Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.4

Submitted by:

California Department of Health Care Services

Submission Date:	

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
A new waiver for individuals with developmental disabilities who elect to direct their services and supports.

State:	California
Date	3/26/08

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

1. Request Information

A. The **State** of **California** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): **Self-Directed Services Waiver for Individuals with Developmental Disabilities**

C. Type of Request *(select only one)*:

☒	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
○	**Renewal (5 Years) of Waiver #**		
○	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
☒	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2008

E.2 Approved Effective Date *(CMS Use)*:

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☒	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	
	California applies the State's definition of "developmental disability" to the target population of the SDS Waiver described in the Lanterman Act, California Welfare and Institutions Code	

	(WIC) §4512(a): "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services (DDS), in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
☒	Not applicable.			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The California Self-Directed Service Waiver for Individuals with Developmental Disabilities (SDS Waiver) serves individuals who expressly elect to self-direct their waiver supports and services. Self-direction is an approach that supports people with developmental disabilities to plan, obtain, sustain and manage services that meet their individual needs and achieve personally defined outcomes in the most inclusive community setting based on five principles:

1. Freedom - The individual, with freely chosen family and/or friends, plans his or her life and customizes the purchase of needed resources and services.
2. Authority - The individual controls a certain sum of dollars in order to purchase the necessary services and supports.
3. Support - For the individual in arranging for resources and formal/informal personnel to assist him/her to reside in the community.
4. Responsibility - As evidenced through the acceptance of a valued role in the community, and accountability for spending public dollars in ways that are life-enhancing.
5. Leadership - Recognition of the important leadership role that self-advocates must hold in Self-Directed Services.

The California Developmental Disabilities Services Act (Lanterman Act), Welfare and Institutions Code(WIC) §4500 et seq., established the regional center system. The Lanterman Act was amended in 2005 to add WIC §4685.7 to authorize the SDS program, contingent upon approval of a federal waiver.

Subject to approval by the Centers for Medicare and Medicaid Services of a 1915(c) Waiver, beginning in Budget Year 2008-09, the Department will implement a Self-Directed Services model of funding and service delivery that will cap individual budgets in exchange for increased consumer control over services.

The goal of the SDS Waiver is to support people with developmental disabilities and their families (when appropriate) to exercise choice and control over needed services and supports and thereby their lives. The SDS Waiver embraces person-centered planning (PCP) and gives participants the authority to manage an individual budget to purchase needed services and supports. All participants shall have an individually selected Supports Broker (SB) and Financial Management Services (FMS) to support the management of services and their individual budgets. Additionally, a case manager from the regional center assists participants with development of the Plan of Care, hereinafter referred to as the Individual Program Plan (IPP).

SDS Waiver enrollment is limited to children (age three and older) and adults with developmental disabilities who do not receive licensed residential or day services as defined in Welfare and Institutions Code (WIC) §4685.7 (i)(3), and who meet the federal Medicaid waiver requirements described in Appendix B. Individuals who are eligible voluntarily elect to self-direct their services and must accept the terms and conditions associated with SDS Waiver participation. Potential participants include individuals served through the existing California Home and Community-Based Services (HCBS) Waiver for the Developmentally Disabled who wish to transfer to the SDS Waiver and other persons who meet the qualifications specified in the SDS Waiver. Prior to SDS Waiver enrollment, interested individuals and families receive an in-depth orientation to self-direction. For those individuals who express an interest and are found eligible to participate in the SDS Waiver, a participant-led PCP process is conducted with the planning team developing the IPP. SDS Waiver services and other supports are specified in the IPP.

The SDS Waiver offers an extensive array of services and supports (fully described in Appendix C) that are intended to enhance community integration, personal empowerment and the achievement of positive

outcomes for each participant. These services and supports include but are not limited to Community Living Supports, Health and Clinical Services, Employment, Training and Education, Environment and Medical Supports, and Transportation, and are furnished in inclusive community settings. Such settings are defined by the presence of a majority of individuals without disabilities. All participants have access to SB and FMS providers to assist them in meeting their responsibilities under the Employer and Budget Authorities afforded by the SDS Waiver. The SDS Waiver provides critical participant protections and safeguards to promote independence and safety; and incorporates a full-featured Quality Management System (QMS) to monitor performance in meeting the SDS Waiver assurances and to inform continuous quality improvement activities throughout the period of the SDS Waiver. The QMS includes meaningful participant and family input at the state and regional center levels.

The SDS Waiver is administered by the Department of Developmental Services (DDS) under an Interagency Agreement with the Department of Health Care Services (DHCS), the California Medicaid Agency. The SDS Waiver is operated in all 21 regional center service areas. Regional centers, as established by the Lanterman Act (Welfare and Institutions Code §4500 et seq.), are private non-profit corporations funded through contracts with DDS to provide case management and coordination of community-based services for individuals with developmental disabilities. Regional centers are responsible for performing SDS Waiver operational functions, including conducting individualized assessments to establish waiver eligibility, SDS Waiver enrollment, assisting in the development of the IPP, and ongoing monitoring of services and participant health and welfare.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

☒	The waiver provides for participant direction of services. *Appendix E is required.*
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. QMS. Appendix H contains the QMS for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

☒	**Yes**
○	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
☒	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the QMS specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The development of this Self-Directed Services (SDS) Waiver has benefited from extensive input by California stakeholders. In 1998, SB 1038 (Welfare and Institutions Code Section 4685.5) was enacted to authorize the Department of Developmental Services (DDS) to launch self-determination pilots at several regional centers. DDS established the Statewide Self-Determination Steering Committee, consisting of the executive directors of five pilot regional centers and the Area Boards on Developmental Disabilities, consumer advocates, the Association of Regional Center Agencies, and the Senate Select Committee on Developmental Disabilities and Mental Health. The Committee met on a quarterly basis and designed the vision and principles that would guide the implementation of self-determination in California. Public

meetings continued as the self-determination pilots progressed over seven years. These meetings focused on updating interested public entities and inviting discussion on any self-determination issues and the expansion of this program statewide. Assembly Bill 131 (Budget Act of 2005, Omnibus health trailer bill) repealed Welfare and Institutions Code Section 4685.5 and added Section 4685.7, which established the SDS program.

In November 2003, the San Diego Regional Center sponsored a two-day Self-Determination and Individualized Funding conference called "My Life – My Way." The conference hosted presenters from all over the United States and other countries. The conference audience included consumers, parents of consumers, advocates, Area Board staff, regional center staff, DDS staff and the interested general public. The conference covered all phases of the implementation of the self-determination pilot and the design of a future Home and Community-Based Services (HCBS) Waiver.

Each of the five self-determination pilots were advised and directed by a local advisory group who expressed desire for self-determination to expand and become a permanent feature of the regional center service delivery system. Each local advisory group consisted of regional center pilot participants, consumers, family members, service providers, advocates, and other interested community members and reflected the multicultural diversity and geographic profile of each regional center catchment area. Pilot participants reported overwhelming satisfaction with their experience in self-determination, having more freedom and responsibility in controlling the direction of their services and supports, and their life choices. The self-determination advisory groups provided valuable input for the development of the SDS Waiver.

In 2004-05, Town Hall conference meetings were initiated by the California Disability Community Action Network, a non-partisan link to thousands of Californians with developmental and other disabilities, and their families, community organizations and providers, direct care and other workers, and other advocates. Several conference calls addressed all aspects of SDS. In 2005, a draft waiver application was posted on the DDS website and circulated for comment. The draft application received extensive comment at the Town Hall meetings and elsewhere.

In 2006-2007, a series of meetings and town hall teleconferences were convened by DDS with Californians with developmental disabilities and their families, advocates, and interested service providers, both from within and outside of the state. These meetings provided all interested parties the opportunity to provide input on the draft regulations that are associated with the development and implementation of the waiver.

DDS has made presentations about the proposed SDS Waiver to People First groups and to conference audiences supporting services for people with developmental disabilities and a wide range of public stakeholders. DDS also maintains information about the SDS Waiver and the experience of the pilot centers on its website.

In September/October 2007, DDS posted revised drafts of proposed regulations and the SDS Waiver to obtain comments from stakeholders. Finally, in early January 2008, DDS posted yet another revised draft of the SDS Waiver for final comments. The draft SDS regulations have been approved by DDS Administration, and have been forwarded to the Office of Administrative Law for review and public comment.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003).

Appendix B describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Susie
Last Name	Morikawa
Title:	Chief, Home and Community-Based Services Unit Section
Agency:	Department of Health Care Services
Address 1:	1501 Capitol Avenue, MS 4612
Address 2:	P.O. Box 997413
City	Sacramento
State	CA
Zip Code	95899
Telephone:	(916) 552-9632
E-mail	Susie.Morikawa@dhcs.ca.gov
Fax Number	(916) 552-9660

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Margaret
Last Name	Anderson
Title:	Branch Manager
Agency:	Department of Developmental Services
Address 1:	1600 Ninth Street, Room 340, MS 3-13
Address 2	P.O. Box 944202
City	Sacramento
State	California
Zip Code	95814
Telephone:	(916) 654-3681
E-mail	Margaret.Anderson@dds.ca.gov
Fax Number	(916) 654-3020

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in § 5 and the additional requirements specified in § 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Stan
Last Name	Rosenstein
Title:	Chief Deputy Director, Health Care Program
Agency:	Department of Health Care Services
Address 1:	1501 Capitol Avenue, Suite 71.6116, MS 0000
Address 2:	P.O. Box 997413
City	Sacramento
State	California
Zip Code	95899-7413
Telephone:	(916) 440-7400
E-mail	Stan.Rosenstein@dhcs.ca.gov
Fax Number	(916) 440-7404

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver *(select one)*:

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):		
	○	The Medical Assistance Unit *(name of unit)*:	
	○	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	
☒	The waiver is operated by Department of Developmental Services a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*		

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Department of Health Care Services (DHCS) is the California Medicaid Agency. The Waiver is operated by DDS, with DHCS providing administrative oversight. An Interagency Agreement (IA) between DHCS and the Department of Developmental Services (DDS) to administer the SDS Waiver is currently under development,. The IA, when completed, will define, specify, and clarify the roles and responsibilities of DDS and DHCS in the administration of the SDS Waiver. DHCS will exercise administrative discretion in the administration and supervision of the SDS Waiver.

DDS contracts with 21 private non-profit corporations to operate regional centers which are responsible under state law for coordinating, providing, arranging, or purchasing all services needed for eligible individuals with developmental disabilities in California. All HCBS waiver services are provided through this system. It is DDS' responsibility to ensure, with the oversight of DHCS, that the SDS Waiver is implemented by regional centers in accordance with Medicaid statute and regulation, and prepare required reports. DHCS, at its discretion, participates on the DDS review team during biennial monitoring reviews.

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

☒	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the

	types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	DDS contracts with 21 non-profit organizations to provide administrative functions as described below.
☐	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. **Role of Local/Regional Non-State Entities**. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☒	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
	The SDS Waiver is operated through 21 non-profit private corporations that are under contract with DDS to operate regional centers and are responsible under State law including the Lanterman Act, California Welfare and Institutions Code (WIC) §4620 et seq., for outreach and prevention, establishing eligibility for services, developing the Plan of Care (hereinafter referred to as the Individual Program Plan [IPP]), coordinating, providing, arranging or purchasing all services needed for eligible individuals with developmental disabilities. Each regional center serves a specific service area. Regional centers are governed by volunteer boards of directors that include individuals with developmental disabilities, families, a representative of the vendor community, and other defined community representatives. Regional centers conduct individualized assessments to establish a consumer's waiver eligibility; develop, monitor and update consumers' IPPs in response to changing needs; monitor the delivery of services; and ensure the health and safety of SDS Waiver participants. DDS ensures, under the oversight of DHCS, the State Medicaid agency, that the SDS Waiver is implemented by regional centers in accordance with Medicaid law and the State's approved Waiver application. The SDS Waiver affords California the flexibility to develop and implement creative community alternatives to institutions. California's SDS Waiver services are available to regional center consumers who are Medicaid (Medi-Cal in California) eligible, meet the level-of-care requirements for an intermediate care facility

	serving individuals with developmental disabilities, voluntarily opt for SDS services and meet all other requirements for participation detailed in later sections of this application. Non-Medi-Cal beneficiaries are ineligible for Waiver services, however may participate in the program using the State's General Fund.
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

DDS has primary responsibility for assessing and overseeing the performance of regional centers related to SDS Waiver operational and administrative functions. The DHCS monitors DDS' oversight of regional center performance.

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DDS performs operational oversight and monitoring of regional center SDS Waiver operational performance through fiscal audits and program policy compliance reviews. When taken together, the oversight and monitoring methods test all six assurances. The methods are described below.

Audits and Financial Accountability: DDS performs fiscal audits of each regional center no less frequently than biennially and completes follow-up reviews of each regional center in alternate years. These fiscal audits are performed using an audit protocol that is approved by DHCS. The results of these audits are reported to DHCS. DHCS retains the authority to review all audit working papers. DDS also requires regional centers to contract with independent certified public accountant auditors to conduct an annual audit for comprehensive accountability.

Program Policy Compliance: SDS Waiver compliance reviews of regional centers will be performed biennially, employing the SDS Waiver Biennial Collaborative Monitoring Protocol as follows:

1. The DDS review team will perform specific duties to be delineated in the Monitoring Protocol (so as to minimize duplication of effort by the two departments). DHCS, at its discretion, will participate in the biennial collaborative monitoring reviews.
2. The SDS compliance reviews include a combination of record reviews, interviews, and desk audits. Record review is employed to examine performance in such areas as level of care determination, IPP development and ongoing monitoring of the delivery of SDS Waiver services. The interviews include the participant, his or her family, qualified service providers, and case managers, as applicable.
3. A random sample of SDS Waiver participant records is identified for review by the team. A minimum sample of 4 percent of all SDS Waiver participants or five SDS Waiver participants per regional center (whichever is greater) is selected unless fewer than five individuals participate in the SDS Waiver.
4. Follow-up reviews are performed in the alternate years as described in #4 below.

Other Oversight Activities

1. DDS may, for specific or non-specific reasons or in response to a complaint, conduct unannounced visits to regional centers or service providers.
2. DHCS retains the authority to conduct an independent focused review (announced or

unannounced) of a regional center to investigate significant special incident reports for SDS Waiver enrollees, (selection basis may include, but is not limited to, gravity of event or unusual nature of circumstances), participant or advocate complaints, CMS concerns, or requests for investigation.

DDS conducts follow-up activities in the year following the biennial review to monitor progress on areas of recommended change. DDS provides ongoing training and technical assistance during the review process that covers all aspects of the SDS Waiver, and is designed to address the needs of administrators, case managers, clinicians, and participants. The on-site training and technical assistance is tailored to each regional center's needs thereby affording maximum opportunity to address issues identified in the compliance review. The results of these follow-up reviews, including the status of the implementation of the remedial corrective action plan, are periodically reported to DCHS.

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☐	☒	☒	☒
Assist individuals in waiver enrollment	☐	☒	☒	☒
Manage waiver enrollment against approved limits	☐	☒	☐	☐
Monitor waiver expenditures against approved levels	☒	☒	☐	☐
Conduct level of care evaluation activities	☐	☐	☒	☒
Review participant service plans to ensure that waiver requirements are met	☐	☒	☒	☒
Perform prior authorization of waiver services	☐	☐	☒	☒
Conduct utilization management functions	☐	☒	☒	☒
Recruit providers	☐	☒	☒	☒
Execute the Medicaid provider agreement	☐	☐	☒	☒
Determine waiver payment amounts or rates	☐	☒	☐	☐
Conduct training and technical assistance concerning waiver requirements	☐	☒	☒	☒

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age: Maximum Age Limit: Through age –	Maximum Age: No Maximum Age Limit
○	**Aged or Disabled, or Both** *(select one)*				
	○	**Aged or Disabled or Both – General** *(check each that applies)*			
		☐ Aged (age 65 and older)			☐
		☐ Disabled (Physical) (under age 65)			
		☐ Disabled (Other) (under age 65)			
	○	**Specific Recognized Subgroups** *(check each that applies)*			
		☐ Brain Injury			☐
		☐ HIV/AIDS			☐
		☐ Medically Fragile			☐
		☐ Technology Dependent			☐
☒	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☒	Autism	**3**		☒
	☒	Developmental Disability	**3**		☒
	☒	Mental Retardation	**3**		☒
○	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

1. California applies the State's definition of "developmental disability" to the target population of the SDS Waiver described in the Lanterman Act, California Welfare and Institutions Code (WIC) §4512(a):

   "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services (DDS), in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

2. Additionally, as established in WIC §4685.7(i), participation in SDS is limited to regional center consumers who:
   a. Are age three (3) or older.
   b. Do not live in a licensed long-term health care facility, as defined in paragraph (44) of subdivision (a) of §54302 of Title 17, CCR, or a residential facility, as defined in paragraph (55) of subdivision (a) of §54302 of Title 17, CCR, or receive day program or habilitation services, as defined in paragraph (16) or (34) of subdivision (a) of §54302 of Title 17, CCR, respectively. Pursuant to the above, when a consumer is found ineligible for self-directed services because he or she receives residential or day services, the consumer and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, may request that a regional center provide person-centered planning services in order to make arrangements for the transition to self-directed services.
   c. Affirmatively accept the following terms and conditions. A participant shall:
      i. Undergo an in-depth orientation to SDS and the SDS Waiver prior to enrollment.
      ii. Agree to use the services and supports available within the SDS Waiver only when generic services cannot be accessed, except for Medi-Cal state plan benefits when applicable.
      iii. Consent to use only services necessary to implement his or her Individual Program Plan (IPP).
      iv. Agree to comply with all terms and conditions for participation in the SDS Waiver, including any related state and federal requirements for participation.
      v. Manage SDS within the allocated prospective individual budget amount, using the individual budget methodology specified in Appendix C-4 of the SDS Waiver.
      vi. Use the services of a Financial Management Service (FMS) provider of his or her own choosing.
      vii. Use the services of a Supports Broker (SB) of his or her own choosing.

3. The SDS Waiver serves Medi-Cal beneficiaries with developmental disabilities who, in the absence of this waiver, would otherwise require the level of care in any one of the following types of facilities that meet the Federal Intermediate Care Facilities/Mental Retardation or Intermediate Care Facilities/Developmental Disabled requirements:
   a. Intermediate care facility services for the developmentally disabled (ICF-DD), pursuant to Title 22, California Code of Regulations (CCR), §51343.
   b. Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH), pursuant to Title 22, CCR, §51343.1.
   c. Intermediate care facility services for the developmentally disabled-nursing (ICF/DD-N), pursuant to Title 22, CCR, §51343.2.

4. Individuals shall be enrolled in only one HCBS waiver at any one time. Individuals who meet the qualifications and receive services through another waiver may voluntarily elect to enroll in the SDS Waiver. Individuals who are not currently enrolled in any waiver may voluntarily elect to enroll in the SDS Waiver. Individuals who disenroll voluntarily or involuntarily from the SDS Waiver may enroll in another waiver for individuals with developmental disabilities they are eligible for, or will be offered other alternative services.

5. For purposes of this SDS Waiver, SDS waiver services to individuals under the age of 21 years are only those services that are not covered as Medicaid State Plan services provided under the Early and Periodic Screening, Diagnosis, and Treatment program pursuant to 42 United States Code section 1396d (r).

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

☒	Not applicable – There is no maximum age limit.
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

☒	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:
	○ ____ %, a level higher than 100% of the institutional average
	○ Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
	○ The following dollar amount: $ ____
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:
	○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	○ The following percentage that is less than 100% of the institutional average: ____ %
	○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Not applicable.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	164
Year 2	1,509
Year 3	3,081
Year 4 (renewal only)	
Year 5 (renewal only)	

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

☒	The State does not limit the number of participants that it serves at any point in time during a waiver year.
○	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

☒	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

☐	The waiver is not subject to a phase-in or a phase-out schedule.
⊗	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

☒	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

	The California SDS Waiver capacity is allocated to the 21 regional centers across the state in accordance with the following methodology: 1. The number of potential SDS Waiver entrants in each regional center service area is identified from the DDS-maintained Client Development Evaluation Report (CDER) data, based on waiver target population criteria and individual qualifying conditions. 2. Based on the universe of potential entrants, each regional center is notified each waiver year of its authority to enroll a number of consumers based on the regional center's proportional share of the approved statewide SDS Waiver capacity. 3. Periodically but not less than annually, DDS assesses the utilization of SDS Waiver capacity among the regional centers. 4. Should actual SDS Waiver utilization reach or exceed waiver capacity, an amendment to expand capacity as necessary will be submitted to Centers for Medicare & Medicaid Services (CMS). Individuals will not be wait-listed for entrance to the SDS Waiver.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

All individuals who express an interest are enrolled in the SDS Waiver upon:

1. Meeting all eligibility requirements specified in Appendix B.
2. Completion of an in-depth orientation conducted by the regional center.
3. Affirmative acceptance of terms and conditions of enrollment as specified in Appendix B-1: 2(c).

California will submit necessary SDS Waiver amendments to accommodate all individuals who are eligible for and express an interest in participating in the SDS Waiver should the approved SDS Waiver capacity be insufficient to accommodate all interested persons.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase-Out Schedule

a. The waiver is being *(select one)*:

⊗	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☒	☒	☒	☒	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month	July	
Phase-in begins	August	1
Phase-in ends	September	4

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:	**See Attachment #1A *Phase-In Phase-Out Schedule***	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Phase-In or Phase-Out Schedule
Waiver Year

Month	Base Number of Participants	Change in Number of Participants	Participant Limit		Unduplicated Total of Participants
1	0	0	0		
2	0	0	0		
3	0	0	0		
4	0	0	0	**SFY 2007-08**	0
5	0	0	0		
6	11	0	11		
7	11	153	164	**FFY 2008**	164
8	164	200	364		
9	364	110	474		
10	474	94	568		
11	568	145	713		
12	713	80	793		
13	793	47	840		
14	840	92	932		
15	932	92	1,024		
16	1024	92	1,116	**SFY 2008-09**	1,105
17	1116	131	1,247		
18	1247	131	1,378		
19	1378	131	1,509	**FFY 2009**	1,345
20	1509	131	1,640		
21	1640	131	1,771		
22	1771	131	1,902		
23	1902	131	2,033		
24	2033	131	2,164		
25	2164	131	2,295		
26	2295	131	2,426		
27	2426	131	2,557		
28	2557	131	2,688	**SFY 2009-10**	1,572
29	2688	131	2,819		
30	2819	131	2,950		
31	2950	131	3,081	**FFY 2010**	1,572
32	3081	131	3,212		
33	3212	131	3,343		
34	3343	131	3,474		
35	3474	131	3,605		
36	3605	131	3,736		
37	3736	131	3,867		
38	3867	131	3,998		
39	3998	131	4,129		
40	4129	131	4,260	**SFY 2010-11**	1,572
41	4260	131	4,391		
42	4391	131	4,522		
43	4522	131	4,653	**FFY 2011**	1,572
44	4653	131	4,784		
45	4784	131	4,915		
46	4915	131	5,046		
47	5046	131	5,177		
48	5177	131	5,308		
49	5308	131	5,439		
50	5439	131	5,570		
51	5570	131	5,701		
52	5701	131	5,832	**SFY 2011-12**	1,572
53	5832	131	5,963		
54	5963	131	6,094		
55	6094	131	6,225	**FFY 2012**	1,572

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

☒	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☒	Low income families with children as provided in §1931 of the Act		
☒	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☒	Optional State supplement recipients		
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	○	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
☒	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☒	Medically needy		
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*	
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
☒	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*

	☒	All individuals in the special home and community-based waiver group under 42 CFR §435.217		
	○	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:		
		☐	A special income level equal to (select one):	
			○	300% of the SSI Federal Benefit Rate (FBR)
			○	% of FBR, which is lower than 300% (42 CFR §435.236)
			○	$ which is lower than 300%
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
		☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)	
		☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)	
		☐	Aged and disabled individuals who have income at: *(select one)*	
			○	100% of FPL
			○	% of FPL, which is lower than 100%
		☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:	

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

☒	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):	
	☒	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. ~~Regular Post-Eligibility Treatment of Income: SSI State and §1634 State.~~ ~~The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:~~

~~**i. Allowance for the needs of the waiver participant** (*select one*):~~			
~~○~~	~~The following standard included under the State plan *(select one)*~~		
	~~○~~	~~SSI standard~~	
	~~○~~	~~Optional State supplement standard~~	
	~~○~~	~~Medically needy income standard~~	
	~~○~~	~~The special income level for institutionalized persons *(select one):*~~	
		~~○~~ ~~300% of the SSI Federal Benefit Rate (FBR)~~	
		~~○~~ ~~_____%~~	~~of the FBR, which is less than 300%~~
		~~○~~ ~~$~~	~~which is less than 300%.~~
	~~○~~	~~_____%~~	~~of the Federal poverty level~~
	~~○~~	~~Other (specify):~~	

State:	California
Date	3/26/08

~~O~~	~~The following dollar amount:~~	~~$~~	~~If this amount changes, this item will be revised.~~
~~O~~	~~The following formula is used to determine the needs allowance:~~		

~~**ii. Allowance for the spouse only** (*select one*):~~	
~~O~~	~~SSI standard~~
~~O~~	~~Optional State supplement standard~~
~~O~~	~~Medically needy income standard~~
~~O~~	~~The following dollar amount:~~ ~~$~~ ~~If this amount changes, this item will be revised.~~
~~O~~	~~The amount is determined using the following formula:~~
~~O~~	~~Not applicable *(see instructions)*~~
~~**iii. Allowance for the family** (*select one*):~~	
~~O~~	~~AFDC need standard~~
~~O~~	~~Medically needy income standard~~
~~O~~	~~The following dollar amount:~~ ~~$~~ ~~The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.~~
~~O~~	~~The amount is determined using the following formula:~~
~~O~~	~~Other (specify):~~
~~O~~	~~Not applicable *(see instructions)*~~
~~**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**~~	
~~a. Health insurance premiums, deductibles and co-insurance charges~~ ~~b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*~~	
~~O~~	~~Not applicable *(see instructions)*~~
~~O~~	~~The State does not establish reasonable limits.~~
~~O~~	~~The State establishes the following reasonable limits *(specify)*:~~

c-1. ~~**Regular Post-Eligibility: 209(b) State**. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:~~

~~**i. Allowance for the needs of the waiver participant** (*select one*):~~				
~~○~~	~~The following standard included under the State plan *(select one)*~~			
	~~○~~	~~The following standard under 42 CFR §435.121:~~		
	~~○~~	~~Optional State supplement standard~~		
	~~○~~	~~Medically needy income standard~~		
	~~○~~	~~The special income level for institutionalized persons *(select one)*~~		
		~~○~~	~~300% of the SSI Federal Benefit Rate (FBR)~~	
		~~○~~	~~____%~~	~~of the FBR, which is less than 300%~~
		~~○~~	~~$~~	~~which is less than 300% of the FBR~~
	~~○~~	~~_____%~~	~~of the Federal poverty level~~	
	~~☒~~	~~Other (specify):~~		
~~○~~	~~The following dollar amount:~~	~~$~~	~~If this amount changes, this item will be revised.~~	
~~○~~	~~The following formula is used to determine the needs allowance:~~			
~~**ii. Allowance for the spouse only** (*select one*):~~				
~~○~~	~~The following standard under 42 CFR §435.121~~			
~~○~~	~~Optional State supplement standard~~			
~~○~~	~~Medically needy income standard~~			
~~○~~	~~The following dollar amount:~~	~~$~~	~~If this amount changes, this item will be revised.~~	
~~○~~	~~The amount is determined using the following formula:~~			
~~○~~	~~Not applicable *(see instructions)*~~			
~~**iii. Allowance for the family** (*select one*)~~				
~~○~~	~~AFDC need standard~~			
~~○~~	~~Medically needy income standard~~			

~~O~~	~~The following dollar amount:~~ $ ~~The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.~~
~~O~~	~~The amount is determined using the following formula:~~
~~O~~	~~Other (specify):~~
~~O~~	~~Not applicable *(see instructions)*~~

~~iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:~~

~~a. Health insurance premiums, deductibles and co-insurance charges~~

~~b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*~~

~~O~~	~~Not applicable *(see instructions)*~~
~~O~~	~~The State does not establish reasonable limits.~~
~~O~~	~~The State establishes the following reasonable limits *(specify)*:~~

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and *§*1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
☒	The following formula is used to determine the needs allowance:			
	The maximum amount of income to be eligible under the SDS Waiver, including any income disregards or exemptions.			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
☒	Not applicable *(see instructions)*			

iii. Allowance for the family *(select one)*:	
○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other *(specify)*:
☒	Not applicable *(see instructions)*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
☒	Not applicable *(see instructions)*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. ~~Regular Post-Eligibility: 209(b) State~~. ~~The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:~~

~~**i. Allowance for the needs of the waiver participant** (*select one*):~~			
~~○~~	~~The following standard included under the State plan *(select one)*~~		
	~~○~~	~~The following standard under 42 CFR §435.121:~~	
	~~○~~	~~Optional State supplement standard~~	
	~~○~~	~~Medically needy income standard~~	
	~~○~~	~~The special income level for institutionalized persons *(select one)*~~	
		~~○~~ ~~300% of the SSI Federal Benefit Rate (FBR)~~	
		~~○~~ ~~%~~	~~of the FBR, which is less than 300%~~
		~~○~~ ~~$~~	~~which is less than 300% of the FBR~~

	~~O~~	~~_____ %~~	~~of the Federal poverty level~~
	~~O~~	~~Other (specify):~~	
~~O~~	~~The following dollar amount:~~	~~$~~	~~If this amount changes, this item will be revised.~~
~~O~~	~~The following formula is used to determine the needs allowance:~~		

~~**ii. Allowance for the spouse only** (*select one*):~~

~~O~~	~~The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:~~		
	~~Specify the amount of the allowance:~~		
	~~O~~	~~The following standard under 42 CFR §435.121:~~	
	~~O~~	~~Optional State supplement standard~~	
	~~O~~	~~Medically needy income standard~~	
	~~O~~	~~The following dollar amount:~~	~~$~~ ~~If this amount changes, this item will be revised.~~
	~~O~~	~~The amount is determined using the following formula:~~	
~~O~~	~~Not applicable *(see instructions)*~~		

~~**iii. Allowance for the family** (*select one*)~~

~~O~~	~~AFDC need standard~~		
~~O~~	~~Medically needy income standard~~		
~~O~~	~~The following dollar amount:~~	~~$~~	~~The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.~~
~~O~~	~~The amount is determined using the following formula:~~		
~~O~~	~~Other (specify):~~		

~~O~~	~~Not applicable *(see instructions)*~~

~~iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:~~

~~a. Health insurance premiums, deductibles and co-insurance charges~~

~~b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*~~

~~O~~	~~Not applicable *(see instructions)*~~
~~O~~	~~The State does not establish reasonable limits.~~
~~O~~	~~The State establishes the following reasonable limits *(specify)*:~~

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**	
○	SSI Standard
○	Optional State Supplement standard
○	Medically Needy Income Standard
○	The special income level for institutionalized persons
○	% of the Federal Poverty Level
○	The following dollar amount: $ If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:
☒	Other (*specify*)**:**
	The maximum amount of income to be eligible under the SDS Waiver, including any income disregards or exemptions.
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*	
☒	Allowance is the same
○	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified § 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
☒	Not applicable *(see instructions)*
○	The State does not establish reasonable limits.
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
ii.	**Frequency of services**. The State requires *(select one)*:	
	○	The provision of waiver services at least monthly
	☒	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:
		The State does not specify a minimum frequency for the provision of SDS Waiver services. The frequency is specified in the Plan of Care, hereinafter referred to as the Individual Program Plan (IPP). The State will meet the requirements for monthly monitoring of the individual through the regional center's review of the monthly IB report submitted by the FMS.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
☒	Other (*specify*):
	Level of care evaluations and reevaluations are performed by regional centers. Regional center performance of this function is monitored by the Department of Developmental Services (DDS) with oversight by the Department of Health Care Services (DHCS).

