of interest. If resolving or mitigating the conflict is not feasible, the waiver agency must take action to minimize the effect(s) of the conflict. These efforts must be reported to the appropriate state waiver contact and are subject to approval. This conflict of interest policy applies to the county waiver agency and to any other entity involved in any aspect of operating the waivers.

A conflict of interest is present whenever a person or any other entity involved in operating any part of the waiver has an interest in or the potential to benefit from a particular decision, outcome or expenditure. A single individual, agency or entity occupying several roles often signals that conflict of interest may be present.

The conflict of interest situations covered by this section include:

1. The conflict of interest that exists when the person who completes the comprehensive assessment and/or individual service plan (Care Manager/ Support and Service Coordinator (CM/SSC)) for a waiver participant also provides other services for him/her. This includes situations when the CM/SSC is employed or otherwise represents the same agency that provides another service to the waiver participant.
2. The conflict of interest that exists if a guardian is **an employee** of the waiver agency or **an employee** of a provider entity that provides services to that

employee's ward and the guardian's employing agency or provider is at the same time funding or serving that guardian's ward. (This does not include guardians who are recruited and paid by county or provider agencies to serve as guardians and who may receive nominal compensation including cost reimbursements for serving in this role.)

3. The conflict of interest that exists when the same entity/individual is Care Manager/Support and Service Coordinator and also manages the participant's finances (e.g., the CM/SSC is the participant's representative payee.)
4. The conflict of interest that exists when the waiver agency, guardian or another entity that manages participant funds also makes any decision that results in the agency or entity receiving participant funds (e.g., cost share, room and board payment, etc.) This excludes nominal reimbursements made to an informal funds manager to reimburse him or her for expenditures when those expenditures were authorized by and made for the waiver participant.
5. The conflict of interest that exists when the same person/entity is the guardian or another legally established decision-maker and at the same time is a compensated waiver service provider.
6. The conflict of interest that exists if an employee of a waiver agency is an alleged perpetrator of abuse, neglect or any other act defined as a reportable incident in Appendix S or defined in statute or regulation as a violation of rights and his/her employing agency is, by rule or statute, responsible to investigate.

B. Waiver Agency Conflict of Interest Policy

The waiver agency must have a written policy describing how the agency will identify, and resolve or mitigate conflicts of interest. The policy must identify all the waiver entities covered; must apply to all waiver programs administered; address each of the conflict of interest situations described in Section A above and is subject to Department approval. The policy must address the following areas:

1. Waiver agency efforts to identify and avoid real or perceived conflict of interest;
2. Waiver agency efforts to resolve any identified conflict of interest;
3. When resolving or avoiding the conflict of interest is not feasible, waiver agency efforts to minimize the effect of the conflict of interest;
4. Waiver agency efforts to ensure that assessment of participant needs occurs in a conflict free environment;
5. Waiver agency efforts to ensure participants are informed of identified conflicts of interest and involved in the effort to resolve them;

6. Waiver agency efforts to ensure that all providers are informed of and operate under conflict of interest policies;
7. Waiver agency internal, programmatic efforts to create a high degree of organizational separation and autonomy in decision-making among the guardian, CM/SSC and other service providers;
8. Waiver agency efforts to secure more than one qualified provider for any allowable service in order to reduce the potential conflict of interest inherent in a lack of available choice.
9. The waiver agency plan to address the conflict that may be present when there is an allegation involving waiver agency staff or an agency-affiliated entity alleging:
 - A violation of participant rights;
 - A violation of statutory protections from abuse/neglect or unreasonable restraint; or,
 - A reportable incident has occurred.

In situations where this is the case, the agency plan must address how any investigation or inquiry will be conducted to avoid the inherent conflict of interest.

Waiver agencies should proceed as directed in DLTC Memo 2008-01 ([DLTC 2008-01](#)) when the allegation concerns persons covered under elder at risk (s. 46.90) or adult at risk s. 55.043 statutes. Where the allegations concern a *reportable incident* the response should proceed as directed in Chapter IX and [Appendix S](#) of this manual.

C. Conflict of Interest Policy Review

The county policy addressing conflict of interest shall be submitted to the Regional Human Service Area Coordinator (HSAC) who coordinates the review and approval process with State Medicaid Agency staff from each waiver program, including CLTS, Brain Injury and CIP 1A/1B, and CIP II/COP-Waiver.

For the COR waiver, county or tribal agencies must submit their conflict of interest policy to the Division of Mental Health and Substance Abuse Services (DMHSAS) Bureau of Prevention, Treatment and Recovery (BPTR) central office for approval.

4.05 Provider Screening Requirements:

The requirement for the completion of caregiver and criminal background checks applies to all service providers, paid or unpaid, who provide services listed on the

Individual Service Plan **and** who meet the definition of a caregiver. For CIP 1A/1B and BIW programs, this includes county employees who are service providers and who meet the definition of a caregiver described in Section C below.

Service providers funded by Medicaid Waivers may not employ, contract with, or accept volunteer services from individuals convicted of child abuse, neglect, or maltreatment; a violation of the Vulnerable Adult Law (s. 940.285 and s. 940.295 WI Stats.); or a felony involving physical harm to any MA Waiver program participant or other health or human service program participant. Agencies shall ensure that applicants for employment by the provider or persons currently employed by the provider do not have histories indicating violations of these laws.

When the caregiver is a minor, the waiver agency should be aware that the adult criminal background check result will only reveal an offense where the minor has been remanded to adult court. Therefore, when the prospective care giver is a minor, the waiver agency must secure the minor's consent for disclosure of that minor's juvenile record so that a review of the minor's criminal record and background can be satisfactorily completed.

A. Informal (unpaid) support providers may be exempted from the background check requirement under the following conditions:

1. The participant requests such an exemption; and
2. The waiver agency determines that the health and safety of the participant will not be compromised if the background check is not completed; and
3. The waiver agency assures that participant health and safety will be monitored in another manner; and
4. The waiver agency documents in the participant record that all of the above conditions have been met.

The waiver agency may use its discretion and decide not to grant an exemption request when the agency determines a background check is appropriate.

B. The caregiver background checks required for waiver service providers must include the following:

1. A criminal history search from the records of the Wisconsin Department of Justice (when the subject recently resided in a different state, the search must also include that state) **and**,
2. A search of the Caregiver Registry maintained by the Wisconsin Department of Health Services, **and**
3. A search of the status of credentials and licensing from the records of the applicable licensing/regulation entity (if applicable).

C. Caregiver Definition

Caregivers are defined as those persons who have *regular, direct contact with waiver participants*. “Regular” means *contact that is scheduled, planned, expected or otherwise periodic*. “Direct” means *face-to-face physical proximity to a participant that affords the opportunity to commit abuse or neglect or to misappropriate participant property*.

Examples of service providers who meet the definition of a caregiver include supportive home care workers, respite providers, substitute care providers and staff, personal care workers and attendants. Generally, supportive home care workers who provide outside chores like lawn mowing and snow removal do not meet the definition of a caregiver.

D. County Agency Responsibility

County waiver agencies must ensure that unless they are exempted, all persons working as caregivers, including those who are employed by contract agencies, have had the background checks completed. The background check process is initiated when the prospective caregiver submits a completed Background Information Disclosure form (The [F- 82064](#) form, available from the DHS forms library) to the employing agency. The agency retains the [F- 82064](#) form and submits a Criminal History Record Request form (DJ-LE-250 or 250A available at [djle250.pdf](#)) to the Department of Justice, Crime Information Bureau. The requesting agency must check the Caregiver box on the DJ-LE-250 or 250A to receive a complete criminal background check report. The Department of Justice will send written results of the record search to the requesting agency. The required checks must be repeated every four years. County agencies may adopt caregiver policies that are more restrictive than those described in this section.

E. Background Check Results

Waiver agencies may not use COP or Medicaid waiver funds to pay for services provided by persons whose background check identifies an offense described as a *serious crime* in s. 50.065 (1) (e) of Wisconsin Statutes. COP or waiver funds may not be used to pay for services provided by persons whose background check reveals a conviction for an offense that is deemed to be “*substantially related*” to the care or service to be provided (See DHS 12.06 for guidance to determine if an offense is substantially related to the care or service to be provided).

Waiver agencies may not use COP or Medicaid waiver funds to pay for services provided by persons who have been denied a professional license, certification or registration by the Department of Regulation and Licensing. In addition, services may not be provided by persons whose credentials have been suspended or

revoked, or who have been denied the renewal of their professional license, registration or certification.

Disclosure: Under 2007 Wisconsin Act 172 and effective November 1, 2008, certain covered entities must disclose in writing to participants and/or their guardians all information obtained regarding background check results revealing conviction of a crime listed in DHS 12.115 and, if the caregiver has received rehabilitation approval, notice of that fact. (See s. 50.065 (1) (c) and s. 50.65 (2m) (a).)

By statute (s. 50.065 (1) (cr)), these entities include a hospital, a licensed home health agency and a temporary employment agency that provides caregivers to another entity. The statute does not name personal care agencies as a covered entity. However, waiver agencies should consider that *any caregiver* providing a waiver service may be subject to the disclosure requirements. Agencies seeking clarification of the disclosure requirements should consult with the county Corporation Counsel.

F. Caregivers Employed by the Participant

Unless exempted, caregivers that are employed by a waiver participant through a fiscal agent system or under a self directed services plan must have background checks completed. COP or waiver funds may not be used to pay for caregiver services provided by a person who has a background check that revealed a conviction for a serious crime (described in s. 50.065 (1) (e) or an offense identified that is deemed to be “*substantially related*” to the care or service to be provided.

If the prospective caregiver’s background check reveals no record of conviction of a *serious* or *substantially related* crime, **and** the participant is fully informed of **any** negative finding **and** the participant continues to express a preference to employ the caregiver, the agency should respect the participant’s choice, unless there is compelling justification not to do so.

G. Review/Reconsideration

Waiver agencies must implement a policy that allows prospective caregivers denied employment due to a negative background check finding the opportunity to request a review and reconsideration of the agency action. The process shall establish clear standards the individual must meet for a decision to be reversed. Such standards must be uniformly applied in the reconsideration of the agency decision. The agency review/reconsideration process should mirror the process outlined in DHS 12.12 (See [dhs012.pdf](#).)

Any prospective caregiver who was denied employment due to a negative background check finding and who successfully completes the local review/reconsideration process may become a qualified provider. If the provider meets all other applicable standards services provided by these persons may be funded by COP and or the Medicaid Waivers.

H. Background Check Costs

Waiver services provider agencies are responsible for the costs of the required background checks for their employees. The costs of the background checks for caregivers employed through a fiscal agent system or employed directly by the county may not be charged to the participant.

4.06 Medicaid Waivers: General Limitations

A. Limitations on Payments to Guardians, Spouses or Parents of Minor Children

Generally, the Medicaid Waivers cannot reimburse guardians, spouses of waiver participants or the parents of minor children who are waiver participants for providing any service. However, county waiver agencies may choose to reimburse those persons for services provided to waiver participants using other funding sources.

Important: Waiver agencies **may not** adopt local policies barring the use of otherwise allowable family members as providers. Parents of adult children who are participants; adult siblings of participants; and adult children of participants may provide waiver services if they are qualified.

For CIP 1A/1B and BIW programs only, for the provision of extraordinary care, family members and legally responsible relatives may be permitted to be chosen as service providers. To qualify, the family member must meet all of the requirements of any provider of the specific service, be registered on the department's web site, have an executed provider agreement and address conflict of interest as outlined in Section 4.04 of this chapter.

B. Requirement to Use Medicaid State Plan Services

With the exception of care management/support and service coordination, the participant service plan must utilize services covered by the Medicaid State plan (Medicaid card services) to the fullest possible extent before using waiver funds for any service that is waiver allowable. For example, if a participant requires 40 hours of personal care per month and Medicaid state plan representatives

authorize 30 hours per month, then the remaining ten hours may be paid with waiver funds.

For children, expanded Medicaid state plan services are available under EPSDT/Healthcheck. These services and supplies must be accessed prior to the provision of these services under the Medicaid waivers. Details related to Healthcheck policies are found at recpubs/healthcheck.htm.

C. Medicaid Denials

For services or items covered by the Medicaid state plan, a Medicaid denial is required before waiver funds may be used. Acceptable documentation of a Medicaid denial may include:

- A copy of the denial letter or a case note indicating the CM/SSC had reviewed a copy of the Medicaid denial; or,
- A case note indicating the CM/SSC had reviewed the Medicaid durable medical equipment, medical supply or other Medicaid covered service listing and found the item or service listed as “not covered.”

Note: A vendor refusal to bill Medicaid or a refusal to accept Medicaid reimbursement is not a Medicaid denial.

D. No Payments to Participants

Under no circumstances may payments be made directly to a Medicaid Waiver participant or to another person on behalf of the participant. All payments for Medicaid waiver covered services must be made directly to the provider of service.

E. No Payments for Services in a Hospital, Nursing Home, ICF-MR/FDD

No payment from waiver funds may be made for services delivered in a hospital, nursing home, ICF-MR or FDD, with two exceptions. The exceptions are institutional respite and adult day care provided in a nursing home, as described in this Chapter, Section 4.10. A person-specific variance approved by the Department is required in order to fund institutional respite in a nursing home or in any other allowable institutional setting.

F. Billing Care Management /Support and Service Coordination

Care management/support and service coordination services must be billed to the waiver program and may not be billed to the participant’s Medicaid card. The exceptions to this requirement are those participants who are also served by a Medicaid certified Community Support Program (CSP) or Comprehensive

Community Services Program (CCS). For these participants, care management/support and service coordination is billed to the CSP or to the CCS Program.

G. Non - Supplanting of Services Under the Individuals with Disabilities Education Act (IDEA)

Educational and educationally related services under IDEA, to which children from birth through 21 years of age are entitled, may not be supplanted by Medicaid waiver services.

4.07 Participant Contributions

Contributions by participants are sometimes viewed as ways to help ensure participants continue to be eligible for services. Federal and state laws prohibit charging participants for waiver or other Medicaid services or receiving recipient funds to pay for covered services. Beyond the payments for cost sharing or those required for co-payments, accepting such contributions, may be viewed as violating these laws.

In circumstances where a participant's eligibility may be in jeopardy due to the accumulation of excess assets, those funds may be used to purchase certain items needed by the participant or for the benefit of the participant. These assets may also be used to pre-purchase funeral/burial services or to make a pre-payment toward the participant's Estate Recovery obligation. Any such decision must be carefully considered and done in the best interests of the participant. Care managers/support and service coordinators addressing such questions are advised to consult with the local Income Maintenance agency.

In some cases, the participant may want to make a contribution to the program. Agencies are reminded that accepting contributions for Medicaid "card" or waiver services may constitute illegal Medicaid supplementation, which may be subject to criminal charges to the county staff or other individual or entity that accepts those funds. This applies to contributions for any waiver coverable service that is included in an individual's ISP and for which the individual has not been placed on a wait list. In order for a provider or waiver agency to be able to accept a contribution made by or on behalf of a participant, the provider or agency must be able to show that the contribution was not made in exchange for or otherwise in connection with obtaining a waiver or "card" coverable service. Local agency staff should consult with the county's corporation counsel before accepting any contribution made by or on behalf of a participant.

4.08 Reserved for Future Use

4.09 Allowable Services Index: CIP 1A, CIP 1B, BIW, CIP II, COP-W, CLTS and COR						
HSRS SPC CODE	SERVICE NAME	CIP 1A/1B & BIW	COP-W & CIP II	CLTS	COR	PAGE NUMBER
112.57 112.99	Adaptive Aids-Vehicle Related Adaptive Aids- Other	Yes	Yes	Yes	Yes	20
102	Adult Day Care	Yes	Yes	No	No	23
202.01	Adult Family Home 1-2 bed	Yes	Yes	Yes	Yes	26
202.02	Adult Family Home 3-4 bed	Yes	Yes	Yes	Yes	28
605.01	Benefit Counseling	No	No	No	Yes	31
604	Care Management/Support and Service Coordination (Formerly Case Management)	Yes	Yes	Yes	Yes	33
203	Children's Foster Care/ Treatment Foster Care – Developmental Disabilities	Yes	Yes	Yes	No	42
203	Children's Foster Care/ Treatment Foster Care - Mental Health	Yes	No	Yes	No	46
203	Children's Foster Care/ Treatment Foster Care – Physical Disabilities	Yes	No	Yes	No	49
112.47	Communication Aids	Yes	Yes	Yes	Yes	52
506.61	Community Based Residential Facility	Yes	Yes	No	Yes	55
609.10	Consumer Directed Supports	Yes	No	No	Yes	59

HSRS SPC CODE	SERVICE NAME	CIP 1A/1B & BIW	COP-W & CIP II	CLTS	COR	PAGE NUMBER
609.20	Consumer and Family Directed Supports	No	No	Yes	Yes	62
609.20 .30	Consumer Directed Supports (COR – Only)	No	No	No	Yes	66
113	Consumer Education and Training	Yes	No	Yes	No	69
507.03	Counseling and Therapeutic Services	Yes	Yes	Yes	Yes	71
110	Daily Living Skills Training	Yes	Yes	Yes	Yes	74
706 706.10	Day Services-Adults	Yes	Yes	No	Yes	77
706.20	Day Services-Children (Developmental Disabilities)	Yes	No	Yes	No	80
706.20	Day Services-Children (Mental Health)	No	No	Yes	No	84
706.20	Day Services-Children (Physical Disabilities)	No	No	Yes	No	88
619	Financial Management/Fiscal Intermediary Services	Yes	Yes	Yes	Yes	92
402	Home-Delivered Meals	Yes	Yes	No	Yes	95
112.56	Home Modifications	Yes	Yes	Yes	Yes	97

HSRS SPC CODE	SERVICE NAME	CIP 1A/1B & BIW	COP-W & CIP II	CLTS	COR	PAGE NUMBER
610	Housing Counseling	Yes	No	Yes	Yes	101
106.03	Housing Start Up	Yes	No	Yes	Yes	103
512	Intensive In-Home Treatment Services	No	No	Yes	No	105
103.01	Natural Supports Training	No	No	No	Yes	113
710	Nursing Services	Yes	Yes	Yes	Yes	115
403.04	Peer/Advocates Supports	No	No	No	Yes	118
112.46	Personal Emergency Response System	Yes	Yes	Yes	Yes	121
108	Pre-vocational Services	Yes	No	No	No	123
106.01 106.03	Relocation Related-Housing Start Up Relocation Related-Utilities	No	Yes	No	Yes	128
711	Residential Care Apartment Complex	No	Yes	No	Yes	131
103 .22 .24 .26 .99	Respite Care Residential Institutional Home-based Other Setting	Yes	Yes	Yes	Yes	134
104.30	Short Term Supervision & Observation	No	No	No	Yes	141

HSRS SPC CODE	SERVICE NAME	CIP 1A/1B & BIW	COP -W & CIP II	CLTS	COR	PAGE NUMBER
112.55	Specialized Medical and Therapeutic Supplies	Yes	Yes	Yes	Yes	144
107 .30 .40 .50	Specialized Transportation One way trips Miles Items	Yes	Yes	Yes	Yes	147
604	Support & Service Coordination/ Care Management (Formerly called case management)	Yes	Yes	Yes	Yes	151
615	Supported Employment	Yes	No	Yes	No	152
104 .10 .20	Supportive Home Care Days Hours	Yes	Yes	Yes	Yes	158
114	Vocational Futures Planning	No	Yes	No	No	162
114.01	Vocational Recovery	No	No	No	Yes	165

4.10 Medicaid Waivers – Allowable Services

The following pages contain descriptions of the allowable services available under the various Medicaid waivers. The descriptions of allowable services include the following categories: Service Definition, Requirements/Limitations/Exclusions, Standards and Documentation. See the note in the heading above each service definition listing which waivers allow the particular service.

Please note that some services are offered by more than one program, but they are **titled differently** (e.g., “Housing Start Up” vs. “Relocation Related Housing Start Up.”) These differences occurred because in some cases the approved federal waivers used different names for the same service. Waiver staff should be aware of these differences as they explore service possibilities for their individual waiver populations.

ADAPTIVE AIDS

SPC 112.57 Adaptive Aids – Vehicles

SPC 112.99 Adaptive Aids – Other

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Adaptive aids are devices, controls or appliances that enable persons to improve or maintain their abilities to perform activities of daily living, participate in typical home and community activities, control their environment and prevent institutionalization. Adaptive aids facilitate independence and may decrease the need for attendant care and reduce the risk of institutionalization. Allowable adaptive aids are items or devices that meet the objectives described in this definition. The list below contains examples of the items or services that may be allowable. The list is instructive and not intended to be an all-inclusive description of allowable items, devices or services. To effectively respond to new technology, items or devices that are not specifically described below may be allowed when it is demonstrated that the item or device will accomplish the purpose and objective of this service and meet an assessed need.

- Van/vehicle lifts, lift/transfer units (manual, hydraulic or electronic), standing boards/frames
- Wheel chairs, walkers and other assistive mobility devices
- Control switches, pneumatic devices, including sip and puff controls
- Portable ramps, over the bed tables, hygiene/meal preparation aids
- Environmental control units, electronic control panels, adaptive security systems, door handles and locks
- Prosthetic devices
- Computer and necessary software

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Includes the cost of installation, maintenance and repair of allowable adaptive aids and equipment.
2. Includes the purchase of adaptive aids that have been denied funding through the Medicaid state plan as well as items or devices in excess of the quantity approved under the Medicaid state plan.

3. The purchase of items/devices costing in excess of \$2,000 requires documentation from a rehabilitation organization, physical therapist, occupational therapist, physician, or other professional with comparable training or experience that the item/device is appropriate for the participant.
4. Includes the cost of testing and/or evaluation to determine the appropriateness of the adaptive aid.
5. Excludes the use of waiver funds for the payment of recurring costs for the same adaptive aid unless it is determined that the item/device has exhausted its useful life or has been rendered unsafe or unusable due to damage or defect.
6. Excludes the purchase of vehicles and any payment for the cost of general repairs or maintenance (e.g. engine, transmission, suspension, etc.) to adapted vehicles that are not directly related to the function of the vehicle adaptation.
7. The decision to use waiver funds for the purchase or rental of the adaptive equipment must be based on the agency's determination of the cost effectiveness of the chosen option.

STANDARDS

Adaptive aids purchased for waiver participants shall meet all the applicable laws, regulations and standards for manufacture and design for item safety and utility. Best practice suggests that to ensure participant safety, the installation or repair of adaptive aids should be completed by professional installers who can provide documentation of their training and experience.

DOCUMENTATION

1. For items costing in excess of \$2,000, there must be documentation in the participant file from a rehabilitation organization, physical/occupational therapist, physician or other professional with comparable training and experience indicating that the purchase is appropriate to the needs of the participant.
2. The participant file must contain documentation that the adaptive aid has been denied by, or cannot be obtained through the Medicaid state plan.
3. For computers purchased with waiver funds, the participant file shall list the adaptive purpose of the computer as well as other assessed service needs that the unit will meet (e.g., lighting, temperature control, etc.).

4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation (F-00180 or F-00180A or F-00180B) form on file with the State Medicaid Agency.

ADULT DAY CARE

SPC 102

Applies to CIP 1A/1B, BIW, CIP II, COP-W

DEFINITION

Adult day care service is the provision of services for part of the day in a state-certified group setting to adults who need an enriched social or health-supportive environment. Adult day care services may also serve adults who may need protection or who need assistance with activities of daily living and leisure time needs. Adult day care provides participants the opportunity to interact and to share a social experience with peers in a safe, supervised environment. Services provided may include personal care, assistance with monitoring medication and managing medical conditions. Adult day care also includes assistance with restorative needs, prescribed therapies, health maintenance activities, as well as social and emotional support. Nutrition and meals may be provided, as long as the meals provided do not meet a participant's full daily nutritional regimen. The cost of transporting participants to and from the site may be included as a part of the service cost when it is a service provided by the Day Care provider.

Adult day care is categorized as follows:

- a. Adult Day Care Center: Care which is provided for part of the day (i.e., less than twenty-four hours) in a group setting for adults.
- b. Family Adult Day Care: Care, which is provided for part of the day for small groups of no more than six adults in the home of the provider.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Waiver funding is not available for Adult Day Care provided in a nursing home or on the grounds of a nursing home unless a variance is granted by the Department. The request for the variance must be submitted in writing together with the participant's ISP to the appropriate waiver quality assurance entity. Any approved variance is both person and provider specific. The request shall contain the following information:
 - a. A description of the participants' assessed need for the service;
 - b. A description of why other waiver allowable resources are not available to meet the need; and
 - c. Written assurance of the CM/SSC that the provider has a current certification from the Bureau of Quality Assurance.

2. All providers of Adult Day Care services to CIP 1A, CIP 1B and BIW participants must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.
3. Providers of adult day care services to COP-W/CIP II participants must promptly communicate with the CM/SSC and/or the county agency adult protective services unit regarding any incidents or situations or conditions that have endangered or, if not addressed, may endanger the health or safety of the participant.
4. Adult day care operators and employees are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions described in Chapter IV, Section 4.05.
5. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

Adult Day Care must be provided in a state certified facility. Providers of services are governed by the certification standards for Adult Day Care issued by the Department of Health Services, Division of Long Term Care. The Standards may be obtained by contacting the DHS Division of Quality Assurance.

DOCUMENTATION

1. Adult Day Care service providers must have documentation of current state certification.
2. The provider must maintain participant specific attendance records to verify the units of service billed to the Medicaid waiver program.
3. Adult day care providers must complete and maintain a written individual care plan for each participant. The plan must be updated as services change and in no case shall it be reviewed and/or updated less than semi-annually.
4. Documentation of current criminal and caregiver background checks must be maintained in the participant or provider file for all persons providing adult day care services.

5. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

ADULT FAMILY HOME 1-2 Beds

SPC 202.01

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

An adult family home is a residence where one or two adults and in which care, treatment, support or service above the level of room and board is provided. The residence is the Adult Family Home operator(s) primary residence.

Adult family home also includes “community care home.” A community care home is a residence where one or two adults reside and in which care, treatment, support or service above the level of room and board is provided. In the community care home the operator owns, rents, or leases the residence and employs staff who provides the care, treatment, support or service. The community care home is not the provider’s primary residence.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Only the costs directly associated with participant care, support and supervision in the adult family home may be billed under this service. No costs associated with room and board of the residents may be billed to the waiver program.
2. The operator of the home, all adult household members and all care providers are subject to required certification standards and also the criminal background checks and hiring prohibitions described in Chapter IV, Section 4.05.
3. All providers of adult family home services to CIP 1A, CIP 1B, BIW and CLTS participants must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.
4. Providers of adult family home services to COP-W, CIP II and COR participants must promptly communicate with the care manager and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered or if they are not addressed, may endanger the health and safety of the participant.
5. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incident reports. If there is immediate risk

to the health, safety and welfare participant, the county must take all reasonable steps to protect the person.

STANDARDS

All 1–2 bed adult family homes shall be certified pursuant to standards established by the Department. Adult Family Home standards are described in the publication Medicaid Waiver Standards for Adult Family Homes, distributed via DDES Memo Series 2005-13. Also see Appendix J of this manual.

DOCUMENTATION

1. The Adult Family Home provider must have documentation that their license/certification is current.
2. The provider must maintain current documentation that caregiver criminal background checks have been completed for all applicable persons working or residing at the facility.
3. The provider must maintain a training record which documents completed training requirements.
4. The provider must maintain and regularly update an Adult Family Home Service Plan for each waiver participant living in the home.
5. The provider must develop a written service agreement for each waiver participant in the home.
6. Documentation that clearly describes the individual room and board **and** care and supervision costs in the facility must be maintained in the participant record located at the waiver agency.
7. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
8. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

ADULT FAMILY HOME 3 - 4 Bed

SPC 202.02

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

An adult family home is a residence where three or four adults who are not related to the licensee live, in which care, treatment; support or service above the level of room and board is provided. The residence is the Adult Family Home operator(s) primary residence.

Adult family home also includes “community care home.” A community care home is a residence where three or four adults who are not related to the licensee live and in which care, treatment, support or service above the level of room and board is provided. In the community care home, the operator owns, rents, or leases the residence and employs staff who provides the care, treatment, support or service. The community care home is not the provider’s primary residence.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Only those costs directly associated with the participant care, treatment, or support may be billed under this service. No costs associated with room and board in the facility may be billed to the waiver program.
2. The operator of the home, all other adults who reside and/or are employed in the home are subject to the required criminal caregiver and licensing background checks and hiring prohibitions described in Chapter IV, Section 4.05 of this manual.
3. Providers of adult family home services to CIP 1A, CIP 1B, BIW and CLTS participants must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.
4. Providers of adult family home services to COP-W, CIP II or COR participants must promptly communicate with the care manager and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered or, if not addressed, may endanger the health or safety of the participant.
5. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must

conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.

STANDARDS

The Department of Health Services, Division of Quality Assurance or another approved licensing agency must license adult family homes for three or four persons. DHS 88 contains the regulations and standards governing this waiver service. The Standards may be obtained by contacting the DHS Division of Quality Assurance.

DOCUMENTATION

1. The Adult Family Home provider must maintain documentation that their license/certification is current.
2. The provider must maintain current documentation that caregiver criminal background checks have been completed for all applicable persons working or residing at the facility.
3. The provider must maintain a training record which documents completed training requirements.
4. The provider must maintain and regularly update an Adult Family Home Service Plan for each waiver participant living in the home.
5. The provider must develop a written service agreement for each waiver participant in the home.
6. Documentation that clearly describes the individual room and board **and** care and supervision costs in the facility must be maintained in the participant record located at the waiver agency.
7. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
8. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State

COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

BENEFIT COUNSELING

SPC 605.01

Applies to COR

DEFINITION

Benefit Counseling includes the provision of services by persons whose principal responsibilities are to ensure rights, provide information on a comprehensive array of private and government benefits and programs, assess the impact of employment on eligibility and ensure that needed benefits are either maintained at current levels or accessible to the consumer by other means. The benefit counselor may assist in applying for needed health or social services, and public or private benefits; assist in the use of appropriate grievance procedures; provide representation for clients at hearings; provide information regarding administrative hearings, and provide information and counseling regarding legal rights and responsibilities.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Includes education and training for participants, their caregivers and/or guardians that is directly related to acquiring private and government benefit and program services.
2. Local agencies will assure that information about Benefit Counseling opportunities is made available to participants and their caregivers and legal representatives.

STANDARDS

1. Providers of Benefit Counseling services must have skills and knowledge that would be typically acquired through a course of study leading to a degree in one of the behavioral sciences and/or training and experience in the specific area of counseling is being offered.
2. Providers of Benefit Counseling services must have skills and knowledge needed to carry out responsibilities assigned to them in a manner that meets the needs and preferences of the consumer as specified in the person-centered individual service plan and in a manner that ensures protection of the individual's health and safety and observance of their rights.
3. A provider will receive training in Recovery and Person-centered Planning within six months of working in the area. Training modules must be approved by the Division of Mental Health and Substance Abuse Services.

4. Providers are subject to the required caregiver, criminal and licensing background checks.

DOCUMENTATION

1. Components of the Benefit Counseling services designed to successfully maintain the individual in the community will be documented as necessary in the individual service plan.
2. The county waiver agency shall document how the services enable the consumer to lead an inclusive community life, build a viable network of support, and result in outcomes specified by the consumer or his/her legal guardian.
3. The county waiver agency shall document that all caregiver and criminal background checks have been completed.
4. The provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

**CARE MANAGEMENT/
SUPPORT AND SERVICE COORDINATION**

(Also known as Case Management)

SPC 604

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Care management/support and service coordination is the provision of service to locate, manage, coordinate and monitor all waiver program services, additional services, (regardless of funding source) and informal community supports provided to eligible applicants/participants and to assure that services are provided in accordance with program requirements. This service is intended to insure the waiver program participant's health and safety by enabling the participant to receive a full range of appropriate services and supports consistent with his/her assessed needs in a planned, coordinated, efficient and cost effective manner. While these general guidelines apply to all care management/support and service coordination provided, the service activities may be target group or age-specific.

This service includes assistance with establishing financial, functional and all other aspects of Medicaid waiver eligibility. Service may also include assisting the participant to access waiver, Medicaid state plan, medical, social and natural supports and services. Beyond plan development and service coordination activities, the CM/SSC role includes the primary responsibility to assure participant health and safety.

When the participant is a child, this service includes providing or facilitating all services and supports, both formal and informal, needed by the child and family to meet identified outcomes. This includes locating, managing, coordinating and monitoring all services and educational assessments as well as informal supports needed by waiver participants and assuring that services are provided in accordance with program requirements and assessed support needs. This service also includes an assessment of family's needs so they may adequately support their minor child in the family home.

Support and Service Coordination may also be directed at connecting the child and family to natural supports. Support and Service Coordination facilitates establishing and maintaining the child and family's individualized support system. Services provided to children include assuring effective implementation of the child and family's support plan; developing, implementing, and updating the family-centered transition plan, and coordinating across systems with all necessary supports and services needed by the child.

Care management/support and service coordination provides a broad range of services that may include any of the following activities:

- a. Assistance to establish and maintain program functional and financial eligibility (includes initial assessment for CLTS, CIP 1A,1B, BIW),
- b. Establishment and reevaluation of level of care,
- c. Ongoing assessment and periodic reassessment of participant health, safety and functional capacity (See Chapter 6, Section 6.02 D, Assessment Content),
- d. Person-centered, family centered service planning and service plan development, service coordination and plan review,
- e. Contracting for services: establishing, contracting for and monitoring service systems specific to the participant's individual service plan,
- f. Reviewing or completing individual service/support plans at required intervals
- g. Identify participant outcomes, arrange services; coordinate and manage multiple service providers and between providers (e.g., schools, therapists, nurses, job coaches, personal care workers, volunteers, etc.) to meet individual outcomes,
- h. Ongoing evaluation of the effectiveness of services and service providers,
- i. Monitoring and review of participant progress toward meeting service or therapeutic goals and objectives and for CLTS outcomes in service plans,
- j. Compiling and maintaining required documentation,
- k. Quality assurance and follow along services to assure participant health and safety, including the use of outcome based methods as applicable (CLTS),
- l. Communicating orally and in writing with participants, appropriate family, guardians, service providers, county/state administration and interested members of the community,
- m. Providing advocacy, information and referral, crisis and critical incident intervention and resolution, protective and guardianship services,
- n. Assistance to participants to locate safe and appropriate housing including the determination of the efficacy of substitute care settings,
- o. Assistance to participants to access necessary medical care and treatment,
- p. Assistance to participants as appropriate, to pursue vocational and/or educational opportunities,
- q. Creation and development of effective provider networks,
- r. Supporting participant programmatic and developmental transitions including transition-planning processes (e.g., child-adult at age 14, employed-retired, etc.),
- s. Providing instruction to participants, families/advocates to independently obtain access to services and supports, regardless of funding source,
- t. Providing institutional discharge-related care management/support and service coordination services up to thirty days prior to discharge that do not duplicate discharge planning services that a hospital, ICF-MR or nursing home is expected to provide (Does not include discharge planning services prior to the initial period of waiver program eligibility.),

- u. Provide transitional care management/support and service coordination for children and adults relocating to the community from an institution beginning up to 90 days prior to discharge and completed on the date of relocation (Up to 180 days prior to discharge may be allowed with Bureau approval.),
- v. Complete specific tasks described in detail under HSRS SPC code 609.20 when the family has selected consumer and family directed services.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. The agency responsible for providing or purchasing Medicaid waiver services shall support the provision of services described above as the primary function of care managers/support and service coordinators.
2. The agency responsible for providing or purchasing Medicaid waiver services shall ensure care management/support and service coordination service is available to all participants served by the waiver program.
3. The waiver agency must ensure that only qualified care managers/support and services coordinators provide this service.
4. Excludes optional targeted case management under the Medicaid state plan.
5. Where care management/support and service coordination is **not** a provided service and/or when the participant's family chooses to coordinate services and supports, the waiver agency must document how the service plan will be managed, including a description of how participant health and safety will be assured.
6. The determination of the type and frequency of contacts with participants, care givers and providers must be based on the following variables as applicable:
 - a. The stability or frailty of the participant's health;
 - b. The ability of the participant to direct his/her own care;
 - c. The strength of in-home supports and the participant's informal support network;
 - d. The stability of in-home care staffing (frequency and reliability of staffing, turnover, availability of emergency back-up staff);
 - e. The stability of the participant's care plan (e.g., history of and/or anticipated frequency of change or adjustment to the plan);
 - f. The participant has lived in the community without a critical incident or an EA/APS referral for three years;
 - g. The participant's guardian is active, interested and involved and is not the waiver participant's service provider.

7. The minimum contact requirements regarding the provision of care management/ support and service coordination vary by waiver program. They include:
- a. Minimum Contact Requirements: Applies to CIP1A, 1B, BIW, CIP II, COP-W and COR.
- (1) Initial monitoring contacts within the first thirty days:

At a minimum, care managers/support and service coordinators must have direct contact (face to face or by telephone) with the participant **and** with a provider agency, caregiver or another person who is significant in the care plan within the first thirty days **after** the waiver program start date.
No exceptions are allowed.

Note: Initial monitoring occurs **after** the waiver start date and **does not** include the initial assessment or plan development contacts.

- (2) Required ongoing monitoring contacts, after the first thirty days include:
- (a) Direct participant or collateral contact is required **monthly**. Direct participant contact includes face to face, telephone or an e-mail/voice mail or written **exchange** with the participant.

Collateral contacts include written, telephone, fax, face to face or an e-mail/voice mail **exchange** with the participant's medical or social service provider, or other person(s) with knowledge of the participant's long term care needs.

"Exchange" is defined as a two-way transmittal of information directly related to the participant his/her service plan or to his/her medical/physical/emotional status. E-mail or voice mail contacts must demonstrate **a connection** is made between both parties wherein information is transferred by one party to the other who then generates a response or reply that is received by the party who initiated the contact. The contact shall result in the acquisition by the CM/SSC of information, data or meaningful insight about the participant's health, well being or overall status.

Note: Collateral contacts **do not** include the mailing or fax transmission or other exchange of documents required for certification or recertification.

- (b) Face to face participant contact is **required every three months**. Annually, at least one of these contacts shall be at the participant's home. To assure health and safety, more frequent contacts may be required.

- (c) **Every six months** the CM/SSC shall review the service plan during a face to face meeting with the participant. No exceptions are permitted.
 - (d) In the event the participant has been adjudicated incompetent, the six-month plan review may be conducted with his/her guardian. However, the CM/SSC must continue to make the required face to face contacts with the participant and must involve the participant in the plan development process, to the extent he or she is able to participate.
- (3) Each participant case record must contain documentation that the minimum contact requirements are met.
- b. Minimum Contact Requirements: CLTS Waivers only
- (1) Monthly collateral contact;
 - (2) Direct contact with the family every three months;
 - (3) Face-to-face contact at least every six months (with the waiver participant);
 - (4) Annually, at least one of the face-to-face contacts shall be at the child and family's place of residence; and
 - (5) More frequent contact may be required in response to individual needs identified in assessments or prior critical incidents to assure health and safety.
 - (6) Direct contact with the family includes written or electronic mail exchanges, telephone conversations, or face-to-face contact. A collateral contact includes written or electronic mail exchange, telephone conversation, or face to face contact with an individual's family member, medical or social services provider, or other person with knowledge of the individual's long-term support needs.

Applies to all waivers:

8. Exceptions to Required Contacts

- a. On occasion, an exception to provide less than the required minimum ongoing monitoring contacts may be made. An exception may be granted only on those occasions where the participant initiates the request and only in those circumstances where the participant resides in his/her own home or apartment.

No exceptions to the required contacts will be made to address agency workload issues. After the first six months of the participant's initial care plan an exception to provide fewer than the minimum ongoing monitoring contacts may be made. Such an exception may be made only after all the variables listed in number 6 a. through 6 g. above have been considered.

- b. Documentation in the participant file must include the following:
- (1) Evidence that the participant or his/her guardian **requested** a reduction in the frequency of contacts, including the date of the request and the participant/family's reason for making the request; and
 - (2) Evidence that the CM/SSC has agreed to the request and that the request has been approved by his/her supervisor; and
 - (3) A description of how participant health, safety and welfare will be assured in the absence of the required contacts; and
 - (4) A description of the contacts that will occur; and
 - (5) Case notes that explain how each of the variables listed in item 6 a. through 6 g above have been applied.

The CM/SSC must renew the contact exception **every twelve months**. The twelve-month exception renewal includes reconsideration of all of the variables listed in item 6 above and re-documentation of the four elements in item 8 above as well, including the signed supervisory approval of the exception. Documentation must also include the participant's signed agreement to the minimum contact exception every twelve months.

Important: The exception to the contact requirements applies only to contacts between the CM/SSC and the participant. Collateral contacts as required in item 7 above must continue for ongoing monitoring. An exception to the required contacts **may not** be made for the 6-month face-to-face plan review.

9. Care managers/support and service coordinators must communicate with designated state/ county staff about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual (for CIP 1A, CIP 1B, BIW and CLTS).
10. For participants not covered by critical incident reporting policies (COP-W, CIP II) care managers/support and service coordinators shall communicate promptly with the county agency adult protective services unit regarding any incidents or situations or conditions that have endangered or if not addressed, may endanger the health or safety of the participant.
11. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.

12. A participant's primary CM/SSC may report time devoted to securing guardians, completing related reports or attending court proceedings under this SPC.
13. In addition, the agency may bill the time of another CM/SSC whose primary responsibilities include guardianship-related services to SPC 604, provided that this worker meets the standards described below and provided that those services represent coordinated activity between all CM/SSCs involved. While this activity may be reported to SPC 604, it cannot be counted toward the required ongoing monitoring contacts.
14. Transitional care management/support and service coordination may be provided for children and adults relocating to the community from an institution beginning up to 90 days prior to discharge and completed on the date of relocation (up to 180 days prior to discharge may be allowed with Bureau approval). Transitional services may include associated tasks such as locating appropriate housing, completing lease/housing subsidy applications, assistance in processing changes in Social Security or Medicaid benefits, and meetings with families and potential formal and informal caregivers.
15. Care management/support and service coordination services that are provided to persons who participate in either a Medicaid-certified Community Support Program (CSP) or a Comprehensive Community Services Program (CCS) and a Medicaid waiver program may not be billed to the waiver program. In such circumstances the cost of this service must be billed to the CSP or to the CCS.

STANDARDS

1. A Care Manager/Support and Service Coordinator (CM/SSC) shall have the skills and knowledge typically acquired:
 - a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience with the target group, or
 - b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons of the specific target group for which they are employed, or
 - c. Through a minimum of four years experience as a long term support CM/SSC, or
 - d. Through an equivalent combination of training and experience that equals four years of long term support practice in long term support case management practice, or
 - e. The completion of a course of study leading to a degree as a registered nurse and one year of employment working with persons of the specific target group for which they are employed.

2. The CM/SSC shall be knowledgeable of the service delivery system, the needs of the target group with which s/he is working, and the availability of integrated services and resources or the need for such services and resources to be developed.
3. For BIW, CIP 1A, CIP 1B and CLTS, the CM/SSC must complete the appropriate approved “waiver basics” training course. Until training is received, the CM/SSC must work under the direct supervision of a qualified care manager/ support and service coordinator and/or supervisor.
4. Care managers/support and service coordinators must meet the initial and ongoing training requirements as described in Section 5.01 of the Community Options Program Guidelines.
5. Supervisors of care managers/support and service coordinators must meet the minimum qualifications specified in Section 5.01 of the Community Options Program Guidelines.
6. Providers of care management/support and service coordination are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions described in Chapter IV, Section 4.05 of this manual.
7. Waiver participants will have only one primary CM/SSC. However, in some circumstances more than one professional may provide care management/support and service coordinator functions, including protective services activities, as long as there is documentation identifying the primary CM/SSC and the participant clearly understands who the primary worker is.
8. For the COR waiver, the Care Manager services are expected to support those waiver services where the consumer chooses participant direction.

DOCUMENTATION

1. The county waiver agency or contract waiver agency must maintain documentation indicating the care management/support and service coordination staff meets required qualifications.
2. The participant record must reflect a frequency and intensity of contacts to support reported units of service and minimum contact requirements. Documentation/case notation of all contacts must reflect an allowable activity and indicate that the activity is related to the participant’s individual service plan.
3. Each participant record must contain documentation that the minimum contact requirements have been met. If an exception to the minimum contact requirements

has been granted documentation of the request and approval must be maintained in the participant record.

4. Where care management/support and service coordination is not provided by the waiver agency, the agency must provide documentation in the participant file describing how participant health and safety will be assured. Acceptable documentation includes case notation describing how and who will manage the provided services.
5. Documentation of current criminal, caregiver and licensing background checks of all care management/support and service coordination staff must be maintained by the waiver agency and be made available upon request.
6. A certificate of attendance indicating that the waiver basics course was successfully completed that is issued by the department must be maintained on file and available on request to verify that each support and service coordinator who serve waiver participants in BIW, CIP 1A, CIP 1B and CLTS, and for whom the waiver agency receives reimbursement is appropriately trained and qualified.
7. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.
8. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

CHILDREN'S FOSTER CARE/TREATMENT FOSTER CARE DEVELOPMENTAL DISABILITIES

SPC 203

Applies to CIP 1A/1B, BIW, CLTS

DEFINITION

A Children's Foster Home is a family oriented residence operated by a person licensed under S. 48.62, of the Wisconsin Statutes, and DHS 56 of the Administrative Code as a Foster Home, or residences operated by a provider licensed under DHS 38 of the Administrative Code as a Treatment Foster Home. Children's Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if the children in foster care are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care, personal care, supervision, behavior and social supports, daily living skills training, and transportation.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Excludes the cost of room and board provided by the Foster Care provider. Other disability or foster care-related funding sources generally cover these costs. Room and board costs are generally reimbursed by sources used to finance basic foster care.
2. Excludes the cost of basic support and supervision provided to children by foster care providers in these settings. These services are minimal and routine for children of the age of the child being served. Compensation for these services is not covered by the Medicaid waivers and is generally covered by other funding sources associated with Foster Care.
3. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs, or physical or personal care needs. Examples to illustrate the range and scope of children's exceptional emotional or behavioral care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social behavior resulting in property offenses, assault, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day.