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR §483.430(a).

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Evaluation and reevaluation is based upon the California ICF-DD (ICF-MR) criteria. Three distinct levels of ICF-DD care are specified in DHCS regulations:

1. Intermediate care facility services for the developmentally disabled (ICF-DD), pursuant to Title 22, CCR, §51343.
2. Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH), pursuant to Title 22, CCR, §51343.1.
3. Intermediate care facility services for the developmentally disabled-nursing (ICF/DD-N), pursuant to Title 22, CCR, §51343.2.

Individuals who require any of these levels of care may enroll in the SDS Waiver. As provided in the California Code of Regulations, Title 22, the determination that an individual requires an ICF-DD level care is based on the following general criteria:

1. Extent of the individual's psychosocial and developmental social needs.
2. The person's need for specialized developmental and training services that are not available through other levels of care.
3. The extent to which the provision of specialized developmental and training services can reasonably be expected to result in a higher level of functioning and a lessening of the person's dependence on others in carrying out daily living activities.
4. Whether the person has, at a minimum, two qualifying conditions that can be in any one area or combination of areas below. Determination that a qualifying condition exists is based on an evaluation that the condition significantly affects the consumer's ability to perform activities of daily living and/or participate in community activities:
   - Motor Domain
   - Independent Living Domain/Self-Help Skills
   - Cognitive Domain
   - Social Domain
   - Emotional Domain
   - Health-Related Conditions

The information necessary to determine whether a person requires a level of ICF-DD care is compiled and entered into the Client Development Evaluation Report (CDER) system that is maintained and operated by DDS. The person's CDER information is reviewed to determine whether the person meets ICF-DD level of care. The CDER serves as California's level of care instrument. CDER information is employed to evaluate/reevaluate need for level of care for both ICF-DD and SDS Waiver services.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

☒	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Process for Level of Care Evaluation/Reevaluation

Initial Evaluation of Level of Care:

1. The regional center determines whether the individual has substantial limitations in adaptive functioning and has needs not available through other levels of care. The regional center also determines the extent to which provisions of specialized developmental and training services would result in higher level of individual functioning and a lessening dependence on others in carrying out daily living activities.
2. The QMRP obtains a copy of the CDER summary profile of the person and identifies whether the individual has potential qualifying conditions.
3. The QMRP reviews the following to ensure that the determination that an individual has qualifying conditions is supported by documentation and that documentation is current:
   - IPP
   - Annual review summaries
   - Quarterly progress reports
   - Medical and psychological evaluations
   - Other evaluations as necessary
   - Interdisciplinary notes
4. The QMRP signs the Medicaid Waiver Eligibility Record form (DS3770) to document the date of the participant's initial HCBS Waiver eligibility certification and annual recertification and qualifying conditions and special health conditions that meet the Title 22 level of care requirements.

Reevaluation of Level of Care:

Reevaluation is performed in conjunction with the annual review of the SDS Waiver IPP. During the annual SDS Waiver review, the IPP planning team reviews the individual's level of care, and determines whether the assessment information that identifies the participant's level of care contained in the regional center file is accurate or whether an update is necessary.

Evaluation and reevaluation results are recorded on the DS 3770.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	Every three months
○	Every six months
☒	Every twelve months
○	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

☒	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

Monthly State computer-generated reevaluation reports are provided to the regional centers.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Regional center. The DS 3770 is retained in the participant's file at the regional center.

Appendix B-7: Freedom of Choice

***Freedom of Choice**. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

By definition, SDS is a voluntary service delivery system [Welfare and Institutions Code §4685.7 (a)(6)]. When an individual is determined to be likely to require a level of care described in Appendix B-6 of this request, the individual, or where appropriate his/her legal representative will be informed of any feasible alternatives under the SDS Waiver and given the choice of either institutional or services under the SDS Waiver. The regional center will provide an opportunity for a fair hearing under Title 17, CCR, §50966, to individuals who are not given the choice of home and community-based services as an alternative to institutional services, or who are denied the service(s), of their choice, or the providers of their choice. Individuals shall be notified, in writing, of their fair hearing rights as described in Appendix F.

The regional center case manager is responsible for informing individuals of the feasible alternatives for obtaining necessary services and giving each eligible individual the choice of receiving necessary care and services in an institutional health facility, through the SDS Waiver, or through the already approved HCBS Waiver for regional center consumers.

The regional center case manager ensures that:

1. Individuals, their legal representative, parents, relatives, or involved persons are informed of the choice of either participating or not participating in the SDS Waiver, if the consumer is determined to be eligible for SDS Waiver services and chooses to receive SDS Waiver services in lieu of institutional services.
2. The individual's choice is documented on the Medicaid Waiver Consumer Choice of Services/Living Arrangement form (DS 2200) at the time of any of the following:
   - Determination of initial eligibility for the SDS Waiver.
   - Reactivation of the SDS Waiver eligibility after an individual's termination from participation in the SDS Waiver.
   - Transition from minor to adult status.
3. The consumer's choice to participate in the waiver is documented in a dated and signed DS 2200.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed DS 2200 is retained in the participant's record at the regional center.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Under the provisions of the California Welfare and Institutions Code (WIC) §4641, regional centers are required to conduct outreach activities to inform their communities of their services and to actively pursue individuals in need of services. Outreach and other information developed and used by regional centers must be available in English and other languages that are reflective of the populations in the service area of the regional center. Outreach activities lead to persons with developmental disabilities finding or being referred to regional centers for intake and assessment and a determination of eligibility for services. DDS monitors and facilitates this requirement where possible.

During intake and assessment, consumers are informed of feasible alternative services under the SDS Waiver. To accomplish this, consumers and families must be able to communicate effectively with regional center staff and other members of the planning team. Every effort is made to communicate in the language of the consumer or family. These efforts include using a facilitator who may also be a member of the planning team, employing bilingual staff at the regional center, and/or using an interpreter or translator. In no case does a planning team proceed to develop a plan or explain alternatives that are not understood by the participant, or where appropriate a family member or legal representative.

WIC §4502.1 requires that information be provided in an understandable form to aid the consumer in making choices by all public or private agencies receiving state funds for the purpose of providing services persons with developmental disabilities.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☒	
Personal Care	☐	
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☒	Employment Development Services
Supported Employment	☒	Employment Supports
Education	☐	
Respite	☒	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-In Caregiver (42 CFR §441.303(f)(8))	☒	

Other Services *(select one)*	
○	Not applicable
☒	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Community Living Supports
b.	Communication Support

c.	Housing Access Supports
d.	Advocacy Services
e.	Participant-Designated Goods and Services
f.	Skilled Nursing
g.	Specialized Therapeutic Services
h.	Nutritional Consultation
i.	Behavior Intervention Services
j.	Integrative Therapies
k.	Family Assistance and Support
l.	Individual Training and Education
m.	Training and Counseling Services for Unpaid Caregivers
n.	Environmental Accessibility Adaptations
o.	Vehicle Adaptations
p.	Specialized Medical Equipment and Supplies
q.	Personal Emergency Response System
r.	Transportation
s.	Crisis Intervention
Extended State Plan Services *(select one)*	
☒	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
Supports for Participant Direction *(select one)*	
☒	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☒	Supports Broker
Financial Management Services	☒	Fiscal Employer Agent, Agency with Choice
Other Supports for Participant Direction *(list each support by service title)*:		

a.	Designated Supports Broker
b.	Designated Financial Management Services

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☒	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☐	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Regional Centers.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-*(select one)*:

☒	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	Under the provisions of Welfare and Institutions Code (WIC) §4685.7(r), a participant may request that a criminal history background clearance be performed on any individual whom the participant would employ as a supports broker or direct care service provider. These criminal history background clearances are mandatory when requested by the SDS Waiver participant. The process for obtaining criminal history background clearances is described in WIC §4685.7(r)(1). For applicants who have resided for less than two continuous years in California, additional criminal record information is required to be obtained from the Federal Bureau of Investigation. The participant is advised during the in-depth orientation to the SDS Waiver that he or she may request such a criminal history background clearance for applicable service providers. Pursuant to WIC §4685.7(b)(1) authorizes DDS to establish specific qualifications which shall be provided of and FMS provider. To implement this requirement, DDS has established that as a condition of providing financial management services, all individuals and entities applying to be a FMS provider must obtain a criminal history background clearance. The process for obtaining a criminal history background clearance is the same as described above for other service providers. In addition, various professions (e.g., nurses) licensed under the provisions of the California Business and Professions Code must undergo a criminal record review as a condition of licensure and license renewal. Under the SDS Waiver, licensed individuals may provide several types of services including skilled nursing, integrative therapies, behavior intervention services, and specialized therapeutic services. Criminal record reviews are performed by the applicable licensing authority. The FMS entity verifies that licensed individuals selected by the participant are properly licensed.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

☒	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
☒	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Adult Residential Facility	Crisis Intervention	N/A – Facility capacity is specified in license.
Residential Care Facility for the Elderly	Crisis Intervention	N/A – Facility capacity is specified in license.
Small Family Home (Child)	Crisis Intervention	N/A – facility capacity is specified in license

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Residential settings are only employed for crisis intervention services in this waiver, not as permanent living arrangements. Regulations contained in California Code of Regulations (Titles 17 and 22) apply to facilities that serve four or more individuals. These regulations contain provisions concerning resident privacy, rights, and other dimensions of ensuring an acceptable living environment.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type Adult Residential Facility	Facility Type Residential Care Facility for the Elderly	Facility Type Group Home	Facility Type Small family home
Admission policies	☒	☒	☐	☒
Physical environment	☒	☒	☐	☒

Sanitation	☒	☒	☐	☒
Safety	☒	☒	☐	☒
Staff : resident ratios	☒	☒	☐	☒
Staff training and qualifications	☒	☒	☐	☒
Staff supervision	☒	☒	☐	☒
Resident rights	☒	☒	☐	☒
Medication administration	☒	☒	☐	☒
Use of restrictive interventions	☒	☒	☐	☒
Incident reporting	☒	☒	☐	☒
Provision of or arrangement for necessary health services	☒	☒	☐	☒

Standard	Facility Type	Facility Type	Facility Type	Facility Type
	Adult Family/Foster Home	Certified Family Home		
Admission policies	☐	☐	☐	☐
Physical environment	☐	☐	☐	☐
Sanitation	☐	☐	☐	☐
Safety	☐	☐	☐	☐
Staff : resident ratios	☐	☐	☐	☐
Staff training and qualifications	☐	☐	☐	☐
Staff supervision	☐	☐	☐	☐
Resident rights	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐
Use of restrictive interventions	☐	☐	☐	☐
Incident reporting	☐	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable.

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor

child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

○	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
☒	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*
	A parent or legal guardian of a minor child served under the SDS Waiver may be paid to furnish personal care or community living supports services specified in the participant's Individual Program Plan when the parent meets the service provider qualifications, and when **all** of the following conditions are met: 1. The parent has left a full-time job or is prevented from obtaining full-time employment because of the need to provide personal care or similar services for his/her child that is extraordinary. Extraordinary care is unique assistance that is required due to the nature of the individual's developmental disability that is not provided to other children of the same age in the household who are without a disability. 2. There is no other suitable provider available. 3. Out-home-placement may be required or inadequate care may be provided if the child does not receive the personal care or similar services needed. 4. All generic services have been exhausted. When a parent or legal guardian furnishes personal care or community living supports services to their minor child, the parent or legal guardian must comply with all applicable requirements concerning the submission of billings to the Financial Management Services entity and such billings are subject to post-payment review by the Regional Center and DDS to ensure that the billings are based on proper documentation of the services rendered.

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
☒	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations

	on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	A relative or legal guardian cannot be paid to furnish waiver services to a participant when the relative or legal guardian exercises decision-making authority over the participant's service plan and/or participant-directed budget as the legal or appointed representative of the participant. Legally responsible individuals cannot be paid to provide other services of any type under the waiver. However, a relative or legal guardian may furnish any waiver service that he/she is qualified to provide except respite services when the relative or legal guardian resides in the same household as the waiver participant. The process for verifying that a relative/legal guardian meets the provider qualifications for a service is the same as is followed for any other prospective provider: namely, the relative/legal guardian must submit necessary information to the FMS entity which verifies that the relative/legal guardian meets applicable provider qualifications in advance of furnishing services to the participant. A relative or legal guardian who furnishes services to a participant must comply with all applicable requirements concerning the submission of billings to the FMS entity. Such billings are subject to post-payment review by the regional center and DDS to ensure that they are based on proper documentation of the services rendered.
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Participants may select any willing and qualified service provider, including non-vendored providers, and refer them to the selected FMS entity for enrollment as providers under this waiver. Under the provisions of WIC §4685.7(q), and except for FMS providers, this waiver is exempt from the provider regional center vendorization requirements in Title 17, CCR, §54300 et seq. It is expected that this exemption will expand the provider network that is available to waiver participants.

All prospective service providers including those currently vendored by the regional center must submit documents to the FMS to verify that the provider meets SDS Waiver service qualifications. Except for the FMS, regional center vendorization does not qualify a prospective provider under the SDS Waiver.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**HOME HEALTH AIDE: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**
Service Definition (Scope)**:**	
Services are defined in 42 CFR §440.70, with the exception that the limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan are not applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix J-2 of this Waiver request. Home health aide (HHA) services provided under the SDS Waiver are in addition to any that are available under the approved State plan. HHA services may only be provided by individuals who are certified home health aides and employed by licensed and certified home health agencies.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The individual prospective budget amount must be sufficient to accommodate the amount of the service.	

Provider Specifications				
Provider Category(s)	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Home Health Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
HHA	Title 22, CCR, §74600 et. seq.	Health and Safety Code §§1725 – 1742. Medi-Cal certification using Medicare standards, Title 22 CCR §51217. Title 22, CCR § 74624; Title 22 CCR §§74745-74749 Health and Safety Code §§1725-1742. Medi-Cal certification using Medicare standards, Title 22 CCR §51217.	Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. A home health aide employed by a home health agency certified by the Licensing & Certification Program of the Department of Public Health must have completed a training program that meets the requirements of 42 CFR §484.36(b) or (e) and must have been certified pursuant to Health and Safety Code §1736.1.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
HHA	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to initial service provision. At least annually thereafter.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed, as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**EMPLOYMENT DEVELOPMENT SERVICES: EMPLOYMENT BUDGET CATEGORY**

Service Definition (Scope)**:**

Employment development services are individually designed and furnished in the manner specified by the participant to achieve personally defined outcomes. In the SDS Waiver, these services must be provided in integrated natural environments where adult participants are provided with opportunities to gain work experience and training as a pathway to employment. For purposes of these services, "adult" is defined as an individual who is 18 years of age or older. Services may include support in locating and performing volunteer work. Volunteer work enables the individual to gain desired work experience and personal satisfaction, and to contribute to the community.

1. Services may also include supportive employment development training as follows:
   a. Basic job skills development
   b. Job-seeking and interviewing skills
   c. Interpersonal and communicative/social skills development
   d. Guidance in acceptable work behaviors and habits
   e. Development of vocationally appropriate dress and grooming
   f. Work-related personal presentation training
   g. Safety skills and training
   h. Work-related skills development (e.g., counting, measuring)
   i. Path planning to future employment opportunities
   j. Community mobility development
   k. Money management and income reporting skills
   l. Development of natural job supports
   m. Workforce integration techniques
   n. Community integration development/relationship building
   o. Creating a pathway to maximize the use of typical business co-workers and staff in supporting the individual's ongoing job performance
2. Services may also include support services as follows:
   a. Personal safety practices training
   b. Housekeeping maintenance skills development
   c. Health maintenance skills development, such as hygiene skills

While participants are receiving these employment development services, they may become eligible for vocational rehabilitation services funded by §110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) or §602(16) and (17) of the Individuals with Disabilities Education Act (IDEA.)(20 U.S.C. 1400). When and if the participant begins receiving services under either act, employment development services cease and the vocational rehabilitation services will not be considered or claimed as SDS Waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Community Rehabilitation Program

State:	California
Date	3/26/08

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Rehabilitation Program	Provider must possess any valid license or certification required by State or local law, and/or any applicable Federal/Tax Exempt Letter.		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Employment development services are provided by individual providers or entities who meet the unique needs and preferences of the participant as specified in the participant's IPP. Individual providers and providers employed by agencies shall be at least 21 years old, have a high school diploma or GED and have a minimum of one year experience providing services of a similar type to persons with developmental disabilities. Providers are responsible to ensure that employment development services meet the participant's health and safety needs, and are directed at the outcome desired by the participant and specified in the IPP. In addition, agencies should possess any required business license/certification.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

All	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Upon selection and prior to initial service provision; at least annually thereafter.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**EMPLOYMENT SUPPORTS: EMPLOYMENT BUDGET CATEGORY**

Service Definition (Scope)**:**

1. "Employment supports" (or Supported Employment) means an individualized array of support services to assist an individual gain and retain employment, including self-employment, in community integrated work environments where the participant interacts with individuals without disabilities, other than the employment supports provider, to the same extent that individuals without disabilities in comparable positions interact with other persons. It also includes an appropriate level of ongoing post-employment support services.
2. Employment supports consist of services specified in the IPP for the purpose of achieving individualized employment outcomes, and may include any combination of the following:
   a. Individualized assessment.
   b. Individualized and group employment counseling.
   c. Job analysis of supported employment opportunities for the participant.
   d. Job development and placement that produce an appropriate job match for the participant and employer.
   e. Direct supervision or training of a participant while they engage in integrated work.
   f. Job coaching provided on or off the worksite.
   g. The use of typical business co-workers and staff in supporting and individual's initial and ongoing job performance.
   h. Community-based training in adaptive functional and social skills necessary to ensure job adjustment and retention.
   i. Counseling with a participant/family and/or authorized representative to ensure support of the participant in job adjustment.
   j. Counseling on benefits planning to ensure a consumer understands the relationship between earned income and receiving public benefits such as SSI, SSA, Medi-Cal, and PASS PLANS.
3. Employment services also consist of services that assist a participant to develop a business and become self-employed. This assistance consists of:
   a. Assisting the participant to identify potential business opportunities.
   b. Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business.
   c. Identification of the supports that are necessary in order for the participant to operate the business.
   d. Ongoing assistance, counseling and guidance once the business has been launched.

Within the foregoing scope of services, the participant, in consultation with the planning team, may specify in the IPP the scope and nature of the employment supports that enable the participant to secure and maintain integrated employment in the community. Participants shall specify desired employment outcomes and the necessary skills and capabilities of the provider(s) who furnish employment supports.

The above-described services are not available under a program funded under §110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) or §602(16) and (17) of the IDEA (20 U.S.C. 1400) to participants in the SDS Waiver. After Rehabilitation Act of 1973 or IDEA, services have concluded, employment supports may be provided under the SDS Waiver.

Participants who cannot receive vocational rehabilitation services under §110 of the Rehabilitation Act due to order of selection may be provided employment supports under the SDS Waiver. Documentation is maintained in the record of each participant receiving this service that vocational rehabilitation services are not available.

Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program. 2. Payments for vocational training that is not directly related to an individual's supported employment program.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individuals		Qualified entities	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law.		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Employment development supports are provided by individual providers or entities who meet the unique needs and preferences of the participant as specified in the participant's IPP. Individual providers and providers employed by agencies shall be at least 21 years old, have a high school diploma or GED and have a minimum of one year experience providing services of a similar type to persons with developmental disabilities. Providers are responsible to ensure that employment development supports meet the participant's health and safety needs, and are directed at the outcome desired by the participant and specified in the IPP. In addition, agencies should possess any required business license/certification.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

State:	California
Date	3/26/08

All	The participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in the IPP and confirms to the FMS entity that the provider is qualified. FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. The participant, with the support of the PCP team as required, shall reassess the qualifications of the participant-employed individuals at least annually during the IPP review meeting.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**RESPITE SERVICES: COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

Respite services are provided to participants who are unable to care for themselves and/or require constant supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them. Respite can be any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals who cannot be left unsupervised.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals who cannot be left unsupervised.
3. Supervision for school age participants who are not receiving community living supports and whose parents or families work outside of the family home. Supports may be provided before or after the school day. Respite services under this option may be used only when other education, day care, or supports programs are not available.

Respite services may be purchased from qualified agencies or individuals. The participant may employ individual respite workers. In all cases, the IPP must specify the necessary training and skills that such workers or other providers must possess.

Respite may be provided in the following locations:

1. Individual's home or place of residence. This type of respite may include community outings.
2. Outside the individual's home or place of residence in the following locations:
   a. Community recreational setting, such as Young Men's Christian Association (YMCA), sports club, Community Parks & Recreation program or other community-based recreation program. A sports club is a supervised follow-up recreational program (health club). The programs are supervised to maximize safety and minimize risk. The program goals and objectives, including level of supervision, are specified in the IPP.
   b. Camping Services.
   c. Child Day Care Facility.
   d. Adult Day Care Facility.

Respite cannot be provided by the primary care provider or his/her spouse under this definition. Respite providers are required to develop and implement a backup plan for times when they are scheduled, but are unable to come and provide the service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The prospective IB amount must be sufficient to accommodate the amount of the service

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Participant-employed individual		Adult Day Care Facility	
	In-home Respite Worker		Agency-with-Choice	
			In-home Respite Services Agency	
			Community Recreational Provider	
			Camping Services	
			Child Day Care Center	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

State:	California
Date	3/26/08

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must have a business license, if required by State law.	Verification of CPR and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross.	Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Providers are responsible to ensure that supports meet the participant's health and safety needs and are directed at the participant's desired outcomes as specified in the IPP.
Participant-Employed Individual			An individual respite provider shall be at least 18 years of age.
In-home Respite Worker			An individual respite provider shall be at least 18 years of age.
Adult Day Care Facility	Health and Safety Code §1502(a)(2) - Title 22, CCR, §§82000-82088.2		Title 22, CCR, §§82000 and 82064 Licensed day care facility that provides non-medical care on less than a 24 hour basis.
Agency-with-Choice			Title 17, CCR, §54342
In-home Respite Services Agency			Provides non-medical respite services in the home or community. The provider must maintain a training program for employees to ensure that they have skills and abilities to meet the defined needs of participants, health and safety requirements and an understanding of SDS.
Community Recreational Provider (YMCA, Sports Club, Community Parks & Recreation Program)			1. Capacity to perform the functions required by the IPP. 2. Dependability and personal integrity. 3. Willingness to pursue training as necessary based upon the individual participant's needs. 4. Certification and licensure appropriate to the exercise program.

Camping Services			A provider of camping services that employs staff who possess competence to supervise safety of camp activities and is one of the following: <u>A day camp which</u>: 1. Provides a creative experience in outdoor living for a limited period of hours per day and days per year. 2. Contributes to the individual's mental, physical, and social growth by using the resources of the natural surroundings. <u>A residential camp which</u>: 1. Possesses a valid fire clearance issued by the California State Fire Marshal, city fire department, or local fire district. 2. Complies with the requirements of Title 17, §§30700 through 30753. 3. Has a registered nurse on staff at all hours of operation. Or 4. Has received a waiver issued by the appropriate agency if any of the requirements specified in 1 through 3 above are not met, and 5. Provides the following: a. A creative experience in outdoor living on a 24-hour-per-day basis for a limited period of time. b. Services which use the resources of the natural surroundings to contribute to the individual's mental, physical and social growth. c. Other consistent services.
Camping Services Continued			<u>A traveling camp</u> which provides camping or vacation experiences by traveling to various campgrounds or other tourist areas.

Child Day Care Center	Health and Safety Code §1596.799 Title 22, CCR, §§10152 - 101169		Possesses a valid family day care license issued by DSS or by an agency authorized by DSS to assume specified licensing responsibilities, and provides non-medical care and supervision to children under 18 years of age on a less than 24-hour per day basis in the vendor's own home; or Possesses a valid day care license for children issued by DSS or by an agency authorized by DSS to assume specific licensing responsibilities, and provides personal care, protection, supervision and assistance to children under 18 years of age with special developmental needs in a nonresidential facility; or Possesses a preschool license issued by the Department of Education or a valid child care center license issued by DSS or an agency authorized by DSS to assume specified licensing responsibilities, and aids children in developing pre-academic skills, group training, and social skills in a nonresidential facility.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Participant-employed individual	The participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in the IPP and certifies that the provider is qualified to the FMS entity. The FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to employment. The participant, with the support of the PCP team as required, shall reassess the qualifications of the participant-employed individuals at least annually during the IPP review meeting.
Agency-with-Choice		Title 17 §54342 Vendorization. Regional center at the time of vendorization and annually thereafter.

All others: In-home Respite Worker Adult Day Care Facility In-home Respite Services Agency Community Recreational Provider Camping Services Child Day Care Center	The FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standard, as applicable	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually during the IPP review meeting.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**LIVE-IN CAREGIVER: COMMUNITY LIVING BUDGET CATEGORY**
Service Definition (Scope)**:**	
Live-in caregiver service provides for the payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the participant. This payment is available only in the case of participants who receive personal care support and live in homes that they rent or lease. A legal guardian may not furnish this service. The way the amount that is paid is determined is specified in Appendix I-6. Payment is not made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The prospective IB amount must be sufficient to accommodate the amount of the service.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:		Agency. List the types of agencies:
	Participant-employed worker who serves as caregiver		Employee of an agency who serves as caregiver	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All			Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. The provider must meet the qualifications to be employed as a personal care provider as detailed in the IPP. The provider must have completed First Aid and cardiopulmonary resuscitation (CPR). The provider cannot be related to the participant. The provider must reside in the same household as the participant. The participant rents or leases his residence.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification

All	FMS entity verifies that the caregiver meets the standards stated above: employed to provide live-in caregiver services; is not related to the participant; and resides in the same household as the participant.	At the time that personal care supports are established and when there is any change in personal care support providers. The participant with the support of the PCP team as required shall verify qualifications at least annually during the IPP review meeting.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**COMMUNITY LIVING SUPPORTS: COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

Community Living Supports are intended to facilitate independence and promote community integration for all participants, regardless of their living arrangements. This service includes support and assistance with socialization, personal skill development, community participation, recreation and leisure, and home and personal care. The specific types and mix of supports that an individual receives as well as any special provider qualifications shall be specified in the IPP:

1. Support with socialization includes development or maintenance of self-awareness and self-control, social responsiveness, social amenities, interpersonal skills, and personal relationships.
2. Support with personal skill development includes activities designed to improve the participant's own ability to accomplish everyday activities of community living, including eating, bathing, dressing, personal hygiene, mobility, and instrumental activities.
3. Support in community participation includes assisting the participant in conducting everyday activities of community living.
4. Support with community participation, recreation or leisure includes the development or maintenance of skills to use community resources, facilities, or businesses and support in accessing such opportunities for community integration.
5. Home and personal care includes support with household activities, such as planning and preparing meals, budgeting, laundry, and maintaining the home in a clean and safe environment. This service includes heavy household chores such as: washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access; integrated pest management yard work; and minor repairs such as those that could be completed by a handyperson.

Community Living Supports providers are required to develop and submit a back-up plan to ensure coverage during times when they are not available.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Individuals employed by the participant		Business entities	
	Self-employed individuals		Agency-with-Choice	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law		Community Living Supports are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

State:	California
Date	3/26/08

			An individual employed by the participant or provided through an agency shall be at least 18 years of age, and have completed First Aid and cardiopulmonary resuscitation (CPR). All individuals employed by the participants will be trained, as specified in the IPP, in the customized needs of the participant prior to service delivery. Employees will be re-assessed, at a minimum, annually by the participant, with support of the PCP team as requested, during the annual IPP meeting. At the request of, and at no charge to, the participant, a criminal record (background) check of direct care service providers will be initiated by the participant's FMS entity.
Parent or legal guardian of a minor			A parent or legal guardian of a minor child served under the SDS Waiver may be paid to furnish personal care or community living supports services specified in the participant's IPP when the parent/legal guardian meets the service provider qualifications, and when **all** of the following conditions are met: 1. The parent has left a full-time job or is prevented from obtaining full-time employment because of the need to provide personal care or similar services for his/her child that is extraordinary. Extraordinary care is unique assistance that is required due to the nature of the individual's developmental disability that is not provided to any other children of the same age in the household who are without a disability. 2. There is no other suitable provider available. 3. Out-home-placement may be required or inadequate care may be provided if the child does not receive the extraordinary personal care or similar services needed. 4. All available generic personal care services have been exhausted.
Agency with Choice			Vendored by the regional center in accordance with Title 17 §54342. The Agency-with-Choice does not provide services under any other Title 17 vendored category.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

All	Participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in the IPP and certifies that the provider is qualified to the FMS entity. The FMS entity reviews Statement of Qualifications submitted by provider and verifies that provider possesses necessary license and/or certificate and meets other standard as applicable.	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually during the IPP review meeting.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**COMMUNICATION SUPPORT SERVICES: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**

Service Definition (Scope)**:**

Communication support services includes communication aides necessary to facilitate and assist persons with hearing, speech, or vision impairment, including individuals who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English (Limited English Proficient or LEP skills). The purpose of this service is to assist individuals to effectively communicate with service providers, family, friends, co-workers, and the general public. The following are allowable communication aides, as specified in the participant's IPP:

1. Facilitators
2. Interpreters and interpreter services
3. Translators and translator services
4. Readers and reading services

This service also includes supports for the participant to use computer technology to assist in communication. Such supports include training in the use of the technology, assessment of need for ongoing training and support, and identification of resources for the support.

Communication support services include evaluation for, and training in the use of, communication aides, including for individuals with LEP skills, as specified in the participant's IPP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The prospective IB amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Facilitator		Business entity that employs qualified individuals	
	Interpreter			
	Reader			
	Translator			
	Computer Technology			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Facilitator	Any valid license or certification required by State or local law.		1. The ability to perform the functions identified in the participant's IPP. 2. Knowledge of the concerns and special needs of persons with developmental disabilities as related to the community. 3. Sensitivity to the communication process between communication-impaired individuals and non-impaired individuals, and the needs of the persons involved in the process. 4. The ability to maintain confidentiality.

State:	California
Date	3/26/08

Interpreter	Any valid license or certification required by State or local law.		Providers of interpretation services shall have: 1. Proficiency in facilitating communication between hearing-impaired and hearing persons individually and/or in groups using American Sign Language and spoken language. 2. The equivalent of six months' experience providing interpreting services to hearing-impaired persons, or possession of at least one valid certificate issued by the Registry of Interpreters for the Deaf. 3. Knowledge of the concerns and special needs of persons with developmental disabilities as related to the community. 4. Sensitivity to the communication process between hearing-impaired individuals and hearing individuals, and the needs of the persons involved in the process. 5. The ability to maintain confidentiality**.**
Reader	Any valid license or certification required by State or local law.		1. The ability to read aloud and to speak intelligibly in a language understood by the participant. 2. Knowledge of the concerns and special needs of persons with developmental disabilities as related to the community. 3. Sensitivity to the communication process between communication-impaired individuals and non-impaired individuals, and the needs of the persons involved in the process. 4. The ability to maintain confidentiality.
Translator	Any valid license or certification required by State or local law.		Providers of translation services shall have: 1. Fluency in both English and a language other than English. 2. The ability to read and write accurately in both English and a language other than English. 3. Knowledge of the concerns and special needs of persons with developmental disabilities as related to the community. 4. The ability to maintain confidentiality.
Computer Technology	Any valid license or certification required by State or local law		Providers of computer technology support shall have knowledge and experience in assisting individuals with developmental disabilities to use computer technology to assist with communication.
Business Entity	Any valid license or certification required by State or local law.		
Verification of Provider Qualifications			

State:	California
Date	3/26/08

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	The FMS entity reviews the Statement of Qualifications submitted by the provider and verifies that provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

State:	California
Date	3/26/08

Service Specification	
Service Title:	**HOUSING ACCESS SUPPORTS: COMMUNITY LIVING BUDGET CATEGORY**
Service Definition (Scope)**:**	
Housing Access Supports is a service that provides assistance to a participant when acquiring housing in the community. The purpose of the support is to enable the participant to identify, select and acquire affordable, accessible housing. Services include counseling and assistance in identifying affordable, safe and accessible options and making choices with respect to the participant's preferences of locations and types of housing; identifying the participant's accessibility requirements (including need for modifications); planning for ongoing maintenance and repair (if this will be the participant's responsibility); and identifying financial resources and eligibility for housing subsidies and other benefits. Reimbursement is made for supports needed by the participant that go beyond typical generic housing access resources such as apartment rental and real estate services, and that assist the participant to use these services. The specific supports that are required by the participant shall be specified in the IPP. The service does not include payment of deposits or other expenses associated with setting up a household. A parent or legal guardian cannot be paid for providing Housing Access Supports to the participant.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The individual prospective budget amount must be sufficient to accommodate the amount of the service.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individual		Business entity	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Housing access supports are provided by individuals or entities who have experience and knowledge in providing the specific housing access supports included in the IPP. The provider must also have the skills and experience to meet the unique needs and preferences of the participant as specified in the participant's IPP. Individuals shall also possess the skills necessary to ensure that the housing support services meet the participant's health and safety needs and are directed at the outcomes desired by the participant.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	The participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in the IPP and certifies that the provider is qualified to the FMS entity. The FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually during the IPP review meeting.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**ADVOCACY SERVICES: COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

Advocacy services support and facilitate the participant in exercising legal, civil and service rights to gain access to generic services and benefits. Advocacy services shall only be provided when other generic sources of similar assistance are not available to the participant, and when advocacy is directed towards obtaining generic services. The specific nature of advocacy services shall be specified in the IPP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individuals		Business entities	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Advocacy services are provided by individuals or entities who have experience in provision of advocacy services, knowledge of the rules and regulations surrounding generic services including how appeals are filed and heard, and the skills and abilities to meet the unique needs and preferences of the participant as specified in the participant's IPP. Providers are responsible to ensure that advocacy services are directed at the participant's desired outcomes.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	The participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in the IPP and certifies that the provider is qualified to the FMS entity. The FMS entity	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's

	reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.		qualifications at least annually during the IPP review meeting.	
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**PARTICIPANT-DIRECTED GOODS AND SERVICES: COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

Participant-Directed Goods and Services consist of services, equipment or supplies not otherwise provided through the SDS Waiver or through the Medicaid State plan that address an identified need in the IPP (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the person's safety in the home environment; and the participant does not have the personal funds to purchase the item or service and the item or service is not available through another funding source. The participant may direct the FMS entity (through the approved IPP) to set aside a portion of his/her monthly prospective IB amount for these items or services. The type, amount and method used to acquire the goods and services shall be documented in the IPP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of these goods and services shall not exceed $3,000 in a year. In addition, the individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individuals		Business entities	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Providers must have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	The participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide the goods and services specified in the IPP and certifies that the provider is qualified to the FMS entity. FMS entity reviews a Statement of Qualifications submitted	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually

	by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.		during the IPP review meeting.	
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**SKILLED NURSING: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**

Service Definition (Scope)**:**

State Plan Services listed in the IPP that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled nursing services under the SDS Waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan. The amount, duration and scope of these services shall be in accordance with the estimates given in Appendix J-2 of this Waiver request. Skilled nursing services provided under the SDS Waiver are in addition to any that are available under the approved State plan.

This service may be furnished by self-employed nurses, or nurses employed by an agency or obtained through a home health agency.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The prospective IB amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Individual Registered Nurse Provider		Home Health Agency	
	Individual Registered Vocational Nurse Provider			
	Registered Nurse			
	Licensed Vocational Nurse			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Registered Nurse Provider	Business & Professions Code §§2725 - 2742 Title 22, CCR, §51067		
Individual Licensed Vocational Nurse Provider	Business & Professions Code §§2859 - 2873.7 Title 22, CCR, §51069		
Registered Nurse	Business & Professions Code §§2725 - 2742 Title 22, CCR, §51067		
Licensed Vocational Nurse	Business & Professions Code		

	§§2859 - 2873.7 Title 22, CCR, §51069		
Home Health Agency	Title 22, CCR, §74600 et. seq.	Health and Safety Code §§1725 - 1742. Medi-Cal certification using Medicare standards, Title 22, CCR, §51217	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**SPECIALIZED THERAPEUTIC SERVICES: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**

Service Definition (Scope)**:**

Generic and/or Medicaid State plan service resources must be exhausted before using this service.

Specialized Therapeutic Services (STS) are services that provide physical, behavioral/social-emotional health, and/or dental health care that have been adapted to accommodate the unique complexities presented by enrolled participants aged 3 years or older. Note: For participants ages 3 to 20, this service is only available when Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are not available. The complexities include requiring:

1. Additional time with the health care professional to allow for effective communication with participants to ensure the most effective treatment.
2. Additional time with the health care professional to establish the participant's comfort and receptivity to treatment to avoid behavioral reactions that will further complicate treatment.
3. Additional time for diagnostic efforts due to the masking effect of some developmental disabilities on health care needs.
4. Specialized expertise and experience of the health care professional in diagnosing health care needs that may be masked or complicated by a developmental disability.
5. Treatment to be provided in settings that are more conducive to the participant's ability to effectively receive treatment, either in specialized offices or facilities that offer better structured interaction with the participant or which may provide additional comfort and support which is needed to reduce participant anxiety that is related to his or her developmental disabilities.

These additional elements to STS are designed and proven effective in ensuring the health and safety of the participants enrolled in the SDS Waiver. They are also designed or adapted with specialized expertise, experience or supports to ensure that the impact of a person's developmental disability does not impede the practitioner's ability to effectively provide treatment. The design features and/or expertise levels required by these participants have been developed through years of experience and are not available through existing State Plan services. These features are critical to maintain, preserve, or improve the health status and developmental progress of each individual, aged 3 years or older, who is referred to these STS.

STS include:

1. Oral Health Services: diagnostic, prophylactic, restorative, oral surgery.
2. Services for maladaptive behaviors/social-emotional behavior impairments (MB/SEDI) due to/associated with a developmental disability, individual and group interventions and counseling.
3. Physical Health Services: physical therapy, occupational therapy, speech therapy, respiratory therapy, diagnostic and treatment, physician services, nursing services, diabetes self-management.

The need for a STS must be identified in the participant's IPP and is to be provided only when the individual's PCP team has:

1. Determined that other generic or State Plan providers delivering routine services cannot/do not meet the participant's unique oral health, behavioral/social-emotional health, physical health needs as a result of the participant's developmental disability and its impact on the delivery of therapeutic services.
2. Determined that a provider with specialized expertise/knowledge in serving individuals with developmental disabilities is needed, i.e., a provider of State Plan services does not have the appropriate qualifications to provide the service.
3. Determined that the STS is a necessary component of the overall IPP that is needed to avoid institutionalization.
4. Consulted with a regional center clinician.

The need to continue the STS will be evaluated during the mandatory annual review of the individual's IPP by determining if utilization is appropriate and progress is being made as a result of the service being provided.

The following specify the differences between STS and services available under the approved State Plan:

1. Provider qualifications

   STS Providers must hold a current State license or certificate to practice in the respective clinical field for which they are providing services and have at least one year of experience providing direct care in the field of licensure with persons with developmental disabilities, validation of which must be obtained by the FMS prior to providing the participant services and maintained on file. This expanded qualification requirement differentiates providers of STS from State Plan providers. These providers include physicians/surgeons, nurse practitioners, registered nurses, licensed vocational nurses, psychologists, social workers, speech therapists, physical therapists, physical therapy assistants, dental hygienists, dentists, and marriage and family therapists. Certified occupational therapists, occupational therapy assistants, respiratory therapists, and chemical addiction counselors are also included.

2. Scope of services

   When provided as a SDS Waiver service, a STS may require one or more of the following if determined critical to the ongoing maintenance of the oral care, health care, or behavioral/social-emotional health care in the participant's residence or program environment. This expansion of the scope of the STS differentiates it from other State Plan services. These are provided as a component of an allowable specialized therapeutic service, are billed to the SDS Waiver as part of the STS being provided, and are designed to improve the participant or caregiver's capacity to effectively access services, interpret care instructions, or provide care as directed by the clinical professional. Each of these will be provided only if it is directly associated with a STS provided to an individual and are included in an approved service plan. The additional components are:

   a. Family support and counseling – A critical component to a full understanding of the impact of involved developmental disabilities on the presenting health care need and effective treatment. The health care practitioner delivering the health, dental, or behavioral/social-emotional health specialized services may need to provide family support and/or counseling, as well as participant training and consultation with other physicians or involved professionals, in order to ensure the proper understanding of the treatment and support in the person's home environment and that it is critical to effective treatment of people with developmental disabilities.
   b. Provider travel necessary to deliver the service.
   c. Consultation with other involved professionals in meeting the physical, behavioral/social-emotional health and/or dental health needs of the participant through specialized therapeutic services. This allows the clinical provider of specialized therapeutic services to properly involve other professional care givers who deliver services in accordance with the individual's plan of care.
   d. Participant training - at times the individual will require additional training by a specialized therapeutic service provider to maintain or enhance the long-term impact of the oral, behavioral/social-emotional health, or health care treatment provided. An appropriately licensed or certified provider, as defined above, will provide this training.

3. The location for the services - the services will be offered either at the participant's home or, when appropriate, the provider's site.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s)	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Dentist (Oral Health)		Entities that employ individuals who meet the	

(check one or both):		provider qualifications specified herein
	Dental Hygienist (Oral Health)	
	Psychologist (Mental Health)	
	Marriage & Family Therapist (Mental Health)	
	Social Worker (Mental Health)	
	Chemical Addiction Counselor (Mental Health)	
	Physician/Surgeon (Physical Health)	
	Speech Therapist (Physical Health)	
	Occupational Therapist and Assistant (Physical Health)	
	Physical Therapist (Physical Health)	
	Physical Therapy Assistant (Physical Health)	
	Respiratory Therapist (Physical Health)	
	Registered Nurse (Physical Health)	
	Licensed Vocational Nurse (Physical Health)	
	Nurse Practitioner (Physical Health)	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All			Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. STS Providers must hold a valid State authorization to practice in the respective clinical field and, at minimum, have one year's experience working with persons with developmental disabilities.
Dentist (Oral Health)	Business and Professions Code §§1628 - 1635.5		
Dental Hygienist (Oral Health)	Business and Professions Code §§1766 - 1769		
Psychologist (Mental Health)	Business and Professions Code §§2940 - 2948		

Marriage & Family Therapist (Mental Health)	Business and Professions Code §§4980 - 4984.9		
Social Worker (Mental Health)	Business and Professions Code §§4996.1 - 4996.2		
Chemical Addiction Counselor (Mental Health)		Chemical Addiction Counselor - certified in accordance with counseling certification organizations	Professionals with advanced or graduate degrees must have: • A Master's Degree from an accredited health care training program. • Three years of post-graduate, supervised experience providing direct health care services to those identified with an addictive disorder. • A portfolio of clinical training with a minimum of 120 hours of training in basic counseling skills including assessment, interviewing and diagnosis, and a minimum of 60 hours of training in each area of specialization. • Three professional recommendations. At least one recommendation must be from a supervisor who is personally familiar with the applicant's work and can document his or her health care experience. Professionals with other degrees or without a degree must: • Be over 18 years of age and have a high school diploma. • Have five years of supervised experience providing direct health care services to those identified with an addictive disorder. • Be presently employed or serving in a volunteer capacity in a social model program, or formerly employed or serving in a volunteer capacity in a social model program within the last full year prior to the filing date. • Have a portfolio of clinical training that includes a minimum of 120 hours

			of training in basic counseling skills including assessment, interviewing and diagnosis, and a minimum of 60 hours of training in each area of specialization; documentation of a minimum of 150 hours of closely supervised on-the-job training in direct alcohol and/or other drug recovery services in a social model setting. • Have three professional recommendations. At least one recommendation must be from a supervisor who is personally familiar with the applicant's work and can document his or her health care experience. Only Chemical Addiction Counselors certified and credentialed by any of the following organizations are authorized to provide services under the SDS Waiver: • California Association of Addiction Recovery Resources • California Association of Alcohol and Drug Educators • California Association of Alcoholism and Drug Abuse Counselors • California Association of Drinking Drivers Treatment Program • Forensic Addiction Counselors Team • American Academy of Providers in the Addictive Disorders, or Indian Alcoholism Commission of California, Inc.
Physician/Surgeon (Physical Health)	Business and Professions Code §§2080 - 2096		
Speech Therapist (Physical Health)	Business and Professions Code §§2532 - 2532.6		
Occupational Therapist and Assistant (Physical Health)	Business and Professions Code §§2570.2 - 2570.6		
Physical Therapist	Business and		

(Physical Health)	Professions Code §§2620 - 2636.5		
Physical Therapy Assistant (Physical Health)	Business and Professions Code §§2655 - 2655.93		
Respiratory Therapist (Physical Health)	Business and Professions Code §§3702 - 3731		
Registered Nurse (Physical Health)	Business and Professions Code §§2725 - 2742		
Licensed Vocational Nurse (Physical Health)	Business and Professions Code §§2859 - 2873.7		
Nurse Practitioner (Physical Health)	Business and Professions Code §§2834 - 2837		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**NUTRITIONAL CONSULTATION: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**

Service Definition (Scope)**:**

Nutritional consultation includes the provision of consultation and assistance in planning to meet the nutritional and special dietary needs of the individual. These services are consultative in nature and do not include specific planning and shopping for, or preparation of, meals for individuals. The nature and scope of these services is specified in the IPP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Dietician		Business entity that employs qualified individuals	
	Nutritionist			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Dietician			Dietician Valid registration as a member of the American Dietetic Association
Nutritionist			Possess a Master's Degree in one of the following: 1. Food and Nutrition 2. Dietetics 3. Public Health Nutrition

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Dietician/Nutritionist	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**BEHAVIOR INTERVENTION SERVICES: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**

Service Definition (Scope)**:**

Behavior Intervention Services consist of the use of behavior intervention programs, development of programs to improve the participant's development, behavior tracking and analysis, and the fading of any intrusive intervention measures. Behavior intervention services are restricted to generally accepted positive approaches. The specific behavior intervention services that are furnished to a participant are specified in the IPP. The need for such programs is documented in the participant's record.

Client/Parent Support Behavior Intervention Training Program serves participants aged 3 years to 18 years. The program utilizes positive behavioral support techniques. The program also intervenes with the family and assists them in developing tools to work with their child. Ultimately, the family will be in a position to maintain the child in the home. This program is not funded by the Department of Education because children and families will be served on an individual basis. However, the child's special education program will not be discontinued or altered. The service is specified in the IPP. The need for such a program is documented in the participant's record.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Psychiatrist		Entities that employ individuals who meet the provider qualifications	
	Behavior Management Assistant: Psychology Assistant			
	Behavior Management Consultant: Psychologist			
	Behavior Management Consultant: Licensed Clinical Social Worker			
	Behavior Management Consultant: Marriage, Family, Child Counselor			
	Behavior Management Assistant: Associate Licensed Clinical Social Worker			
	Registered Nurse – (Psychiatric)			
	Licensed Psychiatric Technician			
	Clinical Psychologist			
	Behavior Analyst			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All			Services are provided by individuals who

State:	California
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			have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.
Psychiatrist	Business and Professions Code, Division 2, Chapter 5, commencing at §2000		Meets conditions of participation in Medi-Cal as established in the California Medicaid State Plan
Behavior Management Assistant: Psychology Assistant	Business and Professions Code §2913		Meets conditions of participation in Medi-Cal as established in the California Medicaid State Plan
Behavior Management Consultant: Psychologist	Business and Professions Code §§2940 - 2948		Meets conditions of participation in Medi-Cal as established in the California Medicaid State Plan
Behavior Management Consultant: Licensed Clinical Social Worker	Business and Professions Code §§4996 - 4997		Meets conditions of participation in Medi-Cal as established in the California Medicaid State Plan
Behavior Management Consultant: Marriage, Family, Child Counselor	Business and Professions Code §§4980 - 4984.9		
Behavior Management Assistant: Associate Licensed Clinical Social Worker	Business and Professions Code §4996.18		
Registered Nurse – (Psychiatric)	Business and Professions Code §§2732 - 2736		Title 9, CCR, §627
Licensed Psychiatric Technician	Business and Professions Code §§4500 - 4524		
Clinical Psychologist	Business and Professions Code, §§800 -809.9; §§2725 -2742 Health and Safety Code §1316.5		
Behavior Analyst	Licensed in accordance with		

	Business and Professions Code as appropriate to the skilled professions staff		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**INTEGRATIVE THERAPIES: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**

Service Definition (Scope)**:**

Integrative Therapies consist of Acupuncture Services, Chiropractic Services, and Massage Therapy.

Acupuncture and Chiropractic Services through the SDS waiver are as defined in the approved Medicaid State Plan except that the limitations on the amount, scope, and provider qualifications do not apply. The following specify the differences between Integrative Therapies Services – Acupuncture and Chiropractic – and similar services that are available under the approved State Plan:

1. Provider qualifications. In addition to valid license or certification, providers of Acupuncture and Chiropractic services must have at least one year of experience providing direct care in the field of licensure/certification with persons with developmental disabilities, validation of which must be obtained by the FMS prior to the provision of services. This expanded qualification requirement differentiates providers of SDS Waiver Acupuncture and Chiropractic services from State Plan providers.
2. The expanded scope of the Integrative Therapies service differentiates it from other State Plan Services. When provided as a SDS Waiver service, an Integrative Therapies service may require one or more of the additional components listed below if determined critical to the ongoing maintenance of the participant's health or emotional care in the participant's residence. These additional components are designed to improve the participant or caregiver's capacity to effectively access services, interpret care instructions, or provide care as directed by the professional. The additional components are provided as a part of an allowable Integrative Therapies service, and therefore are billed to the SDS Waiver as part of the Integrative Therapies service. Each component is provided only if it is directly associated with an individual's Integrative Therapies service and is documented in the participant's record and specified in the IPP. The additional components are:
   a. Provider travel necessary to deliver the service may be included If cost-effective and necessary due to the disabilities of the individual. The need for travel must be documented in the participant's record and specified in the IPP.
   b. Consultation with other involved professionals in meeting the physical and social-emotional health and needs of the participant through Integrative Therapies service. This allows the provider of Integrative Therapies services to properly involve other professional care givers who deliver services in accordance with the individual's IPP. The type and amount of consultation shall be specified in the IPP.
   c. Participant training - at times the individual will require additional training by an Integrative Therapies services provider to maintain or enhance the long-term impact of treatment provided. An appropriately licensed or certified provider, as defined above, will provide this training. The type, amount and duration of the training will be specified in the IPP.
   d. The services will be offered either at the participant's home or when appropriate, the provider's site. The location of the services will be specified in the IPP.

The need for Acupuncture and Chiropractic Services must be identified in the participant's IPP and is to be provided only when the individual's PCP team has:

1. Determined the reason why other generic or State Plan services cannot/do not meet the unique needs of the participant as a result of the participant's developmental disability and the impact of the developmental disability on the delivery of therapeutic services.
2. Determined that a provider with specialized expertise/knowledge in serving individuals with developmental disabilities is needed, i.e. a provider of State Plan services does not have the appropriate qualifications to provide the service.
3. Determined that the individual's needs cannot be met by a State Plan provider delivering routine State Plan services.

4. Determined that the acupuncture or chiropractic service is a necessary component of the IPP that is needed to avoid institutionalization.
5. Consulted with a regional center clinician.

Therapeutic massage and assessment are not covered under the State Plan. Therapeutic massage and assessment consists of:

1. Manipulation of the superficial tissues of the human body with the hand, foot, arm or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation or thermal therapy.
2. Any electrical or mechanical device.
3. The application to the human body of a chemical or herbal preparation.

Indications for this service include:

1. Medical conditions characterized by poor circulation, dysfunction or pain including conditions related to: peripheral vascular insufficiency (in the absence of blood clot); lymph edema; arthritis; spastic colon or bowel disease; and muscle dysfunction, including conditions characterized by muscle rigidity and flaccidity.
2. A need to increase the blood flow through applied pressure and stretching.
3. Deep muscle relaxation to promote more functional joint movement, which assists in the range of motion and prevention of deterioration due to contractures.
4. Assistance in keeping muscles supple and free from fibrous adhesions; and to loosen shortened, contracted muscles and the stimulation of weak and flaccid muscles to promote efficient movement and improved posture.
5. Additionally, therapeutic massage softens tough inflexible skin making it suppler, which promotes comfort and skin integrity, and may:
   a. Prevent or relieve constipation and bowel impaction thereby reducing the need for alternative bowel management strategies.
   b. Achieve respiratory benefits including promotion of deep breathing through stretching techniques.

Massage therapy must be prescribed by a physician, physician's assistant, or nurse practitioner and is limited to participants with the specific medical conditions specified above. This service may be complementary to physical therapy or rendered as a less intrusive alternative. Assessment to determine the specific therapeutic activities to be used and the need for continued services is also an included service. The type, amount and duration of the service must be specified in the IPP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The prospective IB amount must be sufficient to accommodate the amount of the service.

Provider Specifications

Provider Category(s) *(check one or both)*:	☒ Individual. List types:	☒ Agency. List the types of agencies:
	Acupuncture: Physician/Surgeon	Entities that employ qualified individual practitioners
	Acupuncture: Acupuncturist	
	Chiropractic Services	
	Massage Therapy: Physical Therapist	
	Massage Therapy: Physical Therapy Assistant	
	Massage Therapy: Massage Therapist	

Specify whether the service	☐	Legally Responsible	☒	Relative	☒	Legal Guardian

may be provided by *(check each that applies)*		Person				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All			Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. All providers must possess any valid license or certification required by State or local law and at least one (1) year of experience providing services in the area of license or certification to individuals with developmental disabilities.
Acupuncture: Physician/Surgeon	Business and Professions Code §§2080 - 2096		
Acupuncture: Acupuncturist	Business and Professions Code §§4935 - 4949		
Chiropractic Services	Business and Professional Code §§1000 – 1004		
Massage Therapy: Physical Therapist	Physical Therapist: Business and Professions Code §§2620 - 2636.5		
Massage Therapy: Physical Therapy Assistant	Business and Professions Code §§2655 – 2655.93		
Massage Therapy: Massage Therapist	Local business license	Certified as a Massage Therapist by a state-approved school in Massage Therapy Training	.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All Providers	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method

Service Delivery Method	☒	Participant-directed as specified in Appendix E	☐	Provider managed

(check each that applies):				

Service Specification	
Service Title:	**FAMILY ASSISTANCE AND SUPPORT: COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

Family Assistance and Support (Family Support) are supports provided either in or out of the home to a participant/family that enables the participant to continue to live and be supported in the family home. The participant's family includes the participant's biological parents, adoptive parents, stepparents, siblings, children, spouse, domestic partner, or a person who is the legal representative of the participant. Family supports are intended to support both the participant and the rest of the family to live as much like other families as possible in order to prevent or delay unwanted out-of-home placement. Family Assistance and Supports may include training and education services to the family to accommodate the participant's disability in the home and to access supports offered in the community. These supports consist of:

1. Developing interventions to cope with complex problems or unique situations that may occur in the day-to-day life of the family.
2. Assessment of support needs, including assistance with developing plans and obtaining support through generic resources or other SDS waiver services for the participant to participate in family events and leisure activities.
3. Instruction and consultation for family members in effectively supporting the participant to be fully engaged in the life of the family.
4. Instruction, training and education in supporting the unique needs of the participant.

This service also consists of enrollment fees, materials, and, when necessary to enable participation in training and instruction, transportation expenses. The specific supports to be furnished shall be specified in the IPP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individual		Business entity	
	Participant-employed individual			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law		Family assistance and supports will be provided by individuals and entities who have experience and knowledge in the areas of instruction, training and education, and meet the unique needs and preferences of the participant as specified in his/her IPP. Providers shall possess the skills necessary to ensure that the recommended support services meet the participant's health and safety needs and are directed at the participant's desired outcome.