Examples to illustrate the range and scope of children's exceptional physical or personal care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares; exhibits eating or feeding problems including tube or gavage feedings; requires specialized skin and positioning care to treat or prevent serious skin conditions such as pressure sores; requires follow-through on a therapy plan in excess of two hours per day; requires persistent monitoring of complex medical needs, or is non-ambulatory.

4. For children with physical or personal care needs, the types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catheterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child's environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child's environment to prevent aggression, elopement or other disruptive or violent behaviors.
5. Foster Care providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the foster care providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.
6. The support and supervision costs of serving the children with disabilities served may be established at a higher rate if the provider must serve fewer children because of the extra or exceptional care and supervision needs of the children placed in the home described in 3 above. To illustrate this, if a provider could otherwise serve four children and therefore be compensated at a higher amount, the amount they receive for the care they provide to the child with a disability may be adjusted to compensate for this difference.
7. Transportation services may be included under this service or separately billed under the service Specialized Transportation so long as there is no duplicate billing for any unit of service.
8. Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification,

adaptive equipment or communication aid may be covered by the waiver but must be claimed under the services “Home Modifications,” “Communication Aids or “Adaptive Equipment” respectively.

9. If a child receives Medicaid State Plan covered Personal Care, these services may not duplicate services provided by the foster care providers.
10. Joint approval from Division of Children and Family Services and Division of Long Term Care is required for the use of shift staff in a Treatment Foster Home prior to the placement of any waiver participant in the home.
11. All persons providing services and supports to any waiver participant shall be subject to a criminal and caregiver background check before they begin providing services. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. General provider screening requirements for Medicaid Waivers apply to this service.
12. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX.

STANDARDS

Foster homes must be licensed under DHS 56 Family Foster Care for Children or DHS 38 for Treatment Foster Homes.

DOCUMENTATION

1. All providers of foster care must have evidence of valid licensure.
2. Documentation that clearly describes the individual room and board **and** care and supervision costs in the facility must be maintained in the participant record located at the waiver agency. Documentation must show that no waiver funds are being used to reimburse room and board costs.
3. There must be documentation of current criminal and caregiver background checks in the provider or licensing file.
4. There must be documentation that the services provided by the foster home sponsor do not duplicate personal care services if personal care services are also provided.

5. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan or individual medical care plan that the foster care provider will implement.
6. There must be documentation of the specific training the foster parent received related to the child's needs and the psychiatric/behavioral treatment plan or individual medical care plan.
7. For all applicable waivers, the provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

CHILDREN'S FOSTER CARE/TREATMENT FOSTER CARE MENTAL HEALTH

SPC 203

Applies to CLTS

DEFINITION

A Children's Foster Home is a family oriented residence operated by a person licensed under §48.62, of the Wisconsin Statutes, and DHS 56 of the Administrative Code as a Foster Home, or residences operated by a provider licensed under DHS 38 of the Administrative Code as a Treatment Foster Home. Children's Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if the children in foster care are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care; personal care; supervision; behavior and social supports, daily living skills training, and transportation.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Excludes the cost of room and board provided by the Foster Care provider. Other disability or foster care-related funding sources generally cover these costs. Room and board costs are generally reimbursed by sources used to finance basic foster care.
2. Excludes the cost of basic support and supervision provided to children by foster care providers in these settings. These services are minimal and routine for children of the age being served. Compensation for these services is not covered by the Medicaid Waivers and is generally covered by other funding sources associated with Foster Care.
3. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs. Examples to illustrate the range and scope of children's exceptional care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social behavior resulting in property offenses, assault, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day.

4. Foster Care providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. These unique needs are generally related to emotional and behavioral needs. The foster care providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
5. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child's environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child's environment to prevent aggression, elopement or other disruptive or violent behaviors.
6. The support and supervision costs of serving the children with disabilities served may be established at a higher rate if the provider must serve fewer children because of the extra or exceptional care and supervision needs of the children placed in the home described in 3 above. To illustrate this, if a provider could otherwise serve four children and therefore be compensated at a higher amount, the amount they receive for the care they provide to the child with a disability may be adjusted to compensate for this difference.
7. Transportation services may be included under this service or separately billed under the service Specialized Transportation so long as there is no duplicate billing for any unit of service.
8. Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification, adaptive equipment or communication aid may be covered by the waiver but must be claimed under the services "Home Modifications," "Communication Aids or "Adaptive Equipment" respectively.
9. These services may not duplicate services provided by the foster care providers when the child uses the Medicaid State Plan Personal Care benefit.
10. Joint approval from Division of Children and Family Services and the Division of Long Term Care is required for the use of shift staff in a Treatment Foster Home prior to the placement of any waiver participant in the home.
11. All persons providing services and supports to any waiver participant shall be subject to a criminal and caregiver background check before they begin providing services.

Both types of background checks must be repeated every four years.

Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. General provider screening requirements for Medicaid Waivers apply to this service.

12. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX.

STANDARDS

Foster homes must be licensed under DHS 56 Family Foster Care for Children or DHS 38 for Treatment Foster Homes.

DOCUMENTATION

1. All providers of foster care must have evidence of valid licensure.
2. Documentation that clearly describes the individual room and board **and** care and supervision costs in the facility must be maintained in the participant record located at the waiver agency. Documentation must show that no waiver funds are being used to reimburse room and board costs.
3. There must be documentation of current criminal and caregiver background checks in the provider or licensing file.
4. There must be documentation that the services provided by the foster home sponsor do not duplicate personal care services if personal care services are also provided.
5. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan that the foster care provider will implement.
6. There must be documentation of the specific training the foster parent received related to the child's needs and the psychiatric/behavioral treatment plan.
7. For all applicable waivers, the provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

CHILDREN'S FOSTER CARE/TREATMENT FOSTER CARE PHYSICAL DISABILITIES

SPC 203

Applies to CLTS

DEFINITION

A Children's Foster Home is a family oriented residence operated by a person licensed under §48.62, of the Wisconsin Statutes, and DHS 56 of the Administrative Code as a Foster Home, or residences operated by a provider licensed under DHS 38 of the Administrative Code as a Treatment Foster Home. Children's Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if the children in foster care are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care, personal care, supervision, behavior and social supports, daily living skills training, and transportation.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Excludes the cost of room and board provided by the Foster Care provider. Other disability or foster care-related funding sources generally cover these costs. Room and board costs are generally reimbursed by sources used to finance basic foster care.
2. Excludes the cost of basic support and supervision provided to children by foster care providers in these settings. These services are minimal and routine for children of the age being served. Compensation for these services is not covered by the Medicaid Waivers and is generally covered by other funding sources associated with Foster Care.
3. Includes supplementary intensive supports and supervision services to address exceptional physical or personal care needs. Examples to illustrate the range and scope of children's exceptional care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares; exhibits eating or feeding problems including tube or gavage feedings; requires specialized skin and positioning care to treat or prevent serious skin conditions such as pressure sores; requires follow-through on a therapy plan in excess of two hours per day; requires persistent monitoring of complex medical needs, or is non-ambulatory.

4. The types of activities that may be applied include direct personal care provision beyond those age activities expected for a child. Skilled tasks such as tube or gavage feedings, catheterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care.
5. Foster Care providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. These unique needs are generally related to physical, medical and personal care. The provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.
6. The support and supervision costs of serving the children with disabilities served may be established at a higher rate if the provider must serve fewer children because of the extra or exceptional care and supervision needs of the children placed in the home described in 3 above. To illustrate this, if a provider could otherwise serve four children and therefore be compensated at a higher amount, the amount they receive for the care they provide to the child with a disability may be adjusted to compensate for this difference.
7. Transportation services may be included under this service or separately billed under the service Specialized Transportation so long as there is no duplicate billing for any unit of service.
8. Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification, adaptive equipment or communication aid may be covered by the waiver but must be claimed under the services "Home Modifications," "Communication Aids or "Adaptive Equipment" respectively.
9. These services may not duplicate services provided by the foster care providers when the child uses the Medicaid State Plan Personal Care benefit.
10. Joint approval from Division of Children and Family Services and Division of Long Term Care is required for the use of shift staff in a Treatment Foster Home prior to the placement of any waiver participant in the home.
11. All persons providing services and supports to any waiver participant shall be subject to a criminal and caregiver background check before they begin providing services.

Both types of background checks must be repeated every four years.

Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. General provider screening requirements for Medicaid Waivers apply to this service.

12. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX.

STANDARDS

Foster homes must be licensed under DHS 56 Family Foster Care for Children or DHS 38 for Treatment Foster Homes.

DOCUMENTATION

1. All providers of foster care must have evidence of valid licensure.
2. Documentation that clearly describes the individual room and board and care and supervision costs in the facility must be maintained in the participant record located at the waiver agency. Documentation must show that no waiver funds are being used to reimburse room and board costs.
3. There must be documentation that the services provided by the foster home sponsor do not duplicate personal care services if personal care services are also provided.
4. There must be documentation of the specific exceptional needs of the child and the individual medical care plan that the foster care provider will implement.
5. There must be documentation of the specific training the foster parent received related to the child's needs and the treatment plan.
6. There must be documentation of current criminal and caregiver background checks in the provider or licensing file.
7. For all applicable waivers, the provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

COMMUNICATION AIDS

SPC 112.47

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS

DEFINITION

Communication aids are those devices or services necessary to assist persons who have hearing, speech or vision impairments or a language barrier to effectively communicate with family, friends, caregivers, service providers, medical professionals or the community at large. Allowable communication aids include devices that assist the participant to achieve the defined objective of this service. Examples of allowable items or devices are listed below. The list is illustrative and not all-inclusive. To effectively respond to new technology, additional items or devices not specifically named may be allowed when it is demonstrated that the item or device will accomplish the objective of this service and meet an assessed need.

Communication aids may include:

- Assistive listening devices
- Telecommunication equipment
- Low vision magnification equipment
- Braille writing equipment
- Augmentative communication devices
- Visual fire alarm systems
- Direct selection communicators
- Alphanumeric, scanning or encoding communicators
- Speech amplifiers
- Cellular phones, personal pager systems, telephone answering machines
- Interpreter service
- Computers and necessary software

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Includes the cost of installation, maintenance and repair of allowable communication aids and equipment.
2. Only those communication aids that cannot be obtained, have been denied, or exceed the quantity approved under Wisconsin's Medicaid state plan may be purchased with

waiver program funds. The refusal of a Medicaid vendor to accept the Medicaid reimbursement does not constitute a Medicaid denial.

3. Prior to the purchase of communication aids costing more than \$2,000, the agency must obtain the approval and/or recommendation of a rehabilitation organization, an Independent Living Center, physical, occupational or speech therapist, a physician or other professional with comparable training and experience, verifying the item or device is appropriate to the communication needs of the participant.
4. The cost of an evaluation to determine appropriateness of a communication aid or equipment is an allowable expenditure.
5. The purchase of computers and internet access service as a communication aid is limited to those participants who are shown to need the service as their primary means of communication. Excludes payments for additional software for recreational or social purposes.
6. Waiver program participants may receive only one computer as an approved communication aid. This does not include the replacement of an allowable computer.
7. Waiver program funding for interpreter services is limited to only those circumstances where the interpreter assists in communication between the participant and his/her waiver service provider(s).

STANDARDS

1. The providers of systems or devices purchased as communication aids shall ensure that such items meet all the applicable standards of manufacture, safety, design and installation (Underwriter's Laboratory, Federal Communication Commission, etc.) and should be obtained from authorized and qualified dealers.
2. A qualified interpreter is a person who has been certified by the National Registry of Interpreters for the Deaf or one that has successfully participated in the DHS Office for the Deaf and Hard of Hearing program, "Wisconsin Interpreting and Transliterating Assessment (WITA)."
3. Allowable foreign language interpreter services are those provided by a person recognized by the waiver program agency as proficient in the translation of the applicable language and who has been instructed by the agency as to the privacy and confidentiality of the participant-related communication.

DOCUMENTATION

1. For communication aids costing in excess of \$2,000, the waiver agency file must contain documentation that the purchase is appropriate to the specific needs of the participant. This documentation shall be provided by a rehabilitation organization, an Independent Living Center, a physical, occupational or speech therapist, a physician or another recognized professional with comparable training and experience.
2. Documentation on the service plan shall indicate both the unit cost of the **cellular phone** and the monthly cost of the basic cellular service package. Documentation on file should also clearly indicate that the participant understands what cellular services the waiver program will or will not fund (e.g., length of contract, maximum monthly rate, total minutes allowed, etc.) It should also indicate any activity or usage that may be viewed by the agency as cause to terminate coverage of cellular service.
3. The participant file shall contain documentation that the purchase of a **personal computer** and related internet access as a communication aid is necessary as the participant's **primary means of communication**.
4. Documentation on the participant service plan must indicate both the cost of the **personal computer** and the cost of the basic internet service. Documentation should also clearly indicate that the participant fully understands what the waiver funds will or will not cover. It should list the internet provider, type of service connection allowed and any limits on the use of the service. It should clearly state what kind of activity would be viewed as exceeding the service limits and what action the agency will take should that occur.
5. Documentation on the service plan must indicate both the unit cost of the **personal pager** and the monthly cost of the paging system service. Documentation should also indicate that the participant fully understands the limits to the use of the pager system provided. It should clearly state what kind of activity will be viewed by the agency as exceeding those limits and clearly state what action the agency will take if usage or service limits are exceeded.
6. Documentation in the participant file must substantiate that payment for the communication aid has been denied by Medicaid or that it has otherwise been verified that the item cannot be obtained through the Wisconsin Medicaid state plan.
7. For all applicable waivers, the provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) form on file with the State Medicaid Agency.

COMMUNITY BASED RESIDENTIAL FACILITY

SPC 506.61

Applies to CIP 1A/1B, BIW, CIP II, COP-W & COR

DEFINITION

A Community Based Residential Facility (CBRF) is a state licensed facility where five or more unrelated adults reside, in which care, treatment or services above the level of room and board but not including nursing care are provided to residents as a primary function of the facility (DHS 83.03).

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Only those costs associated with the participant's care, support and supervision in the CBRF may be billed under this waiver service. No costs associated with room and board may be billed to the Medicaid waiver programs.
2. All providers of CBRF services and any nonresident adult who lives in the facility shall be subject to the required criminal and caregiver background checks and hiring prohibitions described in Chapter IV, Section 4.05 of this manual.
3. Waiver funds may not be used for the provision of CBRF services when the expenditure of those funds will cause the county to exceed its established limit under s. 46.27(3) (f) and DHS 73.10(1). The Department, per DHS 73.10(3), may grant an exception to the limit.
4. **For CIP 1A, CIP 1B, and BIW**, excludes licensed facilities located within the same structure of a nursing home or in an ICF-MR and also those situations where the facility is connected to a Nursing Home or an ICF-MR.
5. Excludes licensed facilities where the staff is shared with a nursing home or an ICF-MR.
6. **For CIP 1A, CIP 1B and BIW**, waiver funds may not be used to fund services in a CBRF larger than eight beds.
7. **For COP-W, CIP II and COR**, waiver funds may be used to provide services in a CBRF of up to twenty beds. However, a variance must be approved to permit the use of funds in a licensed CBRF with greater than twenty beds. See Chapter V of this manual for a discussion of the variance requirements and procedures.

8. **For CIP II/COP-W and COR programs only**, waiver funds may be used to provide services in a CBRF connected to a nursing home for participants in the frail elderly target group.

Important: CIP II , COP – W and COR waiver funds may not be used to provide services to participants who are under age 65 and physically or developmentally disabled to reside in CBRFs that are structurally connected to a nursing home.

9. **Applies to CIP II/COP-W only:**

Except for services provided in CBRFs consisting entirely of independent apartments or for services provided to persons with a dementia who reside in CBRFs with a dementia care program, waiver funds may not be used for CBRF services unless **all** the following conditions have been met (46.27 (11) (c) (5n), Wisconsin Statutes):¹

- a. The option of in-home services has been discussed with the person, thoroughly evaluated and found to be infeasible, as determined by the county agency in accordance with DHS 73.11.
 - b. The waiver agency has determined that the facility is the person's preferred residence or is a setting preferred by the person's guardian.
 - c. The waiver agency has determined that the facility provides a quality environment and quality care services.
 - d. The waiver agency has determined that the placement is cost effective compared to other options, including in home care and nursing home care.
10. Within the limits of laws on confidentiality, providers of CBRF services to CIP 1A, CIP 1B and BIW participants must communicate with designated county staff and other providers about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.
11. Within the limits of laws on confidentiality, providers of CBRF services to COP-W, CIP II and COR participants must promptly communicate with the care manager and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered or, if they are not addressed, may endanger the health or safety of the participant.
12. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County

¹ In October 2007 the legislature repealed the requirement for a CBRF preadmission assessment. This action effectively eliminated the "penalty" affecting participants that did not receive a PAAC. These changes and additional new requirements will be addressed in more detail in the next revision of Chapter 5.

waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.

STANDARDS

Wisconsin Administrative Code DHS 83, Community Based Residential Facilities, contains the regulations and standards governing this service. Copies of DHS 83 may be obtained from the Department of Health Services, Division of Quality Assurance. The Standards may be obtained electronically at:

<http://www.legis.state.wi.us/rsb/code/dhs/dhs083.pdf> or by contacting the Bureau.

DOCUMENTATION

1. The provider must have and make available current documentation of CBRF licensure.
2. The CBRF provider must have a cost allocation methodology in place that clearly distinguishes waiver allowable costs from room and board costs.
3. Documentation that clearly describes the individual room and board **and** care and supervision costs in the facility must be maintained in the participant record located at the waiver agency.
4. When a CBRF serves participants with an irreversible dementia the facility must document in their program statement a full description of the special needs of the population as well as an explanation of the care and services to be provided by the facility to adequately meet those needs.
5. In order to serve persons who are under the age of 65, and disabled in a CBRF licensed for more than twenty beds (COP-W, CIP II only), a variance must be obtained and a copy maintained in the participant file. The variances are **facility-specific**. Should the person later move to another facility licensed for more than twenty beds and the new facility has not had a variance approved, a new variance request must be submitted. (See Chapter V of this manual for additional information about variance requirements.)
6. In order to serve persons who are **elderly** in a CBRF larger than twenty beds or in a facility that is structurally connected to nursing home, a person – specific variance must be obtained and a copy maintained in the participant file. (See Chapter V for a description of the specific variance requirements.)

7. Where necessary (CIP II and COP-W), documentation that the required CBRF preadmission criteria were met shall be maintained in the participant file.
8. The provider must maintain current documentation that caregiver background checks have been completed for all applicable persons working or residing at the facility.
9. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
10. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

CONSUMER-DIRECTED SUPPORTS

SPC 609.10

Applies to CIP1A, 1B, BIW (See 609.20 for similar service)

DEFINITION

The provision of a flexible array of services provided to participants that include a specified portion of the services covered by the waiver. Services are planned and implemented through processes characterized by:

1. Support for the consumer and those close to the consumer to assist in identifying the consumer's goals and means of reaching those goals, in a manner that reflects consumer preferences as closely as possible;
2. Planning that occurs within the limits of an individualized budget that is based on typical service costs for Waiver participants with similar needs in similar situations; and
3. An emphasis on identifying and strengthening networks of informal supports and on making use of generic community resources to the maximum extent possible.
4. Processes and supports for person-centered service planning, implementation, operation and monitoring that are established through a locally developed county Consumer-directed Services (CDS) implementation plan that is subject to approval by the department. Based on this plan, a Memorandum of Understanding (MOU) is executed between the county and department. This MOU governs county operation of this service.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. This service is only available if the county has a memorandum of understanding with the Department. Department agreement with the MOU constitutes approval to provide this service.
2. The MOU shall describe the county's plan for how they intend to address the following program elements with an emphasis on how they differ from waiver service provision done outside the context of this service:
 - a. Outreach and Public education;
 - b. The methods to be used in soliciting public, consumer and guardian comment on the method used in individual budgeting. Said method must be continuously available for public review and must be periodically reevaluated.

- c. Participant education on all aspects of the CDS program;
 - d. Support and service coordination including any use of non-traditional agents such as service brokers describing the roles of both of these types of providers;
 - e. The content of assessments and person-centered, individualized service plans;
 - f. The methods to be used in setting individual budgets must be described;
 - g. Methods to be used in budget problem solving must be specified;
 - h. The nature and scope of financial assistance provided to CDS participants;
 - i. The strategy and policies associated with the use of informal supports;
 - j. The scope of services that will be available under this service as provided by the county; and
 - k. The methods, if different, that will be used to assure health and safety and access to assistance in asserting rights under law and rule.
3. The array of waiver-covered services included in Consumer-Directed Services includes all services covered by the waiver programs except CBRF services, Adult Family Home services in 1-2 bed and 3-4 bed homes, Children's Foster Home/Treatment Foster Home Services and Support and Service Coordination.
 4. Includes additional support and service coordination and arrangement if provided by support brokers or someone described in the approved MOU. This person may be someone other than and in addition to the regular Support and Service Coordinator.
 5. Provider Screening Requirements: All persons providing any Waiver-covered service under this service category shall be subject to criminal and caregiver background checks before they begin employment. This includes all informal supports and natural caregivers listed on the Individual Service Plan. Persons providing these services shall comply with all relevant provisions of Section 4.05 of Chapter IV of the Medicaid Waivers Manual.
 6. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter IX.

STANDARDS

1. Providers under Consumer-Directed Supports (CDS) must have skills and knowledge needed to carry out responsibilities assigned to them in a manner that meets the individual needs and preferences of the participant as specified in the individual service plan and in a manner that ensures protection of participant health and safety and observance of participant rights.

2. The county and consumer-directed support service provider shall comply with all provisions of the approved MOU. Department approval of the MOU constitutes qualification of the county as a provider of CDS.
3. Counties shall have a process to share the method used in individual budgeting that is subject to continuous public review and not less than annual reevaluation.
4. Other services provided to participants of consumer-directed services must meet the standards for those services.
5. Consumer-Directed Service providers shall meet the standards for the waiver-covered service they provide or meet provider qualifications that are based on the needs and characteristics of the specific individual or individuals served.
6. Each individual must have an annual budget document that lists total expenditures for each participant by type of expense.

DOCUMENTATION

1. There must be an annual budget document in each participant's file. The basis for calculation of the individual's budget should also be in the participant's file.
2. Evidence of qualifications of all waiver providers that provide covered waiver service under CDS must be in the participant's file.
3. There must be documentation that the person's individualized plan reflects waiver participant's views and preferences and that the goals and outcomes sought are those of the waiver participant. This description shall include the basis for this conclusion.
4. The individualized plan must document the purpose of all expenditures made for each individual under this service.
5. Evidence that the services billed were actually delivered must be in the participant file.
6. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

CONSUMER AND FAMILY DIRECTED SUPPORTS

SPC 609.20

Applies to CLTS (See 609.10 for similar service)

DEFINITION

Consumer and Family Directed Supports are designed to assist children and their families to build, strengthen, or maintain informal networks of community supports. Consumer and Family Directed Supports include the following specific activities at the request and direction of the child or his/her family. The types of services and supports provided through consumer and family directed supports are the same as other waiver allowable services and may include: adaptive aides, communication aides, consumer education and training, counseling and therapeutic resources, daily living skills training, day services, foster care, home modifications, personal emergency response, respite care, specialized medical and therapeutic supplies, specialized transportation, supported employment, and supportive home care. The provider of each service and support must meet the provider qualifications for the specific service as noted in this waiver manual.

The method of arranging for the provision of services and the supervision of these services will occur as described below. These activities include provision of support, care and assistance to the child and family, to prevent out-of-home placement of the child, and to support the child's inclusion in the community. Representative examples include:

1. Provision of services and supports, which assist the child, family, or friends to:
 - a. Identify and access formal and informal support systems;
 - b. Develop a meaningful child and family support plan; or
 - c. Increase and/or maintain the capacity to direct formal and informal resources.
2. Completing activities which assist the child, family, and friends to determine future plans.
3. Developing and implementing a family-centered support plan, which provides the direction, assistance and support to allow the person with a disability to live in the community, establish meaningful community associations, and make valued contributions to the community.
4. Ongoing consultation, community support, training, problem-solving, and technical assistance to assure successful implementation of a family-centered plan.

5. Developing and implementing community support strategies, which aid and strengthen the involvement of community members who assist the child to live in the community.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Each local agency offering family-directed support services will develop a written plan to implement Consumer and Family Directed Supports, which will:
 - a. Specify how children, families and other natural supports were involved in developing the plan and will be involved in ongoing oversight of the plan.
 - b. Specify how the local agency will provide information about Consumer and Family Directed Supports to consumers, families and other natural supports and providers.
 - c. Specify how participating children and their families, guardians and other natural supports will be supported to: know their rights as citizens and consumers; learn about the methods provided by the Consumer and Family Directed Supports plan to take greater control of decision-making; and develop skills to be more effective in identifying and implementing personal goals.
 - d. Establish support for development of family-centered support plans which are based on individual goals and preferences and which allow the person with a disability to live in the community, establish meaningful community associations, and make valued contributions to the community.
 - e. Provide for mechanisms for consultation, problem-solving, and technical assistance to assist consumers in accessing and developing the desired support(s), and to assist in securing administrative and financial management assistance to implement the supports(s).
 - f. Establish a mechanism for allocating resources to individuals for the purpose of purchasing family-directed community support services based upon identified factors. These factors may include the person's skills, his/her environment, the supports available to the person, and the specialized support needs of the person.
 - g. Describe how the local agency will promote use of informal and generic sources of support.
 - h. Describe how the county will promote availability of a flexible array of services that is able to provide supports to meet identified needs and that is able to provide consumer choice as to nature, level and location of services.

- i. Describe how the local agency will assure that Consumer and Family Directed Supports meet the child's health and safety needs.
- j. Provide for outcome-based quality assurance methods.

Services provided under a plan for Consumer and Family Directed Supports may not duplicate any other services provided to the person.

STANDARDS

1. Providers under Consumer and Family Directed Supports must have skills and knowledge needed to carry out responsibilities assigned to them in a manner that meets the individual needs and preferences of the child and family as specified in the individual service plan and in a manner that ensures protection of the child's health and safety.
2. The Department must review and approve the County plan to implement Consumer and Family Directed Supports prior to implementation of this service.
3. Counties shall have a method to share the method used in individual budgeting that is subject to continuous public review and not less than annual reevaluation.
4. Other services provided to children of Consumer and Family Directed Supports services must meet the standards for those services.
5. Consumer and Family Directed Support providers shall meet the standards for the Waiver-covered service they provide or meet provider qualifications that are based on the needs and characteristics of the specific individual or individuals served.
6. Each child must have an annual budget document that lists total expenditures for each child by type of expense.

DOCUMENTATION

1. The child and family support plan shall contain documentation that the Consumer and Family Directed Supports prevent the child from entering an out-of-home placement.
2. The county waiver agency shall document how the community support services enable the person to lead an inclusive community life, build a viable network of support, and result in outcomes specified by the child and family.

3. The county waiver agency shall document that the supports and services provided assure the child's health and safety needs, including the use of providers who meet appropriate qualification and skills for the particular service provided.
4. The county waiver agency shall document that Freedom of Choice for all services and supports selected has occurred.
5. Each child's file must contain an annual budget document together with documentation of the basis for calculating the individual budget.
6. Each child's file must contain evidence of the qualifications of all providers that provide waiver service under Consumer and Family Directed Supports.
7. The county waiver agency shall document that the child's individualized plan reflects the views and preferences of the child and family and that the goals and outcomes sought are those of the child and family. This documentation shall include the basis for this conclusion.
8. The individualized plan must document the purpose of all expenditures made for each child under this service.
9. The county waiver agency shall document that the services billed were actually delivered.
10. The county waiver agency shall document that all caregiver and criminal background checks have been completed.
11. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.
12. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

CONSUMER-DIRECTED SUPPORTS

SPC 609.20 and SPC 609.30

Applies to COR

DEFINITION

Consumer-Directed Supports offer support, care and assistance to an individual, to successfully maintain the individual in the community and allow the person to live an inclusive life. Consumer-Directed Supports are designed to help a consumer develop self-advocacy skills, exercise civil rights, acquire skills needed to exercise control and responsibility over other support services, and build, strengthen or maintain informal networks of community support for the person.

Consumer-Directed Supports include the following specific activities at the request and direction of the consumer or his/her legal representative:

- a) Provision of services and supports that assist the person, family or friends to:
 - Identify and access formal and informal support systems;
 - Develop a meaningful consumer support plan; or
 - Increase and/or maintain the capacity to direct formal and informal resources.
- b) Completion of activities that assist the consumer, their guardian, their family, or other natural supports to determine the consumer's own future.
- c) Development and implementation of person-centered support plans that provide the direction, assistance and support to allow the individual to live in the community, establish meaningful community associations, and make valued contributions to their community.
- d) Ongoing consultation, training, problem-solving, technical assistance and financial management assistance to assure successful implementation of their person-centered plan.
- e) Development and implementation of community support strategies that aid and strengthen the involvement of community members who assist the person to live in the community.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Providers must have skills and knowledge that would be typically acquired through a course of study leading to a degree in one of the behavioral sciences and/or training and experience in the specific area of services being offered.
2. Providers must have skills and knowledge needed to carry out responsibilities assigned to them in a manner that meets the needs and preferences of the consumer as specified in the person-centered individual service plan and in a manner that ensures protection of the individual's health and safety and observance of their rights.
3. A provider will receive training in Recovery and Person-Centered Planning within six months of working in the area. This training must be approved by the Division of Mental Health and Substance Abuse Services.
4. Providers are subject to the required caregiver, criminal and licensing background checks. Limited exception may be requested by the consumer for family member or significant relationship.

STANDARDS

1. Consumers and guardians or consumer representatives will demonstrate skills in self advocacy or advocacy.
2. Providers must have skills and knowledge needed to carry out responsibilities assigned to them in a manner that meets the needs and preferences of the consumer as specified in the person-centered individual service plan and in a manner that ensures protection of the individual's health and safety and observance of their rights.

DOCUMENTATION

1. Components of the consumer-directed supports designed to successfully maintain the individual in the community will be documented as necessary in the individual service plan/personal support plan.
2. The county waiver agency shall document how the services enable the consumer to lead an inclusive community life, build a viable network of support, and result in outcomes specified by the consumer or his/her legal guardian.
3. The county waiver agency shall document that all caregiver and criminal background checks have been completed.

4. The provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

CONSUMER EDUCATION AND TRAINING

SPC 113

Applies to CIP 1A/CIP1B, BIW, CLTS

DEFINITION

The provision of educational services to help the participant develop self advocacy skills, exercise civil rights and acquire the skills needed to exercise control and responsibility over their other supportive services. Educational services may include individualized tutoring and instruction, and instructional materials provided that the services (for children) are not funded by a program funded by the Individuals with Disabilities Education Act (IDEA). Covered expenses may include enrollment fees, books and other educational materials and transportation related to participation in training courses, conferences and other similar events that address the objectives of this service category.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Includes education and training for participants, their caregivers and/or legal representatives that is directly related to building or acquiring the skills described in the definition above.
2. Local agencies will assure that information about educational and/or training opportunities is made available to participants and their caregivers and legal representatives.
3. Excludes educationally related services provided to children unless there is a compelling and accepted reason, and sufficient documentation that the service is not available under IDEA or other relevant funding sources.
4. Excludes education/training costs exceeding \$2500 per participant annually.
5. Excludes payment for hotel and meal expenses while participants or their legal representatives attend allowable training/education events when payment is made in the form of reimbursement to the participant.
6. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

The waiver agency will assure that only competent and qualified providers of consumer education and training services are paid with waiver funds.

DOCUMENTATION

1. The participant file must contain documentation identifying how the waiver funded consumer education and training services meet participant-specific goals or the desired participant outcomes.
2. Payment may only be made to providers upon receipt of a written statement detailing the allowable fees or expenses.
3. Documentation must be maintained in the file of each child that the service does not supplant services otherwise available under another funding source (e.g., IDEA).
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

COUNSELING AND THERAPEUTIC RESOURCES

SPC 507.03 – 507.04

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Counseling and therapeutic services includes the provision of professional evaluation, consultation and treatment-oriented services to participants identified needs for physical, medical, personal, social, behavioral, cognitive, developmental, emotional, or substance abuse treatment. The goal of counseling and therapeutic services is to maintain or improve participant health, welfare or functioning in the community. The therapy or treatment service may be provided in a natural setting or in a service provider's office. Includes therapies or treatments provided by state licensed or certified medical professionals or practitioners of the healing arts, which are not available under the state plan.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Waiver funds may only be used for those therapies or therapeutic services denied funding by the Medicaid state plan or when services needed exceed the amount authorized by the state plan.
2. Rehabilitative and habilitative services for children are available under Healthcheck/EPSTDT and are not reimbursable under this service until after Healthcheck/EPSTDT has been exhausted.
3. Any counseling or therapeutic service funded by the waiver program must address an assessed need and be directly related to a therapeutic goal.
4. Items, supplies or devices that are a necessary component of allowable counseling or therapeutic services that are not allowable under the Medicaid state plan should be billed to SPC 112.55, Specialized Medical Supplies.
5. Providers of counseling and therapeutic services must submit progress reports to the local agency at specified intervals not to exceed six months. The provider reports may be used to evaluate the need for the continuation or modification of treatment or therapy services.
6. The licensing and certification provisions of Chapter IV, Section 4.05 –E of this manual, apply to persons providing services under this SPC.

7. Waiver funds **may not** be used to provide counseling and therapeutic supports and services that are experimental (as defined in DHS 107.035) or aversive in nature or that may otherwise jeopardize the health and safety of the participant.
8. For CIP1A, CIP1B, CLTS and BIW participants, service providers must communicate with designated county staff and other providers about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.
9. For COP-W and CIP II participants who are not covered by Critical Incident reporting requirements, service providers shall communicate promptly with the care manager and/or county agency Adult Protective Services, may endanger the health or safety of the participant. unit regarding any incidents or situations or conditions that have endangered or, if not addressed
10. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.
11. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

1. Medical counseling shall be provided by a licensed physician or by a registered nurse in accordance with the Professional Practice Act.
2. Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
3. If services are provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification, the services must be authorized by a medical professional or approved by DHS or its designee.
4. Providers are subject to required caregiver, criminal and licensing background checks.

DOCUMENTATION

1. Documentation in the participant file shall demonstrate that waiver funded counseling or therapeutic services were prescribed, ordered or recommended by a medical professional, or a licensed or certified treatment professional and were denied funding by the Medicaid state plan.
2. Provider documentation describing assessed needs and reporting progress toward treatment/therapeutic goals shall be maintained in the participant file.
3. For billing purposes, providers must supply documentation that the units of service were actually provided.
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
5. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

DAILY LIVING SKILLS TRAINING

SPC 110

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Daily living skills training services provide education and skill development or training to improve the participant's ability to independently perform routine daily activities and effectively utilize community resources. Services are instructional, focused on skill development and are not intended to provide substitute task performance. Daily living skills training may include skill development in:

- Personal hygiene
- Food preparation
- Home upkeep/maintenance
- Money management
- Accessing and using community resources
- Community mobility
- Parenting

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes substitute task performance, which may be classified as supportive home care.
2. Excludes activities that are primarily recreation.
3. Includes funding for educational or training services that are of a direct benefit to the participant. When the agency determines that the training has ceased to be of benefit to the participant, this service should be discontinued and other services explored.
4. Providers shall complete a written report every six months that details the participant's progress toward each of the objectives outlined in the daily living skills training plan and, if indicated, recommendations for changes. This report shall be provided to the waiver program CM/SSC. The waiver agency may use these provider reports to evaluate the need for continuation or modification of the daily living skills training services.
5. Providers are subject to the required caregiver, criminal and licensing background checks and hiring prohibitions described in Chapter IV, Section 4.05 of this manual.

6. Excludes educationally related services provided to children when the service is available from IDEA or other relevant funding sources.
7. Providers of daily living skills training services to CIP 1A, CIP 1B, CLTS and BIW participants must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.
8. Providers of daily living skills training services to COP-W, CIP II or COR participants must promptly communicate with the care manager and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered or, if not addressed, may endanger the health or safety of the participant.
9. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.
10. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

1. Providers of daily living skills training must have a minimum of two years experience working with the target population. However, the county agency may employ qualified providers who are less experienced. In that event the waiver agency must ensure that the provider receives comprehensive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the care plan.
2. Providers shall ensure Daily Living Skills Training staff are knowledgeable in the adaptation and use of specialized equipment and in the modification of participant environments and that these staff complete regular training/continuing education coursework to maintain/update their level of expertise.
3. Providers shall assure that the ratio of staff to participants is adequate to meet the specific needs of the participant(s) receiving services.

DOCUMENTATION

1. Documentation verifying Daily Living Skills providers meet the requirements of training and experience must be maintained by the provider agency and be accessible for review by the waiver agency.
2. The six-month progress reports must be maintained in the participant file and reviewed at the time of other semi-annual activities. The report shall contain documentation regarding the progress toward achieving the objectives of this service and may include recommendations for service changes.
3. Current documentation of completed criminal, caregiver and licensing background checks must be maintained by the provider and must be accessible for review by the waiver agency.
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
5. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

DAY SERVICES – ADULTS

SPC 706.10

Applies to CIP 1A/1B, BIW, CIP II, COP-W & COR

DEFINITION

Day services programs provide regularly scheduled, individualized skill development activities to participants. Services are typically provided in a non-residential setting. Program goals may include developing/enhancing participant skills for social interaction, communication, or community integration. Day services must have a training component providing service above the level of supervision. Services are typically provided four or more hours per day, up to five days per week outside the home of the participant. Services may occur in a single physical environment or multiple environments or in the community at large.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes services provided in a certified adult day care facility (SPC 102).
2. Excludes Pre-vocational services, work training experience, sheltered workshops and production piecework, paid or unpaid.
3. Day services provided in a residential setting must be a clearly defined and separate activity from basic care and supervision services.
4. Providers shall complete a written report every six months that details the participant's progress toward each of the objectives outlined in the day services plan and if indicated, recommendations for changes. This report shall be provided to the waiver program CM/SSC. The waiver agency may use these provider reports to evaluate the need for the continuation or modification of the day services.
5. Recreational activities may be allowed when those activities are approved as part of the day services plan and are related to a specific therapeutic goal.
6. Within the limits of laws on confidentiality, providers of day services to CIP 1A, CIP 1B, and BIW waiver participants must communicate with designated county staff and other providers about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.

7. Within the limits of laws on confidentiality, providers serving COP-W, CIP II and COR participants shall communicate promptly with the care manager and/or the county agency adult protective services unit regarding any incidents or situations or conditions that have endangered or if not addressed, may endanger the health and safety of the participant.
8. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.
9. Providers are subject to the required caregiver, criminal and licensing background checks and hiring prohibitions described in Chapter IV, Section 4.05 of this manual.
10. Day services provided at a residential setting must be billed as a separate and distinct from any residential service provided residential services (care and supervision provided).
11. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

1. The day services program director must have the skills and knowledge typically acquired through a course of study leading to a bachelor's degree in a human service field and a minimum of two years of supervisory or administrative experience in programming for the target population.
2. Day services program staff shall have two years of relevant education or experience working with the target population.
3. Day services programs shall have a minimum of two direct service staff to every fifteen (15) day services program participants. Programs must recognize that this is a minimum ratio requirement and that the staffing side the ratio may need to be increased based on the needs of specific persons served.
4. Day services program plans shall provide at least one of the following:
 - a. Independent living skills

- b. Mobility skills
 - c. Social, emotional and personal development
 - d. Communication skills
 - e. Community access/integration
5. A day services program that has been certified by the Rehabilitation Accreditation Commission for Activity Services has met the provider qualification requirements.

DOCUMENTATION

1. The waiver agency must maintain documentation that the day services provider meets the required standards for staff qualification and programming.
2. The required six-month day services progress report and a copy of the day services plan must be maintained in the agency's participant record.
3. The record must clearly show that the Day Services activities are distinct from general residential care and supervision provided.
4. Provider records must contain the day services plan and where necessary indicate how the staff to participant ratio will be adjusted to meet the needs of individual participants.
5. Provider records must include documentation that any day services provided at a residential setting are separate and distinct from the residential services (care and supervision) provided.
6. Current documentation of completed criminal, caregiver and licensing background checks must be maintained by the provider and must be accessible for review by the waiver agency.
7. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
8. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

DAY SERVICES – CLTS-DD

SPC 706.20 CHILDREN

Applies to CLTS (DD), CIP 1A, CIP 1B, BIW, (Children)

DEFINITION

Day Services for children provide children with regularly scheduled activities for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs that provide after school supervision, daytime services when school is not in session, and services to pre-school age children. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families. Coordination activities may involve the implementation of components of the child's the family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes any services available through public education programs funded under the Individuals with Disabilities Education Act.
2. Excludes the basic cost of day care unrelated to a child's disability that may be needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of day care" here means the rate charged by and paid to a child care center for children who do not have special needs. Basic cost of childcare does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service.
3. Excludes any service that falls under the definition of daily living skills training, Pre-vocational services, or respite care.
4. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs, or physical or personal care needs.

5. Examples to illustrate the range and scope of children's exceptional emotional or behavioral care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social behavior resulting in property offenses, assault, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day.
6. Examples to illustrate the range and scope of children's exceptional physical or personal care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares; exhibits eating or feeding problems including tube or gavage feedings, requires specialized skin and positioning care to treat or prevent serious skin conditions such as pressure sores; requires follow-through on a therapy plan in excess of two hours per day, requires persistent monitoring of complex medical needs, or is non-ambulatory.
7. For children with physical or personal care needs, the types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catheterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child's environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child's environment to prevent aggression, elopement or other disruptive or violent behaviors.
8. Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.
9. All children's day services program must be licensed under applicable requirements of DHS 45 or DHS 46.

10. A criminal and caregiver background check for all persons providing direct care to any child must be conducted. Both of these background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of this service shall not be considered qualified for the provision of this service
9. Providers must communicate with county staff and other providers within confidentiality laws, any incidents or situations regarded as Critical Incidents as defined in the Medicaid Home and Community-Based Services Waivers Manual, Chapter IX.
10. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

1. Staff in Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.
2. Family Child Care Centers must be licensed under DHS 45, Licensing Rules for Family Child Care Centers.
3. Group Child Care Center means a center that provides care and supervision for nine or more children. Group Child Care Centers must be licensed under DHS 46, Licensing Rules for Group Child Care Centers.

DOCUMENTATION

1. The county agency must maintain documentation that the provider has the qualifications contained in this section and meets the applicable standards for providers of the type of Day Services program offered.
2. A progress report containing a statement on progress toward objectives of the individual service plan and recommendations for change must be filed in the county copy of the participant record not less than once every six months.
3. The provider must have evidence of current licensure or certification under the applicable provision of DHS 45 or DHS 46 (Licensing Rules for Family Child Care Centers or Licensing Rules for Group Child Care Centers).

4. When the day service program involves work, school or training related child day care, there should be documentation about specific costs of the supplementary staff or environmental modifications funded under this service.
5. Documentation of current caregiver and criminal background checks of all day services staff must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.
6. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan or individual medical care plan that the provider will implement.
7. There must be documentation of the specific training the provider received related to the child's needs and the psychiatric/behavioral treatment plan or individual medical care plan.
8. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

DAY SERVICES - CLTS -MH

SPC 706.20 CHILDREN

Applies to CLTS

DEFINITION

Day Services for children provide children with regularly scheduled activities for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs that provide after school supervision, daytime services when school is not in session, and services to pre-school age children. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families. Coordination activities may involve the implementation of components of the child's the family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes any services available through public education programs funded under the Individuals with Disabilities Education Act.
2. Excludes the basic cost of day care unrelated to a child's disability needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of day care" here means the rate charged by and paid to a child care center for children who do not have special needs. Basic cost of child care does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service.
3. Excludes any service that falls under the definition of daily living skills training, Pre-vocational services, or respite care.
4. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs.

Examples to illustrate the range and scope of children's exceptional care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social behavior resulting in property offenses, assault, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day.

5. Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program and to ensure their health, safety and welfare. These unique needs are generally related to emotional and behavioral needs. The providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
6. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child's environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child's environment to prevent aggression, elopement or other disruptive or violent behaviors.
7. All children's day services program must be licensed under applicable requirements of DHS 45 or DHS 46.
8. A criminal and caregiver background check for all persons providing direct care to any child must be conducted. Both of these background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of this service shall not be considered qualified for the provision of this service
9. Providers must communicate with county staff and other providers within confidentiality laws, any incidents or situations regarded as Critical Incidents as defined in the Medicaid Home and Community-Based Services Waivers Manual, Chapter IX.
10. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

1. Staff in Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.
2. Family Child Care Centers must be licensed under DHS 45, Licensing Rules for Family Child Care Centers.
3. Group Child Care Center means a center that provides care and supervision for nine or more children. Group Child Care Centers must be licensed under DHS 46, Licensing Rules for Group Child Care Centers.