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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	The participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in IPP and certifies that the provider is qualified to the FMS entity. FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually during the IPP review meeting.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**INDIVIDUAL TRAINING AND EDUCATION: TRAINING AND EDUCATION BUDGET CATEGORY**

Service Definition (Scope)**:**

Individual Training and Education service includes: training the participant in his or her responsibility as an employer, job discovery, community inclusion, relationship building, problem solving, and decision making designed to facilitate the participant's self-advocacy skills, exercise the participant's human and civil rights, and exercise control and responsibility over their SDS and supports. This service includes enrollment fees, materials, and transportation expenses that are necessary to enable participation in the individual training and education. This service is defined by learning activities such as classes; instruction; tutoring; distance learning; courses; instructional materials including books, software, internet access fees, enrollment fees, tuition fees, supplies, or other expenses related to the education and skill development of the person, as outlined in the IPP. This service is not provided when funding is available through Public Education as required in IDEA (P.L. 105-17, the IDEA). The specific nature of the service is specified in the IPP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individuals		Business entities	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Providers have expertise and knowledge in the subject matter, experience in providing training to persons with developmental disabilities, and the experience and expertise to meet the unique needs and preferences of the participant as specified in the participant's IPP. Providers are responsible for ensuring that training settings meet the participant's health and safety needs and that training is directed toward the participant's desired outcomes.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	The participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in the IPP, and certifies that the provider is qualified to the FMS entity. FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually during the IPP review meeting.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**TRAINING AND COUNSELING SERVICES FOR UNPAID CAREGIVERS: COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, "individual" is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided to train paid caregivers. Training includes instruction about services and supports included in the IPP, use of equipment specified in the IPP, and updates as necessary to safely maintain the participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the IPP. The service includes the cost of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the IPP. The costs for travel, meals and overnight lodging to attend a training event or conference are not covered under this service definition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individuals		Business entities	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Training	Providers must possess any valid license or certification required by State or local law		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Training is provided by providers who have expertise and knowledge in the subject matter, experience providing training to caregivers, and the experience and expertise to understand the unique needs and preferences of the individuals with developmental disabilities.
Counselors	Providers must possess any valid license or certification required by State or local law		Services included within this service definition shall be provided by the following persons: 1. Family Counselor - Possesses a valid Marriage and Family Therapist license issued by the California Board of Behavioral Science Examiners, and

			provides support and counseling to help the care provider to meet the needs of the participant as specified in the IPP. 2. Social Worker - Possesses a valid Clinical Social Worker's license issued by the California State Board of Behavioral Science Examiners, and provides support and counseling to help the care provider meet the needs of the participant as specified in the IPP.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	Participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in the IPP, and certifies that the provider is qualified to the FMS entity. FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually during the IPP review meeting.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS: ENVIRONMENTAL AND MEDICAL SUPPORT BUDGET CATEGORY**

Service Definition (Scope)**:**

Environmental Accessibility Adaptations are physical adaptations to the private residence of the participant or participant's family that are necessary to ensure the health, welfare, and safety of the participant and/or enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, and installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Environmental accessibility adaptations, including the model and type of equipment or other specifications, are based upon an assessment by a qualified professional and identified in the participant's IPP.

Excluded from this benefit are adaptations or improvements which add to the total square footage of the residence except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair), or that are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, and central air conditioning. Environmental accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of services. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Environmental accessibility adaptations consist of necessary assessments to determine the types of modifications that are necessary; purchase; installation; and ongoing maintenance repairs. Allowable environmental accessibility adaptations must:

1. Specifically accommodate the participant's disability.
2. Have utility primarily for the participant.
3. Not be an item or modification that a family would normally be expected to provide for a non-disabled family member.
4. Not be in the form of room and board or general maintenance.
5. Meet the specifications, if applicable, for the modification as set by the American National Standards Institute.
6. Be provided in accordance with applicable state or local building codes.

Environmental accessibility adaptations may include the cost of reversing modifications identified in the participant's previous IPP when such change is specified in the current IPP.

Provided that they are allowable as specified above, other environmental accessibility adaptations and repairs may be approved on a case-by-case basis as technology changes or as a participant's physical or environmental needs change.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The prospective IB amount must be sufficient to accommodate the amount of the service.

Provider Specification				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individual		Contractor/Community Business	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

State:	California
Date	3/26/08

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Professional license as required to perform adaptation	Professional certification as required to perform adaptation	Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Individuals or agencies who provide environmental accessibility adaptation services shall be qualified to perform, repair or maintain the adaptation as demonstrated by a current professional license, certification, registration with the State and/or references as appropriate for the type of adaptation being performed. The provider shall also possess a current local business license, and have knowledge of applicable State or local building codes.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**VEHICLE ADAPTATIONS: TRANSPORTATION BUDGET CATEGORY**

Service Definition (Scope)**:**

Vehicle adaptations include adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified in the IPP as necessary to enable the participant to integrate more fully into the community and to ensure the health and safety of the participant. The following adaptations are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and not of direct medical or remedial benefit to the individual.
2. Purchase or lease of a vehicle.
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

The service includes the repair, maintenance, installation, and training in the care and use of these items. Vehicle adaptations must be performed by the manufacturer's authorized dealer, as should repairs to and maintenance of such equipment where possible. Vehicle adaptations will only be provided if they are documented in the IPP, and there is a written assessment by a licensed Physical Therapist or a registered Occupational Therapist.

The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services. Only one vehicle, the primary means of transportation, may be adapted. Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The prospective IB amount must be sufficient to accommodate the amount of the service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Individual proprietor		Business entity	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by state or local law.		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Services in accordance with industry standards, Title 9, CCR, §7165 (d)(1)-(5). Providers of vehicle adaptations shall have a

			current license, certification, or registration with the State as appropriate for the services being purchased. The provider shall also possess a current local business license. Providers shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**

Service Definition (Scope)**:**

Specialized medical equipment and supplies allow participants to increase their abilities to perform activities of daily life, or to perceive, control, or communicate within the environment. This service excludes medical equipment and supplies that are available under the State Medicaid Plan. The service also excludes items that are not of direct medical or remedial benefit to the participant. Medical equipment and supplies that can be covered under the State plan should be furnished as expanded EPSDT benefits to SDS Waiver participants under the age of 21. All items must meet applicable standards of manufacture, design, and installation, and Underwriter's Laboratory or Federal Communications Commission codes, as applicable.

The service is comprised of: (a) devices, controls, or appliances specified in the IPP that enable participants to increase their ability to perform activities of daily life, (b) devices, controls, or appliances that enable the participant to perceive, control or communicate with the environment in which they live, (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, (d) such other durable and non-durable medical equipment not available under the State plan or covered by Medicare that is necessary to address participant functional limitations, and (e) necessary medical supplies not available under the State plan. The repair, maintenance, installation, and training in the care and use of these items are also included. This service includes the cost of extended warranties or service agreements, repair, and/or maintenance above the warranty and/or service agreement. Where possible, the manufacture's authorized dealer shall perform repairs to, and maintenance of, such equipment.

Specialized medical equipment and supplies are only to be provided if they are documented in the participant's IPP and there is a written assessment by a licensed Physical Therapist or a registered Occupational Therapist. A parent or legal guardian cannot be paid for providing Specialized Medical Equipment and Supplies to the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The prospective IB amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individual		Business entity	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law.		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.

	The provider shall also possess a current local business license.		Providers of specialized medical equipment and supplies must have a current license, certification, or registration with the State as appropriate for the type of equipment or supplies being purchased. Providers shall also be authorized by the manufacturer to install, repair, and maintain such systems if such a manufacturer's authorization program exists. The provider shall demonstrate knowledge of applicable standards of manufacture, design, and installation, and appropriate government codes.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter for continuing services.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**PERSONAL EMERGENCY RESPONSE SYSTEM: ENVIRONMENTAL AND MEDICAL SUPPORT BUDGET CATEGORY**

Service Definition (Scope)**:**

The Personal Emergency Response System (PERS) is a 24-hour emergency assistance service which enables the recipient to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS services are individually designed to meet the needs and capabilities of the recipient and are specified in the IPP. The services include training, installation, repair, maintenance, and response needs. The following are allowable:

1. 24-hour answering/paging
2. Beepers
3. Med-alert bracelets
4. Intercoms
5. Life-lines
6. Fire/safety devices, such as fire extinguishers and rope ladders
7. Monitoring services
8. Light fixture adaptations (blinking lights, etc.)
9. Telephone adaptive devices not available from the telephone company
10. Other electronic devices/services designed for emergency assistance

PERS services are limited to those individuals who have no regular caregiver or companion for periods of time, and who would otherwise require extensive routine supervision. By providing immediate access to assistance, PERS services prevent institutionalization of these individuals. All items must meet applicable standards of manufacture, design, and installation. Where possible, the manufacturer's authorized dealers shall perform repairs to and maintenance of such equipment. A parent or legal guardian cannot be paid for providing Personal Emergency Response System services to the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The prospective IB amount must be sufficient to accommodate the amount of the service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individual		Business entity	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law.		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. PERS providers shall have a current license, certification, or registration with the State as appropriate for the type of system being

			purchased. The provider shall also possess a current local business license, and demonstrate knowledge of applicable standards of manufacture, design and installation.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**TRANSPORTATION: TRANSPORTATION BUDGET CATEGORY**

Service Definition (Scope)**:**

Transportation services enable a participant to gain access to SDS Waiver and community services, employment and leisure activities, and participate in community life as specified in the IPP. Reimbursement for mileage to transport the participant to services and supports shall not exceed the usual and customary rate charged to the general public for this service. A variety of modes of transportation may be provided, depending on the needs of the participant and availability of services. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be used. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Medicaid Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individual		Business entity	
			Company	
			Public Transit Authority	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative	☒	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Valid California driver's license Valid California registration of the vehicle		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Proof of maintenance of insurance coverage in the amount specified by California law.
Individual	Welfare and Institutions Code § 4648.3		An individual transportation provider shall be at least 18 years of age and competent in the use of wheelchairs, hydraulic lifts, ramps and other equipment used for transporting, boarding and exiting consumers from the vehicle, as applicable. Transportation services will be provided by providers who meet the unique needs and preferences of the participant as specified in the participant's IPP. Providers are responsible to ensure that supports meet the participant's health and safety needs and

			are directed toward the participant's desired outcomes.
Business Entity	Welfare and Institutions Code §4648.3	Appropriate business license	
Company	Current business license	Appropriate business license	Welfare and Institutions Code §4648.3 Services of the company must be available to the general public.
Public Transit Authority	Welfare and Institutions Code §4648.3	Appropriate business license	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	The participant, with the assistance of the SB as requested, assesses the skills and capacity of the provider to provide services and supports specified in IPP and certifies that the provider is qualified to the FMS entity. FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually during the IPP review meeting.
Business Entity Company Public Transit Authority	FMS entity reviews a Statement of Qualifications submitted by the provider and verifies that the provider possesses the necessary license and/or certificate and meets other standards as applicable.	Upon selection and prior to service provision. Annually thereafter.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**CRISIS INTERVENTION: HEALTH AND CLINICAL SERVICES BUDGET CATEGORY**

Service Definition (Scope)**:**

Crisis intervention services are specialized services that provide short-term care and intervention to provide relief and support of the caregiver and protection for the participant or others living with the participant. Crisis intervention services do not duplicate other services provided to the participant.

When it is determined that such services are needed, they are immediately authorized by the regional center. Crisis intervention can be provided to a participant as follows:

1. Mobile crisis intervention in his or her home. Mobile crisis intervention means immediate therapeutic intervention on a 24-hour emergency basis to a participant exhibiting acute personal, social, and/or behavioral problems. Mobile crisis intervention provides immediate and time-limited professional assistance to a participant who is experiencing personal, social or behavioral problems which, if not ameliorated, will escalate and require that the participant be moved to a more restrictive setting.
2. Out-of-home crisis intervention when necessary for the relief of the caregiver and the protection of the participant or others living in the home may be provided in a licensed care facility. Payment for out-of-home crisis intervention will include payment for room and board costs when the service is provided in a licensed care facility developed for the provision of crisis intervention that is not a private residence.

As necessary, crisis intervention services are composed of the following participant-specific activities:

1. Assessment to determine the precipitating factors contributing to the crisis.
2. Development of an intervention plan in coordination with the planning team.
3. Consultation and staff training to the provider and/or caregiver as necessary to ensure successful implementation of the participant's specific intervention plan.
4. Development and implementation of a transition plan to aid the participant in returning home if out-of-home emergency respite was provided.
5. Ongoing technical assistance to the caregiver or provider in the implementation of the intervention plan developed for the participant.
6. Provision of recommendations to prevent or minimize future crisis situations in order to increase the likelihood of maintaining the participant in the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
				Mobile Crisis Intervention Team
				Crisis Intervention Facility (Adult): Adult Residential Facility
				Crisis Intervention Facility (Adult): Residential Care Facility for the Elderly
				Crisis Intervention Facility (Child): Small Family Home
				Crisis Intervention Facility (Child): Foster Family Home
				Crisis Intervention Facility (Child): Foster Family Agency/Certified Family Homes

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All			Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP.
Mobile Crisis Intervention Team		Behavior Analyst (if required): Certification by the Behavior Analyst Certification Board	Providers of Mobile Crisis Intervention services shall be a team which is supervised by or has access to a licensed psychologist, psychiatrist, or Behavior Management Consultant. Such teams shall be vendored specifically to provide mobile crisis intervention services. All members of the Mobile Crisis Intervention teams shall maintain a current license, registration or certification as appropriate for the professional services being provided. All unlicensed staff shall have at least one year of full-time experience in serving persons with developmental disabilities and shall have completed at least 40 hours of training in crisis intervention techniques prior to providing services.
Crisis Intervention Facility (Adult): Adult Residential Facility	Health and Safety Code §§1500-1569.87 Title 22, CCR, §§85000 - 85092		Crisis Intervention Facilities shall be an appropriate level residential care facility specifically vendored by the regional center to provide emergency placement for individuals in need of intensive intervention services in order to maintain their preferred living option. Facilities shall have available staff who are supervised by or have access to a licensed psychologist, psychiatrist, or Behavior Management Consultant.
Crisis Intervention Facility (Adult): Residential Care Facility for the Elderly	Health and Safety Code §§1500 - 1569.87 Title 22, CCR, §§87100-87730		
Crisis Intervention Facility (Child): Small Family Home	Title 22, CCR, §§83000 - 83088		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Mobile Crisis Intervention Team	Regional Center	

Crisis Intervention Facility (Adult): Adult Residential Facility	Department of Social Services Regional Center	Annual
Crisis Intervention Facility (Adult): Residential Care Facility for the Elderly	Department of Social Services Regional Center	Annual
Crisis Intervention Facility (Child): Small Family Home	Department of Social Services Regional Center	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**SUPPORTS BROKER: COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

Supports Broker (SB) means a service or function that shall, at a minimum, assist the participant to:

1. Participate in the person-centered planning process.
2. Identify immediate and long-term needs, preferences, goals and objectives of the participant for developing the IPP.
3. Make decisions about the individual budget.
4. Develop options to meet the identified needs and access community services and supports specified in the IPP.
5. Negotiate rates of payments and written agreements with service providers.
6. Select, hire and train service providers, as applicable.
7. Develop and implement risk management agreements and emergency back-up plans.
8. Conduct self-advocacy and assist with filing grievances and complaints.
9. Provide information and practical skills training to the participant in the following areas:
   - A. Person-centered planning and its application.
   - B. The range and scope of individual choices and options.
   - C. The process for changing the IPP and individual budget.
   - D. Recruitment and hiring of service providers.
   - E. Management of service providers, including effectively directing, communicating, and problem-solving.
   - F. Participant responsibilities in self-directed services, including the appeal process.
   - G. Recognition and reporting of abuse, neglect, and exploitation.

SBs do not provide direct care to participants and are responsible for reporting special incidents to regional centers.

The participant/family must hire, contract with or designate an SB, and shall specify the activities which the SB will conduct in the IPP. A designated SB does not receive compensation from the IB for performing the function. This service does not duplicate services provided by the participant's service coordinator. A parent or legally responsible individual can only provide support brokerage services as a "designated" service provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Self-employed individuals		Business entities that employ qualified supports brokers	
	Participant Employed Individual			

Specify whether the	☒	Legally Responsible	☒	Relative	☒	Legal Guardian

State:	California
Date	3/26/08

service may be provided by *(check each that applies):*		Person				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
All	Providers must possess any valid license or certification required by State or local law		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. **<u>Supports Broker Training</u>** Using materials developed by DDS and made available in both written form and on the DDS website, SBs shall be trained in and demonstrate through a test understanding of: 1. Principles of self-direction and the SDS Waiver. 2. Locating and securing informal and unpaid services and supports. 3. Payment authorization. 4. Ethics and professionalism. SBs shall also have the skills and abilities to train participants as described in 9A-G above. SBs shall engage in ongoing training as needed. At the request of the participant/family, the SB shall coordinate with the FMS to obtain a criminal history record clearance funded by the State. **<u>Conflict of Interest</u>** All paid SBs shall be free of any conflict of interest including membership on the Board of Directors of the regional center; provision of any other SDS Waiver service to the same participant; employment or membership on the State Council on Developmental Disabilities regional office, or employment on the State Department of Developmental Services (DDS), and/or Protection and Advocacy, Inc. A parent or legal guardian who serves as an SB cannot provide any other SDS waiver services to the same participant. **<u>Knowledge and Skills</u>** <u>SB to a Single Participant or Family</u> - shall have the: 1. Ability to communicate in the preferred language of the participant's/family's choice.

			2. Knowledge and awareness of community resources. 3. Ability to complete the initial SB training program and participate in ongoing training as needed. <u>SB to Multiple Participants and/or Families</u> - shall provide support brokerage to no more than 30 participants and shall: 1. Possess ability to effectively communicate with multiple participants/families. 2. Possess experience and/or training in conducting PCP. 3. Possess ability to identify, coordinate and access resources, including generic services. 4. Possess ability or training in assisting the participant/family to negotiate rates. 5. Assist the participant/family to enter into agreements with service providers and as specified in the participant's IPP. **<u>Education and Experience:</u>** <u>All</u> 1. 21 years old with a High School diploma or General Education Development Test (GED). 2. Knowledge of family/natural supports and private/public resources. 3. Knowledge of a variety of approaches to support the participant. 4. Awareness of participant health and safety needs. 5. Knowledge of entitlement and benefit programs. 6. Ability to develop and maintain good relationships with community agencies and representatives. 7. Ability to use effective interpersonal skills that consistently respect children and adults with developmental disabilities and their families. 8. Ability to work in a cooperative and collaborative manner as a team member. <u>SB to a Single Participant or Family</u> 1. One year paid or unpaid experience working with individuals with developmental disabilities. 2. Familiarity with the participant. 3. Friends and/or participant/family would

			provide a letter of recommendation for this person, or three references from people who have direct knowledge of capabilities outlined above, including at least one reference from a participant with a developmental disability. SB to Multiple Participants and/or Families 1. Three years of paid work experience with a human services delivery system including at least one year full-time paid work in direct service to people with developmental disabilities; or 2. A bachelor's degree in a human services-related field, plus a minimum of one year of paid experience in direct service to an individual with developmental disabilities; and 3. Résumé with minimum of two professional references and one reference from an individual with developmental disabilities.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	FMS entity reviews Statement of Qualifications submitted by provider and verifies that provider possesses necessary license and/or certificate and meets other standards as applicable.	Upon initial selection and prior to service delivery. The participant, with the support of the PCP team as required, shall reassess the provider's qualifications at least annually during the IPP review meeting.

Service Delivery Method

Service Delivery Method	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**FINANCIAL MANAGEMENT SERVICES – VENDOR FISCAL/EMPLOYER AGENT** (Operating under Title 26, §3504 of the IRS Code and Revenue Procedure 70-6, 1970-1 C.B. 420 and as modified by IRS Proposed Notice 2003-70): **COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

The FMS provider will operate as an Internal Revenue Service (IRS) authorized Vendor Fiscal/Employer Agents (F/EAs) for participants for the purpose of processing and paying payroll and associated federal and state income tax withholding and employment taxes for workers hired directly by participants or their representatives, as appropriate. The FMS provider also will process and pay participant-approved invoices for goods and services authorized in the IPP and funded through the individual budget. The FMS provider may also furnish additional assistance, as specified by the participant and provided for in the IPP, to aid the participant in managing his/her own services.

This service definition applies to FMS providers who are authorized by the IRS as Vendor F/EAs. The Vendor F/EA performs the following functions as the employer agent to the participant, who is the common law employer, or his or her legal representative in accordance with Title 26, **§**3504 of the IRS Code and Revenue Procedure 70-6, 1970-1 C.B. 420 and as modified by IRS Proposed Notice 2003-70:

1. Develop a Vendor F/EA Policies and Procedures Manual that includes policies, procedures and internal controls for all Vendor F/EA tasks. This Manual should be updated as needed and at least annually.
2. Develop a system and written policies, procedures and internal controls for staying up-to-date with federal, state and local tax, labor, worker's compensation insurance and Medicaid program rules, policies and procedures.
3. Develop and implement an effective customer service system for participants and representatives including, as needed, the ability to:
   a. Communicate in languages other than English, including American Sign Language and using a Telecommunication Device for the Deaf (TTY) line and/or state relay system.
   b. Produce and distribute information and forms in alternate print format.
   c. Receive, respond to/resolve and track the receipt of calls and grievances from participants and their representatives and service providers, including the reporting of critical financial/fraud incidences to the regional center as a mandatory reporter.
   d. Provide services in accordance with the philosophy of self-direction.
4. Obtain and use a separate Federal Employer Identification Number (FEIN), used only to file the IRS Forms 2678, *Agent/Payer Authorization* and 8821, *Tax Information Authorization* and selected federal tax forms, and deposit federal income tax withholding and employment taxes on the participant's behalf.
5. Execute an IRS Form 2678, *Agent/Payer Authorization*, and receive written IRS employer agent authorization for each participant or representative it represents as employer agent.
6. Execute and IRS Form 8821, *Tax Information Authorization* with each participant or representative it represents as agent.
7. Execute a State income tax and/or unemployment insurance tax Power of Attorney, as required by state taxation agencies.
8. As defined in the Memorandum of Understanding between the vendored F/EA and the vendoring regional center, execute provider agreements on behalf of the State Medicaid Agency and maintain documentation in the FMS files
9. Develop a system for receiving, disbursing and tracking participants' IB funds.
10. Establish a system for developing and maintaining Vendor F/EA, participant, service worker and vendor records and files (both current and archived) that is secure and Health Insurance Portability and Accountability Act (HIPPA) compliant.

11. Develop a Disaster Recovery Plan for restoring software and master files and hardware backup if management systems are disabled. The Disaster Recovery Plan shall be tested and procedures practiced at least annually.
12. Develop a service agreement between the participant or representative, as appropriate, and the Vendor F/EA. The enrollment tasks shall include, but not be limited to: preparing and distributing participant enrollment packets (that include information about the Vendor F/EA's organization and services and the role and responsibilities of the Vendor F/EA and the participant/representative); providing all required federal and state tax forms; providing any required agreements to be completed and signed by the participant/employer; and assisting the participant/representative with completion and submission of the required forms and agreements; and providing the participant/representative with orientation and training on the use of Vendor F/EA services and the role of employer.
13. Timely and accurately, perform payroll and benefits administration tasks, as applicable. This includes, but is not limited to, the timely collection and processing of service workers' time sheets and the preparation, the distribution of service workers' payroll, and the management of federal, state and local income tax withholding and employment taxes. When the participant employs a service worker, the Vendor F/EA provider prepares and distributes a service worker employment packet to the participant or his/her representative, assists them in understanding the information and forms contained in the packet and the process for completing and submitting the required federal (IRS Form W-4, US CIS Form I-9) and state (State Form W-4, state new hire form), and local employment forms. The Vendor F/EA then calculates, withholds, files and deposits all required federal, state, and local income tax withholding and employment taxes, and processes any garnishments, liens or levies on the service workers' pay prior to issuing service workers' paychecks. The Vendor F/EA issues service workers' paychecks in accordance with state Department of Labor requirements and offers service workers the option of direct deposit.
14. Process and distribute IRS Forms W-2 (and Forms W-3, if Forms W-2 are not electronically filed) for all participants' service workers.
15. Process and refund to the vendoring regional center, the employer and employee portions of over-collected Medicare and Social Security taxes Federal Insurance Contributions Act (FICA) annually in accordance with the December 18, 2000 IRS Letter.
16. Process and pay vendors for invoices for approved goods and services as authorized and included in the participant's IB and IPP.
17. Process and pay service providers who are legitimate sole proprietor independent contractors.
18. Process and disburse IRS Form 1099 *Miscellaneous* to independent contractors who earn more than $600 in a calendar year for the provision of services to a participant.
19. Assist the participant to understand his/her role and responsibilities related to being an employer and using FMS.
20. Revoke federal and state employer agent and tax information authorizations and powers of attorney, and retire federal and state tax employer identification and account numbers when a participant/representative is no longer receiving services and is not a permanent employer.
21. Perform the required federal and state tasks and execute the required revocations and forms when a participant/representative switches Vendor F/EA for any reason.
22. Submit any unclaimed funds for all entities (support service workers and vendors) to the State Treasury Department in accordance with the *California Unclaimed Property Act.*
23. Process wage information requests from federal and state agencies and other qualified entities.
24. Provide and receive information from the regional center electronically, as required.
25. Process policy applications and pay workers' compensation insurance premiums for participants and representatives from their individual budgets.
26. Prepare a report at least monthly for the participant/representative, his/her SB and the regional center, that details payments made on behalf of the participant and shows the status of the participant's IB, including payments made by the FMS provider and the regional center in an electronic and (where

requested by the participant) in a paper format, as specified by the DDS.

27. Identify expenditures that are over or under budget and communicate this information to the regional center in a format and based on a time schedule specified by the regional center.
28. Ensure service providers employed by the participant meet applicable employment requirements and submit to criminal history record (background) clearances as required/requested by the participant.
29. Assist the participant with all claims related to workers' compensation and state unemployment insurance.
30. Report incidents of financial abuse, fraud, exploitation or other incidents affecting the participant and the fiscal accountability of the service program that comes to the Vendor F/EA's attention.
31. Submit claims electronically to the regional center for participants' payroll and invoice payment expenses according to specifications and within the time frames specified by the vendoring regional center.
32. Submit claims to the regional center for payment to the FMS for services rendered.
33. Accept payment from the regional center electronically.
34. Develop a system and provide ongoing training to Vendor F/EA staff that covers federal, state and local taxes; labor and workers' compensation insurance; service program laws, policies, procedures, forms and policy changes; updates on emerging technologies and promising practices; and other information as needed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications							
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☒	Agency. List the types of agencies:			
			Vendor Fiscal/Employer Agent				
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vendor Fiscal/ Employer Agent	Providers must possess all valid licenses or certifications required by State or local law		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. Certified by DDS and vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. As a condition of certification, an individual or the executive director of the entity or other person serving in like capacity shall have and maintain a criminal history background clearance. Services shall be performed by a Vendor F/EA provider who is authorized by the IRS, free of any conflict of interest, and not an employee or board member of the regional center or of another service provider providing

			services to the same participant, or otherwise employed by the participant. The provider shall not be an employee or board member of the State Council on Developmental Disabilities regional office, or Protection and Advocacy, Inc., if the participant is receiving services from these entities. As a condition of regional center vendorization, an FMS must engage in ongoing training that includes an update of emerging technologies, resources, policy changes, and other information as needed. The FMS shall function as an IRS-authorized Vendor F/EA under §3504 of the IRS Code and Revenue Procedure 70-6 and as modified by IRS Proposed Notice 2003-70. The Vendor F/EA shall obtain a separate FEIN (in addition to the organization's corporate FEIN) for the sole purpose of filing certain federal tax forms and depositing Federal income tax withholding and employment (FICA and Federal Unemployment Tax Act (FUTA)) taxes for the participants and representatives it represents as employer agent. The Vendor F/EA shall apply for and receive authorization from the IRS to act as an employer agent for each participant or representative it represents as employer agent using the IRS Form 2678, *Agent/Payer Authorization.* The Vendor F/EA shall revoke its employer agent authorization in accordance with IRS Form 2678 instructions when it stops representing a participant or representative for any reason, permanently. The Vendor F/EA shall execute an IRS Form 8821, *Tax Information Authorization* with each participant and representative it represents as employer agent. The Vendor F/EA shall renew the IRS Form 8821 as required and permanently revoke the IRS Form 8821 authorization when it no longer represents a participant/representative, in accordance with IRS Form 8821 instructions. The Vendor F/EA shall execute the required state powers of attorney and revoke them as required by state taxation agencies and per their instructions. The Vendor F/EA and must maintain

			liability insurance, fiduciary bond and/or a performance bond in a reasonable amount as determined by the regional center. The Vendor F/EA shall submit all reports and a monthly updated list of qualified providers electronically to the appropriate regional center. Vendor F/EA staff shall demonstrate to DDS through the certification process an understanding of Vendor F/EA tasks and related federal, state and local service program, tax, labor and workers' compensation insurance rules, policies, procedures and forms as described in the Service Definition (Scope) above and be able to perform the tasks in accordance with federal, state and local rules and regulations.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	Vendoring regional center	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**FINANCIAL MANAGEMENT SERVICES – AGENCY-WITH-CHOICE : COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

Financial management service (FMS) Agency-with-Choice providers will operate as co-employers with SDS waiver participants (participants) for the purpose of ensuring that the necessary employer related duties and tasks, including payroll are carried out as described below. Agencies-with-Choice shall be certified by the Department of Developmental Services.