DOCUMENTATION

1. The county agency must maintain documentation that the provider has the qualifications contained in this section and meets the applicable standards for providers of the type of Day Services program offered.
2. A progress report containing a statement on progress toward objectives of the individual service plan and recommendations for change must be filed in the county copy of the participant record not less than once every six months.
3. The provider must have evidence of current licensure or certification under the applicable provision of DHS 45 or DHS 46 (Licensing Rules for Family Child Care Centers or Licensing Rules for Group Child Care Centers).
4. When the day service program involves work, school or training related child day care, there should be documentation about specific costs of the supplementary staff or environmental modifications funded under this service.
5. Documentation of current caregiver and criminal background checks of all day services staff must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider file.
6. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan that the provider will implement.
7. There must be documentation of the specific training the provider received related to the child's needs and the psychiatric/behavioral treatment plan.

8. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

DAY SERVICES – CLTS- PD

SPC 706.20 CHILDREN

Applies to CLTS

DEFINITION

Day Services for children provide children with regularly scheduled activities for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs that provide after school supervision, daytime services when school is not in session, and services to pre-school age children. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families. Coordination activities may involve the implementation of components of the child's the family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes any services available through public education programs funded under the Individuals with Disabilities Education Act.
2. Excludes the basic cost of day care unrelated to a child's disability needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of day care" here means the rate charged by and paid to a child care center for children who do not have special needs. Basic cost of child care does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service.
3. Excludes any service that falls under the definition of daily living skills training, Pre-vocational services, or respite care.
4. Includes supplementary intensive supports and supervision services to address exceptional physical or personal care needs.

Examples to illustrate the range and scope of children's exceptional care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares, exhibits eating or feeding problems including tube or gavage feedings, requires specialized skin and positioning care to treat or prevent serious skin conditions such as pressure sores, requires follow-through on a therapy plan in excess of two hours per day, requires persistent monitoring of complex medical needs, or is non-ambulatory.

5. Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program and to ensure their health, safety and welfare. These unique needs are generally related to physical, medical and personal care. The provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.
6. The types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catheterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care.
7. All children's day services programs must be licensed under applicable requirements of DHS 45 or DHS 46.
8. A criminal and caregiver background check for all persons providing direct care to any child must be conducted. Both of these background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of this service shall not be considered qualified for the provision of this service
9. Providers must communicate with county staff and other providers within confidentiality laws, any incidents or situations regarded as Critical Incidents as defined in the Medicaid Home and Community-Based Services Waivers Manual, Chapter IX.
10. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

1. Staff in Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.
2. Family Child Care Centers must be licensed under DHS 45, Licensing Rules for Family Child Care Centers.
3. Group Child Care Center means a center that provides care and supervision for nine or more children. Group Child Care Centers must be licensed under DHS 46, Licensing Rules for Group Child Care Centers.

DOCUMENTATION

1. The county agency must maintain documentation that the provider has the qualifications contained in this section and meets the applicable standards for providers of the type of Day Services program offered.
2. A progress report containing a statement on progress toward objectives of the individual service plan and recommendations for change must be filed in the county copy of the participant record not less than once every six months.
3. The provider must have evidence of current licensure or certification under the applicable provision of DHS 45 or DHS 46 (Licensing Rules for Family Child Care Centers or Licensing Rules for Group Child Care Centers).
4. When the day service program involves work, school or training related child day care, there should be documentation about specific costs of the supplementary staff or environmental modifications funded under this service.
5. Documentation of current caregiver and criminal background checks of all day services staff must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.
6. There must be documentation of the specific exceptional needs of the child and the individual medical care plan that the provider will implement.
7. There must be documentation of the specific training the provider received related to the child's needs and the treatment plan.

- 8 For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

FINANCIAL MANAGEMENT SERVICES

SPC 619

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Financial management services are services that assist waiver participants and their families to manage service dollars. This service involves a person or agency paying service providers after the participant, guardian or family authorizes payment to be made for services included in the participant's approved individualized service plan. Financial Management Services providers, sometimes referred to as fiscal intermediaries, are organizations or individuals that write checks to pay bills for personnel costs, tax withholding, worker's compensation, health insurance and other taxes and benefits appropriate for the specific provider consistent with the individual's and families ISP. The Financial Management service provider or fiscal intermediary serves at the request of the county waiver agency and is made available to the participant/family to insure that appropriate compensation is paid to providers of services. This service also includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the participant ensure that sufficient funds are available for needs.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. The Financial Management Services provider must have a contractual relationship with the county that specifies the scope of services, payment rates for all providers and other policy directives that the intermediary must follow.
2. The Financial Management Services provider is accountable for insuring compliance with all federal and state laws associated with tax withholding and all other employee benefits.
3. The Financial Management Services provider must be subject to an audit to ensure all transactions have been properly executed.
4. Excludes payments to court appointed guardians or court appointed representative payees if the court has directed them to perform these functions.
5. This service is necessary to prevent institutionalization.
6. For the COR waiver, Financial Management Services will assist the consumer in carrying out the Employer Authority duties in self-directing Peer-Advocate Supports, Supportive Home Care, Transportation, and Vocational Recovery waiver services.

STANDARDS

1. Providers must be an agency, unit of an agency or individual that is qualified to provide all of the financial services involved. Providers must have training and experience in accounting or bookkeeping.
2. The Financial Management Services provider must be bonded.
3. The provider must retain all documents and records for seven years as required by law and regulation. Records shall be organized so that lay people easily understand individual service expenses.
4. Providers should be capable of communicating with waiver participants/ family members and are expected to promptly respond to questions about the participant's financial position relative to service expenditure at any given point in time.
5. The Financial Management Services provider shall have a system in place, which recognizes the participant or their legally authorized representative as the agent required to initiate payment for any provider/service.
6. The fiscal intermediary shall have a system in place which addresses :
 - a) The response rate to participant requests;
 - b) The capacity to promptly issue payroll or other funds in emergency situations; and
 - c) A means to assure and communicate about the accuracy of payments made.
7. The fiscal intermediary shall comply with Patient Rights as found in DHS 92 rules and all other applicable laws and rules governing confidentiality.
8. Providers are subject to the required caregiver, criminal and licensing background checks.

DOCUMENTATION

1. The county shall have documentation on file that indicates the provider is qualified.
2. The provider shall keep records of all transactions associated with paying providers in an accessible location available for state or county agency review.
3. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

4. Documentation of current caregiver and criminal background checks must be available and easily accessed upon request. This documentation may be in either each participant's county file or the county's provider files.

HOME DELIVERED MEALS

SPC 402

Applies to CIP 1A/1B, BIW, CIP II, COP-W & COR

DEFINITION

Home delivered meal services include the provision of meals to participants who are at risk of institutionalization due to inadequate nutrition. Home delivered meals costs include the purchase and planning of food, supplies, equipment and labor, as well as the transportation costs associated with the delivery of one or two meals per day to the participant's home. Participants provided with home delivered meals may be unable to plan, prepare or obtain nutritional meals without assistance or may be unable to manage a special diet recommended by their physician. Generally these meals are provided in the participant's home. This service does not constitute a full nutritional regime.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes meals provided to participants by any substitute care facility in which the participant lives. Meals provided by these facilities are a component of room and board in the facility and may not be funded by the waivers. Also excludes meals provided to participants at an adult day center, vocational setting or at a congregate meal site.
2. Excludes the retail purchase of commercially available frozen meals, or nutritional supplements (e.g., Ensure) under this SPC. However, the purchase of nutritional supplements for some participants may be allowed under SPC 112.55, Specialized Medical Supplies.
3. Includes the purchase of prepared frozen meals from the home delivered meal vendor, for consumption by the participant on those days that home delivered meals are not available.
4. More than one home delivered meal provider may be used to meet the participant's need.
5. Reimbursement to the provider must cover the full cost of the meal. The full cost of the meal includes direct and indirect costs including food, labor, preparation and delivery. Separate charges for these costs are not allowable. If this service is on the participant's Individual Service Plan the waiver program must pay the full cost of the meal. Home delivered meal costs may not be broken down and split among the parties.

6. Providers of home delivered meals and waiver agencies may not require a participant to pay or donate towards the cost of a home delivered meal.

STANDARDS

1. Home delivered meal providers must be licensed food service providers or Older American's Act program providers. Licensed providers include restaurants, nursing facilities, hospitals, public schools, etc. Older American's Act programs and licensed providers must comply with Wisconsin Statutes 254 and DHS 196. Hospitals that provide home delivered meals must comply with DHS 124. Nursing facilities that provide these meals must comply with DHS 132.
2. Meals purchased must assure adequate nutrition and must meet not less than one third of the daily dietary needs of the participant receiving the meal.
3. Specially prepared meals, necessary to meet unusual dietary requirements or restrictions may be reimbursed, provided the cost of these meals is the same as that charged to persons who are not waiver program participants (i.e., the usual and customary cost).

DOCUMENTATION

1. The waiver agency will maintain a list of vendors and shall assure that all vendors listed comply with the standards outlined in #1 above.
2. The unit cost of home delivered meals must be listed on the participant's Individual Service Plan.
3. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

HOME MODIFICATIONS

SPC 112.56

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Home modifications are those services that are designed to assess the need for, arrange for and provide modifications and/or improvements to a participant's residence that address a need identified to improve health, safety, accessibility, or provide for the maximization of independent functioning. Home modifications may include the materials and services needed to complete the installation of specific equipment, the modification of the physical structure, or the reconfiguration of essential systems within the home. Home modifications are generally permanent fixtures/changes to a physical structure.

For the COR waiver, this service is called **Environmental Accessibility Adaptations** and must be required by the individual's service plan.

Home modifications may include adaptations to the home such as:

- Ramps (fixed, non portable)²
- Porch/stair lifts
- Doors/doorways, door handles/door opening devices
- Adaptive door bells, locks/security items or devices
- Plumbing, electrical modifications
- Medically necessary heating, cooling or ventilation systems
- Shower, sink, tub and toilet modifications
- Faucets/water controls
- Accessible cabinetry, counter tops or work surfaces
- Grab bars, handrails
- Smoke/fire alarms and fire safety adaptations
- Adaptive lighting/light switches
- Flooring and/or floor covering to address health and safety
- Wall protection
- Modifications that add to the square footage of the home if specific criteria are met (See requirement number 7 below)

Modifications not specifically described above may be approved if the item or service meets the definition and the standards for allowable home modifications. The Bureau or

² A portable ramp may be allowed as an Adaptive Aid (see SPC 112.99).

its designee will determine if the modification is waiver allowable and notify the agency of the decision.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. **All plans for ramps, regardless of cost, are subject to Bureau approval.** All other proposed home modifications or any repair or maintenance of existing modifications that are expected to cost \$2,000 or more must be submitted for plan approval.
2. Excludes adaptations, improvements or repairs to the residence which are of general utility, and are not of direct medical or remedial benefit to the participant or in some way related to the participant's disability.
3. Excludes general home repairs or routine replacements to the structure including roof, windows, and siding, or like structural repairs or replacements.
4. Subject to prior approval, includes fences for safety or repairs necessary as a direct result of damage caused by the participant, which is a result of the participant's disability.
5. Includes the costs of a professional evaluation conducted to determine the need for a modification or to prescribe its type and/or design.
6. Includes the necessary repair and maintenance and the reasonable replacement of an approved home modification.
7. Includes³ home modification that adds to the square footage of the residence if **all** of the following criteria are met, documentation is provided and Bureau prior approval is received:
 - a. The modification must be made to assure the health, safety or independence of the person and prevent institutionalization or out-of-home placement of a child; and
 - b. The modification must be shown to be the most cost effective means of meeting an assessed need and that other options have been considered and have been found to be financially or structurally infeasible; and
 - c. The proposed modification has been recommended by a physical or occupational therapist, a physician or other qualified professional or by a rehabilitation organization as necessary to assure health, safety or accessibility; and

³ Modifications that add square footage to the home are **not allowed** under CIP II/COP-W and CLTS Waivers.

- d. The design and construction of the home modification will be completed by qualified building trade's professionals and will conform to all applicable state and local building codes.
8. Excludes payments for modifications to a licensed or certified substitute care facility. In these settings building repairs and/or modifications are a cost of facility operation.
9. Excludes home modifications allowable under the Medicaid state plan.
10. For the COR waiver, providers are selected by the consumer and care manager based on availability, cost-effectiveness and record for quality services. The care manager or designee is responsible for arranging and monitoring this service.

STANDARDS

1. The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
2. All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

DOCUMENTATION

1. Home modifications submitted for plan approval must include a description detailing how the modification meets an assessed need or meets the participant's desired outcome.
2. Plans proposing home modifications that add to the square footage of the residence must include documentation that addresses all of the criteria in number seven of the Requirements above, including a written recommendation from a qualified, licensed medical, occupational or rehabilitation professional.
3. The home modification must be listed on the ISP. A detailed description of the proposed home modification must accompany a new or updated ISP submitted to the Bureau for approval. A complete breakdown of labor and material costs must be provided in order for the Bureau to determine if all or part of the proposed modification is waiver allowable.
4. The waiver agency must maintain a copy of any approved home modification plan in the participant file.

5. The participant file must contain documentation that the modification is not covered by the Medicaid state plan (see Section 4.06 –B).
6. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

HOUSING COUNSELING

SPC 610

Applies to CIP 1A/1B, BIW, CLTS & COR

DEFINITION

The provision of services to waiver participants to provide people with comprehensive guidance on housing opportunities that are available to meet their needs and preferences. Includes guidance on how a participant may gain access to available public and private resources available to assist the person to obtain or retain safe, decent, accessible, and affordable housing and avoid institutionalization. Housing Counseling includes planning, guidance and assistance in accessing resources related to:

1. Home ownership, both pre and post purchase.
2. Home financing and refinancing.
3. Home maintenance, repair and improvements including abating environmental hazards.
4. Rental counseling, not including any cash assistance.
5. Accessibility and architectural services and consultation.
6. Weatherization evaluation and assistance in accessing these services.
7. Lead based paint abatement evaluation.
8. Low income energy assistance evaluation.
9. Access to transitional or permanent housing.
10. Accessibility inventory design.
11. Health and safety evaluations of physical property.
12. Debt/credit counseling.
13. Homelessness and eviction prevention counseling.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. A qualified provider must be an agency or unit of an agency that provides Housing Counseling as a regular part of its mission and is not free.

2. Counseling must be provided by staff with specialized training and experience in any of the housing issues listed in the definition of this service.
3. Housing counseling service must be provided by an agency or person whose services are also available to the general public. The cost to the waiver must be a reasonable and customary charge, no greater than the amount charged to persons who are not waiver participants.
4. Excludes reimbursement if this service is provided by an agency that also provides residential support services or support/service coordination to the waiver participant.
5. Excludes funding for physical alterations of a person's home to address accessibility. These may be included under SPC 112.56, Home Modifications.
6. Excludes funds to pay for necessary housing start up expenses. These may be covered under SPC 106, Housing Start Up.

STANDARDS

1. Persons or agencies providing Housing Counseling must have expertise in housing issues relevant to the Waiver participant and their needs as identified in the Individual Service Plan.
2. Providers must receive Recovery and Person-centered Planning training or other comparable training approved by the Division of Mental Health and Substance Abuse Services within the first six months of providing Housing Counseling services.
3. Providers are subject to the required caregiver, criminal and licensing background checks.

DOCUMENTATION

1. The County shall have documentation on file that indicates that the provider is qualified.
2. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

HOUSING START UP

SPC 106.03

Applies to CIP 1A/1B, BIW, CLTS

(For CIP II and COP-W and COR – See Relocation-Related Housing Start Up)

DEFINITION

The provision of services and essential items needed to establish a community living arrangement for persons who are relocating from an institution or who are moving from a home to establish an independent living arrangement. Includes person-specific services, supports or goods that will be put in place in preparation for the participant's relocation to a safe, accessible, affordable community living arrangement.

SERVICE REQUIREMENTS/EXCLUSIONS/LIMITATIONS

1. Allowable services or items covered by this service may not be purchased more than 180 days prior to the date the participant relocates from the facility in which the person currently resides per the allowable cost manual provision on start up costs.
2. Includes purchase of necessary furniture, kitchen appliances not furnished by the landlord in the housing arrangement, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies and bathroom and bedroom furnishings.
3. Housing start up services may include the payment of a security deposit, heating/electric/water utility connection costs and telephone installation charges.
4. Excludes home modifications necessary to address safety and accessibility in the person's living arrangement. These must be classified under that service.
5. Includes payments for moving the participant's personal belongings to their new community living arrangement and services needed to prepare the selected community living arrangement for occupancy. This preparation activity may include general cleaning and the organization of the household.
6. Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.).

STANDARDS

1. Furnishings and equipment purchased must be in good condition and in safe, working order.
2. Persons hired to prepare the household for occupancy or moving the participant shall meet the standards for supportive home care providers that provide household services (see Appendix T).

DOCUMENTATION

1. County agencies shall document all payments made under this service.
2. County agencies shall document in the participant record or in an accessible location within the agency verifying that the providers of housing preparation or moving services meet supportive home care requirements.
3. Each service or item provided under housing start up must be listed separately on the Individual Service Plan and must also be described in the Individual Service Plan Narrative.
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

INTENSIVE IN-HOME TREATMENT SERVICES

SPC 512

Applies to CLTS (SED, DD only)

DEFINITION

Intensive In-Home Treatment Services use Intensive treatment-oriented behavioral methods to change socially important behaviors in measurable and meaningful ways in the child's daily life. The services are provided on a one-to-one basis in a child's home in a manner that is individualized to each child's developmental needs with the goal of building a range of important communication, social, and learning skills, as well as reducing challenging behaviors typically found in children diagnosed with a congenital developmental disorder, such as autism, Asperger Syndrome or Pervasive Developmental Disorder, not otherwise specified (PDD-NOS). These services differ from those provided to children with cognitive or physical disabilities due to the intense focus on the specific interactions of behavioral, social, and communicative deficits. The specific skills addressed for each child are clearly defined in observable terms and measured carefully by direct observation throughout each treatment session. Data from continuous assessment of the child's skills in learning, communication, social competence and self care guide the scope of the curriculum for the child. The sequence of easier, precursor skills leading to more complex tasks are presented in a formal manner to the child to assist with mastery of each simple task until these can be successfully combined to achieve the more complex task.

This treatment method is proven effective for services that consist of the introduction of a particular approach to improve a child's social, behavior and communication skills in order to demonstrate measurable outcomes in these areas and overall developmental benefits. The intent is for the child to have fewer needs in the future and make clinically significant gains as a direct result of this service towards normal development. This includes an increase in social, behavioral and communication functioning in the home and community.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. These services are habilitation services, as defined in 42 USC § 1396n(c) (5), which are available only under a Home and Community-Based Services Waiver, not under the State Medicaid Plan or the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medicaid benefit.

2. Any treatment that is to be funded by the waiver under this service must be directly related to an individual child's therapeutic goals.
3. To be funded by the Children's Long-Term Support (CLTS) Waivers, intensive in-home treatment services must be coordinated with other relevant services, such as educational services through the public schools, State Medicaid Plan covered services, and private supports and services.
4. When a school-aged child is identified as having a disability, the child is entitled to receive educationally necessary services under the Individuals with Disabilities Education Act (IDEA). The Individual Education Plan (IEP) developed by the Local Educational Agency (LEA) for that child must include a statement of the special education and related services, and supplementary aids and services to be provided to the child [Wis.Stat. § 115.787(2) (c)]. To the maximum extent appropriate, a child with a disability is educated with non-disabled peers unless the IEP team can justify separation from the regular educational environment, based on child-specific data and not on school convenience. Special classes, separate schooling, or other removal of a child with a disability from the regular education environment occurs only when the nature or severity of the child's disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily [Wis. Stat. § 115.79 (1)(d)]. The CLTS Waivers do not cover intensive in-home treatment services in cases where the child has a shortened school day for the sole purpose of meeting the intensive level of services. The CLTS Waivers may cover the services if there is an approved shortened school day for school-related issues included in the child's IEP.
5. The cost of travel time is included in the rate paid to the provider of this service. If extensive travel is required due to the rural and remote location of the child's residence, a variance to increase hours over 35 per week may be requested from the Department of Health Services (DHS). The DHS requires that the child's Intensive In-Home Treatment Services provider submit written documentation to justify an increase in hours due to travel, including the following information:
 - a. The actual amount of travel time for all staff per week.
 - b. A description of the provider's efforts to recruit senior and line staff in close proximity to the child's home.
 - c. Information on the appropriateness of an alternative schedule for the child's treatment, which may include an attempt to consolidate treatment time, distance monitoring for the senior therapist, and family involvement in service delivery.
 - d. The long range plan to minimize the travel time for staff.
 - e. If the child has recently begun services, please provide specific information on the number of hours of service provided each week

- (broken down to separate face-to-face time from travel time), as well as verification that the child's therapy team is currently fully staffed.
- f. The child's Support and Service Coordinator should indicate whether or not they and the child's family support the request for an increase in hours.
 6. Only a treatment-oriented behavioral services type program consistent with best practice and research on effectiveness will be covered under this waiver service. The specific skills addressed for each child must be clearly defined in observable terms and measured carefully by direct observation throughout each treatment session. Data from continuous assessment of the child's skills in learning, communication, social competence and self-care are expected to guide the scope of the curriculum for the child.
 7. This service is limited to children who can benefit from the services and demonstrate a reduction in delay. This is demonstrated through an independent evaluation conducted by using the Diagnostic and Statistical Manual IV (DSM IV) in conjunction with peer reviewed research results on effectiveness. Eligible children must meet the required diagnostic and functional criteria before starting services.
 8. The intensive in-home treatment services must begin before the child reaches the age of eight years.
 9. A child must be receiving this service at an intensive level to be eligible for CLTS Waiver coverage of this service. Intensive levels of services are defined as 20 to 35 hours of face-to-face treatment per week provided in the child's home. Individual hours are based on the provider's clinical assessment and evaluation regarding the behavioral needs of the child with input from the child's team including providers and the child's family, subject to approval by the county. Individual plan hours may vary; however, the child's service level must remain at the defined intensive hours of 20 to 35 hours per week, unless a variance has been granted by the DHS.
 10. Services are provided in the child's home on a face-to-face basis with the child present and engaged in intervention. A variance may be requested to provide services outside the home to meet the exceptional needs of a child related to specific treatment goals and objectives. This request must specifically address why the alternative setting is necessary to meet treatment outcomes. The request must be submitted and approved by the County Support and Service Coordinator prior to the implementation of services outside of the child's home.
 11. The families of children receiving intensive in-home treatment services are vital members of the in-home behavioral team. They must be involved in the initial training session, team meetings and must remain actively involved at a sufficient level to initiate intensive in-home treatment services, reinforce behavior and

implement therapeutic goals as developed by the behavioral team.

12. The CLTS Waiver funding can be used to ensure that children who meet all eligibility requirements may receive up to a maximum of three years of intensive in-home treatment. This includes all services meeting this service definition that were provided prior to participation in the CLTS Waivers regardless of the payer sources of this service. Payer sources may include, but are not limited to: private insurance, Medical Assistance, private pay, or other state-funded programs.

The county waiver agency is required to verify the scope and frequency of any intensive in-home treatment services a child may have received or may currently be receiving.

Parents are required to provide all information necessary to verify receipt of any current or previous intensive treatment services. This verification will determine if a child is eligible to receive this service as well as the duration under the CLTS Waivers. The DHS will determine the end date of the three years of service and will notify the county waiver agency of this date. The DHS will base this calculation on the first date of intensive in-home treatment services and/or the calculated duration of services meeting this definition.

13. During any period when the intensive in-home treatment services is funded by a specific State funding source on behalf of a particular participant, it does not pay for other home and community-based waiver services except for support and service coordination. Counties may provide funding for other waiver services if there is a local funding source.
14. For policies concerning this service (SPC 512) please refer to Appendix E.
15. A variance to extend the intensive services beyond the identified end date may be requested from the DHS. This extension variance was created so that the clinical effectiveness of early and intensive in-home treatment services can be ensured without detrimental interruptions of service in appropriate circumstances. A child must have experienced a disruption in service for a minimum of 90 days to be considered for an extension of service beyond the three years. However, during the first 90 days of service, the provider may deliver less than 20 hours of face-to-face treatment in order to begin gradually instituting the child's program. The initial 90 days of service are thus not an appropriate circumstance for an extension variance request. The granting of an extension of services must remain neutral to the DHS budget under the CLTS Waiver. The length of the extension will depend upon individual circumstances and will be authorized by the Department. An approved extension will be granted only one time. The request for an extension variance must include verification or evidence of the following:

- a. The family must have been ready and willing to accept intensive services during each of the calendar weeks during which the child did not receive services at the intensive level. For example, a family that opted not to receive services or missed scheduled visits would not be considered to have been ready and willing to accept services. This will require documentation from the service provider.
 - b. The child must be less than 11 years of age at the time of the extension request.
 - c. There must be a clinical justification from the intensive in-home treatment services provider that intensive therapy is the most appropriate approach for continued progress, and the provider agrees to continue to provide the intensive therapy if the extension is granted.
 - d. There must have been at least 26 consecutive calendar weeks, each of which was at the intensive level of treatment service, delivered to the child at some point within the child's original three-year timeframe.
14. Prior to the end of CLTS Waiver funding of intensive in-home treatment services, an eligible child may be approved to transition to CLTS Waiver funding of other home and community-based waiver supports and services. The county support and service coordinator must request approval from DHS at least 30-45 days prior to the anticipated transition date, and services may not continue until and unless approval has been granted. A county may request approval for a child to transition who is nearing the three year maximum, with at least 12 months of continuous treatment services provided under the Wisconsin CLTS Waiver. If the child is transitioning prior to the three-year end date, the county must provide a clinical justification from the provider and agreement from the team that the transition is appropriate.
15. During any period when the intensive in-home treatment services is funded by a specific State funding source on behalf of a particular participant, it does not pay for other home and community-based waiver services except for support and service coordination. Counties may provide funding for other waiver services if there is a local funding source.

For additional policies concerning this service (SPC 512) please refer to Appendix E.

STANDARDS

A. Provider Team Composition

The in-home intensive treatment team consists of:

1. Lead therapist:

A provider who has the following credentials and experience **MUST** lead the in-home intensive treatment team. The lead therapist must present written evidence of the following requirements, prior to the provision of services:

A doctoral degree in psychology, or a medical degree from an accredited educational institution;

Actively licensed by a state board of examiners of psychiatry or psychology

Has completed 1500 hours of training or supervised experience in the application of behaviorally based therapy models consistent with best practice and research on effectiveness, for children with congenital developmental disorders such as autism, Asperger's disorder and pervasive developmental disorder (NOS); who meet all criteria to receive this service, and

At least two years of experience as an independent practitioner, and as a supervisor of less experienced clinicians.

2. Senior therapist:

The senior therapist must be a certified psychotherapy provider, legally authorized to perform psychotherapy, with either a master's degree in one of the behavioral sciences who has at least 400 hours of training or supervised experience in the use of behaviorally based therapy models consistent with best practice and research on effectiveness for children with Autism Spectrum Disorders who meet all criteria to receive this service; in addition to, or as part of their 3000 hours of training/supervision; OR

A bachelor's degree in a human services discipline and at least 2,000 hours of training or supervised experience in the use of behaviorally based therapy models consistent with best practice and research on effectiveness for children with Autism Spectrum Disorders who meet all criteria to receive this service.

3. Line staff:

Line staff must be at least 18 years old and a high school graduate.

Prior to the provision of services, Line staff must have obtained at least 30 hours of direct supervised experience in the use of behaviorally based therapy models consistent with best practice and research on effectiveness, for children with Autism Spectrum Disorders who meet all criteria to receive this service OR have at least 160 hours working in any setting with children with developmental disorders.

The lead therapist and the child's family will recruit all staff with careful consideration given to background checks and compatibility.

Line staff must work under the direction of the lead therapist and the senior therapist.

Line staff must be oriented to the specific outcomes and approach for provision of services for an individual child.

Line staff must be directly supervised during their initial visit with a child.

B. Team Roles

The lead therapist assesses the child and develops the intensive treatment plan based upon the child's individual needs. The senior therapist then provides the ongoing supervision of the implementation of the treatment plan; this includes training and supervision of the line staff, training for the family to review the child's progress and develop an intervention plan for the next week. Line staff implement the discrete trials presenting a series of tasks to a child that are positively rewarded. Families also follow through on discrete trial activities, although these hours are not billable to the waiver. The lead therapist monitors progress on at least a monthly basis and more frequently if needed to address issues with the child's outcomes.

1. Lead therapist:

On teams with a senior therapist: Following the initial training session, the lead therapist trains and directs the team by conferring with the Senior Therapist at least weekly either in person or by telephone and by working with the child in person and with the Senior Therapist and one or more line staff at least every two months.

On teams without a senior therapist: Following the initial training session, the lead therapist trains and directs the team by working with the child in the home and the line staff at least weekly.

2. Senior therapist:

The senior therapist is an extension of the lead therapist and works with the child, the child's family, and other team members in the home a minimum of two hours weekly. The senior therapist confers with the lead therapist at least weekly in person or by telephone and implements any changes in the treatment plan that might result from the conference and, works with the child, the child's family, and line staff to assure that the treatment plan is being accurately followed.

3. Line staff:

Line staff are trained by the lead therapist and senior therapist and directly supervised by the lead therapist and/or senior therapist to implement the behavioral plan. The lead therapist is responsible to assure that line staff follow the behavioral plan and provide good quality safe care.

The line staff documents the nature and scope of the services, as directed by the lead therapist and/or senior therapist, provided during each session with the child.

4. Family involvement:

The families of children receiving intensive in-home services are vital members of the in-home behavioral team. They must be involved in the initial training session and all team meetings. They must remain actively involved at a sufficient level to initiate intensive in-home behavioral team. The family must be knowledgeable regarding the goals and treatment approaches developed by the interdisciplinary team. They are expected to implement the established approaches and generalize the skills in other settings.

DOCUMENTATION

1. The lead therapist is required to provide a written progress report to the child's service coordinator and family at least every six months or as stated in the county/provider contract. The progress report must contain documentation of progress made in all of the identified behavioral goals.
2. All of the services provided must be clearly documented in the child's chart by one of the team members present. Documentation must include location of service, time spent and team members present. Documentation must also include the nature of the time spent in the home by the team members; i.e., behavioral services or staff training activities. Documentation must include travel time to and from the child's home, staffing time and direct service time, as reflected on the required Individual Service Invoice.
3. For billing purposes, the Individual Service Invoice for the Provision of SPC 512 Services is a required form that must be completed by all providers of these services. This completed form must be submitted by the provider to the county waiver agency (the county of responsibility or contracted provider acting on behalf of the county of responsibility) for reimbursement for these services provided to children participating in the Children's Long Term Support (CLTS) Waivers. The form must be completed for each child authorized to receive this service.
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

NATURAL SUPPORTS TRAINING

SPC 113.01

Applies to COR

DEFINITION

Natural Supports Training includes services to the consumer's family or other natural supports, not including training for paid providers, for the primary purpose of strengthening and promoting the individual's mental or physical health and improved social and community functioning or preventing deterioration. Services, which are typically provided to consumer's family and natural supports, are information, and education/training. These services include a wide variety of activities designed to make constructive changes in community living conditions to help strengthen a consumer's personal, social and community functioning. The training may be to an individual, a family or a group, and provides a curriculum with information on mental illness, recovery principles, community-based services, and family and social problems. With a goal to help develop and support good mental health and living practices the instructor, group leader or trainer will use printed, audiovisual, educational and training materials that focus on teaching unpaid caregivers to support, and strengthen an individual's personal, social and community functioning, prevent deterioration and coordinate with the service facilitator and other community agencies. This service may be provided in a group setting but must also provide unique training that is individualized for specific consumer's caregivers.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Natural supports are individuals who are connected to the participant as a family member, a friend, neighbor, companion, or community person who provide unpaid supports to the waiver participant.
2. The training may not be provided, as a waiver service, to a paid provider/caregiver.
3. Training provided to a natural support is individualized to address the specific waiver participant's needs. Areas of information include understanding the diagnosis and condition, using equipment, understanding medications, symptoms and side effects. A strength based recovery approach is at the core of the training.
4. The training will be directed to the role of the unpaid caregiver. Costs of travel, meals and overnight stays to attend a conference are not FFP allowable.

STANDARDS

1. A trainer of natural supports will have at least a B.A in a related area and experience in Behavioral Health and training. The trainer will have completed core training in recovery principles and in person centered planning.
2. Providers are subject to the required caregiver, criminal and licensing background checks.

DOCUMENTATION

1. Natural Supports Training will have and provide evidence of a curriculum, a competency evaluation and an evaluation of the training by the participants.
2. The training as other services must be included in the individual's service plan.
3. The individual's service plan must include the unpaid provider/natural support, name, role, and start and end dates.
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

NURSING SERVICES

SPC 710

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Nursing services are those medically necessary, skilled nursing services that may only be provided safely and effectively by a nurse practitioner, a registered nurse, or a licensed practical nurse working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act and are not otherwise available to the participant under the Medicaid state plan. Nursing services may include periodic assessment of the participant's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a participant's fragile or complex medical condition as well as the monitoring of a participant with a history of noncompliance with medication or other medical treatment needs. **For the COR waiver, this service is called Skilled Nursing Services.**

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Excludes skilled nursing care reimbursable by the Medicaid state plan and Healthcheck/EPSTD. Medicaid covered nursing services may include assessments necessary due to unstable condition; the potential onset of an acute episode; medical complications; adverse reactions to prescribed medication; teaching and training of a participant or a non-professional caregiver, as well as skilled medical procedures identified in the Medicaid Provider Handbook. Medicaid covered nursing services generally require prior approval. Necessary nursing services that exceed the total services authorized by Medicaid or that have been denied Medicaid coverage may be funded by the waiver program.
2. Nursing services must be performed by a registered nurse or an Advanced Practice Nurse (An Advanced Practice Nurse in Wisconsin is an RN with advanced training and certification, commonly known as a Nurse Practitioner.) See Wis. Stats. s. 50.01 (1b) and s. 441.16 (2). A licensed practical nurse may provide services under the supervision of a registered nurse licensed to practice in Wisconsin.
3. The need for skilled nursing services must be recommended or prescribed by the participant's physician and reviewed by the CM/SSC.

4. Excludes consultation provided by a registered nurse to an interdisciplinary team, including participation in the reassessment and care plan development process. Assessment and care planning activity is Care Management/Support and Service Coordination and should be billed to the waiver under SPC 604.
5. Providers of skilled nursing services are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions described in section 4.05 of this manual.
6. Providers of skilled nursing services to CIP 1A, CIP 1B, BIW and CLTS waiver participants must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as critical incidents as defined in Chapter IX of this manual.
7. Providers of skilled nursing services to COP-W and CIP II participants must promptly communicate with the care manager and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered or, if they are not addressed, may endanger the health or safety of the participant.
8. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.

STANDARDS

Licensing, accreditation and practice standards under Chapter 441, Wisconsin Statutes (Board of Nursing) shall apply.

DOCUMENTATION

1. The participant file must contain documentation of a Medicaid denial or an explanation as to the reasons that skilled nursing care cannot be obtained through the Medicaid state plan.
2. The participant file shall contain documentation that the provider of skilled nursing services is duly licensed in Wisconsin or another state.

3. Documentation of current criminal, caregiver and licensing background checks must be maintained in the participant or provider agency file for all persons providing skilled nursing care services.
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
5. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

PEER/ADVOCATE SUPPORTS

SPC 403.04

Applies to COR

DEFINITION

Peer / Advocate Supports includes individuals trained and approved as Recovery Coaches serve as advocates, provide information and peer support for consumers in emergency, outpatient, community or inpatient settings. Recovery Coaches perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. Recovery Coaches function as role models demonstrating techniques in recovery and in ongoing coping skills through:

1. Offering effective recovery-based services;
2. Assisting consumers in finding self-help groups;
3. Assisting consumers in obtaining services that suit that individual's recovery needs;
4. Teaching problem solving techniques;
5. Teaching consumers how to identify and combat negative self-talk and how to identify and overcome fears;
6. Supporting consumer's vocational choices and assist them in overcoming job-related anxiety, enhance job acquisition and foster tenure;
7. Assisting consumers in building social skills in the community that will enhance integration opportunities;
8. Assisting non-consumer staff in identifying program environments that are conducive to recovery;
9. Lending their unique insight into mental illness and what makes recovery possible;
10. Attending treatment team and crisis plan development meetings to promote consumer's use of self-directed recovery tools;
11. Assisting the consumer in obtaining safe and affordable housing of his or her choice;
12. Informing consumers about community and natural supports and how to utilize these in the recovery process;

13. Assisting consumers in developing empowerment skills through self-advocacy and stigma-busting;
14. Providing "warm-line" telephone support; and
15. Offer supportive counseling in day service settings, "club-house" or "drop-in center". This service is included in participant direction of services employer authority option.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. This service is included as an option for participant directed services employer authority.
2. Providers of Peer / Advocate Supports must be able to promote consumer hope, personal responsibility, empowerment, education and self-determination in the community in which the consumer lives.

STANDARDS

1. Providers are qualified by reason of their personal experience and knowledge of the target population, conditions, services and methods to assist in recovery.
2. State approved training in Recovery and Person-Centered Planning, unless waived by the Division of Mental Health and Substance Abuse, must be completed prior to being a provider of this service.
3. Other training for the Peer/Advocate will include information about mental illness and related medical, physical and social conditions will be provided. Risk, safety and recognizing and responding to emergency situations policy and procedures will be trained and understood prior to initiating service provision.
4. Other training for the Peer/Advocate to be completed in the first 90 days of work in this area will be related to the standards and scope of the service expectations, policies and agency expectations.
5. Peer/Advocates will work under the supervision of a Day Service or Supervisor Care Manager or otherwise similarly qualified provider.
6. Providers are subject to the required caregiver, criminal and licensing background checks.

7. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.

DOCUMENTATION

1. The County shall have documentation on file that indicates that the Peer Advocate is qualified.
2. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
3. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

SPC 112.46

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

A personal emergency response system is a service that provides immediate assistance in the event of a physical, emotional, or environmental emergency through a community-based electronic communications device. This service can provide a direct link to health professionals, enabling the user to secure an immediate response by the activation of an electronic communications unit in the participant's home. Allowable items under this SPC may also include a cellular telephone and cellular service used when a conventional PERS system is not feasible.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. The base monthly charge for basic telephone service that is necessary to allow PERS operation and which is paid by the participant may be counted as a medical/remedial expense for participants who have a cost share.
2. Costs associated with initial telephone line installation or the adaptation of existing lines or connections are allowable under this SPC if the line installation or adaptation is necessary to install and/or operate the personal emergency response system.
3. The base monthly charge for basic telephone service necessary for PERS operation **may** be a waiver allowable cost if the CM/SSC determines that the following conditions are met:
 - a. It is in the best interest of the participant's health, safety or security to have the PERS installed, **and**
 - b. The base monthly charges for telephone services present an economic hardship for the participant, **and**
 - c. The telephone service is in the name of the participant, **and**
 - d. The participant resides in his/her own home or apartment.
4. Monthly charges for basic cellular services are allowable costs under this SPC when the cellular service is the participant's emergency response system.

STANDARDS

1. The PERS provider should assure that these devices, where applicable, meet Federal Communications Commission standards or Underwriters Laboratory standards or the equivalent.
2. The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available the agency should seek experienced technicians to complete necessary line adaptations.

DOCUMENTATION

1. The determination as to the type of emergency response system used, as a cost effective means to prevent institutionalization and meet the need for participant safety or security, must be described in the participant's waiver program file.
2. For those participants whose base, monthly telephone charges are to be paid under this SPC, the participant file shall contain documentation that the decision to pay those costs was based on the care manager/support and services coordinator's determination that the service is necessary for the health, safety or security of the participant **and** that the cost of the monthly telephone service presents a financial hardship.
3. For those participants whose basic, monthly cellular service will be funded by the waiver program, the individual service plan must show the PERS costs and the telephone service as separate costs.
4. For those participants whose basic, monthly cellular service will be funded by the waiver program, the individual service plan must show the cellular telephone unit cost and the monthly cellular service charges as separate costs.
5. Documentation on file should also clearly indicate that the participant understands what cellular services the waiver program funds will, or will not cover (e.g., length of contract, maximum monthly rate paid, total minutes allowed, charges not covered, etc.). Documentation should also indicate any activity, or usage that may be viewed by the agency as cause to discontinue coverage of cellular services.
6. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

PRE-VOCATIONAL SERVICES

SPC 108

Applies to CIP1A/1B, BIW

DEFINITION

Pre-vocational services are the provision of services to teach an individual the skills necessary to succeed in employment. Services occur over a defined period of time and involve training and the provision of opportunities for experiences that enhance basic work-related skills. Training is intended to teach an individual concepts necessary to effectively perform a job in the community and may include following directions, attending to tasks, task completion, appropriate responses to supervisors/co-workers, attendance/punctuality, problem solving, safety and mobility training. Work-related skills include reporting to work on time, taking proper sanitary measures, wearing appropriate clothing, acting in a manner that is appropriate to the situation and other skills necessary for successful employment. Services include supervision and training. The focus is on general habilitative rather than specific employment goals.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Pre-vocational Services do not include services available as defined in S4 (a) (4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which are otherwise available to the individual through a program funded under S110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
2. Participants with measured productivity higher than 50% of the industrial standard for their jobs may not start a program of Pre-vocational Services.
3. If, after receiving this service, a participant's productivity rises above 50% of the industrial standard for their job, the participant will be permitted to continue to receive this service funded by the Waiver only if the following conditions are met:
 - a. There is written documentation that the participant was given the informed choice indicating they can receive Supported Employment Services,
 - b. The county indicates in the informed choice communication that any funds currently being used to pay for the pre-vocational services will be available to the participant so the participant can access Supported Employment Services promptly; and

- c. If a participant requests a Supported Employment assessment, a DVR funded assessment will be arranged and provided.
- d. Services must be reflected in the person's vocational plan and must focus on general work skills rather than specific employment objectives.
- e. Vocational counseling must be provided as needed. (DVR Technical Specifications are used as guidelines.)
- f. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.
- g. **Provider Screening Requirements:** All persons providing this service shall be subject to criminal and caregiver background checks before they begin employment. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 4.05 of Chapter IV of the Medicaid Waivers Manual.
- h. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter IX.

STANDARDS

1. Minimally, a Vocational Service Plan is required to address the following:
 - a. Establishes each participant's rate of pay and any anticipated wages;
 - b. Focuses on and describes general habilitative objectives and clearly indicates the specific pre-vocational activities that the participant will engage in;
 - c. Provides the rationale as to why the participant is not expected to join the general work force, or participate in supported employment within a year; and
 - d. Addresses what the participant needs to do to participate in supported employment.

2. Services must be reviewed semi-annually to determine if progress is being made toward achieving goals and if pre-vocational services remain the most appropriate for the participant.
3. Providers that are accredited by the Rehabilitation Accreditation Commission (CARF) are deemed to have met the standards for this service. Providers not accredited by CARF must meet the standards and requirements of this service.
4. **PERSONNEL.** There shall be a direct service staff person or persons who shall possess skills and knowledge that typically would be acquired through:
 - a. A course of study that would lead to a bachelor's degree in one of the human services, or
 - b. A minimum of 2 years of academic, technical or vocational training consistent with the type of work to be supervised or
 - c. A minimum of 2 years experience in a work situation related to the type of work supervised.
 - d. Additional staff or consultants who are knowledgeable and skilled in adapting or modifying equipment and environments, and the application of special equipment for persons with physical disabilities shall be available, as needed.
 - e. Agencies offering Pre-vocational Services shall maintain the following staff ratios when the program is operating:
 - (1) There shall be a minimum of 2 direct service staff for the first 15 people receiving Pre-vocational Services.
 - (2) The actual ratio of staff to program participant shall reflect the specific needs of the individuals being served. A ratio reflecting the needs of the specific participants served shall be provided.
5. **PROGRAM.** Pre-vocational Services shall include remunerative work including supervision and instruction in work tasks and observance of safety principles in a realistic work atmosphere. A realistic work atmosphere is most effectively provided within a community job site setting, whenever possible.
 - a. Work orientation shall be provided to encourage good work habits. The orientation shall include proper care and handling of equipment, materials, tools and machines, and shall also include information on good attendance, punctuality, and safe work practices. Work orientation shall afford a work pace consistent with the participant's potential.
 - b. The layout of work positions and the assignment of operations shall ensure the efficient flow of work and appropriate relationship of each operation to all other operations in its sequence with respect to the time required for its completion. The organization of work shall embody awareness of safe practices and of the importance of time and motion economy in relation to the needs of individuals being served.

- a. Information concerning health and special work considerations of participants should be taken into account and shall be clearly communicated in writing to supervisory personnel.
 - b. Vocational counseling shall be available.
6. The agency offering pre-vocational Services, shall maintain provisions either within its parent organization or through cooperative agreements with the Division of Vocational Rehabilitation or other job placing agencies, for the placement of any individuals served into regular competitive industry. Individuals shall be informed of the availability of placement services in regular competitive industry.
7. The agency offering pre-vocational services shall maintain payroll sub-minimum wage certificates and other records for each participant employed in compliance with the Fair Labor Standards Act.
8. The agency offering pre-vocational services shall provide the participant with effective and accessible grievance and complaint procedures.
9. Pre-vocational Services shall be provided as recommended in the individual service plan.
10. Appointed staff supervising the pre-vocational services shall send a written report to the Care Manager/ Support and Service Coordinator at least every six months. The report shall contain a statement on progress toward the goals and objectives of the participant service plan and the recommendations for changes.
11. If the participant receiving pre-vocational services displays challenging needs, a positive written behavior support plan must be developed and implemented to assist the participant.