This service definition applies to all certified FMS Agency-with-Choice providers. Requirements include:

1. Being employers of record for workers employed by the agency including those who are recruited, referred and managed by participants.
2. Providing the co-employment services in which the participant or his/her representative, as appropriate has the right to:
    a. Recruit and refer prospective workers to the Agency-with-Choice for hire and assignment back to the participant.
    b. Orient and train workers.
    c. Determine workers' terms and conditions of work and work schedules.
    d. Supervise workers' day-to-day activities.
    e. Evaluate workers' performance.
    f. Discharge workers as necessary from their work sites (homes).
    g. Request that the Agency-with-Choice refer workers for consideration and assignment to the participant.
3. When a participant or his/her representative chooses not to perform the function(s), providing the following co-employment services:
    a. Recruit and hire workers.
    b. Set terms and conditions of work.
    c. Supervise their day-to day activities.
    d. Evaluate workers' performance.
    e. Discharge workers.

    The FMS Agency-with-Choice also may refer workers as requested by participants for consideration for assignment to the participant.
4. Developing a system to enroll and disenroll a participant or representative, as appropriate, with the FMS Agency-with-Choice.
5. Ensuring that service workers referred by the participant to the agency for hire or referred to the participant by the agency for consideration for assignment to the participant meet applicable employment requirements established for the service. Processing criminal background clearances and obtaining clearances on prospective employees as required or requested.
6. Implementing and maintaining a worker registry to assist participants, when requested, to access candidates for employment and/or backup workers.
7. Developing and implementing an effective customer service system for participants and representatives including the ability to: (1) communicate in languages other than English and including American Sign Language and using a TTY line and/or state relay system, (2) produce and distribute information and forms in alternate print, (3) receive, respond to/resolve and track the receipt of calls and grievances from participants and their representatives and service providers, including the reporting of incidents to the Regional Center as a mandatory reporter, and (4) provide services in accordance with the philosophy of self-direction.
8. Establishing a system for developing and maintaining Agency-with-Choice FMS, participant, service worker, and vendor records and files (both current and archived) that is secure and HIPPA compliant.

9. Developing a Disaster Recovery Plan for restoring software and master files and hardware backup if management systems are disabled. The Disaster Recovery Plan shall be tested and procedures practiced at least annually.
10. Performing accurate and timely payroll services, providing workers compensation insurance and other benefits administration for workers, as applicable.
11. Using generally accepted accounting practices for record keeping.
12. Providing skills training to participants or representatives as requested regarding recruiting, training, managing and discharging employees.
13. Developing a FMS Agency-with-Choice Policies and Procedure Manual that includes policies, procedures and internal controls for all FMS Agency-with-Choice tasks. This Manual shall be updated as needed and at least annually.
14. Providing standard and individualized training to workers and including the participant and/or representative as defined in the Service Design submitted to the Regional Center as a part of the approved vendorization application.
15. Developing a system and written policies and procedures and internal controls for staying up-to-date with waiver program rules, policies, and procedures.
16. Developing and implementing a quality assurance program to ensure continuous quality improvement including measurements of participant/representative satisfaction.
17. Reporting special incidents as required by Title 17, CCR, §54327.
18. Providing information to and receiving information from the Regional Center electronically, as required.
19. Demonstrating the ability to submit claims to the Regional Center for payment to the FMS for services rendered.
20. Demonstrating the ability to accept payment from the Regional Center electronically.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications

Provider Category(s) *(check one or both)*:		Individual. List types:	☒	Agency. List the types of agencies:
				FMS Agency-with-Choice

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person		Relative	☐	Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
FMS Agency with Choice	Providers must possess any valid license or certification required by State or local law	Certificate to do business in the State of California	Certified by DDS and vendored by the Regional Center in accordance with Title 17, CCR, §§54310 and 54326. As a condition of certification, the executive director of the entity or other person serving in like capacity shall have and maintain a criminal history background clearance. Services shall be performed by a FMS Agency-with Choice provider who is free of any conflict of interest and not an employee of

			DDS, or an employee or board member of the Regional Center or of another service provider providing services to the same participant, or otherwise employed by the participant. The provider shall not be an employee or board member of the State Council on Developmental Disabilities regional office, or Protection and Advocacy, Inc. if the participant is receiving services from these entities. As a condition of regional center vendorization, an FMS must engage in ongoing training that includes an update of emerging technologies, resources, policy changes, and other information as needed. Title 17, CCR §54342 (88). The FMS Agency-with-Choice must demonstrate and show proof of financial viability. The FMS Agency-with-Choice must maintain liability insurance, a fiduciary bond and/or a performance bond in a reasonable amount as determined by the Regional Center. The FMS Agency-with-Choice shall prepare and submit all required reports electronically to the vendoring regional center. The Agency-with-Choice shall also provide a monthly utilization summary report to the participant and Supports Broker electronically or in hard copy if requested. FMS Agency-with-Choice staff shall be trained in and demonstrate an understanding of FMS Agency-with-Choice tasks as described in the service definition including the philosophy of self direction in accordance with program rules.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	Vendoring Regional Center	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	X☐	Provider managed

Service Specification	
Service Title:	**FINANCIAL MANAGEMENT SERVICES – DESIGNATED FISCAL AGENT: COMMUNITY LIVING BUDGET CATEGORY**

Service Definition (Scope)**:**

FMS providers act as fiscal agents for SDS waiver participants who are the employers of record or have budget authority to direct services and supports authorized in their IPP and funded through their individual budgets. All participants are required to use FMS to assist in the management of the IB and to perform various employer-related tasks. The FMS provider may also furnish additional assistance, as specified by the participant and provided in the IPP, to aid the participant in managing his/her own services.

This service definition applies to fiscal agents who are designated by the participant to act as his or her fiscal agent. Designated fiscal agents are not compensated for their services through the IB or from the regional center. They provide the services free of charge.

The Designated Fiscal Agent performs the following functions as the agent to the common law employer or his or her legal representative in accordance with relevant federal and state tax laws:

1. Performs timely and accurate payroll, bill payment, benefits administration, and record keeping. When the participant employs a service worker, the FMS provider provides the required employment forms, enrolls the employee, and calculates and deducts all required federal, state, and local taxes, including unemployment insurance premiums, prior to issuing reimbursement or paychecks. Is responsible for depositing all required federal, state and local tax withholdings and unemployment taxes as required by law.
2. Assists the participant to understand billing, documentation, and employer responsibilities.
3. Ensures that goods and services paid on behalf of the participant have been authorized and included in the participant's IB.
4. Prepares a report at least monthly for the participant and the regional center that details payments made on behalf of the participant and shows the status of the participant's IB including payments made by the FMS provider and the regional center.
5. Identifies expenditures that are over or under budget.
6. Ensures service workers employed by the participant meet applicable employment requirements established for the service and submit to criminal record (background) checks as required/requested by the participant.
7. Ensures other service providers meet applicable requirements established for the service.
8. An FMS shall assist the participant with all claims related to workers compensation and state unemployment insurance.
9. Reports incidents of abuse, exploitation or other incidents affecting the free exercise of rights, or health and safety of the participant that comes to their attention.

The FMS shall execute and hold necessary provider agreements and shall receive and pay invoices from providers in accordance with the IPP and as approved by participants.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual prospective budget amount must be sufficient to accommodate the amount of the service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	☐	Agency: List the types of agencies
	Persons designated as Fiscal Agent			

Specify whether the	☒	Legally Responsible	☒	Relative	☒	Legal

State:	California
Date	3/26/08

service may be provided by *(check each that applies):*		Person				Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Designated Fiscal Agent	Providers must possess any valid license or certification required by State or local law		Services are provided by individuals who have the skills and abilities necessary to meet the unique needs and preferences of the participant as specified in the participant's IPP. The agent is vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. As a condition of vendorization, an individual or the executive director of the entity or other person serving in like capacity shall have and maintain a criminal history background clearance. Services will be performed by a provider who is free of any conflict of interest and not an employee or board member of another service provider providing services to the same participant, or otherwise employed by the participant. The FMS functions as a fiscal employer agent and must maintain liability insurance, a fiduciary bond and/or a performance bond in a reasonable amount as determined by the regional center. All reports and a monthly updated list of qualified providers shall be submitted electronically to the appropriate regional center. As a condition of regional center vendorization, FMS providers shall demonstrate understanding of: 1. Principles of self-direction and the SDS Waiver Program. 2. Role of the participant. 3. Development and implementation of the IPP. 4. Role of the SB. 5. Role of the FMS including, without limitation: a. Supporting the participant with accounting and tax services. b. Supporting and training participants on budget management and payment for authorized services. c. Service procurement/authorization. d. Knowledge of available service options including generic services.

			e. Supporting participants in hiring. f. Supporting participants in management of individual budgets. g. Fiduciary safeguards related to identification and reporting of abuse, neglect and exploitation. h. Knowledge of participant protections. An FMS must engage in ongoing training that includes an update of emerging technologies, resources, policy changes, and other information as needed. As a condition of regional center vendorization, the FMS provider shall demonstrate the capacity to: 1. Act as a bill payer. 2. Generate and distribute IRS Forms W-2 and/or Form 1099. 3. Appropriately withhold, file, and deposit employer taxes in accordance with IRS and Department of Labor laws/regulations. 4. Comply with all State and Federal labor laws and regulations. 5. Use accepted accounting practices for record keeping. 6. Process all judgments, garnishments, tax levies, or any related holds on an employee's funds as may be required by local, state, or federal laws. 7. Distribute, collect, and process all employees' time sheets as summarized on payroll summary sheets completed by the participant or his/her representative. 8. Prepare employee payroll checks. 9. Establish a customer service mechanism to respond to concerns from participants and service providers. 10. Communicate effectively in different languages, as needed. 11. Communicate effectively with participants who have a variety of disabilities and who may require the use of communication aides. 12. Submit and accept electronically any information required by the regional center. FMS providers under this service definition must have experience in areas that require execution of similar fiscally related functions, e.g. accounting. In addition to the above, the FMS shall also demonstrate the ability to electronically accept

			payment from the regional center, issue electronic payments for bills received, and provide monthly reports of participants' receipts, expenses, and account balances to the regional center, participant, and their SB in an electronic format specified by DDS. The FMS must demonstrate that all transactions and related processes are HIPAA compliant. As part of this requirement, the FMS will have a Disaster Recovery Plan for restoring software and master files and will have hardware backup if management information systems are disabled.
Parent or legal guardian of a minor			A parent or legal guardian who serves as a Designated Fiscal Agent cannot be paid for providing any other SDS service to the same participant.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All	Vendoring regional center	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☐	Provider managed

Appendix C-4 : Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☒	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
	Prior to enrollment and each year thereafter, the participant selects an Individual Budget (IB) which is the total amount of funding available to the participant for services and supports necessary to implement their Individual Program Plan (IPP). The participant is required to manage self-directed services within the limits of IB amount chosen.
☒	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
	The methodologies used to compute the prospective maximum individual budget (IB) amount for a participant are described in WIC §4685.7(e)(1). Prior to enrollment, two maximum IB amount(s) are provided in writing to the prospective waiver participant (or, when appropriate, his or her parent[s], legal guardian or conservator, or authorized representative). The participant selects one calculated IB amount. Once this amount is selected, an SDS participant's IB amount is calculated no more than once in a 12-month period. One prospective IB amount is equal to 90% of the annual purchase of service costs for the individual. The annual costs must reflect the average annual costs for the previous two fiscal years for the individual. The 90% benchmark reflects the expectation that the use of participant-directed service methods will result in a more cost effective service delivery. The second method establishes a budget amount that is equal to 90% of the annual purchase of services costs for the previous two fiscal years for consumers with similar characteristics, who do not receive services in the SDS program. This IB amount is based upon factors including age, type of residence, type of disability or ability, functional skills, and whether the individual is in transition. These factors are derived from fiscal and consumer data from DDS' information system. DDS will, not less than annually, publish the values associated with these factors. When a person for whom a 24-month cost history is not available elects to enroll in the waiver, the second method is used. Based upon indentified needs specified in the participant's IPP, regional centers fund the actual costs to purchase the following services, as described in Appendix C: specialized medical equipment and supplies only when "durable," environmental accessibility adaptations, and vehicle adaptations. The maximum budget amount that the participant selects is then customized to reflect as necessary participant-specific services and related costs.

The maximum budget amount remains available to the participant for a period of 12 months. In addition, consistent with the date of implementation of the IPP, annually the regional center ascertains from the participant whether there are any circumstances that require a change in the participant's annual IB amount.

During the period in which the maximum amount selected by the participant is in effect, additional funds may be made available in the event that there is a substantial change in the participant's service and support needs that were not known at the time that the maximum amount was set. These adjustments may be necessitated by an urgent need to change the person's residence or to remain in the existing living arrangement, or as a result of catastrophic injury or illness. Subject to funding availability, DDS manages risk pool funds equal to 5% of the annual expenditures of individuals who participate in the waiver to address these unanticipated needs, and allocates any adjustments within the maximum amount of risk pool funds available for participants statewide (WIC 4685.7(b)(9).

Modifications to the IB during an IPP period (described above) must be documented in the participant's IPP and cannot exceed the maximum budget amount selected by the participant. In the event that the maximum amount (including supplementary funding through the risk pool) is insufficient to meet the health and welfare needs of the waiver participant, the participant is offered a transfer to the HCBS Waiver for the Developmental Disabled or other services that are available in California.

Based upon a review of any change in a participant's circumstances, the participant may change the distribution of funds among budget categories (described in Appendix C-4) under specific conditions: 1) the total amount of the IB does not change; 2) for a transfer of up to 10 percent of the original funds in any budget category, a participant shall notify the FMS provider. The participant may complete any number any number of these transfers from one budget category or categories to another budget category or categories. The amount transferred shall not be more than 10 percent of the original amount allocated to the budget category from which the funds are transferred. 3) For a transfer in excess of 10 percent of the original funds in any budget category, the participant shall obtain approval from the regional center in the following manner: a) The participant shall request the transfer from the regional center; b) The regional center shall convene a planning team meeting with the participant to make a decision about the requested transfer; and c) Upon planning team agreement of the transfer, the regional center shall amend the IPP, and forward the amended IPP to the participant and the financial management services provider within 10 working days from the time the IPP amendment is agreed upon. The regional center may only deny a transfer if necessary to protect the health or safety of the participant. An individual who is dissatisfied with the maximum IB amount that would apply to the service plan may appeal the calculation of the maximum amount as specified below or elect not to enroll in this waiver.

The basic methodologies by which the prospective maximum amount(s) is calculated are incorporated in WIC §4685.7 (e). The statutes and regulations to implement SDS are available through regional centers and are posted on the DDS website. DDS will prepare and make available materials to the public that describe the operation of the SDS Waiver, including the individual budget methodology. In addition, during the orientation to the waiver and during the development of the IPP, the participant is informed of the methods for the calculation of the individual limit and the application of these methods.

☐ **Budget Limits by Level of Support**. Based on an assessment process and/or other factors,

	participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Individual Program Plan (IPP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
☒	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR §483.430(a) who is employed as a case manager by the regional center that serves the community in which the participant resides.
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

☒	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) The SDS Waiver is designed to empower participant (and/or family or legal representative, as appropriate) to exercise greater choice and control over his or her needed services and supports. A critical aspect of empowerment is the provision of in-depth orientation and informational materials about the principles, mechanics, and rights of participants in the self-directed program. Prior to enrollment in self-directed services, a consumer and, when appropriate, his or her parents, legal guardian or conservator, or authorized representative shall receive an in-depth orientation to self-directed services provided by the regional center pursuant to subsection 4685.7(d) of the Welfare and Institutions Code, using materials and guidelines developed by DDS. A regional center may develop and use additional training materials. The information will be provided in language that is easily understood by the participant and his or her family.

The training process and materials that have been developed include information about:

1. The relationship between IPP development and the principles of self-direction.
2. SDS Waiver services, supports, and standards.
3. Risk assessment, prevention, and mitigation, including special incident reporting.
4. Individual budget planning and management.
5. The roles and responsibilities of the participant, regional center case manager, the Financial Management Service, Supports Broker and others whom the participant may choose to involve in the planning process.
6. Self-Advocacy.
7. Appeals procedures described in Appendix F, pursuant to the Welfare and Institutions Code (WIC) as part of the Lanterman Act for Persons with Developmental Disabilities §§4700 - 4730.

Also key to empowerment is the provision of adequate support to enable the participant to direct and to be actively engaged in the service planning process, hereinafter referred to as the individual program planning (IPP) process. In accordance with WIC §4646.5 and §4685.7(k), the planning team shall utilize the person-centered planning process to develop the IPP for the participant. The IPP shall detail goals and objectives for the participant to be met through both the use of generic services and the purchase of participant-selected services and supports. The team shall include the participant and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, the regional center case manager, and any others invited by the participant, pursuant to WIC §4512(j).

A participant directs implementation of the IPP with the assistance of the SB and FMS provider, as needed. An adult participant may designate a representative to effect implementation of the IPP, pursuant to WIC §4685.7(m).

(b) The participant's authority to determine who is included in the process is defined in California statute. Per WIC §4512(j), "planning team" includes, among others, any individual invited by the consumer. WIC §4685.7(b)(6) defines self-directed services as a mix of services and supports, selected and directed by a participant in order to meet all or some of the objectives in his or her IPP. Finally, WIC authorizes the participant to choose his or her own FMS provider [§4685.7(i)(4)(E)] and SB [§4685.7(i)(4)(F)].

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Plan Development Responsibility, Participants and Timing
The IPP is the service plan for all services to a person with developmental disabilities in California, including services under the SDS Waiver. The development of the IPP is governed by the Lanterman Act in WIC §§4512(j), 4646, 4646.5, 4647 and 4685.7(k). In essence, the statute requires that the IPP be developed by a planning team using a person-centered planning process. It is the responsibility of the regional center case manager to facilitate, coordinate and

represent the regional center in the development of the IPP.

The Lanterman Act, in WIC §4512(j), defines the IPP planning team as "the individual with developmental disabilities, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, the authorized representative, including those appointed pursuant to subdivision (d) of §4548 and subdivision (e) of §4705, one or more regional center representatives, including the designated regional center service coordinator pursuant to subdivision (b) of §4640.7, any individual, including a service provider, invited by the consumer, the parents or legally appointed guardian of a minor consumer or the legally appointed guardian of a consumer, or the authorized representative." The SB will be included in the planning team for SDS Waiver participants when invited by the participant.

Within 30 days of a consumer request to enroll in SDS services, the regional center makes a determination of eligibility pursuant to WIC §4685.7(i), and for a consumer determined to be eligible, convenes a planning team meeting to initiate planning for transition to the self-directed services program. Within the same time frame, the regional center shall provide in writing to the consumer two individual budget amounts [developed utilizing the methodology in WIC §4685.7(e)] from which the consumer selects one. Subsequently, within 60 days from the date of the initial planning team meeting, the regional center re-convenes the planning team to complete the IPP for self-directed services, unless a longer time period is requested by the consumer. During this planning team meeting, the consumer proposes an individual budget to meet their needs, which will be used to implement the IPP.

When a consumer is found ineligible for self-directed services because he or she receives residential or day services pursuant to WIC §4685.7(i)(3), the consumer and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, may request that a regional center provide person-centered planning services in order to arrange for the transition to self-directed services. When a consumer makes such a request, within 60 days, the regional center shall initiate person-centered planning services necessary to assist the consumer with planning for the transition to self-directed services.

The regional center shall ensure there is no gap in services and supports during the participant's transition to SDS. Consistent with WIC §4646.5, the planning team shall determine the type and amount of services needed to assist the consumer with planning for the transition to self-directed services.

(b) Assessments Conducted to Support the Service Plan Development Process

Participant needs and preferences are assessed by gathering information from the participant, family and friends about the participant's personal goals, abilities, strengths, barriers and concerns or problems. The IPP is centered on the individual and the family of the individual with developmental disabilities, and takes into account the needs and preferences of the individual and family, where appropriate, as well as promoting community integration, independent, productive, and normal lives, and stable and healthy environments. A review of the general health status of the adult or child, including a medical, dental, and mental health needs are conducted when agreed to by the participant, the parents or legally appointed guardian of a minor consumer, or the legally appointed conservator of an adult consumer, or the authorized representative. In response to any concerns, a risk assessment may be performed to determine what, if any, risk mitigation may be indicated. This process is conducted in a manner that reflects awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and the family.

(c) Information on Services Available Under the Waiver

Prior to and during development of the IPP, the participant is informed of services available in

the SDS Waiver through the in-depth orientation described in Appendix E-1.

(d) Plan Development Process to Ensure that the Service Plan Addresses Participant Goals, Needs (including health care needs), and Preferences.

The IPP is developed using a person-centered approach in which the participant plays a central role. The process ensures that the IPP comprehensively addresses the individual's identified needs for SDS Waiver services, health care, and other supports and is reflective of the participant's expressed personal preferences and goals. The IPP identifies and addresses the following:

1. The participant's preferences and assessed needs.
2. The participant's desired outcomes and the type and amount of services needed to achieve the outcomes.
3. Service provider qualifications, skills and abilities as necessary to meet the needs of the participant.
4. Name(s) of the selected SB and FMS provider(s).
5. An individual budget amount chosen by the participant to implement the IPP.
6. A statement that the participant agrees with the terms and conditions for participation in SDS.
7. Consistent with the type and amount of services identified, and as determined by the participant, the individual budget funds distributed among the following budget categories:
   - Community living
   - Health and clinical services
   - Employment
   - Training and education
   - Environment and medical supports
   - Transportation

The case manager ensures the amount of services authorized in the IPP is within the prospective individual budget amount chosen by the participant. The participant agrees to purchase the type and amount of services and supports only as specified in the IPP. Modification in the type and amount of services or supports is described in Appendix E.

(e) Coordination of Waiver Services

See below.

(f) Assignment of Responsibility

The IPP identifies the service provider or providers responsible for implementing the IPP, including but not limited to the SB, FMS, generic service agencies, and natural supports. The participant directs implementation of the IPP with the assistance of the SB and FMS provider. Periodic monitoring of plan implementation is conducted by the case manager.

(g) Service Plan Update

The IPP is reviewed annually by the planning team to ascertain that planned services have been received within specified times, and that participants are satisfied with implementation of the IPP. The case manager verifies that the types and amounts of services authorized in the IPP are purchased within the individual budget amount chosen by the participant. If the annual review indicates that the IPP is meeting the participant's needs in a satisfactory fashion, the IPP is continued. A new IPP must be developed no less frequently than every three years.

The participant or the participant's representative may request a review of the IPP at any time. This review must be scheduled within 30 days of the request. Additionally, a review must take place when modifications to the individual budget include addition of services not described in

the IPP or when the participant wishes to reallocate funds in excess of the levels specified in Appendix E-2: 3, b. iv. Annually from the time of enrollment, the case manager ascertains from the participant if there are any circumstances that require a change to the individual budget amount. Furthermore, the IPP is reviewed whenever the regional center becomes aware of a situation that potentially indicates a problem or issue in assurance of the participant's health and safety, including the potential over- or under-expenditure of funds.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Participant risk and safety considerations are identified during the person-centered planning process, and potential interventions considered that promote independence and safety with the informed involvement of the participant. The IPP planning team documents the assessment and identification of any potential risk or safety consideration, in addition to recommended interventions that promote the participant's independence and safety. The IPP shall specify appropriate emergency back-up services, including the use of natural supports and community-based services.

Each regional center has a Risk Management and Mitigation Plan that covers all consumers, including coordination with local licensing, protective service and law enforcement agencies pursuant to Title 17, CCR, §54327.2. Regional center systems include, without exception, existing community emergency systems,. As part of the IPP assessment and development process, the regional center case manager shall ensure that participants are provided with information about the regional center's plan for assuring 24-hour emergency response capability, including how to request assistance.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During enrollment to the SDS Waiver, participants are furnished information about available providers. In addition, a major responsibility of the participant's SB is to assist the participant in locating and selecting qualified service providers.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Service plans (the participant's IPP) are made subject to the approval of the Medicaid agency through the execution of the SDS Waiver Biennial Monitoring Protocol, (as described in Appendix H). The Protocol will provide that a sample of SDS Waiver participants served by each regional center are subject to in-depth records review and are the focus of participant interviews. The IPP is the core document in the review. In addition, the Department of Health Care Services (DHCS), the Medicaid agency, conducts targeted reviews of IPPs and other documents when the need arises.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary

☒	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
☐	Case manager
☒	Other (*specify):*
	Regional Center

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

In accordance with the principles of self-direction, the participant has lead responsibility for the implementation of the IPP. This responsibility includes recruitment, selection and direct management of qualified service providers. In the event problems are encountered related to access to services or assurance of the participant's health and welfare, the participant and the participant's SB have an affirmative responsibility to identify the problem or issue, notify the case manager, and seek assistance from the case manager to resolve the matter.

The participant's regional center case manager has responsibility for monitoring the implementation of the IPP. The regional center shall conduct face-to-face meetings with participants to review implementation of the IPP and progress toward achievement of IPP objectives:

1. At least quarterly for participants who reside in their own homes.
2. At least annually for participants who reside with parents or guardians.
3. More frequently if specified in the IPP.

Additionally, the case manager may periodically contact the participant and/or the participant's SB to determine the status of the IPP implementation. The case manager shall contact the participant and the participant's SB when the monthly expenditure report prepared by the FMS entity reveals potential over or under-expenditure of individual budget funds. Furthermore, case managers are responsible for follow-up in the event the participant is involved in a special incident.

b. Monitoring Safeguards. *Select one:*

☒	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

☒	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

☒	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
○	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The SDS Waiver is designed to afford participants the opportunity to directly manage all SDS Waiver services and supports. The SDS Waiver provides for a complete, in-depth orientation on self-direction to interested individuals prior to enrollment and includes continued post-enrollment support for participants in the management and direction of services and supports. The participant's individual budget (IB) spans all participant-directed SDS Waiver services.

DDS develops informational materials about the SDS Waiver and self-direction which the regional center provides to potential participants. The regional center may also develop additional training materials. Prior to implementation, DDS will provide training to regional centers on the principles of SDS, how the SDS Waiver operates and the rights of consumers and families as candidates for, and participants in, the SDS Waiver. Regional centers hold periodic local meetings or forums for purposes of outreach and information to provide regional center participants and families information about the SDS Waiver. These meetings and forums are conducted in a manner that accommodates the diverse cultural and communication needs of attendees.

Individuals must complete the in-depth orientation as a condition of SDS Waiver enrollment. This orientation is designed to prepare an individual for participation in self-directed services. The in-depth orientation consists of instruction as described in Appendix D-1: 1(c). Subsequently, the consumer selects or designates an FMS and SB, who assists with the transition to SDS. The participant has the option of choosing a designated SB or FMS to provide services on a non-paid basis. A designated SB

or FMS may be a parent of a participant or another qualified person selected by the participant.

FMS and SB services are distinct and uniquely designed to assist the participant in directing his/her SDS Waiver services and supports and are provided as described in the Appendix C respective service definitions.

Participants may choose among three types of FMS providers:

- A Fiscal Employer Agent serves as a paid agent who manages and directs the disbursement of IB funds, provides fiscal and payroll services, and conducts fiscal accounting activities for the participant.
- An Agency-with-Choice serves as a paid co-employer with the participant, conducts employment-related tasks, and provides fiscal and payroll services.
- A Designated Fiscal Agent serves as a non-paid agent who provides fiscal and payroll services, and conducts fiscal accounting activities for the participant.

The SDS Waiver provides the participant with both Budget Authority and Employer Authority. Each participant shall exercise Budget Authority over all participant-directed services in the IPP. The Employer Authority extends to respite services, live-in caregiver services, community living supports, family assistance and supports, participant-directed goods and services, supports broker services and financial management services. The Employer Authority provides the mechanism for a participant to exercise the full-range of decision-making about whom he/she will employ.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
☒	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☒	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one):*

☒	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Each regional center conducts periodic local meetings or forums to provide information about the SDS Waiver to participants and families. When an individual or family expresses interest in participating in the SDS Waiver, a mandatory in-depth orientation to the waiver is conducted by the regional center. This in-depth orientation is designed to prepare the individual for self-advocacy and the new participant-directed service-delivery model and to assist individuals, families, and conservators in transitioning from current programs and services received from the regional center to the SDS Waiver. This training and education, which occurs prior to enrollment in SDS is described in Appendix D-1: 1(c).

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○	The State does not provide for the direction of waiver services by a representative.	
☒	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	☒	Waiver services may be directed by a legal representative of the participant.
	☒	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		An adult may designate an authorized representative to effect implementation of the IPP. Consistent with WIC §4685.7(m), the representative shall: (1) Be at least 18 years of age. (2) Be approved by the participant to act in the capacity of a representative. (3) Demonstrate knowledge and understanding of the participant's needs and preferences. (4) Be willing and able to comply with SDS Waiver requirements.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Home Health Aide	☒	☒
Employment Development Services	☒	☒
Employment Supports	☒	☒
Respite Services	☒	☒
Live-In Caregiver	☒	☒
Community Living Supports	☒	☒
Communication Support Services	☒	☒
Housing Access Supports	☒	☒
Advocacy Services	☐	☒
Participant-Directed Goods and Services	☐	☒
Skilled Nursing	☒	☒
Specialized Therapeutic Services	☐	☒
Nutritional Consultation	☐	☒
Behavior Intervention Services	☐	☒
Family Assistance and Support	☒	☒
Integrative Therapies	☐	☒
Individual Training and Education	☐	☒
Training and Counseling Services for Unpaid Caregivers	☐	☒
Environmental Accessibility Adaptations	☐	☒
Vehicle Adaptations	☐	☒
Specialized Medical Equipment and Supplies	☐	☒
Personal Emergency Response System	☐	☒
Transportation	☐	☒
Crisis Intervention	☐	☒
Supports Broker	☒	☒
Financial Management Services - Vendor F/EA	☒	☒
Financial Management Services - Agency-With-Choice	☒	☒
Financial Management Services - Designated Fiscal Agent	☒	☒

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

☒	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
☐	Governmental entities

☒	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

☒	FMS are covered as the waiver service entitled as specified in Appendix C-3.	Financial Management Services
○	FMS are provided as an administrative activity. *Provide the following information:*	

i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
	☐	Assist participant in verifying support worker citizenship status
	☐	Collect and process timesheets of support workers
	☐	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	☐	Other *(specify):*
	Supports furnished when the participant exercises budget authority:	
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance–of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☐	Receive and disburse funds for the payment of participant-directed services under

		an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify):*

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DDS contracts with 21 private, non-profit corporations to operate regional centers which are responsible under State law for providing, arranging, or purchasing all services needed for eligible individuals with developmental disabilities in California. Through this statewide system, the SDS Waiver is a distinct service delivery option for regional center consumers who voluntarily elect to self-direct their services and supports.

DDS annually conducts a review of a random statewide sample of financial transactions performed by the financial management services providers to verify compliance with the above.
The review also verifies that all paid invoices in the sample are properly documented.

If there are discrepancies or inaccuracies, DDS will conduct a focused follow-up. The regional center, DDS, and DHCS have the authority to audit a FMS provider with or without notice. Upon request, all service providers shall make available any books and records pertaining to a provided service and be subject to audit.

Pursuant to WIC §4685.7(q), only FMS service providers are required to apply for vendorization in accordance with Title 17. Eligible FMS vendor applicants, except a prospective "Designated FMS," must first be certified by DDS. Prior to vendorization by a regional center, a prospective (paid) FMS service provider submits to DDS a signed statement of qualifications and required documents to verify the following:

- A criminal history background clearance.
- Staffing qualifications and organizational requirements.
- Physical plant, equipment, technological and development, system implementation and maintenance.
- Plans to coordinate and communicate with the participant and planning team members.
- Administrative policies and procedures.
- Receipt, disbursement and tracking of Medicaid funds.
- Records management process.
- Preparation and electronic submittal of required reports to the state and participants, (written reports may be submitted to the participant upon his/her request).
- A customer service system.
- Process to produce and disburse participant enrollment and worker's compensation packets, including criminal records clearance of prospective service providers upon the request of the participant.
- Approval from the United States Internal Revenue Service to be a Vendor FEA, as applicable.
- Payroll and invoice payment-related tasks.

- The maximum allowable fee for services based upon a cost statement.

A Designated FMS is not compensated for services provided through the IB or the regional center; services are provided free of charge. A Designated FMS must still meet the requisite FMS qualifications listed above and demonstrate these to the regional center. The Designated FMS performs FMS functions as the agent to the participant, who is the common law employer. Prior to vendorization by a regional center, an FMS must show proof of capacity to maintain liability insurance, a fiduciary bond and/or a performance bond in a reasonable amount as determined by the regional center.

All other SDS Waiver service providers must possess applicable state licenses, certifications, or other state requirements, but are exempt from vendorization. The FMS ensures and documents that all service providers meet requirements specified in the SDS Waiver for any service that may be delivered to the participant. A monthly updated list of qualified service providers is submitted electronically to the regional center.

It is DDS' responsibility, with the oversight of DHCS, to ensure that all SDS Waiver services, are provided in accordance with Medicaid statute and regulation. DDS exercises this responsibility through the compliance review process, described in Appendix A.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

All participants have an assigned regional center case manager. Case managers furnish the following types of information and assistance in support of participant self-direction:

- Facilitate the development of the IPP.
- Assist the participant and the planning team in development of risk prevention and mitigation strategies, as needed.
- Support the participant and planning team in effecting implementation and coordination of the IPP.
- Review and maintain the participant's monthly IB statements submitted by the FMS provider.
- Meet with the participant to review and document the participant's progress toward achieving IPP objectives and IB statements.
- Respond to any participant or SB request for information related to policies and procedures that affect implementation of the IPP.
- Furnish, as requested, information related to training and technical assistance with respect to self-direction and other resources available through the regional center or from other sources in the community.

The foregoing information and assistance in support of participant direction are performed as part of a regional center's generic responsibilities in the provision of service coordination. Regional center case managers do not perform the types of activities or functions that are performed by the SB on behalf of and at the direction of the SDS Waiver participant.

☒ **Waiver Service Coverage**. Information and assistance in support of participant direction are

	provided through the waiver service coverage (s) specified in Appendix C-3 entitled: Supports Broker (SB)
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one)*.

☒	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
	All individuals who receive services through regional centers have access to a Clients' Rights Advocate (CRA) assigned to each regional center. CRAs are employed by the Office of Clients' Rights Advocacy (OCRA), a statewide office that is operated by [California] Protection & Advocacy, Inc. The CRAs have been trained to assist people with developmental disabilities in the protection of their rights. The CRA can consult with and help people with developmental disabilities and their families obtain services; directly represent people with developmental disabilities in administrative hearings; and, provide training about rights to participants, their families, regional center service providers, and interested community groups. Individuals also have access to services provided by Protection & Advocacy, Inc., a statewide protection and advocacy program that operates under the federal Developmental Disabilities Assistance and Bill of Rights Act and the California WIC §4900 et seq. Protection & Advocacy, Inc., is an independent agency. An additional source of independent advocacy is provided by the 13 Area Boards on Developmental Disabilities that serve designated counties throughout the state. Expressly created under the California WIC §4543, Area Boards assure that the legal, civil, and service rights of persons with developmental disabilities are adequately guaranteed. Area Boards are independent entities overseen by the California State Council on Developmental Disabilities. Area Boards have the authority to pursue legal, administrative, and other remedies to ensure the protection of the legal, civil, and service rights of persons who require services or who are receiving services in the area served by the board. Finally, advocacy services can be purchased through the SDS Waiver, as described in Appendix C.
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A participant may voluntarily terminate participation in the SDS Waiver at any time. The participant shall notify the regional center case manager of his/her decision to no longer direct SDS Waiver services and supports. The regional center case manager shall ascertain the reason(s) why the participant wishes to terminate participant direction and, as appropriate, offer assistance that might address the reason(s) for termination. The case manager shall inform the participant of available alternatives.

When the participant expresses interest in receiving alternative services, the regional center case manager shall arrange to convene the IPP planning team to develop a new IPP and initiate actions necessary to transition the individual to the selected alternative. The case manager shall review the current IPP to determine the services that the participant is receiving and consult with the participant's

SB to identify the services and supports that are vital to assuring the participant's health and welfare during the interim period until the new IPP is finalized and the participant selects providers vendored through the regional center. The regional center case manager, the SB and the participant shall prepare an interim plan to ensure the vital services continue to be furnished until the effective date of the new IPP. A participant who voluntarily disenrolls from SDS or who is determined ineligible by the regional center is permitted to re-enroll in SDS upon meeting all eligibility criteria and after 12 months' time has elapsed from the effective date of disenrollment.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An individual will be involuntarily terminated from the SDS Waiver in the following circumstances:

1. The individual no longer meets eligibility criteria pursuant to WIC §4685.7(i).
2. The individual not fulfilling any responsibility resulting from his or her participation.

When the regional center determines that involuntary termination is necessary, the case manager shall inform the participant of available alternatives for obtaining services and supports. In addition to informing the participant and FMS entity of the date and basis of the termination, the regional center shall inform the participant of fair hearing rights pursuant to WIC §§4700 - 4730, inclusive, as described in Appendix F.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		400
Year 2		1,700
Year 3		3,300

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☒	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:*
	Agency-with-Choice (AWC) providers perform FMS services described in Appendix C as co-employer. The AWC acts as employer of record for workers managed by the SDS Waiver participant. Entities eligible to provide this service are certified by DDS, prior to being approved by the regional center as an FMS-AWC vendor. Vendor approval is received before FMS-AWC services are provided to any participant. Additional safeguards include the regional centers' and DDS' authority as established in WIC 4648.1, to conduct reviews of service providers with or without notice and to monitor services and supports purchased by the participant.
☒	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

☒	Recruit staff
☒	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☒	Hire staff (common law employer)
☒	Verify staff qualifications
☒	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	DDS, as part of the FMS certification process, requires each (paid) FMS entity to secure, at its own expense, a criminal history clearance. The participant may request a criminal history background check for a prospective or current service provider of direct care services or support brokerage services. No charge is made against the participant's budget for securing these clearances.
☒	Specify additional staff qualifications based on participant needs and preferences so long

	as such qualifications are consistent with the qualifications specified in Appendix C-3.
☒	Determine staff duties consistent with the service specifications in Appendix C-3.
☒	Determine staff wages and benefits subject to applicable State limits
☒	Schedule staff
☒	Orient and instruct-staff in duties
☒	Supervise staff
☒	Evaluate staff performance
☒	Verify time worked by staff and approve time sheets
☒	Discharge staff (common law employer)
☒	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply*:

☒	Reallocate funds among services included in the budget
☒	Determine the amount paid for services within the State's established limits
☒	Substitute service providers
☒	Schedule the provision of services
☒	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☒	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☒	Identify service providers and refer for provider enrollment
☒	Authorize payment for waiver goods and services
☒	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The amount of the participant-directed budget for each SDS Waiver participant is the same as the prospective IB amount as specified in Appendix C-4 of the SDS Waiver. The methods used to

determine the participant-directed budget are also described in Appendix C-4. The methods are spelled out in DDS materials and other applicable documents and data reports, which are publicly available at regional centers and on the DDS website.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Prior to enrollment in the SDS Program, and based upon the methodologies described in Appendix C-4, the regional center provides the prospective SDS Waiver participants in writing two initial individual budget amounts. During the IPP development process, the consumer selects one of those amounts as the participant-directed individual budget that will be used to implement services and supports available in the SDS waiver. Each year, the regional center shall ascertain from the participant whether there are any circumstances that require a change in the amount of the IB. The participant may request a recalculation of the two IB amounts no more than once in a 12-month period.

iv. Participant Exercise of Budget Flexibility. *Select one:*

☒	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	The IPP shall include an allocation of dollars in the participant's IB within the following budget categories: (A) Community Living (B) Health and Clinical Services (C) Employment (D) Training and Education (E) Environment and Medical Supports (F) Transportation. The SDS Waiver participant has the authority to manage services and supports included in the IPP and IB. The participant selects services and supports to achieve the desired outcomes described in the IPP and has the ability to reallocate funds within the IB categories (above). The participant may transfer up to 10 percent of the original amount of funds in the participant-directed budget from any of the budget categories (above) to another budget category or categories, without prior approval from the regional center. The participant shall notify the FMS provider of any transfer,. The participant may complete any number of these transfers from one budget category or categories to another budget category or categories. The amount transferred shall not be more than 10 percent of the original amount allocated to the budget category from which the funds are transferred. Transfers in excess of 10 percent of the original amount allocated to any budget category require review and approval by the planning team. The regional center may deny such a transfer only when it determines that denying the transfer is necessary to protect the health and welfare of the participant. When a transfer is approved, the regional center updates the IPP and IB to reflect the amount of the transfer and forwards the amended IPP to the participant and FMS provider within 10 working days from the time the IPP is agreed upon. In the event of a denial, the regional center shall provide written

	notification of the reasons to the participant and FMS provider within five (5) working days. In addition, the regional center sends the participant his/her application appeal rights. The FMS will document all changes to the IB. Except for purchases related to the risk pool described in Appendix C-4, the IPP must be amended in advance when a participant wishes to purchase a service that is not included in the current IPP. The regional center then forwards the amended IPP to the participant and FMS provider within five (5) working days.
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS entity selected by the participant is required to prepare an individual monthly report that details participant expenditures for SDS Waiver services. The monthly report is distributed to the participant, the regional center case manager, and the participant's SB. In addition, the FMS entity is required to alert these same individuals and entities whenever there is a pattern of expenditures that reveals the potential that the self-directed budget might be prematurely exhausted. The regional center case manager reviews the monthly expenditure report to identify potential problems, including the potential over-expenditure of funds or expenditure patterns that might indicate that the participant is having difficulty in accessing authorized services. In either instance, the case manager follows up with the participant and/or SB to ascertain whether there are problems that must be addressed, including whether it is necessary to conduct an interim review of the IPP.

The SDS Waiver includes safeguards to prevent the premature depletion of the IB. FMS entities implement and enforce budget/line-item expenditure controls. These controls ensure that expenditures remain within the amounts allocated to each budget category. These controls ensure against premature depletion of the overall participant-directed budget. Major changes in services or funding reallocations among budget categories must be reviewed by the regional center case manager/IPP planning team, before they can take effect. This added safeguard ensures that the reallocation will not adversely affect the participant's health and welfare.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

1. When an individual is determined to be likely to require a level of care indicated in item 2 (below) of this request, the individual or his or her legal representative will be:
    a. informed of any feasible alternatives under the Waiver
    b. given the choice of either institutional or home- and community-based services.
2. DDS will provide the opportunity for a fair hearing under Title 17, CCR, §50900 et seq., Fair Hearing Process, to individuals who are:
    a. not given the choice of home- and community-based services as an alternative to institutional care, or
    b. denied the service(s) of their choice, or the provider(s) of their choice
3. The following are attached to this Appendix:
    a. A copy of the form used to document freedom of choice and to offer a fair hearing: The Medicaid Waiver Consumer Choice of Services/Living Arrangement Statement, DS 2200 form, and the instructions for completing the form.
    b. A description of the agency's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the Waiver.
    c. A description of the State's procedures for allowing individuals to choose either institutional or home- and community-based services. The procedures for 3.b and 3.c are described below as a connected process completed by the Service Coordinator (case manager) with each consumer. The Service Coordinator is responsible for informing consumers of the feasible alternatives for obtaining necessary services and giving each eligible consumer the choice of receiving necessary care and services in an institutional health facility, or a community living arrangement.
    Pursuant to the "HCBS Waiver Primer and Policy Manual," the Service Coordinator shall ensure that:
    - consumers, their legal representative, parents, relatives, or involved persons are informed of the choice of either participating or not participating in the DDS Self-Directed Services program, if the consumer is determined to be eligible for Waiver services.
    - the consumer's choice is documented on the DS 2200 form at the time of:
        - determination of initial eligibility for the Waiver program,
        - reactivation of the Waiver eligibility after a participant's termination from participation in the Waiver program, or

- transition form minor to adult status.

- Waiver participants are given free choice of all qualified providers for each service included in the Individual Program Plan.

d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Pursuant to the "HCBS Waiver Primer and Policy Manual", participants shall be informed of the right to an appeal or to request a fair hearing. The Service Coordinator shall ensure that a waiver participant is notified of such a right if:

- the choice of home- and community-based services versus institutional care was not offered.
- the Waiver participant was denied his/her choice of services, type of service, service provider, type of provider, or amount of service.

The current procedure for assuring that the consumer is offered the opportunity to request a fair hearing is described "HCBS Waiver Primer and Policy Manual",

California will fully comply with the requirements of 42 CFR Part 431, subpart E. Fair hearings will be conducted through the State Medicaid fair Hearing process.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

☒	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
○	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and time frames), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Voluntary Mediation
Upon notice of fair hearing rights described in Appendix F-1, a participant is also offered the opportunity to request an informal meeting and mutually agreed upon voluntary mediation.

- In the event the participant declines an informal meeting, or is dissatisfied with the regional center's decision at the informal meeting and does not request mediation, the matter proceeds to a fair hearing.
- If a participant requests mediation, the regional center or the participant may withdraw at any time from the mediation and proceed to a fair hearing.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

☒	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Pursuant to the California Welfare and Institutions Code, §4731, a participant may pursue a Consumer Rights Complaint against a regional center or service provider.

- The initial complaint is filed with the Executive Director of the regional center.
- An appeal of a decision of the Executive Director may be made to the Director of DDS.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

If the participant believes the regional center or a service provider has violated or improperly withheld a right to which the participant is entitled under the law, the participant may use the Consumer Rights Complaint process. (This process is not to be used to resolve issues regarding services and supports that are addressed in the State fair hearing process.) The initial referral of the complaint shall be to the Executive Director of the regional center. There is no timeframe specified for this action. Upon receipt of the complaint, the Executive Director has 20 working days to investigate the matter and send a written proposed resolution to the participant or representative. If the participant or representative is not satisfied with the proposed resolution, the participant or representative shall refer the matter in writing to the Director of the DDS within 15 working days of receipt of the proposed resolution. The Director shall, within 45 days of receiving the complaint, issue a written administrative decision, and send a copy of the decision to the participant and Executive Director of the regional center.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DEPARTMENT OF DEVELOPMENTAL SERVICES REPORTING REQUIREMENTS

a. Reportable Incidents

Service providers, including SDS Waiver providers, are required to comply with special incident reporting requirements described in California Code of Regulations (CCR), Title 17, § 54327. A parent or participant acting as a designated provider is exempt from these special incident reporting requirements.

DDS has responsibility for overseeing and monitoring critical events or incidents defined in Title 17, CCR, §54327. The incidents fall into two categories. The first category, described in 1 through 5 below, is reportable if the event occurred while the participant was receiving services and supports from any caregiver, including providers of services and supports under the SDS Waiver. The second category, described in 6 and 7 below, are reportable regardless of when or where they occur.

1. The participant is missing and the service provider has filed a missing persons report with a law enforcement agency.
2. Reasonably suspected abuse/exploitation including physical, sexual, fiduciary, emotional/mental, or physical and/or chemical restraint.
3. Reasonably suspected neglect including failure to: provide medical care for physical and mental health needs; prevent malnutrition or dehydration; protect from health and welfare hazards; assist in personal hygiene or provision of food, clothing or shelter; or exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult.
4. A serious injury/accident including lacerations requiring sutures or staples; puncture wounds requiring medical treatment beyond First Aid; fractures; dislocations; bites that break the skin and require medical treatment beyond; internal bleeding requiring medical treatment beyond First Aid; any medication errors; medication reactions that require medical treatment beyond; or burns that require medical treatment beyond First Aid.
5. Any unplanned or unscheduled hospitalization due to the following conditions: respiratory illness including but not limited to asthma, tuberculosis, and chronic obstructive pulmonary disease; seizure-related; cardiac-related including but not limited to congestive heart failure, hypertension and angina; internal infections including but not limited to ear, nose and throat, gastrointestinal, kidney, dental, pelvic, or urinary tract; diabetes including diabetes-related complications; wound/skin care including but not limited to cellulitis and decubitus; nutritional deficiencies including but not limited to anemia and dehydration; or involuntary psychiatric admission.

6. The death of any participant, regardless of cause.
7. The participant is a victim of a crime including robbery, aggravated assault, larceny, burglary, and rape including attempts to commit rape.

b. Mandated Reporters and Reporting Timeframes for Critical Events and Incidents

1. All vendored service providers (FMS) are required to report special incidents, pursuant to Title 17, §54327. In addition, pursuant to WIC §4685.7(a), all service providers in the SDS Waiver directly employed by the participant shall comply with these special incident reporting requirements. In SDS, a parent or a participant who acts as a designated provider is exempt from these reporting requirements.

   Timeframe: Report by telephone, electronic mail, or FAX immediately but not later than 24 hours after learning of the occurrence. Written report within 48 hours of the occurrence of the incident unless a written report was provided within the 24-hour period.

   Reported to: Regional Center.

   Copies to: SDS Waiver providers send a copy to the participant's SB.

2. Regional Centers (Title 17, CCR, §54327.1)

   Timeframe: Initial report submitted to DDS within two working days following receipt of the incident report from the provider.

   When a regional center has knowledge of an incident that has not been reported an initial report shall be sent to DDS within two working days of learning of the occurrence. Required information that is not submitted with the initial report shall be submitted within 30 working days following receipt of the report of the incident.

   Regional centers are required to comply with all DDS requests for initial and follow-up information pertaining to the incident.

   Reports are considered to be complete when all required information has been submitted.

   Reported to: DDS

   Copies to: Reports may be made to Child Protective Services, Adult Protective Services, or State Long-Term Ombudsman.

CHILD PROTECTIVE SERVICES REPORTING REQUIREMENTS

a. Reportable Incidents

The California State Child Abuse Reporting Law (Penal Code §11164 et seq.) provides the legal basis for action to protect children. Providers and others working in the developmental disabilities service delivery system are mandated reporters. The law defines child abuse as any of the following:

1. Physical injury by other than accidental mean.
2. Subjection to willful cruelty or unjustifiable punishment.
3. Sexual abuse or exploitation.
4. Neglect by a parent or caretaker who fails to provide adequate food, clothing, shelter, medical care or supervision.

b. Mandated Reporters and Reporting Timeframes for Critical Events and Incidents

Penal Code §11165.7 includes a number of categories of individuals and entities employed in the developmental disabilities service delivery system that are mandated reporters. For example,

employees and administrators in public or private organizations that provide direct services or supervision to children, social workers and teachers are mandated reporters under this statute.

Timeframe: Report immediately or as soon as is practicably possible by telephone. Written report within 36 hours of receiving the information.

Reported to: Child Protective Services.

DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS

a. Reportable Incidents
The adult protective services program, as described in Welfare and Institutions Code §15600 et seq., is intended to provide intervention activities directed toward safeguarding the well-being of elders and dependent adults residing in other than long-term care facilities and suffering from or at risk of abuse, neglect, including self neglect, or exploitation. The definitions of abuse, neglect and exploitation are found in Welfare and Institutions Code §15610 et seq.

b. Mandated Reporters and Timelines
Welfare and Institutions Code §15630 lists mandated reporters that include all of the individuals engaged in the developmental disabilities service delivery system.

Timeframe: Report by telephone immediately or as soon as practicably possible.

Written report within two working days following the occurrence of the event.

Location: All other locations.

Report to: Local Adult Protective Services.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and Information - General
The responsibility for providing training and information to participants and their informal caregivers concerning protections from abuse, neglect and exploitation, and how to notify the appropriate authorities is shared among DDS, regional centers, and the SB.

DDS has overall state-level responsibility for planning, coordinating and overseeing implementation of the State's risk management program for persons with developmental disabilities.

As a part of its oversight, DDS develops and/or disseminates easily understood materials for consumers and families, (e.g., *The Consumers Guide to the Lanterman Act* and *Care of Children and Adults with Developmental Disabilities*). Additionally, DDS provides a wealth of information on its website in easily understood formats. Recent topics on the DDS Safety Net include *Recognizing the Signs of Physical and Sexual Abuse* and *Staying Safe on the Internet*. The State has also provided regional centers with an individualized risk assessment tool for use in person-centered planning.

DDS also engages the services of an independent, specialized risk management and mitigation contractor possessing a multidisciplinary (clinical, research, data analysis, training, business) capacity. Training and dissemination of relevant information is a part of the responsibilities of the independent contractor. The risk management contractor provides training and information as follows:

1. Perform ongoing review and analysis of the research and current literature with respect to preventing accidents, injuries, and other adverse incidents.
2. Develop and disseminate periodic reports and materials to the field (providers, regional

centers, families, disability organizations, etc.) on best practices related to protecting and promoting the health, safety, and well-being of consumers.

3. Maintain a website (www.ddssafety.net) for consumers and their families, providers, professionals, and regional center staff. The site includes information from across the nation on current research and best practices and practical information directed towards improving consumers' health and safety.
4. Assist DDS in planning, coordinating, and providing statewide training related to risk management and other related topics.
5. Provide technical assistance to regional centers related to local risk management plans and activities.

The information is available on the website (www.ddssafety.net) for consumers and their families as well as providers, professionals, and regional center staff. The website is dedicated to the dissemination of information on the prevention and mitigation of risk factors for persons with developmental disabilities. This site includes information from across the nation on current research, best practices and practical information directed towards improving participants' health and welfare.

In addition, a quarterly newsletter on prevention and mitigation of risk management is published and disseminated to regional center staff, providers and participants and families.

Regional centers have local level responsibility for planning, coordinating, and implementing the risk management program. The provision of training and information is an important part of the regional center's activities in this regard. Regional centers provide training and information on a region-wide and individual level. With respect to participants and informal care providers, the regional centers provide:

1. Applicants for and recipients of services with extensive information about regional center services and supports, including protective service agencies and the complaint process for reporting violations of rights. The information is provided routinely during annual and quarterly reviews.
2. Opportunities and funding for participants and families to attend conferences and training.
3. Periodic training to participants and families on various topics including maintaining a safe and healthy environment.
4. Sponsorship to self-advocacy organizations.

SBs provide ongoing training, education and support to participants and families on health and safety issues including reporting of abuse, neglect and exploitation.

Training and Education – SDS Waiver

Prior to the implementation of SDS Waiver services, the participant and his or her family representatives, receive training in the management of services and supports identified in the IPP. One topic of the training is on rights and responsibilities, including incident reporting.

The responsibilities of the SB include assisting and training the participant in various topics including recognizing and reporting critical events.

Training and counseling for unpaid caregivers is an available service under the SDS Waiver. The training and counseling is also directed at providing information on effective ways to support the participant, and to maintain a healthy and safe environment. In addition, recognizing and reporting critical events is an important part of such training.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Note: The State uses the term "special incident" for critical incident.

DDS has overall state-level responsibility for planning, coordinating and overseeing implementation of the State's risk management program for persons with developmental disabilities.

Special Incident Review and Response Process (Note: The SDS Waiver uses the same special incident reporting (SIR) system and process as is used system-wide for all consumers.)

1. DDS SIR Process – Special Incident Reporting Timelines

Reporter: All service providers in the SDS Waiver who are directly employed by the participant shall comply with special incident reporting requirements, pursuant to Title 17, CCR, §54327. In SDS, a parent or a participant who is a designated provider is exempt from these reporting requirements. In addition, all regional-center-vendored providers (FMS) must comply.

Timeframe: Report by telephone, electronic mail, or FAX immediately but not later than 24 hours after learning of the occurrence. Written report within 48 hours of the occurrence of the incident unless a written report was provided within the 24-hour period.

Report to: Regional Center.

Copies to: Licensed programs transmit copy to Department of Social Services, Community Care Licensing Division.

Reporter: Regional Centers (Title 17, CCR, §54327.1)

Timeframe: Initial report submitted to DDS within two working days following receipt of the incident report from the provider. When a regional center has knowledge of an incident that has not been reported, an initial report shall be sent to DDS within two working days of learning of the occurrence. Required information that is not submitted with the initial report shall be submitted within 30 working days following receipt of the report of the incident. Regional centers are required to comply with all DDS requests for initial and follow-up information pertaining to the incident. Reports are considered to be complete when all required information is submitted.

Report to: DDS.

Copies to: When appropriate reports are made to Child Protective Services, Adult Protective Services, or State Long-Term Ombudsman.

2. SIR Evaluation, Investigation and Follow-up

Regional centers have local-level responsibility for evaluation, investigation and follow-up of SIRs. Regional centers are required to report special incidents and follow-up activities to DDS. Regional centers are required to pursue follow-up activities until there is a satisfactory resolution of the immediate issue and mitigation of future risk to participants. Upon receipt of the special incident report, the regional center:

1. Reviews the incident report, ensures participant's safety and contacts the participant's authorized representative, as appropriate.
2. Reports the incident to investigative/protective services agencies, as appropriate.
3. Enters the initial information into special incident reporting system within two working days of learning of the incident.
4. Engages in activities to protect the participant's health and welfare and to prevent future incidents.
5. Records medical and other health related care received by the participant for his/her significant medical conditions in the period prior to the special incident.
6. Reviews medical records and coroner reports to ensure appropriate medical attention was sought and/or given.

7. Coordinates with other agencies (e.g., licensing, protective services, law enforcement agencies, coroners, long-term care ombudsman, etc.) to gather and review the results of their investigations and using this information to prevent the recurrence of similar problems.
8. Conducts on-site and chart review activities to gather and report initial and follow-up SIR information.
9. Adds required information to the initial SIR within 30 working days following initial report and updates SIR on a flow basis.
10. Closes the SIR when all required information and all follow-up activities are completed and entered into the electronic reporting system.

3. DDS Report Review and Evaluation Process
DDS has state-level responsibility for evaluation and follow-up of SIR reports and for reviewing on-site highly unusual, suspicious and/or very sensitive individual incidents where DDS Headquarters involvement is indicated. DDS evaluates and follows up on special incidents by:

1. Daily review of SIR transmissions to ensure regulatory compliance and proper notifications have been made to legally required entities, and that appropriate follow-up activities are occurring.
2. Aggregating and analyzing SIR data by regional centers, risk indicators, client characteristics, programs, incident types, corrective actions, residence and other relevant factors.
3. Providing analysis to the risk management contractor for further analysis and to regional centers for follow-up as appropriate.

4. Process for Notifying Participants of the Results of the Investigation
Regional centers are responsible for notifying participants, authorized representatives, SDS Waiver providers and other agencies of the results of the investigation. There is no formalized process for such notification.

5. Timeframes for Conduct of an Investigation and Informing Participants
Regional centers are required to report additional information to DDS within 30 days of receiving the SIR, but this timeframe does not apply a requirement that the investigation must be completed by that time. The requirement is that the regional center must add information on a flow basis and close the SIR when all required information and all follow up activities are completed and entered into the electronic reporting system. DDS has a well-established follow-up system to track "open" SIRs. The system includes regular contact with the regional center. There are no specified timeframes for informing participants, but there is an expectation that regional centers will do so as a part of closing the SIR.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Oversight of Reporting and Response to Critical Incidents

DDS has overall state-level responsibility for planning, coordinating and overseeing the implementation of the State's risk management program for persons with developmental disabilities, including those that are SD Waiver participants. DDS carries out this responsibility by:

1. Developing, implementing and maintaining a uniform, statewide automated SIR database system.
2. Reviewing daily all individual SIRs to identify issues or concerns requiring additional follow-up.
3. Revising regulations related to SIR requirements to address new system requirements.
4. Conducting periodic, on-site monitoring visits to review regional center and provider

compliance with SIR regulatory requirements, as well as ensuring consistent and accurate reporting.