DOCUMENTATION

1. The county or contract agency must be able to provide documentation verifying that the provider and personnel meet the standards in this section. County agencies may choose to include a provision in contracts or provider agreements with provider agencies requiring that the personnel and program meet standards.
2. The Vocational Service Plan must include the following information:
 - a. Documentation of each participant's rate of pay and wages;

- b. Documentation indicating that the intent of the program is not directed toward a specific job skill;
 - c. A description of services which focuses on general habilitative rather than specific employment objectives;
 - d. A description of the specific Pre-vocational activities that the participant will be engaged in, and
 - e. Written rationale as to why the participant is not expected to join the general work force, or participate in Supported Employment, within a year and a statement addressing what the participant would need to do to participate in supported employment.
3. The agency offering pre-vocational services shall maintain payroll, sub-minimum wage certificates in compliance with the Fair Labor Standards Act.
4. The agency, when appropriate, will report participant's wages to Social Security.
5. The agency offering pre-vocational services shall provide the participant with effective grievance procedures that link to the county's process under DHS 94.
6. If separate transportation is provided, the cost of transportation must be clearly identified separately from other pre-vocational services.
7. The county must maintain documentation that a semi-annual review has been done that addresses progress toward Pre-vocational objectives, reasons why pre-vocational services remain appropriate, and recommendations for any changes.
8. There shall be documentation of current and up to date criminal and caregiver background checks in the participant's or a provider file on all persons providing services and supports to any waiver participant.
9. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency

**RELOCATION RELATED – UTILITIES
SPC 106.01**

**RELOCATION RELATED– HOUSING START UP
SPC 106.03**

Applies to CIP II, COP-W & COR

(See Housing Start Up for CIP 1A/1B, BIW and CLTS)

DEFINITION

Relocation related services include the payment of certain costs associated with relocating from an institution. Costs may include the initial fees to establish utility service or the purchase of essential items and services needed to establish a community living arrangement.

Relocation related housing start up services includes person-specific services, supports or goods that may be arranged, scheduled, contracted or purchased, and that will be put in place in preparation for the participant's relocation to a safe, accessible community living arrangement. There is no institutional length of stay requirement that must be met in order to access this service.

SERVICE REQUIREMENTS/EXCLUSIONS/LIMITATIONS

1. Allowable relocation related services under this SPC may be initiated up to 90 days prior to the date of relocation. Services provided between 90 and 180 days prior to discharge must be approved by the Bureau.
2. Relocation related utility services may include payment of initial utility connection costs and or fees (heating/electric/water and telephone installation charges).
3. Includes the purchase of essential home furnishings, such as necessary basic furniture and kitchen appliances not furnished in the housing arrangement. Includes telephone(s), cooking/serving utensils, basic cleaning equipment and household supplies as well as basic bathroom and bedroom furnishings.
4. Allowable relocation related costs may include the payment of a security deposit.
5. Home modifications necessary prior to the relocation are allowable, but are reported under home modifications (SPC 112.56).

6. Includes initial services to move personal belongings and to prepare the selected community living arrangement. This preparation activity may include general cleaning and the organization of household supplies and furnishings.
7. Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc).
8. Excludes the use of waiver funds to purchase service agreements or extended warranties for appliances or any other home furnishings provided under this SPC.
9. Providers of relocation related services who meet the definition of a caregiver are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions described in Chapter IV, Section 4.05, of this manual.

STANDARDS

1. Security deposits for lease agreements may only be made to owners or providers of safe, quality housing who comply with all local housing and building codes.
2. Furnishings and equipment purchased must be in good condition and safe working order.
3. Payments for utility or telephone service connection charges may only be made to providers registered with the Wisconsin Public Service Commission.
4. Providers of services to prepare the housing arrangement for occupation and assist the participant with the moving of personal belongings must meet the same standards applied to Supportive Home Care workers.

DOCUMENTATION

1. County agencies shall maintain copies of the participant lease agreement as well as copies of telephone and utility connection billings paid by the agency.
2. County agencies shall maintain documentation in the participant record or in an accessible location within the agency verifying that the providers of housing preparation services meet the training requirements for Supportive Home Care as described in Appendix T of this manual.

3. Each service provided under housing start up must be listed separately on the ISP.
4. The county or contract agency shall maintain in the participant file or in an accessible location within the agency, documentation that the appropriate caregiver/criminal background checks were completed.
5. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

RESIDENTIAL CARE APARTMENT COMPLEX

SPC 711

Applies to CIP II, COP-W & COR

DEFINITION

Residential care apartment complex (RCAC) means a place where five or more adults reside and which consists of independent apartments, each having an individual lockable entrance and exit. Each unit must have a kitchen, including a stove or microwave oven (of at least 1000 watts), an individual bathroom, sleeping and living areas. The RCAC may provide to residents of the place, not more than 28 hours per week of supportive, personal and nursing services.

An RCAC does not include a nursing home or a community based residential facility, but may be physically part of a structure that is a nursing home or community based residential facility (DHS 89.13 (1)). To be a Medicaid waiver allowable setting, the facility or a distinct part of the facility must consist entirely of certified RCAC units or a combination of certified RCAC units and conventional independent apartments.

RCAC services means services provided by an RCAC, either directly or under contract, to meet the needs identified in a tenant's service agreement, to meet unscheduled care needs or to provide emergency services 24 hours a day (DHS 89.13 (2)). In addition to supportive, personal and nursing services provided directly by the RCAC, other persons or agencies may also provide services directly or under arrangement with the RCAC, that supplement but do not supplant those provided by the facility.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. The RCAC must be certified by the Department in accordance with DHS 89.
2. To be eligible for waiver funding, the RCAC resident must have an approved service agreement that does not exceed a maximum daily cost, set annually by the Department, for supportive, personal and nursing services provided by the RCAC. Service costs above the maximum will result in the loss of eligibility for waiver funding for the resident in the facility.
3. A certified RCAC may not admit a person who has been found incompetent or who has an activated power of attorney for health care or a person who has been found by a physician or psychologist to be incapable of recognizing danger, summoning assistance or making care decisions (DHS 89.29 (1).) However, any person who was

a tenant in the facility prior to a finding of incompetence may be retained by the facility if the RCAC can meet the standards outlined in DHS 89.29 (2) (b).

4. The RCAC operator must have a cost allocation methodology that clearly distinguishes waiver allowable and non-waiver allowable (room and board) costs.
5. RCAC services may not be funded by the COP program.
6. Excludes costs associated with room and board in the facility.
7. Billing waiver services under SPC 711 precludes billing the waiver program for SPCs 104, 112.46, 112.56 and 710. This means that waiver participants residing in an RCAC may not receive funding for supportive home care, personal emergency response systems, home modifications or nursing.
8. To assure the health and safety of RCAC residents, the county agency must visit the facility to verify and document the facility is able to meet the participant's needs.
9. RCAC providers and staff are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions described in Section 4.05 of this manual.
10. Providers of RCAC services to COP-W, CIP II and COR participants must promptly communicate with the care manager and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered, or if not addressed, may endanger the health or safety of the participant.
11. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.

STANDARDS

The RCAC must be certified by the Department and be in satisfactory compliance with Chapter 50.034, Wisconsin Statutes and DHS 89. Copies of DHS 89 may be obtained at code/dhs/dhs089.pdf or by contacting the DHS Division of Quality Assurance.

DOCUMENTATION

1. The RCAC provider must maintain documentation of current certification from the Bureau of Quality Assurance. The county agency must assure that the facility is certified.
2. The RCAC provider must have a cost allocation methodology to distinguish waiver allowable costs from non-waiver allowable costs, such as room and board. The operator must provide written, participant-specific billing statements to the waiver agency that outline the cost break-down within the RCAC rate.
3. Documentation that clearly describes the individual room and board **and** care and supervision costs in the facility must be maintained in the participant record located at the waiver agency.
4. A participant residing in an RCAC must have a written service agreement based on a comprehensive assessment conducted prior to admission. The service agreement must be maintained in the resident record at the facility and must be available for review.
5. A participant residing in an RCAC must have a written, signed and dated individualized risk agreement with the facility. The agreement, at a minimum, will contain all of the information outlined in the sample risk agreement available from the Bureau. The risk agreement shall be updated at any time the participant's condition or service needs change and the change affects participant risk. The risk agreement shall be maintained in the resident record at the facility and must be available for review.
6. Current documentation of completed criminal, caregiver and licensing background checks must be maintained by the RCAC provider and must be accessible for review by the waiver agency.
7. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
8. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

RESPITE CARE

SPC 103.22 – Residential Respite
SPC 103.24 – Institutional Respite
SPC 103.26 – Home Based Respite
SPC 103.99 – Other Setting Respite

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Respite care services are those services provided to a waiver eligible participant on a short-term basis, to relieve the participant's primary caregiver(s) from care demands. Respite care services may be provided in a residential setting, institutional setting, the home of the participant, or in another community setting not described above. All respite occurring in an institution requires prior approval from the Department.

1. Residential Respite

Residential respite may be provided in the following allowable settings:

- a. Adult Family Home certified for one or two persons
- b. Adult Family Home licensed for three or four persons
- c. Children's Foster Home, including Treatment Foster Home
- d. Children's Group Home
- e. Community Based Residential Facility⁴
- f. Residential Care Apartment Complex⁵

Residential respite may involve overnight stays or partial day stays by the participant. Costs for room and board in these settings **may** be included in the charge to the waiver program. The actual length of the respite stay must be specified in the participant record.

2. Institutional Respite

A. CIP 1A/1B, CIP II, COP-W and COR

Institutional respite care service may be provided in a Medicaid certified institutional setting, including any of the following, as applicable:

- 1) Hospital
- 2) Nursing Home

⁴ The CBRF 8-bed limit applies to CIP 1A, CIP 1B, BIW and CLTS. The 8 -bed size limit does not apply to COP-W and CIP II.

⁵ RCACs are not an allowable setting for waiver participants using CIP 1A, CIP 1B, BIW and CLTS.

3) Intermediate Care Facility for the Mentally Retarded (ICF-MR)

B. CLTS Waivers

1. CLTS- DD

Institutional respite care services may be provided in a Medicaid certified institutional setting including any of the following:

- (a) Hospital
- (b) Nursing Home
- (c) Intermediate Care Facility for the Mentally Retarded (ICF-MR)
- (d) Residential Care Center /Child Caring Institution
- (e) Wisconsin State Developmental Disability Center

2. CLTS - PD

Institutional respite care services may be provided in a certified Medicaid institutional setting including any of the following:

- (a) Hospital
- (b) Nursing Home
- (c) Intermediate Care Facility for the Mentally Retarded (ICF-MR)
- (d) Residential Care Center/Child Caring Institution

3. CLTS - SED

Institutional respite care services may be provided in a certified Medicaid institutional setting including any of the following:

- (a) Residential Care Center/Child Caring Institution
- (b) Wisconsin State Mental Health Institution

Institutional respite services may involve over night or partial day stays by the participant. Costs for room and board in these settings **may** be included in the charge to the waiver. The actual length of the respite stay must be specified in the participant record.

3. Home Based Respite

When respite care service is provided in the home of the participant it is defined as Home Based Respite. Home based respite care services may be provided in partial day or overnight increments. Costs for room and board in these settings **may not** be included in the charge to the waiver program. The actual length of the respite stay must be specified in the participant record.

4. Other Setting Respite

Other Setting Respite services may be provided in a home other than the home of the participant or in another setting not described above. Services may involve overnight or partial day stays by the participant. The actual length of the respite stay must be specified in the participant record.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Respite care services may not be used for any purpose (e.g. treatment) other than to relieve the participant's caregiver from care demands.
2. Respite care stays may not exceed 28 days without prior approval by the Bureau or its designee.
3. Institutional respite care services require prior approval by the Department, except in an emergency situation. Emergency situation is defined as a situation where the primary caregiver suddenly or unexpectedly becomes unable to provide care due to death, illness, disability or other unanticipated event.

Requests for approval of institutional respite must include the rationale for the use of respite in such settings. The request for prior approval must include the following information:

- a. The reason for the request, identifying the caregiver in need of respite;
 - b. The anticipated length of the respite placement;
 - c. A description of the barriers to the use of alternative community based services;
 - d. A description of the proposed respite setting and the reasons that setting was chosen;
 - e. A plan to address the length of stay limitation in institutional respite.
4. **For CIP II, COP-W and COR:** Once prior approval of an Institutional Respite placement has been issued, subsequent placements of that participant to the approved institution do not require approval. However, if a different institutional respite setting is later sought for the participant, a new prior approval must be obtained.
 5. The variance requirements for CIP 1A, CIP 1B and BIW include time limitations and other restrictions. Please refer to Chapter VI of this manual for variance specifics.
 6. Payment for other duplicative services is precluded while the participant a person is in respite care.
 7. Respite care services may not be used to fill gaps in the participant's service plan due to worker shortages or other home care shortfalls. Respite care services may not be used to meet the needs of persons temporarily without a permanent living arrangement.
 8. Room and board costs **may not** be included in the charge to the waiver program for **Home Based Respite** and **Other Setting Respite** services.

9. Room and board costs **may** be included in the charge to the waiver program for **Residential Respite** and **Institutional Respite** services.
10. When **Other Setting Respite** care services are provided in a private home other than the home of the participant the following conditions apply:
 - a. When the planned length of stay is to be **72 hours or less**:
 - (1) The home is the preferred choice of the participant and the primary caregiver, **and**
 - (2) The caregiver assures that the home is safe and the respite provider is trained and capable of providing the appropriate level of care and supervision needed.
 - b. When the planned length of stay is to be longer than 72 hours:
 - (1) The CM/SSC must assure that the home meets the specifications as specified in Section 202.05 of the Medicaid Waiver Standards for Wisconsin Adult Family Homes located in Appendix J(Adults) and DHS 38.11 and 56.07-08 (Children), **and**
 - (2) The CM/SSC assures that the provider meets the standards of **Appendix T** and is capable of providing the appropriate level of care and supervision needed by the participant.
11. When **Other Setting Respite** is provided in a family day care setting, the CM/SSC must assure that the family day care setting has a current license.
12. When **Residential Respite** care is provided, the admission of the waiver participant to the facility **shall not** result in the provider exceeding the licensed capacity of the facility or the terms of its license or certification. No respite placement may be made to any facility that is at its licensed capacity.
13. In CIP II, COP-W and COR; if residential respite occurs in a CBRF that is larger than 20 beds, or in a facility that is structurally connected to a nursing home, or other institution, a variance as described in Chapter V, Section 5.05 must be obtained.
14. All respite care providers are subject to the required criminal, caregiver and licensing background checks described in Section 4.05 of this manual.
15. All providers of respite care services to CIP 1A, CIP 1B, BIW and CLTS participants must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.

16. All providers of respite care services to COP-W, CIP II and COR participants must promptly communicate with the care manager and/or the county adult protective services unit any incidents or situations or conditions that have endangered or, if not addressed, may endanger the health or safety of the participant.
17. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.
18. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

Residential Respite

The facility must meet all of the provider standards required of a certified or licensed Adult Family Home, a licensed Community Based Residential Facility, or a certified Residential Care Apartment Complex, as described in applicable Wisconsin statutes and DHS administrative rules.

Institutional Respite

The facility must be a Medicaid certified hospital, nursing home or an intermediate care facility for the mentally retarded (ICF-MR).

Home Based Respite

Individual providers of respite care provided in the home of the participant must meet the training standards described in **Appendix T** of this manual.

Other Setting Respite

1. When respite care is to be provided in a private home which is not the home of the participant for a period of 72 hours or less, care managers/support and service coordinators shall assure that the home is the preferred choice of the participant and the caregiver. The CM/SSC shall also assure that the respite provider has been trained regarding the needs of the participant.

2. When Other Setting Respite is to be provided in a private home which is not the home of the participant for a period greater than 72 hours, care managers/support and service coordinators shall assure that the home meets the standards described in DHS 82.05 (Adults) and DHS 38 and DHS 56 (Children) **and** that the respite providers meet the standards for training as described in **Appendix T** of this manual.
3. When Other Setting Respite is provided to a child in a Family Day Care setting or in a day care center for children, the center must have current licensure under DHS 45 or DHS 46, respectively.

DOCUMENTATION

1. Residential Respite providers must maintain documentation of current licensure or certification under the applicable statutes or administrative rules and must assure that providers and staff meet the training standards as described in **Appendix T** of this manual. The CM/SSC shall document the required provider training standards have been met and document the planned length of the respite stay in the participant record.
2. Institutional Respite providers must have documentation of current Medicaid certification. The CM/SSC shall document the planned length of stay in the participant record.
3. Providers of Home Based Respite and Other Setting Respite shall document that the applicable standards for training and home environment have been met. The CM/SSC shall document that applicable provider training standards have been met and document the planned length of stay in the participant record.
4. For residential and institutional respite, the provider agencies must maintain documentation that the criminal, caregiver and licensing background checks have been completed for all respite care providers.
5. For home based and other setting respite, the waiver agency must maintain documentation that the criminal, caregiver and licensing background checks have been completed for all respite care providers.
6. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
7. For the COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies

are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

SHORT-TERM SUPERVISION and OBSERVATION

SPC 104.30

Applies to COR

DEFINITION

Short Term Supervision and Observation is the provision of up to 24 hours a day monitoring of a person who is unstable but cleared by a psychiatrist to remain in the community supervised by trained staff under the direction of a medical professional. Trained staff may include peer specialists. Services include supportive activities typically described in a crisis/behavior support plan. The STSO can be either a temporary residential stay or in-home services. At the consumer's request, observation and supervision is provided to prevent the escalation of psychiatric symptoms. This service is developed as an “advance directive or “WRAP” Wellness Recovery Action Plan during the person centered planning process specifically to be used at the time of crisis. The decision will be made by a physician that the individual can safely be provided this level of care as opposed to requiring an inpatient setting.

Following are examples of situations in which this service may be applicable: a consumer who is fearful they may self-mutilate; a consumer who recognizes the beginning of a manic phase and is concerned that they may start gambling or engage in other self-destructive activities; a consumer who is fearful of being alone during a transition, such as a discharge from a psychiatric hospitalization. Without this support the consumer's symptoms may escalate to the point of needing hospitalization or institutionalization.

The interventions provided are those usually offered as Supportive Home Care, i.e. Personal and household services. The condition of the individual is unstable, in need of close support and under the supervision of an on call psychiatrist, physician or nurse who is available to respond to a provider with immediacy.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Services available through the State’s Medicaid Plan and DHS 34 “Emergency Mental Health Services” must be accessed prior to using the COR SPC. If the service is not available or extends beyond the amount authorized, or when Medicaid funding from other sources are denied, the waiver funding may be used.
2. Payments to spouses are excluded for Short Term Monitoring and Observation. Other family members who meet the standards may however be qualified as providers.

3. Short Term Monitoring and Observation excludes Daily Living Skills Training.
4. Short Term Monitoring and Observation is a service which may be directed by a Wellness Recovery Action Plan (WRAP) or advanced directive developed and approved prior to the time of crisis and including demonstrated techniques proven to be of help in assisting the person recover from the temporary crisis.
5. Household maintenance provided during this period is minimal, usual and customary, and as needed for health and sanitary conditions. Food preparation, dishwashing and clean up in the kitchen, laundry, and bathroom as needed are examples of such service.
6. Services may be provided outside of the person's home but will not supplant services purchased as part of the license or certificate of a substitute care setting.
7. Providers are subject to caregiver and criminal background checks.
8. Services are anticipated to be provided for 72 hours but may be extended up to 30 days as needed and authorized by a psychiatrist.
9. Providers must communicate immediately any concerns or changes in condition involving health or safety that require consultation or change in services.
10. All providers of respite care services to COR participants must promptly communicate with the care manager and/or the county adult protective services unit any incidents or situations or conditions that have endangered or, if not addressed, may endanger the health or safety of the participant.
11. The county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.
12. Procedures to ensure backup providers are an essential and required element of Short term Supervision and Observation.

STANDARDS

1. Providers of STSO must have training in WRAP and/advance directives, emergency mental health services, trauma and techniques to assist in recovery.

2. Supportive Home Care standards as identified in Appendix T of the manual are additional training requirements for qualified providers.

DOCUMENTATION

1. A personnel file for each provider will contain evidence of qualifications and required training that demonstrates standards are met.
2. A statement or denial that Medicaid Plan services were denied or not available.
3. The personnel file for the provider will document the caregiver and criminal background screen and successful completion.
4. Progress notes will be provided in a manner required to the Care Manager for each unit of an intervention provided, described, signed and dated.
5. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
6. For Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

SPECIALIZED MEDICAL AND THERAPEUTIC SUPPLIES

SPC 112.55

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Specialized medical and therapeutic supplies are those items necessary to maintain the participant's health, manage a medical or physical condition, improve functioning or enhance independence. Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan when coverage of the additional items or devices has been denied. Items or devices provided must be of direct medical or remedial benefit to the participant.

Allowable items devices or supplies may include incontinence supplies, wound dressings, IV or life support equipment, orthotics, nutritional supplements, vitamins, over the counter medications and skin conditioning lotions/lubricants. Additional allowable items may include books, videos and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, air purifiers, humidifiers and water treatment systems may be allowable when recommended or prescribed by the participant's physician.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Waiver funds may be used to purchase specialized medical supplies in the following circumstances:
 - a. When the CM/SSC has determined that the items or supplies are not covered by or exceed state plan service limits or the items or supplies have been denied Medicaid state plan coverage; or
 - b. When the CM/SSC determines that the items or supplies provided with Medicaid state plan coverage do not adequately or safely meet the assessed needs of the participant; or
 - c. When the CM/SSC determines that the service is not allowed under Healthcheck/EPSTDT for a child.
2. Includes only those medical or therapeutic items or supplies that have a direct medical or remedial benefit to the health or safety of the participant.

3. Excludes items that are experimental (as defined in DHS 107.035) in nature or that are in aversive to the participant in any manner.
4. Excludes medication set up charges that are a Medicaid state plan covered service.
5. The cost of professional set up, installation and routine maintenance (excluding medication set up) of allowable specialized medical or therapeutic supplies may be covered under this waiver service. Installation that requires a significant change to the structure of the home is considered a home modification and those installation costs should be billed to SPC 112.56. For example, cutting an opening in a wall to install a room air conditioner is a home modification. The cost of the air conditioning unit itself is billed to specialized medical and therapeutic supplies, SPC112.55.

STANDARDS

All items and supplies shall meet applicable standards of manufacture, design, installation, safety and treatment efficacy.