5. Aggregating and analyzing SIR data by regional centers, risk indicators, client characteristics, programs, incident types, corrective actions, residence, and other relevant factors. Providing such data to the risk management contractor for further analyses and to regional centers for follow-up, as appropriate.
6. Providing training and technical assistance to regional centers on legal obligations in abuse reporting; documentation requirements; the definition of "special incident;" best practices for identifying consumer abuse; using and maintaining the automated SIR system; risk assessment; and proactive risk assessment and prevention planning through the individualized program planning process.
7. Developing and maintaining a statewide mortality review system that includes development and maintenance of a statewide database of all persons who have died, and conducting studies to educate and inform the service system so as to improve quality of life outcomes for participants.
8. Preparing, implementing and managing the risk assessment and mitigation contract.
9. Reviewing on-site highly unusual, suspicious and/or very sensitive individual incidents where DDS Headquarters involvement is indicated.

b. DHCS is the single state agency for the SDS Waiver. DDS is the operating agency for the SDS Waiver. DDS exercise oversight of the waiver through biennial collaborative full scope waiver monitoring program reviews at the 21 regional centers. Several components of the review address risk management activities, including SIRs.

1. DDS reviews compliance with reporting, meeting mandated timelines and appropriate and complete follow-up activity through the review of SDS Waiver participant records at the regional center and at day and community living service providers for the review sample.
2. DDS reviews compliance with reporting, meeting mandated timelines and appropriate and complete follow-up activity for SIRs of SDS Waiver participants, described in Appendix H-1: 6.
3. DHCS, at its discretion, may participate with DDS in conducting collaborative and other reviews.

c. DHCS, at its discretion, may perform additional focused on-site reviews of SIRs.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion *(select one):*

☒	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
	In California, pursuant to WIC § 4502(h), persons with developmental disabilities "have a right to be free from harm, including unnecessary physical restraint, or isolation, excessive medication, abuse, or neglect." In addition, the SDS Waiver provides for the following: Restraint(s) 1. California prohibits using restraint(s) on any person with a developmental disability, pursuant to Title 17, CCR, §50515. 2. The service agreement with SDS Waiver providers makes clear that the use of restraints is specifically prohibited in California. Seclusion 1. California prohibits placing any person with a developmental disability in seclusion pursuant to Title 17, CCR, §50515. 2. The service agreement with SDS Waiver providers makes clear that seclusion is specifically prohibited in California. Oversight Responsibility The unauthorized use of restraints and seclusion is monitored in the SDS Waiver through quarterly/annual monitoring visits conducted by the regional center case manager and the ongoing contact with the participant by the SB. In California, the discovery of the unauthorized use of restraints and seclusion would result in the cancellation of the contract of the responsible provider. A special incident would be filed with the regional center which would investigate and take action, and transmit the information to DDS.
○	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

☒	The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive

	interventions and how this oversight is conducted and its frequency:
	Restrictive Interventions 1. Each person with a developmental disability is entitled to the same rights, protections, and responsibilities as all other persons under the laws and Constitution of the State of California. The rights include the right to refuse behavior modification techniques that cause pain or trauma. This right cannot be waived. 2. The contract with SDS Waiver providers makes clear that the use of restrictive interventions is specifically prohibited in California. Oversight Responsibility The unauthorized use of restrictive interventions is precluded under the SDS Waiver through quarterly monitoring visits conducted by the regional center case manager and the ongoing contact with the participant by the SB. In California, the discovery of the unauthorized use of restrictive interventions would result in the cancellation of the contract of the responsible provider. A special incident would be filed with the regional center which would investigate and take action, and transmit the information to DDS.
○	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
☒	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

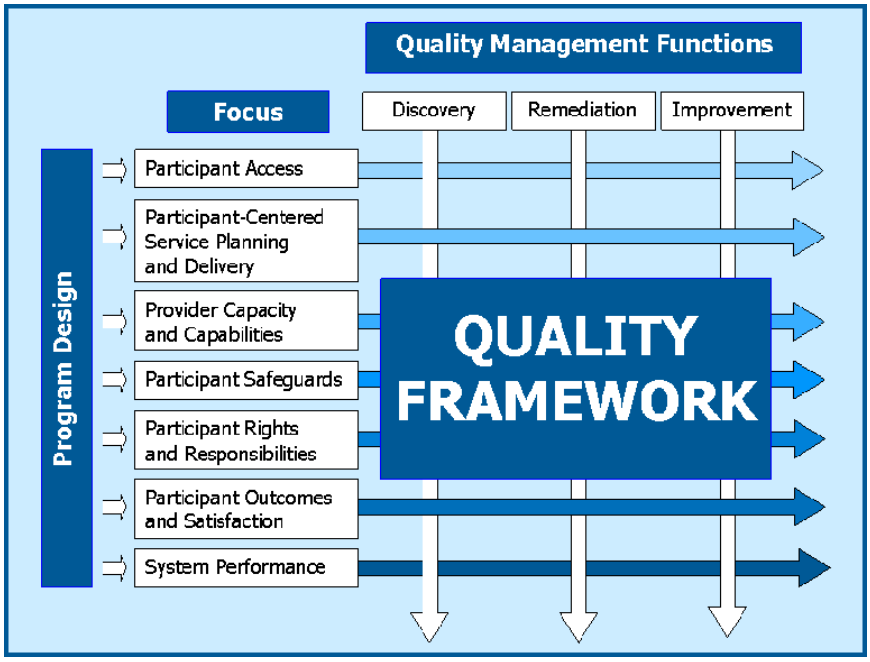
ii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: QMS

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS Waiver requires that (CMS) determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of SDS Waiver operations. Renewal of an existing SDS Waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS Waiver application, the State specifies how it has designed the SDS Waiver critical processes, structures and operational features in order to meet these assurances.



Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's SDS Waiver Quality Management Strategy (QMS) may vary depending on the nature of the SDS Waiver target population, the services offered, and the SDS Waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific SDS Waiver assurances and requirements.

It may be more efficient and effective for a QMS to span multiple SDS Waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other SDS Waiver programs and long-term care services that are addressed in the QMS.

Quality management is dynamic and the QMS may, and probably will, change over time. Modifications or updates to the QMS shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR § 441.302 (h) and at the time of SDS Waiver renewal.

QMS: Minimum Components

The QMS that will be in effect during the period of the SDS Waiver is included as Attachment #1 to Appendix H. The QMS should be no more than ten pages in length. It may reference other documents that provide additional supporting information about specific elements of the QMS. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major SDS Waiver assurances.
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances.
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances.
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances.
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the state's QMS is not fully developed at the time the SDS Waiver application is submitted, the state may provide a work plan to fully develop its QMS, including the specific tasks that the state plans to undertake during the period that the SDS Waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QMS spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the QMS.

Attachment #1 to Appendix H

The QMS for the SDS Waiver is:

The California QMS focuses on critical processes, structures, and operational features of the service system necessary to produce desired participant outcomes. The core of the QMS is the participant and, where appropriate, his/her family and/or legal representative; all remaining system structures revolve around the central goal of "doing the right thing" for the people served by the system. "Doing the right thing" is guided by desired outcomes, values and principles of the Lanterman Act as well as federal assurances and requirements. To assure quality, the model SDS Waiver will operate within the general framework of the HCBS Waiver for the Developmentally Disabled Control Number 0336, but will be tailored to accommodate the unique aspects of self-direction. The QMS is based, in part, on best practices and lessons learned from the administration of the five self-determination pilot projects over the past seven years. The QMS is a "work in progress" that may be modified as California gains experience with the implementation of the SDS Waiver.

H.I. SDS WAIVER ASSURANCES

H.1.a. LEVEL OF CARE (LOC) DETERMINATION *(APPENDIX B-6)*

A. Discovery Method/Performance Measurement

The Department of Developmental Services (DDS) monitors on a monthly basis each regional center's SDS Waiver eligibility activity to determine:

- Number of SDS Waiver participants, not exceeding the maximum authorized in the SDS Waiver.
- Timeliness of initial LOC evaluations and annual LOC reevaluations, notifying regional centers monthly of any overdue reevaluations.

- Number of LOC evaluation denials and participant appeals.
- Number and nature of complaints about LOC evaluation process or outcomes.

DDS provides information to the regional centers regarding LOC determinations and SDS Waiver eligibility through a number of routine reports:

- Client Master List that includes the names and current SDS Waiver eligibility status (MWS 220), by regional center, of all consumers who have ever been on the HCBS Waiver or prospectively the SDS Waiver.
- List of participants due for recertification including a delineation of any issues with the participant's ongoing eligibility (MWS 410).
- Medi-Cal eligibility report that includes current and 12 months' history of Medi-Cal eligibility for SDS Waiver participants (MWS 770).
- Medicaid SDS Waiver Listing of Active Consumer Population Report that provides the total number of participants (MWR 420).

Timeliness of regional center electronic reporting of annual reevaluations is monitored through use of the MWR 411 PO report. Recent data (11/04-3/05) indicates that, system-wide, 99.4% of the reevaluations met the timeframe.

The following are the routine reports used by DDS in monitoring LOC and eligibility:

- Client Master List (MWS 220)
- List of participants with overdue recertifications (MWR 411)
- Detailed Transaction Report, listing all eligibility adjustments or transactions submitted by the regional centers (MWS 199D)
- Eligibility Transaction Error Report (MC533BN)
- Medicaid SDS Waiver Listing of Active Consumer Population Report (MWR 420)

2. Biennial Collaborative Monitoring Review and Follow-Up Reviews:

DDS verifies the appropriateness of LOC decisions and the use of the instruments to establish certification and recertification through the Biennial Collaborative On-Site Monitoring Review and Follow-Up Reviews described in Appendix A. The verification review of each regional center includes verification that:

- qualified personnel appropriately and timely document LOC initial evaluations and reevaluations, including accuracy of approvals and denials.
- approved instruments were used in certifications and recertifications, and that the forms are current and completed properly.
- information identified in the Client Development Evaluation Report (CDER) (i.e., the assessment instrument) is reviewed annually and is supported by and consistent with other information in the participant's record.

These reviews provide the information to trigger remediation and continuous quality improvement activities with respect to LOC. This includes taking action to remedy any errors such as an inappropriate denial. The State provides written reports to regional centers on the outcome of these reviews, and monitors the regional center' remediation and continuous quality improvement activities related to LOC.

H-1-b. SERVICE PLAN (INDIVIDUAL PLAN OF CARE) *(APPENDIX B-7, APPENDIX D-1, AND APPENDIX D-2)*

A. Discovery Method/Performance Measurement

The service plan review will include the individual program planning (IPP) process, IPPs and other data as components of these reviews to ensure timeliness, thoroughness, and consistency with SDS Waiver requirements. Both Biennial and Follow-Up Reviews will be conducted by DDS to:

- Review records to ensure that IPPs:
  - Address participant assessed needs (including health and welfare risk factors) and personally defined outcomes, and identify all services and supports (regardless of funding source or means) that address the needs and goals in accordance with state policies.
  - Are reviewed at appropriate intervals (at least annually) and revised when necessary, and modified as necessary to respond to participant changing needs.
  - Document choice between SDS Waiver services and institutional care through completion of a signed Medicaid SDS Waiver Consumer Choice of Services/Living Arrangement form.
  - Document participant choice of services and providers in development of IPPs.
  - Specify the type, amount, duration, scope and frequency of services.
  - Document that the individual is informed of and assisted with exercising his/her due process rights.
- Verify that case managers meet quarterly with participants who do not reside with their families, to assess the provision of services described in the participant's IPP, determine if any changes in services are needed, and document meeting outcomes.
- Interview case managers to gather additional information on the ongoing assessment of needs, development of IPPs, monitoring services and supports, and special incident reporting.
- Interview the Supports Broker (SB) to determine their participation in ongoing assessment of need, participation in the development of the IPP, actual provision of services, and responses to emergencies and other issues.
- Interview FMSs and a sample of service providers to review records and documentation necessary to ensure that participants are receiving appropriate services consistent with the IPP and that progress is being made.
- Interview participants to determine satisfaction with, and opinions about, their services and supports, including their role in IPP development using the person-centered process (PCP). For children served, the interview is conducted with family members.

The reviews provide information to trigger any remediation needed and continuous quality improvement activities with respect to individual plans. This includes taking action to remedy any non-compliance. The State provides written reports to regional centers on the outcome of these reviews and monitors any plans of corrections that arise out of the reviews.

B. Additional Discovery Efforts:

The State uses additional discovery methods in the area of participant and family satisfaction and suggestions for improvements in service delivery by:

- Seeking the active participation of the State's Consumer Advisory Committee at its quarterly meetings, and
- Using information gathered by regional center Boards of Directors in community meetings held to develop the annual performance plans.

All information gathered from these sources is analyzed and incorporated into setting policy direction for the service delivery system, including administration of the SDS Waiver.

H-1-c. QUALIFIED PROVIDERS *(APPENDIX C-3)*

Provider qualifications are established through the service definitions found in Appendix C-3. Service providers under the SDS Waiver fall into two categories. The first category is the DDS-certified FMS providers (F/EA and Agency-with-Choice) that are vendored by the regional center in accordance with Title 17, CCR, Chapter 3, Subchapter 2, §54300 et seq. The second category includes all other service providers who are selected by the participant.

A. Discovery Method/Performance Measurement

1. FMS Service Providers

- Pursuant to WIC §4685.7(q), only an FMS provider is required to apply for regional center vendorization. The vendorization process will include verification of qualifications such as submission of all information including licenses, credentials, certificates, bonds of insurance required for operation of the service, financial management experience, ability and capability to perform financial transactions consistent with Waiver service requirements, and a criminal history background clearance. Prospective paid FMS providers must be certified prior to vendorization. The FMS entity shall ensure and document that all the participant's service providers meet specified requirements outlined in Appendix C for any service delivered to the participant.
- Regional centers will vendorize the DDS-certified FMS providers and will execute a Medicaid Provider Agreement.
- A designated or non-paid FMS provider must be vendored by a regional center and demonstrate to the regional center the capacity to fulfill the roles and responsibilities as defined in the Waiver service definition. Additionally, the designated FMS is subject to criminal history background clearance.
- The participant, with the assistance of his/her SB as needed, will evaluate the performance of the FMS annually and submit the evaluation to the vendoring regional center.

2. Other SDS Service Providers Selected by the Participant

- The qualifications, including required training for these providers, are established through the SDS Waiver service descriptions and the IPP.
- The participant, with assistance as needed, selects a qualified service provider. The qualifications are verified by the FMS through the execution of a Medicaid Provider Agreement.
- The participant establishes a service agreement with the qualified provider.
- The participant with the assistance of an SB and an FMS Agency-with-Choice, as applicable, is responsible for training providers in the individualized needs of the participant.
- The participant, as a condition of enrollment, uses only service providers who meet the requisite requirements defined in the SDS Waiver.
- The participant evaluates the performance of the FMS provider and the SB annually and submits the evaluations to the regional center.

3. Biennial Collaborative Monitoring Review and Follow-Up Reviews:

DDS will review the qualifications of a sample of FMS service providers and compliance with SDS Waiver standards. Additionally, DDS will review a sample of other provider records maintained by the FMS to include:

- Validation of initial and continued compliance with provider qualification requirements and standards consistent with the service provided and the IPP.
- The existence of executed and maintained provider agreements.
- Interviews with a sample of qualified service providers to confirm awareness of responsibilities for risk mitigation and incident reporting to ensure that participant health, safety and welfare are protected; and review evidence of appropriate reporting of, and response to, special incidents.

H.1.d. HEALTH AND WELFARE *(APPENDIX D-2; APPENDIX G)*

SDS Waiver providers are required to report special incidents to the regional center, except that a parent or participant acting as a designated provider is exempt from these special incident reporting requirements.

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A. Discovery Method/Performance Measurement

Performance in meeting federal requirements is determined through the following:

1. Statewide Risk Management and Mitigation System Monitoring:

Refer to Appendix G.

2. Biennial Collaborative Monitoring Review and Follow-Up Reviews:

DDS will review at each regional center its special incident reporting and risk mitigation process. The monitoring protocol will include: interviews of participants, case managers, service providers and the SB, to determine, as appropriate, level of satisfaction with assistance towards mitigating risks to health and safety. In addition, at each regional center, DDS will follow-up on any SIR reports that occurred during the review period of participant sample.

3. Focused Reviews:

On occasion, the State (DDS and/or DHCS) may perform focused reviews of SIR reporting based upon information gathered on an ongoing basis and through the Biennial Collaborative Review and Follow-Up Reviews.

H.1.e. ADMINISTRATIVE AUTHORITY *(APPENDIX A)*

A. Discovery Method/Performance Measurement

Performance in meeting federal requirements is determined through the following:

1. Routine State-Level Sources of Data:

The State's routine sources of data are:

- State's Biennial Collaborative SDS Waiver Monitoring Review and Follow-Up Reviews
- Statewide Risk Management/Mitigation Database
- DDS contract for Life Quality Assessments
- DDS/regional center annual Performance Contracts
- DDS Fair Hearing database
- DDS participant complaint process

2. Regular Meetings and Reports:

The State's regular meetings and reports are:

- DDS Biennial SDS Waiver Monitoring Report to DHCS

DDS and DHCS SDS Waiver coordination quarterly meetings

3. Other DHCS Monitoring Activities:

As the Medicaid Single State Agency, DHCS maintains the authority to:

- Ensure technical compliance and correctness of the Interagency Agreement with DDS.
- Refer all fiscal integrity issues, identified during the DHCS monitoring reviews, to DDS Audits and DHCS Audits & Investigations for investigation and to the appropriate sections in DDS and DHCS for information.
- Conduct independent focused reviews to investigate significant SIRs, participant/advocate complaints, or CMS concerns or requests for investigation.
- Participate in the standing DDS Executive Management Quality Management Committee meetings.

4. Other DDS Monitoring and Continuous Quality Improvement Activities:

As the operating agency, DDS will:

- Operate the DDS Executive Quality Management Committee meetings and activities.
- Provide training and technical assistance to regional centers including presentations to Association of Regional Center Agencies (ARCA) Chief Counselors and Federal Revenues Committees focusing on CMS expectations.
- Allocate resources to regional centers to meet federal SDS Waiver requirements.
- Enter into annual Regional Center Performance Contracts and complete Year-End Assessment

Reports.

- Follow up on Fair Hearing Trends related to SDS.
- Investigate and issue final administrative decisions per the Welfare & Institutions Code §4731 complaint process.

H.1.f. FINANCIAL ACCOUNTABILITY *(APPENDIX I)*

Refer to Appendix I for a description of discovery methods relative to financial accountability.

A. Discovery Method/Performance Measurement

Planned UFS Modification:

DDS is modifying the existing Uniform Fiscal System (UFS) operating in all 21 regional centers to incorporate data elements specific to administration of the SDS Waiver program. When UFS is modified, it will provide an additional automated data source/database and enhance the ability of DHCS, DDS, and regional centers to conduct discovery, remediation and improvement activities on a continuous basis. UFS SDS modifications will enable the state and regional centers to: identify SDS Waiver eligibility dates; approved participants; capability to disallow the enrollment in more than one waiver; provide budget options based on DDS defined methodologies; capture and maintain annual budget history; calculate a budget based on the formulaic method and capture CDER information at the time of calculation; store factors that were used in budget calculations; define annual budget into budget categories; modify an IB; track IBs by category; establish a table of authorized SDS Waiver service codes against which all payment transactions will be verified; track expenditures against budget; place limits on expenditures that exceed the budget; and alert the State when a risk pool expenditure has been authorized. The system is currently being developed with a rollout date of March 2008.

H.2. ROLES AND RESPONSIBILITIES

The QMS for the SDS Waiver is defined by four levels: participant, service provider, regional center and state (including the single state agency and operating agency and advisory groups).

A. Participant

The core of the QMS is the participant, where appropriate, and/or legal guardian. The participant level is focused on ensuring that individual consumers have the opportunity to make informed decisions about participation in SDS Waiver services and, if selected, the support and tools necessary to successfully self-direct all of their services to achieve their personally defined outcomes.

The participant plays an enhanced QMS role in SDS through management of his/her services and supports and playing a major role in shaping and evaluating service quality. The participant directs the development and implementation of the IPP through a PCP process, and the development and use of the IB. The participant, with assistance as needed from his/her SB and FMS, identifies, hires, trains and manages service providers to deliver the defined IPP services and supports. Participants have the responsibility as self-advocates to exercise their right to appeal decisions with which they disagree. Participants are the source of information on satisfaction with the quality of services and supports they receive.

B. Service Provider

The second level of the QMS is service providers (as identified in Appendix C-3). SDS Waiver service providers either work for or under the direction of the individual participant. The service providers support participants in achieving their goals and desires identified in IPPs by participating in the development (if requested), promoting and assisting participants to exercise choice, advocating on behalf of participants, providing specified services and supports, and safeguarding participant health and welfare.

In addition, service providers are responsible for ensuring the integrity of their own business operations. The QMS processes are:

- Ongoing compliance with service provider qualifications, e.g., licensure, certification, academic degree, and other qualifications set forth in the SDS Waiver (as described in Appendix C-3).
- Ongoing compliance with the purchase agreement (i.e., per the IPP), accepted business practices, Provider Service Agreement and other requirements, as appropriate.

C. Regional Center

The third level of the QMS is the 21 non-profit regional center corporations which: 1) perform intake and assessment activities, including determining initial and ongoing eligibility for the SDS Waiver, 2) develop participant IPPs through a PCP process and monitor IPP implementation, 3) provide case management for all SDS participants, 4) assure the health and welfare of participants, including receiving, analyzing and taking appropriate action on SIRs, 5) vendor qualified FMS providers, and 6) operate financial systems necessary to reimburse service providers, audit and account for state and federal expenditures.

While regional centers themselves perform a number of important functions, they are also responsible for collecting and reviewing data gathered from FMS providers and SDS participants on quality assurance measures. At this level, regional centers use several processes designed to promote high quality services for participants served under the SDS Waiver. The QMS processes are:

- Monitor delivery of services consistent with each participant's IPP.
- Review participant's monthly IB expenditure reports submitted by the FMS.
- Update participant IPP to meet changing needs or desires.
- Participate in state-directed risk management system and review SIRs and other related data.
- Conduct activities to secure participant and other stakeholder feedback to continuously improve operations.
- Carry out remediation and continuous quality improvement activities associated with the findings of the SDS Waiver monitoring and follow-up reviews.

D. State Agencies

The fourth level of the QMS is overall developmental disability system oversight and monitoring. There are two state agencies responsible for the SDS Waiver: DHCS and DDS. The DHCS is the Medicaid Single State Agency (as described in Appendix A.) and has responsibility for the oversight of the SDS Waiver. DDS administers the SDS Waiver and ensures compliance with Medicaid statutes, regulations and SDS Waiver requirements.

The DDS, under an interagency agreement (under development) with DHCS, is the "operating agency" responsible for day-to-day operation of the SDS Waiver (as described in Appendix A.2). DDS enters into an annual performance contract with each regional center that specifies performance expectations (including outcomes on statewide public policy and compliance measures) and requirements. DDS instructs and oversees regional center LOC determinations, IPP development and implementation, administration of qualified provider requirements, and protection of participant health and welfare. DDS also provides technical assistance and training to regional centers in best practices and remediation, which they can distribute to their staff, service providers, and the community. In addition, DDS conducts fiscal and programmatic oversight and monitoring of regional centers, including service provider performance. DDS performs five primary QMS activities: 1) Biennial Collaborative Monitoring Review; 2) Focused Reviews; 3) biennial fiscal audits of regional centers; 4) FMS certification; 5) regional center performance plan development and contracts; and 6) statewide Risk Management System.

In addition, two state-level bodies provide advice and/or policy direction to these state agencies in administrating and operating existing services. These bodies and their current responsibilities include:

- Statewide Consumer Advisory Committee (CAC) is a 15-member committee that meets at least quarterly to advise DDS on policies, programs, legislation, and regulations affecting the delivery of

services and supports to people with developmental disabilities in California. Members are nominated by a local People First or self-advocacy group. The CAC membership is representative of the geography, ethnicity, and type of disability and living arrangements of individuals served by California's developmental disabilities service delivery system. The CAC assists DDS in gathering input from consumers and incorporating the suggestions into the development of public policy.

- Executive Quality Management Committee is comprised of DDS and DHCS executive-level staff of equivalent rank or designees, and meets at least quarterly to review QMS information, identify areas needing improvement, establish priorities, and develop strategies for remediation and improvement. The Committee performs the following tasks and reports results from the process via the annual report to CMS:
  - Reviews reports to identify areas needing improvement: including performance reports developed from the biennial monitoring reviews, risk management trends, ad hoc status reports, etc.
  - Seeks additional information and/or research, as necessary, to better define and/or explore options for remediation.
  - Prioritizes areas needing improvement.
  - Prepares a written report to summarize the issues, findings, actions and timelines for completion.

1. Biennial Collaborative Monitoring Review and Follow-Up Reviews

The QMS uses the Biennial Collaborative Monitoring Review process as the primary source of data used to measure programmatic performance under the SDS Waiver. The specific format for and the roles and responsibilities of the monitoring review team will be detailed in the Interagency Agreement.

The SDS monitoring will address key aspects of SDS Waiver operations including LOC determinations, development of IPPs and monitoring implementation, qualified providers, health and welfare and the extent to which self-direction of services are occurring. The SDS review results will be:

- Discussed with the regional center at the end of the review.
- Issued in draft review report released within 60 days of the close of the review, with recommendations for corrective action as appropriate to improve performance and compliance.
- Issued in a formal review report to the regional center's Board of Directors.

Follow-up reviews are conducted for regional centers with deficiencies in the year following the biennial review to determine improvement in identified areas.

2. Focused Reviews

DDS, and DHCS at its discretion, will conduct focused reviews at regional centers experiencing ongoing difficulties in complying with state and/or federal mandates and SDS Waiver requirements. These reviews will provide additional discovery information to more effectively develop remedial activities, such as training and technical assistance.

3. Biennial Fiscal Audits of Regional Centers and Service Providers

DHCS Audits and Investigations (A&I) Division is assigned responsibility for fiscal oversight of the Waiver. DHCS A&I works collaboratively with DDS and the DHCS programmatic division and independently to ensure the Waiver program and services are implemented in accordance with Medicaid statute, regulations and Waiver requirements. The responsibilities include monitoring DDS compliance with fiscal provisions relative to audits of regional centers; reviewing DDS audit protocol to ensure compliance with the Waiver; ensuring that DDS audits of regional centers are conducted on a biennial basis, are in accordance with established protocols, and meet Generally Accepted Government Auditing Standards requirements; referral and follow-up of any program integrity issues identified during oversight activities to DHCS and DDS for investigation, and to DDS Audits and the appropriate DHCS programmatic division for information; reviewing working papers prepared by DDS audit staff of regional centers on a sample basis and attending entrance and exit conferences of selected regional center audits; participating in full-scope monitoring as required; and issuing an annual report to the

DHCS Director and to CMS that summarizes oversight functions performed.

DDS will: 1) perform fiscal audits of each regional center no less than every two years, and complete follow-up reviews of each center in alternate years (Note: the DDS audit is designed to "wrap around" the independent CPA audit [below] and ensure comprehensive financial accountability); 2) require regional centers to contract with independent auditors to conduct an annual audit; 3) coordinate its activities with DHCS A&I who reviews DDS' audit reports of regional centers; 4) perform ongoing reviews of a random sample of FMS financial transactions; and 5) operate the billing and payment system.

4. Annual Regional Center Performance Plan Development and Contracts

DDS enters into an annual performance-based contract with each regional center to measure system and individual outcomes through 15 public policy and 10 compliance measures. Regional centers must develop an outcome-based performance plan that addresses each of the public policy measures in collaboration with the community served, including at least one publicly noticed community meeting.

Annual DDS/regional center performance contracts measure progress on public policy and compliance measures against baseline data for each center on a calendar year basis. The performance contract process involves:

- DDS providing baseline data to each regional center in a draft year-end report in February, for use in the current year contract.
- DDS providing semi-annual data reports based on the Client Master File (CMF) and CDER data for relevant public policy and compliance measures to regional centers by July 15 and January15 in the contract year.
- Regional center review and comment on DDS draft semi-annual reports.
- DDS review, at the end of the contract period, of the baseline and year-end performance data for the statewide public policy and compliance measures for each regional center and provides the information to each center in their individualized year-end reports.

Regional center successful achievement on each item requires an outcome showing: 1) improvement over the prior year's baseline; 2) performance exceeding the statewide average; or, 3) performance equaling a DDS set standard. All of this information is made available to SDS Waiver participants, families, local communities and other interested parties.