DOCUMENTATION

1. Documentation in the participant file must indicate a denial of Medicaid state plan Healthcheck/EPSTDT authorization for the item or supply or that Medicaid authorized limits have been reached.
2. Documentation in the participant record must provide the rationale that the CM/SSC used to determine that state plan provided items do not adequately or safely meet the participant needs.
3. Documentation in the participant record must address the direct medical or remedial benefit of the item or supplies purchased with waiver funds. Acceptable documentation may include:
 - a. An order or prescription from the participant's physician
 - b. A written recommendation from the medical/therapy professional
 - c. A case note verifying a verbal contact between the CM/SSC and the medical/therapy professional verifying the recommendation of the item or supply
 - d. A case note containing a detailed description of the medical/remedial benefit of the item or supply to the participant.
4. The specialized medical or therapeutic supply purchased and the unit cost must be listed on the participant's individual service plan.

5. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

SPECIALIZED TRANSPORTATION

SPC 107.30 – One Way Trips

SPC 107.40 – Miles

SPC 107.50 – Items

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Specialized transportation is the provision of services to permit a waiver program participant's access to the community to obtain services, use necessary community resources and participate in community life. Specialized transportation services may include the pre-purchase or provision of such items as tickets, passes, vouchers or other fare medium or may include a direct payment to providers covering the cost of conveyance. Services may also include the development of a standing participant account between the agency and the transportation provider.

Specialized transportation services are intended to maintain or improve the participant's mobility in the community, increase independence and community participation and prevent institutionalization. Community should be broadly defined and should not be limited to the boundaries of any particular municipality. The county should have a written policy to ensure that the community criteria are consistently and equitably applied.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Limited to that transportation which assists or improves a participant's general mobility and their ability to perform such daily tasks as shopping or banking, as well as for the purpose of accessing community resources, employment or other activities as described in the participant record.
2. Excludes transportation provided principally to access a planned waiver program service when such transportation is already covered as a part of the daily cost of that program or service.
3. May include payment for transportation that may otherwise be covered under the state Medicaid plan when Medicaid-funded transportation is unavailable at the time the medical care or treatment is needed or scheduled **and** the care or treatment cannot be safely or reasonably rescheduled. "Unavailable" means that the ride could not be booked due to provider(s) lack of capacity, or provider(s) are unable to respond to meet the scheduled need. "Unavailable" is not a Medicaid denial.

4. Excludes payment of participant co-payment charges for Medicaid-funded transportation.
5. A fare or contribution to the cost of this service may not be collected per s. 49.49 (3m) Wis. Stats. if the participant's transportation is reimbursed as Specialized Transportation.
6. Includes the fare or other transportation charges for an attendant, if needed, to accompany the participant when accessing the community. Attendant costs related to care or supervision services are excluded under this SPC but may be allowed under SPC 104, Supportive Home Care.
7. Excludes the rental or leasing of accessible vans or any other vehicle.
8. For the COR waiver, this service is included as an option for participant directed services employer authority.

STANDARDS

1. Mass transit carriers are regulated under s. 85.20, and the provision of specialized transportation is regulated under s. 85.21 of Wisconsin Statutes.
2. Individual or volunteer providers of transportation services must provide documentation of current liability insurance coverage, possess a valid driver's license and provide written assurance of the following:
 - a. The vehicle used is mechanically sound, has properly functioning lighting, safety, ventilation and braking systems, and
 - b. The vehicle has tires that are properly inflated, without excessive wear.
3. All transportation providers that meet the definition of caregiver are subject to the required criminal, caregiver and licensing background checks described in Section 4.05 of this manual.
4. Providers of specialized transportation services to CIP 1A, CIP 1B, CLTS and BIW participants must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.
5. Providers of specialized transportation services to CIP II, COP-W or COR participants must promptly communicate with the care manager and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered or, if not addressed, may endanger the health or safety of the participant.

6. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.

DOCUMENTATION

1. The participant file must contain documentation that the standards described in item 2, (STANDARDS), above have been met in a manner appropriate to the provider's situation. This documentation may include a checklist, completed and signed by each provider that is submitted initially and resubmitted on an annual basis. Such documentation must be submitted for any new individual or volunteer provider as each is added to the service plan.
2. When waiver funding is used for transportation services that may otherwise have been funded by Medicaid, the CM/SSC must document in the participant record that:
 - a. A reasonable effort was made to schedule the ride from Medicaid transportation providers **and**
 - b. Medicaid transportation providers were unable to provide the service at the time the care or treatment was needed, **and**
 - c. The care or treatment could not safely or reasonably be rescheduled.
3. Transportation as a distinct service need must be identified in the assessment and listed on the individual service plan.
4. For persons providing this service who meet the definition of caregiver, documentation of current criminal, caregiver and licensing background checks must be maintained in the participant or provider agency file for all persons providing specialized transportation.
5. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
6. For COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State

COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

SUPPORT AND SERVICE COORDINATION / CARE MANAGEMENT

(Formerly known as Case Management)

SPC 604

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

Please refer to the definition of the service “Care Management/Support and Service Coordination” contained in this Manual (Chapter IV, page 33).

SUPPORTED EMPLOYMENT SERVICES

SPC 615

Applies to CIP 1A/1B, BIW, CLTS

DEFINITION

Supported Employment is the provision of assistance to facilitate the employment of a participant in an integrated work setting. Includes job development aimed at developing a position in a community job or a carved out portion of an already existing position. Participants using this service may need ongoing support to maintain employment. Specific services include vocational/ job-related assessment, job development, referral, on-the-job support and coaching, education or training and transportation. Other support services including services not specifically related to job skill training may also be provided based on the needs of the specific participant served.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. The Medicaid Waiver may not fund supported employment until all Vocational Rehabilitation funding is exhausted, unnecessary or unavailable.
2. Federal and state wage certificates must cover the participant and the employer whenever the participant is paid at a rate that is less than the state's minimum wage.
3. All local, State and Federal laws governing any aspect of employment must be followed.
4. The provider must be able to demonstrate the ability and qualification to provide this service through one of the following ways:
 - a. Accreditation by the Rehabilitation Accreditation Commission (CARF);
 - b. Accreditation by another nationally recognized accreditation agency;
 - c. The existence of a current contract with the State's Vocational Rehabilitation agency (DVR) for supported employment service provision; or
 - d. The submission of written documentation that evidences the organization meets all DVR Technical Specifications related to supported employment.
5. All persons providing services and supports to any waiver participant shall be subject to a criminal and caregiver background check before they begin employment. Both types of background checks must be repeated every four years.

Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. Persons providing these services shall comply with all relevant provisions of Section 4.05 of Chapter IV of the Medicaid Waivers Manual.

6. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter IX.
7. The provider shall send a written report to the Support and Service Coordinator not less than once every six months. A copy of this report shall be sent to the participant or their guardian.
8. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.

STANDARDS

A. Program

1. Participants must be paid wages commensurate with their productivity. The employment is expected to be integrated, stable and safe. It shall provide regular and predictable working hours, and opportunities for advancement or expansion of job duties.
2. The Supported Employment provider agency must be able to deliver service in accordance with the Technical Specifications for Supported Employment. These specifications include the following :
 - a. Assessment:
The assessment is an evaluation of a participant's functional abilities in a variety of settings. The provider must involve the participant and as appropriate, the participant's family and advocates. The assessment shall document the preferences, values and needs of the individual. The assessment occurs in environments both familiar and unfamiliar to the participant. The assessment may include community work experiences. Not less than 80% of the assessment may occur in the community. Assessments must be updated as necessary.

The purpose of the assessment is to determine:

- (1) The participant's desire for supported employment;
- (2) A participant's appropriateness for supported employment;
- (3) The nature and intensity of services which may be necessary for the participant to obtain and sustain employment;
- (4) The participant's strengths and abilities;
- (5) The participant's employment goals;
- (6) The participant's economic status and the possible loss or reduction of public benefits;
- (7) The participant's relevant health information;
- (8) The participant's need for assistive technology or other accommodation;
- (9) The participant's preference for job development strategies;
- (10) The participant's current support systems;
- (11) The participant's past vocational experience, education and training;
- (12) The participant's accessibility needs; and
- (13) Any safety considerations that may be needed for a supported employment placement.

b. Plan for Job Development

Upon completion of the assessment, the plan for job development is completed. This plan along with the assessment is sent to the county and the participant/guardian. Job placement cannot occur prior to a review of the assessment and plan for job development. The plan for job development must include the following elements:

- (1) A description identifying the procedures and process used to complete the assessment;
- (2) A statement that describes how and to what degree the participant will control their supports;
- (3) A summary of the participant's preferred days, time of day and hours per week to work;
- (4) A description of any preferred industry/employer where the participant would prefer to work ;
- (5) Approximate amount and type of support the participant needs on and off the job in order to sustain the employment.
- (6) Identification of the amount and type of long-term support service needs of the participant;
- (7) A description of the specific service to be provided in conjunction with the supported employment services and the identity of the providers and individuals that will provide each service;

- (8) Identification of job development strategies that will be used;
 - (9) Identification of potential job sites;
 - (10) Identification of job training/coaching and any strategies to fade out supports; and
 - (11) The plan for monitoring the participant's outcomes or goals.
- c. Job Coaching/Teaching (Supported employment training)
Job coaching/teaching includes specific job skill teaching provided either on or off the job site, coordination of work related services such as transportation, providing assistive technology resources and other disability related accommodations and teaching the participant about work-related behavior and other employment standards.

B. Personnel

1. Supported employment services shall be provided by personnel that have skills and abilities in the areas of assessment, job development, job placement, job retention and evaluation. Typical skill that personnel should have include:
 - a. Knowledge, skill and abilities in assessing individuals who have developmental disabilities including:
 - (1) Observational methods and techniques;
 - (2) Interviewing methods;
 - (3) Developing work experiences for situational assessments;
 - (4) Performing person-centered planning;
 - (5) General awareness of human service delivery systems and the local business community; and
 - (6) Awareness of best practices in supported employment.
 - b. Skill in work site analysis including:
 - (1) Identifying essential job functions;
 - (2) Identifying job quality standards;
 - (3) Identifying opportunities for job restructuring.
 - c. Skill in assessing needs for assistive technology, disability accommodation and individualized ergonomics.
 - d. Skill in the area of job development including:
 - (1) Job restructuring and/or position carve out;
 - (2) Conducting community labor market surveys;
 - (3) Initiating and maintaining employer contacts;

- (4) Using targeted marketing approaches in job development efforts;
 - (5) Conducting job analysis;
 - (6) Matching individuals to specific jobs
 - (7) Following up with employers (especially after trainer fade-out) and,
 - (8) Facilitating job expansion or advancement.
- e. Skill in the areas of sales and marketing including:
- (1) Developing and presenting a proposal on behalf of an individual;
 - (2) Assisting an individual to present their need for accommodation;
 - (3) Facilitating achievement of natural support from co-workers;
 - (4) Marketing of supported employment;
 - (5) Developing and maintaining positive relationships with employers;
 - (6) Identifying and meeting employer expectations;
 - (7) Using community resources effectively;
 - (8) Working with teams;
 - (9) Communicating with staff about job market trends and training needs; and
 - (10) Training the community and employers on the merits of supported employment.
- f. Skills in the area of job coaching including:
- (1) Understanding developmental and other learning styles;
 - (2) Designing and implementing strategies to accomplish job retention.
 - (3) Understanding successful on-the-job training, including fading strategies;
 - (4) Understanding the value of employer consulting and,
 - (5) Providing employment counseling and knowing when to offer it.
- g. Skill in the area of outcome development and program evaluation.
- (1) Measuring personal outcomes of participants, and
 - (2) Implementing participant satisfaction surveys and other quality assurance, quality improvement and evaluation tools and methods.

DOCUMENTATION

1. The participant file that is maintained by the service coordinator shall contain an assessment where the need for this service must be documented.
2. The participant file shall contain documentation that DVR services were either denied, exhausted or are not available before the Waiver was used to fund this service.
3. The participant's county file must contain a copy of the supported employment assessment, job development plan and all six-month progress reports.

4. The county must document that the service provider meets all applicable standards.
5. The provider shall maintain an individual file for each participant served. This file record must include the assessment, job development plan, training/coaching plan and plan for long-term support.
6. Documentation of current caregiver and criminal background checks of all service providers must be available and easily accessed upon request. This documentation may be in either the participant's county file or in the county record.
7. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.

SUPPORTIVE HOME CARE

SPC 104.10 days SPC 104.20 hours

Applies to CIP 1A/1B, BIW, CIP II, COP-W, CLTS & COR

DEFINITION

Supportive Home Care (SHC) is the provision of a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community.

Supportive home care services include:

1. Personal Services
 - a. Assistance with activities of daily living such as eating, bathing, grooming, personal hygiene, dressing, exercising, transfer and ambulation;
 - b. Assistance in the use of adaptive equipment, mobility and communication aids;
 - c. Accompaniment of a participant to community activities;
 - d. Assistance with medications that are ordinarily self-administered;
 - e. Attendant care;
 - f. Supervision and monitoring of participants in their homes, during transportation (if not done by the transportation provider) and in community settings;
 - g. Reporting of observed changes in the participant's condition and needs; and
 - h. Extension of therapy services. "Extension of therapy services" means activities by the SHC worker that assist the participant with a PT, OT or other therapeutic treatment plan. These activities may include assistance with exercise routines, range of motion exercises, standing by during therapies for safety reasons, having the SHC worker read the therapist's directions, helping the participant remember and follow the steps of the exercise plan or hands on assistance with equipment/devices used in the therapy routine. It does not include the actual service the therapist provides.
2. Household Services
 - a. Performance of household tasks and home maintenance activities, such as meal preparation, shopping, laundry, house cleaning, simple home repairs, snow shoveling, lawn mowing and running errands;
 - b. Assistance with packing and general house cleaning when a participant moves.
3. Room and board costs for SHC providers who "live in" are allowable under this SPC.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Services should first be explored through the state's Medicaid plan. When the participant requires care, which extends beyond the amount of authorized Medicaid personal care, or when Medicaid funded services are denied or cannot be provided, waiver funding may be used.
2. Excludes payments for supportive home care services to the spouse of the participant or to the parent or stepparent of a minor child. Family members other than those listed above may be allowable providers if they meet the standards outlined in the standards located in **Appendix T** of this manual.
3. Supportive Home Care services exclude Daily Living Skills Training (DLST) services. DLST is distinguished from SHC by the intent of the provider. SHC providers perform tasks the participant is unable to do without assistance while DLST is intended teach the participant to complete the task independently.
4. When participants choose to direct some or all of their supportive home care services the waiver agency must take steps to first determine the participant's ability and/or desire to direct Supportive Home Care and then provide support to the participant in directing his/her service.
5. Excludes household maintenance that changes the physical structure of the home. Certain structural adaptations to the home may be allowable under Home Modifications (SPC 112.56).
6. Excludes general home maintenance activities including painting, plumbing or electrical repairs as well as exterior maintenance.
7. Participants who are residents of a Residential Care Apartment Complex are not eligible to receive waiver-funded supportive home care services.
8. SHC services funded by the waivers may be provided in a setting other than the home of the participant as long as the provider meets the training standards described in **Appendix T**. However, SHC services may not supplant services already purchased in a licensed or certified substitute care setting.
9. All SHC providers that meet the definition of caregiver are subject to the required criminal, caregiver and licensing background checks described in Section 4.05 of this manual.

10. Providers of supportive home care services to CIP 1A, CIP 1B, CLTS and BIW participants must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter IX of this manual.
11. Providers of supportive home care services to CIP II, COP-W and COR participants must promptly communicate with the care manager and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered or, if not addressed, may endanger the health or safety of the participant
12. For the COR waiver, the county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.
13. County and provider agencies shall ensure that procedures are in place to provide back up services when the assigned supportive home care provider is not available.
14. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under specialized transportation (SPC 107), but not both. All providers shall ensure that the standards described in SPC 107 are met.
15. For the COR waiver, this service is included as an option for participant directed services employer authority.

STANDARDS

1. Supportive home care standards for training are described in **Appendix T** of this manual.

DOCUMENTATION

1. The county or contract agency shall maintain documentation in the participant record that all persons providing supportive home care to the participant meet the training standards and documentation requirements described in **Appendix T**.
2. The care manager/ support and service coordinator must document that Medicaid funded services were denied or could not be provided.

3. The waiver agency shall document that the required criminal, caregiver and licensing background checks described in Section 4.05 of this manual have occurred. Documentation may include written certification from the caregiver's employing agency that the required background screenings were completed.
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
5. For COR waiver Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.

VOCATIONAL FUTURES PLANNING

SPC 114

Applies to CIP II, COP-W

DEFINITION

Vocational Futures Planning (VFP) service is a consumer directed, team based comprehensive employment readiness service that supports waiver program participants of any age to obtain, maintain or advance in employment. Vocational futures planning service may consist of the following six activities:

1. Identification of the barriers to work, including an assistive technology pre-screen and, if required, an in-depth comprehensive assessment including any barriers that may be present as a result of stigma associated to a particular disability or aging group.
2. Benefits analysis
3. Career exploration
4. Job seeking support
5. Ongoing support

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Vocational futures planning may only be funded through a Medicaid waiver program when it is not available under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
2. Includes services of a qualified Employment Specialist, Benefits Counselor and an Assistive Technology Consultant, as indicated.
3. Includes ongoing support services provided periodically to address work-related issues as they arise (e.g., understanding employer leave policies, scheduling, time sheets, tax withholding, etc.) Ongoing support may also involve assistance to address issues in the work environment, including accessibility, employee – employer relations, etc.
4. Excludes the day to day job coach activities and services as described in SPC 615.
5. Excludes supported employment job placement as defined in SPC 615 or sheltered employment and work activity services as defined in SPC 108.

STANDARDS

1. Providers of Vocational Futures Planning services shall have skills and knowledge typically acquired through:
 - a. Completion of a BA/BS degree in Vocational Rehabilitation, Social Work, Special Education or other related human services field, and
 - b. One year of experience in working with elderly individuals or persons with a physical disability, and
 - c. Knowledge gained through ongoing training from a qualified entity providing a recognized vocational curriculum.

DOCUMENTATION

1. Each waiver participant record must contain copies of the required reports completed by the participant's VFP providers. The completed reports must be filed within 30 days of receiving services. These reports include:
 - a. Barriers and Assets Identification Report, documenting the barriers and assets that the consumer states and identifies. The report includes recommendations as to reducing or eliminating barriers to employment.
 - b. Benefits Analysis Report, providing an explanation of the benefits, entitlements and services the consumer receives and the impact over time of earnings on these benefits, entitlements and services.
 - c. Assistive Technology (AT) Assessment, determining the consumer's need for AT devices and identifying available equipment and devices that will assist the participant to prepare for and engage in employment.
 - d. Career Exploration Report which establishes a career goal as well as short-term employment/training objectives and identifies additional training and/or education needs and rehabilitation technology or employment-related accommodations
 - e. Job Seeking Support Report, describing the consumer's level of preparedness to complete a job application or a resume or to participate in interviews, as well as assistance that may be required (e.g., mock interviewing) and any identified needs for additional education and/or training.

- f. Ongoing Support Reports, documenting concerns and problems that arose so that all parties involved may assist in identifying possible solutions; including monitoring those remedies for their effectiveness.
2. The waiver agency shall document that the required criminal, caregiver and licensing background checks described in Section 4.05 of this manual have occurred.
3. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency

VOCATIONAL RECOVERY

SPC 112.56

Applies to COR

DEFINITION

Vocational Recovery employment services are a full range of activities that are consumer-directed and recovery-team based supports that address the participant's particular needs to prepare for, obtain, maintain or advance in employment. Under the participant's direction the team will focus on the development of self-awareness, assess for skills transference in resume development, identify and address areas of potential stigma, offer opportunity for consumer direction, increase individual confidence, and positive social interaction. Upon transition to community life programs may use voluntary community work experience as a means to assess and develop basic skills, compliance, attendance, customary workplace interactions, task completion, promote creative goal setting, explore careers in a tangible way, and analyze benefits and identified barriers. Among employment models, a person centered planning and recovery model is chosen by the individual, and implemented by the team. The team selected and directed by the participant consists of providers and informal supports that listen to the individual's choices and promote the individual's position to take charge. Team activities at the request of the individual are resource team coordination; job seeking support; interviewing and counseling regarding employment goals; connecting to public and private work and vocational training sites; ensuring needed benefits are either maintained at current levels or accessible to the consumer by other means. Of particular significance are activities to sustain employment including job coaching, transportation, safety and mobility training. This service is included in the participant direction of services employer authority option.

SERVICE REQUIREMENTS/LIMITATIONS/EXCLUSIONS

1. Vocational Recovery may only be funded through the COR Waiver for services that are not typically funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). It is a funding of last resort used to support a variety of skill building related interventions, directed to the needs of the individual, and based on specific symptoms of the disability which interfere with the participant obtaining and holding a job. COR may be used to supplement services not otherwise paid for by Vocational Rehabilitation, Work Force Development, or other state/federal programs available to other citizens.
2. Vocational Recovery includes activities as defined in the SAMHSA toolkit "Supported Employment" that are directed to the individual's Mental Health

management and symptom reduction, but excludes the activities of an employment specialist that focus on the development of a job and requirements of the employer. Activities provided in this area will meet the Fidelity criteria identified in the toolkit. In particular the team may be from CSP, CCS or COR but must include a team that includes an Employment Specialist and other qualified professionals as selected by the participant. It excludes services defined in SPC 615 Supported Employment.

3. Vocational Recovery will help to determine accommodations that will need for a specific job but will not use COR Waiver to fund those accommodations which are allowed required by law.
4. Peer Specialists may be used within the Vocational Recovery SPC if they are trained in the specific area of support identified in the Vocational Recovery definition, are part of the Recovery Team selected by the participant, and are supervised by an individual who has at a minimum a Bachelor's Degree and related training or experience in the area of Vocational Rehabilitation and employment.
5. Providers are subject to criminal and caregiver background check prior to initiating service delivery.
6. The county must report Critical Incidents to the State COR staff in the Division of Mental Health and Substance Abuse Services (DMHSAS). County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the county must take all reasonable steps to protect the person.
7. Transportation may be included as part of the SPC but may also be reimbursed under a separate Transportation service billing.
8. Vocational Recovery is included as an option for participant directed services employer authority.

STANDARDS

Standards will follow those provided in the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) toolkit for "Supported Employment" within the evidence based practice fidelity criteria.

DOCUMENTATION

1. Documentation will meet the standards required by the COR waiver for all services and will be maintained by the identified care manager including specialized assessments and progress notes.
2. Documentation that services were not otherwise allowable through DVR, DWD or another source.
3. The personnel file for each provider will include qualifications, training and other documentation to support that the provider meets applicable standards. It will also include a copy of the caregiver criminal background check.
4. For all applicable waivers, the service provider must have an executed Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation form (F-00180 or F-00180A or F-00180B) on file with the State Medicaid Agency.
5. For COR Critical Incidents, a preliminary report with further details and disposition of the CIR is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days. County waiver agencies are required to report critical incidents to the State staff responsible for the COR waiver using the Critical Incident Report (CIR) form. The CIR is sent to the State COR waiver staff in DMHSAS within 24 hours of a report of the incident. An investigation begins immediately within a county waiver agency and is completed within seven days. A report of the findings is forwarded to the State.