5. Statewide Risk Management and Mitigation System

DDS has overall state-level responsibility for planning, coordinating and overseeing implementation of the State's risk management program for persons with developmental disabilities, including participants in the SDS Waiver. In performing this function, DDS contracts with an independent, risk management and mitigation contractor to provide specialized expertise and analysis of risk management data. The contractor possesses a multidisciplinary capacity, e.g., clinical, research, data analysis, training, business. DDS (with contractor assistance):

- Maintains a uniform, statewide, automated SIR database system, and reviews SIRs daily to identify issues or concerns requiring additional follow-up.
- Aggregates and analyzes SIR data by regional center, risk indicators, client characteristics, programs, incident types, corrective actions, residence, and other relevant factors; identifies health and welfare risk trends and incidents patterns requiring further analysis or action; and provides such data to regional centers for follow-up, as appropriate.
- Conducts mortality reviews and maintains a statewide mortality review system.
- Reviews and analyzes the research and current literature with respect to risk management, preventing accidents, injuries, and other adverse incidents.
- Provides training and technical assistance to regional centers and other interested parties to improve

quality of life outcomes for participants, e.g., risk management tools such as an individualized risk assessment formats.

- Develops and disseminates periodic reports and materials to the field (providers, regional centers, families, disability organizations, etc.) on best practices in protecting and promoting the health, welfare, and well-being of participants.
- Maintains a website (www.ddssafety.net) on the DDS homepage (www.dds.ca.gov) for consumers and their families, providers, professionals, regional centers and other interested parties, with information and tools from across the nation on current research, best practices and practical information directed towards improving consumers' health and welfare.
- Provides risk management data to the DDS's Quality Management Executive Committee at their quarterly meetings in order that they can establish priorities and develop strategies for remediation and improvement.

H.3. PROCESSES TO ESTABLISH PRIORITIES AND DEVELOP STRATEGIES FOR REMEDIATION AND IMPROVEMENT

Included in H.2. Roles and Responsibilities.

H.4. COMPILATION AND COMMUNICATION OF QUALITY MANAGEMENT INFORMATION

Section H.2. above lists the routine reports developed for and utilized by the SDS Waiver to measure performance. The explanation in the assurances describes how the reports are utilized. As a part of the implementation of the SDS Waiver, the following groups will participate in the review of information from the reports, assist in monitoring implementation and make recommendations on system change, areas of focus and overall improvements: the Statewide Consumer Advisory Committee, the Executive Quality Management Committee, and the Association of Regional Center Agencies.

DDS maintains an extensive website that is used to communicate information to the public, providers, participants and others. The website includes links to the SDS program and the Statewide Consumer Advisory Committee. The plan under the SDS Waiver is to expand those portions of the website to include information on the demographics, utilization, satisfaction, and the status of SDS Waiver implementation.

H.5. PERIODIC EVALUATION AND REVISION OF THE QMS

The State will periodically evaluate and revise, as appropriate, the QMS. The State recognizes that the QMS is dynamic and should reflect changes in policy, procedure, and practice. Therefore, the Executive Quality Management Committee will review the QMS annually (more frequently if a need is identified) to ensure that it reflects changes in priorities, use of different approaches to measure progress, changes in data sources, and/or changes in roles and responsibilities of key entities. The Committee will utilize the information gained from the groups participating in the compilation and communication of quality management information explained in the previous section. If the evaluation results in revision of the QMS, the revised QMS will be shared with CMS as part of the annual SDS Waiver report submission.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

FMS providers, functioning as either a Fiscal/Employer Agent or an Agency-With-Choice, are certified by DDS and vendored by regional centers. The FMS reviews the billings of all providers, and after verification of accuracy, submits them to the regional center. The FMS reviews the billings to verify that:

- the record specifies the date, actual service time, locations, units of service, cost and nature of the services provided, as appropriate.
- the services billed are the same service verified in the service provider's statement of qualifications and as specified in the IPP and the IB.

DDS annually conducts a review of a random statewide sample of financial transactions performed by the financial management services providers to verify compliance with the above. The review also verifies that all paid invoices in the sample are properly documented.

If there are discrepancies or inaccuracies, DDS will conduct a focused follow-up. The regional center, DDS, and DHCS have the authority to audit a FMS provider with or without notice. Upon request, all service providers shall make available any books and records pertaining to a provided service and be subject to audit.

DDS performs a fiscal audit of each regional center no less frequently than biennially and completes follow-up reviews of each regional center in alternate years. These fiscal audits are performed under an audit protocol that is approved by DHCS. The results of these audits are reported to DHCS, which retains the authority to review all audit working papers. The DDS audit is designed to "wrap around" the independent Certified Public Accountant (CPA) audit to ensure comprehensive financial accountability. As described below, DDS coordinates its activities with the DHCS A&I.

The DHCS A&I is assigned responsibility for fiscal oversight of the SDS Waiver. DHCS A&I works both collaboratively with DDS and the DHCS programmatic division and independently to ensure the SDS Waiver and services are implemented in accordance with Medicaid statute, regulations, and waiver requirements. The responsibilities include:

1. Monitoring DDS compliance with fiscal provisions relative to audits of regional centers.
2. Reviewing DDS audit protocol to ensure compliance with the SDS Waiver.
3. Ensuring that DDS audits of regional centers are conducted on a biennial basis.
4. Ensuring that audits conducted by DDS are in accordance with established protocols and meet Generally Accepted Government Auditing Standards requirements.
5. Ensuring that DDS and regional centers are conducting fiscal reviews of FMS vendors and other service providers.
6. Referring and following up on any program integrity issues identified during oversight activities to

DHCS and to DDS for investigation, and to DDS Audits and the appropriate DHCS programmatic division for information.

7. Reviewing working papers prepared by DDS audit staff of regional centers on a sample basis.
8. Attending entrance and exit conferences of selected regional center audits; participating in full-scope monitoring as required.
9. Issuing an annual report to DHCS Director and to Centers for Medicare & Medicaid (CMS) that summarizes oversight functions performed.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Except for paid FMS providers, payment rates for all SDS Waiver services are negotiated between the SDS Waiver participant (with the assistance of a Supports Broker [SB] as desired or necessary) and each provider selected by the participant. When the participant is the sole employer of an individual who provides a service to the participant, the wage rates negotiated must comply with applicable federal, state, and local minimum wage rates.

The payment rate for paid FMS providers will be established through the DDS FMS certification process. Through this process, the FMS proposes a fee schedule for his/her services and the basis for the fees to be charged.

DDS posted this waiver application for self-directed services and related draft regulations on its website to provide an opportunity for public input for stakeholders. Subsequently, a stakeholder meeting was convened to discuss the waiver application, including any comments related to the process for establishing rates and submitting billing claims.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All SDS Waiver billings flow from providers to the FMS entity selected by the SDS Waiver participant, except for the entity's billings for its own services. The FMS submits invoices of all SDS Waiver services provided, including FMS services, for approval by the participant. The FMS pays the approved invoices for all services except its own and submits claims for reimbursement directly to the regional center. These reimbursement claims must include a unique service code for SDS Waiver service and related information sufficient to establish and maintain an audit trail back to the provider of services to the participant.

Regional centers operate under a fiscal agent contract with DDS. Regional centers receive billings from FMS providers (for the FMS furnished by such entities and the amount paid by such entities on behalf of SDS Waiver participants for other waiver services). Regional centers transmit to DDS all service authorization and billing data/information necessary to support the provider claim and provide a complete audit trail.

c. Certifying Public Expenditures *(select one)*:

☒		**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
	☒	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

		Payments for SDS Waiver services are made by DDS from state tax revenues appropriated to DDS. These payments are made by DDS based on service authorization and billing data submitted by regional centers to DDS and adjudicated by DDS. Payments are made only for services rendered and the amount charged by the SDS Waiver service provider. The amount claimed for federal financial participation is based solely on adjudicated claims.
	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
○	**No**. Public agencies do not certify expenditures for waiver services.	

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The SDS Waiver employs a multi-tiered billing validation process. Invoices submitted by participant-selected or participant-employed providers to the FMS provider are verified by the participant with the assistance of the participant's SB to determine that the charges are allowable. FMS providers verify that the invoice is completed, the service is authorized in the participant-directed budget and IPP, and that the provider has executed a service provider agreement. In addition, on a monthly basis, the FMS provider prepares and transmits to the participant, the SB and the regional center case manager a report of invoices received/paid.

The FMS provider then invoices the regional center for reimbursement. These reimbursement claims must include a unique service code for SDS Waiver service and related information sufficient to establish and maintain an audit trail back to the provider of services to the participant.

The regional center then transmits reimbursement claim (billing) data to DDS which verifies that all necessary information accompanies the claim before processing, and claims are submitted only for waiver-eligible individuals. The DDS claims payment system interfaces with the DHCS (the Medicaid agency) Medicaid Eligibility Data System (MEDS) to verify that the individual for whom the claim was paid was Medicaid eligible on the date that the service was rendered. Only federally qualifying payments are submitted for reimbursement to DHCS, which forwards it to CMS.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

☒	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☒	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	The DDS functions as a limited fiscal agent for the SDS Waiver. DDS operates an approved MMIS payment system and has a fiscal agent contract with the DHCS, the Medicaid Agency, to perform claims payment. The system establishes and tracks regional center authorization and billing data by the FMS vendor number, authorization number, participant number, service code and general ledger account number. Each regional center bills DDS for all services furnished under the SDS Waiver. DDS adjudicates these claims, including ensuring that the claim includes all necessary information and that the participant was eligible at the time of service through an automated check through the Medicaid Eligibility Data System (MEDS) that is maintained and operated by DHCS. Regional center claims are not paid unless the appropriate authorization and billing data have been provided and the participant was eligible at time of service. The audit of SDS Waiver operations reviews DDS' performance as a limited fiscal agent.

☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. § 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. § 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

☒	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
☒	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. Amount of Payment to Public Providers. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. § 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

☒	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
☒	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

☐	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
☒	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services.

	Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
☒	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☐	**Appropriation of State Tax Revenues to the State Medicaid agency**
☒	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
	The non-federal share is appropriated to the California DDS. Non-federal funds are expended as CPEs.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☒	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

☒	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.	
○	The following source (s) are used. *Check each that applies.*	
	☐	Provider taxes or fees
	☐	Provider donations
	☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
☒	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

As specified in Appendix C-3, some types of crisis intervention services are furnished on an overnight basis in residential settings. Payment for these services includes the cost of room and board as provided in 42 CFR, §441.310(a)(2)(i).

No other services in the SDS Waiver are furnished in residential settings other than the participant's home, or the home of the parent or legal guardian.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

☒	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
	The maximum payment for the rent and food expenses of a live-in personal caregiver is the sum of: (a) one-half of the most recent published federal Housing and Urban Development (HUD) Fair Market Rent (FMR) for a two-bedroom living unit in the geographic area where the participant resides and (b) the current United States Department of Agriculture allowance for a single individual. The participant must document to the FMS provider that housing costs (rent or mortgage payment) are equal to or greater than the FMR. The live-in personal caregiver shall submit the participant's written charges for rent and food expenses to the FMS provider entity for payment. The FMS shall pay these charges to the caregiver who, in turn, will compensate the participant. Periodically, the FMS provider shall confirm with the participant and/or the SB that the amount reimbursed to the live-in caregiver has been paid to the participant.
○	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

☒	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

State:	California
Date	3/26/08

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

☒	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded~~;~~ and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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APPENDIX J - FINANCIAL DOCUMENTATION
APPENDIX J-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g., hospital and nursing faciltiy), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	Total D + D'	FACTOR G	FACTOR G'	Total G + G'
1*	$ 17,674	$ 7,079	$ 24,753	$ 68,062	$ 4,914	$ 72,976
2	$ 19,903	$ 7,972	$ 27,875	$ 73,918	$ 5,484	$ 79,402
3	$ 20,333	$ 8,145	$ 28,478	$ 77,161	$ 5,610	$ 82,771
4	$ 21,984	$ 8,806	$ 30,790	$ 79,625	$ 5,739	$ 85,364
5	$ 22,578	$ 9,044	$ 31,622	$ 82,154	$ 88,025	$ 170,179

* SDS Waiver to be implemented on August 1, 2008. Data refers to 11 months of services.

State:	California
Draft Date	3/26/08

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1*	200
2	1,600
3	3,100
4	4,700
5	6,300

EXPLANATION OF FACTOR C:
Check one:

X The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

— The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as Factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

* SDS Waiver to be implemented on August 1, 2008. Data refers to 11 months of services.

State:	California
Date	3/26/08

APPENDIX J-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES
FACTOR D

LOC: ICF/MR

The estimated annual average per capita Medicaid cost for home and community-based service for individuals in the Waiver program *is calculated as follows:*

AVERAGE LENGTH OF STAY (ALOS)

ALOS is calculated by dividing the total number of enrolled days of all waiver participants by the unduplicated recipients, as reported in the the RENEWAL DD WAIVER #0336.

FACTOR D DERIVATION

The Factor D value is estimated on the actual number of users, utilization, and cost per unit. Utilization adjustments take into account the ALOS calculation above. Inflation adjustments are based on the California Consumer Price Index as reported by the California Department of Finance.

Certain services are estimated using the RENEWAL DD WAIVER #0336 as a guideline.

For other services, estimates were based on actual data from individuals in our system, or surveys.

The demonstration of Factor D estimates is on the following pages.

State:	California
Date	3/26/08

Version

APPENDIX J
FACTOR D

LOC:ICF/MR
Demonstration of Factor D estimates:

Waiver Year (1) 2007/08 (2) (3) (4) (5)

		#Undup.Recipients (users) Column B	Avg.#Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
J-1	Supports Broker	200	37.45	$50.00	$374,458
J-2	Financial Management Services-Vendor Fiscal/Employer Agent	100	9.36	83.00	77,700
J-3	Financial Management Services-Agency with Choice	98	9.36	83.00	76,146
J-4	Financial Management Services-Designated Fiscal Agent	2	0.00	0.00	0
J-5	Community Living Supports	129	350	24.58	1,108,878
J-6	Communication Support Services	2	9.36	59.71	1,191
J-7	Respite Services	167	9.36	232.72	363,826
J-8	Live-in Caregiver	9	9.36	2,349.21	197,928
J-9	Housing Access Supports	17	3.48	34.04	2,016
J-10	Advocacy Services	2	1.10	142.00	312
J-11	Participant-Directed Goods and Services	200	9.36	288.18	539,565
J-12	Skilled Nursing	4	9.36	344.06	12,884
J-13	Specialized Therapeutic Services				
	Oral Health	1	0.87	757.26	659
	MB/SEBI	0	16.28	101.59	0
	Physical Health	1	12.34	44.66	551
J-14	Home Health Aide	10	9.36	559.80	52,405
J-15	Nutritional Consultation	2	9.36	41.53	778
J-16	Behavior Intervention Services	18	9.36	321.35	54,149
J-17	Integrative Therapies	50	71	35.47	126,250
J-18	Supported Prevocational Services	23	9.36	291.99	64,099
J-19	Employment Developmental Supports	23	9.36	291.99	64,099
J-20	Family Assistance and Support	8	9.36	270.75	20,277
J-21	Individual Training and Education	18	0.95	40.00	684
J-22	Training and Counseling Services for Unpaid Caregivers	15	9.36	339.69	47,700
J-23	Environmental Accessibility Adaptations	0	0.87	5,700.37	0
J-24	Vehicle Adaptations	0	0.87	5,649.50	0
J-25	Specialized Medical Equip & Supplies	3	9.36	154.17	4,330
J-26	Personal Emergency Response System	1	9.36	15.74	147
J-27	Transportation	172	9.36	152.22	245,667
J-28	Crisis Intervention	2	9.36	160.89	3,012
J-29	One-time transition costs	200	0.95	500	95,000
	TOTAL				$3,534,711

TOTAL ESTIMATE UNDUPLICATED RECIPIENTS 200

FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS): 17,674

AVERAGE LENGTH OF STAY: 5.96 months/Client/Year

State:	California
Date	3/26/08

Version

APPENDIX J
FACTOR D

LOC:ICF/MR
Demonstration of Factor D estimates:

Waiver Year (1) (2) 2008/09 (3) (4) (5)

		#Undup.Recipients (users) Column B	Avg.#Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
J-1	Supports Broker	1,600	40.85	$51.00	$3,333,360
J-2	Financial Management Services-Vendor Fiscal/Employer Agent	800	10.21	85.00	694,450
J-3	Financial Management Services-Agency with Choice	784	10.21	85.00	680,561
J-4	Financial Management Services-Designated Fiscal Agent	16	0.00	0.00	0
J-5	Community Living Supports	1,296	381.42	22.71	11,224,887
J-6	Communication Support Services	17	10.21	61.08	10,626
J-7	Respite Services	1,337	10.21	238.07	3,250,635
J-8	Live-in Caregiver	70	10.21	2,410.29	1,723,056
J-9	Housing Access Supports	132	3.80	34.93	17,521
J-10	Advocacy Services	19	1.20	145.69	3,313
J-11	Participant-Directed Goods and Services	1,600	10.21	295.68	4,831,411
J-12	Skilled Nursing	29	10.21	351.97	104,240
J-13	Specialized Therapeutic Services				
	Oral Health	5	0.95	774.68	3,680
	MB/SEBI	2	17.76	103.93	3,691
	Physical Health	5	13.46	45.69	3,075
J-14	Home Health Aide	83	10.21	572.68	485,425
J-15	Nutritional Consultation	14	10.21	42.49	6,075
J-16	Behavior Intervention Services	147	10.21	328.74	493,517
J-17	Integrative Therapies	53	78	34.52	142,100
J-18	Supported Prevocational Services	188	10.21	298.71	572,288
J-19	Employment Developmental Supports	188	10.21	298.71	572,288
J-20	Family Assistance and Support	63	10.21	277.79	178,727
J-21	Individual Training and Education	144	1.90	41.04	11,237
J-22	Training and Counseling Services for Unpaid Caregivers	123	10.21	348.52	437,789
J-23	Environmental Accessibility Adaptations	2	0.95	5,831.48	11,080
J-24	Vehicle Adaptations	4	0.95	5,779.44	21,962
J-25	Specialized Medical Equip & Supplies	24	10.21	157.72	38,657
J-26	Personal Emergency Response System	11	10.21	16.10	1,809
J-27	Transportation	1,379	10.21	155.72	2,193,299
J-28	Crisis Intervention	20	10.21	164.59	33,618
J-29	One-time transition costs	1,600	0.95	500	760,000
	TOTAL				$31,844,377

TOTAL ESTIMATE UNDUPLICATED RECIPIENTS 1,600

FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS): 19,903

AVERAGE LENGTH OF STAY: 10.21 months/Client/Year

State:	California
Date	3/26/08

Version

APPENDIX J
FACTOR D

LOC:ICF/MR
Demonstration of Factor D estimates:

Waiver Year (1) (2) (3) 2009/10 (4) (5)

		#Undup.Recipients (users) Column B	Avg.#Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
J-1	Supports Broker	3.100	40.85	$52.33	$6,626,810
J-2	Financial Management Services-Vendor Fiscal/Employer Agent	1.550	10.21	87.21	1,380,480
J-3	Financial Management Services-Agency with Choice	1,519	10.21	87.21	1,352,870
J-4	Financial Management Services-Designated Fiscal Agent	31	0.00	0.00	0
J-5	Community Living Supports	2,000	381	29.21	22,286,360
	Homemaker Service	509	345.80	19.95	3,511,443
	Chore	509	15.20	205.68	1,591,305
	Day Habilitation	1,274	10.21	775.27	10,084,305
	Adult Residential	217	10.21	3,204.28	7,099,307
J-6	Communication Support Services	33	10.21	62.48	21,055
J-7	Respite Services	2,591	10.21	243.55	6,444,476
J-8	Live-in Caregiver	135	10.21	2,472.96	3,409,439
J-9	Housing Access Supports	255	3.80	35.84	34,729
J-10	Advocacy Services	37	1.20	149.48	6,620
J-11	Participant-Directed Goods and Services	3,100	10.21	303.37	9,604,315
J-12	Skilled Nursing	56	10.21	360.07	205,924
J-13	Specialized Therapeutic Services				
	Oral Health	10	0.95	792.50	7,529
	MB/SEBI	4	17.76	106.32	7,551
	Physical Health	10	13.46	46.74	6,292
J-14	Home Health Aide	160	10.21	585.85	957,279
J-15	Nutritional Consultation	27	10.21	43.59	12,019
J-16	Behavior Intervention Services	284	10.21	336.30	975,388
J-17	Integrative Therapies	56	78	33.71	146,606
J-18	Supported Prevocational Services	363	10.21	305.58	1,134,309
J-19	Employment Developmental Supports	363	10.21	305.58	1,134,309
J-20	Family Assistance and Support	122	10.21	285.01	355,101
J-21	Individual Training and Education	279	1.90	42.11	22,339
J-22	Training and Counseling Services for Unpaid Caregivers	238	10.21	357.58	869,125
J-23	Environmental Accessibility Adaptations	4	0.95	5,965.60	22,669
J-24	Vehicle Adaptations	8	0.95	5,912.37	44,934
J-25	Specialized Medical Equip & Supplies	46	10.21	161.35	75,798
J-26	Personal Emergency Response System	22	10.21	16.47	3,700
J-27	Transportation	2,672	10.21	159.30	4,347,216
J-28	Crisis Intervention	38	10.21	168.38	65,344
J-29	One-time transition costs	3,100	0.95	500	1,472,500
	TOTAL				$63,033,086

TOTAL ESTIMATE UNDUPLICATED RECIPIENTS 3,100

FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS): 20,333

AVERAGE LENGTH OF STAY: 10.21 months/Client/Year

State:	California
Date	3/26/08

Version

UNIT COST DISTRIBUTION OF FORMULA: FACTOR D

	WAIVER SERVICES	Unit	Recipients WY 01	Recipients WY 02	Recipients WY 03	Units Per Recipient WY 01	Units Per Recipient WY 02	Units Per Recipient WY 03
J-1	Supports Broker	Hour	200	1,600	3,100	37.45	40.85	40.85
J-2	Financial Management Services-Vendor Fiscal/Employer Agent	Hour	100	800	1,550	9.36	10.21	10.21
J-3	Financial Management Services-Agency with Choice	Hour	98	784	1,519	9.36	10.21	10.21
J-4	Financial Management Services-Designated Fiscal Agent							
J-5	Community Living Supports	Month	129	1,296	2,000	349.65	381.42	381.42
J-6	Communication Support Services	Month	2	17	33	9.36	10.21	10.21
J-7	Respite Services	Month	167	1,337	2,591	9.36	10.21	10.21
J-8	Live-in Caregiver	Month	9	70	135	9.36	10.21	10.21
J-9	Housing Access Supports	Hour	17	132	255	3.48	3.80	3.80
J-10	Advocacy Services	Hour	2	19	37	1.10	1.20	1.20
J-11	Participant-Directed Goods and Services	Month	200	1,600	3,100	9.36	10.21	10.21
J-12	Skilled Nursing	Month	4	29	56	9.36	10.21	10.21
J-13	Specialized Therapeutic Services		0	0	0	0.00	0.00	0.00
	Oral Health	Visit	1	5	10	0.87	0.95	0.95
	MB/SEBI	Hour	0	2	4	16.28	17.76	17.76
	Physical Health	Hour	1	5	10	12.34	13.46	13.46
J-14	Home Health Aide	Hour	10	83	160	9.36	10.21	10.21
J-15	Nutritional Consultation	Hour	2	14	27	9.36	10.21	10.21
J-16	Behavior Intervention Services	Hour	18	147	284	9.36	10.21	10.21
J-17	Integrative Therapies		50	53	56	71.19	77.66	77.66
J-18	Supported Prevocational Services	Hour	23	188	363	9.36	10.21	10.21
J-19	Employment Developmental Supports	Hour	23	188	363	9.36	10.21	10.21
J-20	Family Assistance and Support	Month	8	63	122	9.36	10.21	10.21
J-21	Individual Training and Education	Course	18	144	279	0.95	1.90	1.90
J-22	Training and Counseling Services for Unpaid Caregivers	Month	15	123	238	9.36	10.21	10.21
J-23	Environmental Accessibility Adaptations	Adaptation	0	2	4	0.87	0.95	0.95
J-24	Vehicle Adaptations	Adaptation	0	4	8	0.87	0.95	0.95
J-25	Specialized Medical Equip & Supplies	Piece	3	24	46	9.36	10.21	10.21
J-26	Personal Emergency Response System	Month	1	11	22	9.36	10.21	10.21
J-27	Transportation	Day	172	1,379	2,672	9.36	10.21	10.21
J-28	Crisis Intervention	Day	2	20	38	9.36	10.21	10.21
J-29	One-time transition costs	One-time	200	1,600	3,100	0.95	0.95	0.95

State:	California
Date	3/26/08

Version

UNIT COST DISTRIBUTION OF FORMULA:
FACTOR D (continued)

			Average Unit Cost			Estimated cost (in thousands)		
WAIVER SERVICES		**Unit**	**WY 01**	**WY 02**	**WY 03**	**WY 01**	**WY 02**	**WY 03**
J-1	Supports Broker	Hour	$50.00	$51.00	$52.33	$374	$3,333	$6,627
J-2	Financial Management Services-Vendor Fiscal/Employer Agent	Hour	$83.00	$85.00	$87.21	$78	$694	$1,380
J-3	Financial Management Services-Agency with Choice	Hour	$83.00	$85.00	$87.21	$76	$681	$1,353
J-4	Financial Management Services-Designated Fiscal Agent							
J-5	Community Living Supports		$24.58	$22.71	$29.21	$1,109	$11,225	$22,286
J-6	Communication Support Services	Month	$59.71	$61.08	$62.48	$1	$11	$21
J-7	Respite Services	Month	$232.72	$238.07	$243.55	$364	$3,251	$6,444
J-8	Live-in Caregiver	Month	$2,349.21	$2,410.29	$2,472.96	$198	$1,723	$3,409
J-9	Housing Access Supports	Hour	$34.04	$34.93	$35.84	$2	$18	$35
J-10	Advocacy Services	Hour	$142.00	$145.69	$149.48	$0	$3	$7
J-11	Participant-Directed Goods and Services	Month	$288.18	$295.68	$303.37	$540	$4,831	$9,604
J-12	Skilled Nursing	Month	$344.06	$351.97	$360.07	$13	$104	$206
J-13	Specialized Therapeutic Services							
	Oral Health	Visit	$757.26	$774.68	$792.50	$1	$4	$8
	MB/SEBI	Hour	$101.59	$103.93	$106.32	$0	$4	$8
	Physical Health	Hour	$44.66	$45.69	$46.74	$1	$3	$6
J-14	Home Health Aide	Hour	$559.80	$572.68	$585.85	$52	$485	$957
J-15	Nutritional Consultation	Hour	$41.53	$42.49	$43.59	$1	$6	$12
J-16	Behavior Intervention Services	Hour	$321.35	$328.74	$336.30	$54	$494	$975
J-17	Integrative Therapies		$35.47	$34.52	$33.71	$126	$142	$147
J-18	Supported Prevocational Services	Hour	$291.99	$298.71	$305.58	$64	$572	$1,134
J-19	Employment Developmental Supports	Hour	$291.99	$298.71	$305.58	$64	$572	$1,134
J-20	Family Assistance and Support	Month	$270.75	$277.79	$285.01	$20	$179	$355
J-21	Individual Training and Education	Course	$40.00	$41.04	$42.11	$1	$11	$22
J-22	Training and Counseling Services for Unpaid Caregivers	Month	$339.69	$348.52	$357.58	$48	$438	$869
J-23	Environmental Accessibility Adaptations	Adaptation	$5,700.37	$5,831.48	$5,965.60	$0	$11	$23
J-24	Vehicle Adaptations	Adaptation	$5,649.50	$5,779.44	$5,912.37	$0	$22	$45
J-25	Specialized Medical Equip & Supplies	Piece	$154.17	$157.72	$161.35	$4	$39	$76
J-26	Personal Emergency Response System	Month	$15.74	$16.10	$16.47	$0	$2	$4
J-27	Transportation	Day	$152.22	$155.72	$159.30	$246	$2,193	$4,347
J-28	Crisis Intervention	Day	$160.89	$164.59	$168.38	$3	$34	$65
J-29	One-time transition costs	One-time	$500.00	$500.00	$500.00	$95	$760	$1,473

State:	California
Date	3/26/08

APPENDIX J-3

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

___ The State will not reimburse for the rent and food expenses of an unrelated live-in caregiver who lives with the individuals(s) serviced on the Waiver.

X The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual on the Waiver. The service costs of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (costs of Waiver services) in Appendix J-2 of this Waiver request.

Survey of Live-In Caregivers:

In compliance with the rules of Wage Order 15, Live-in caregivers are paid minimum wage for the number of hours they are on. Out of this, the Live-in Caregiver must pay rent. The maximum monthly rent is currently $438/mo. (going up to $451.38 in Jan 08)

State:	California
Date	3/26/08

APPENDIX J-4

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of Factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the Waiver program."

Factor D' includes the following:

The cost of all State plan services (including home health, personal care, and adult day health care) furnished in addition to Waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of Waiver services and ended BEFORE the end of the Waiver year IF the person returned to the Waiver.

Factor D' does not include the following:

The costs of institutional care, if the person did NOT return to the Waiver following institutionalization.

Institutional costs incurred BEFORE the person is first served under the Waiver in this Waiver year.

Costs for institutional respite care provided as a service under this Waiver. Such costs are included in the calculation of costs under Factor D.

Costs of prescription drugs furnished to Medicare/Medicaid dual eligibles, in compliance with Part D, have been removed from the baseline figures used to calculate Factor D'. The data was identified through an analysis of the State's Medicaid system done by the Single State Agency.

State:	California
Date	3/26/08

APPENDIX J-4
FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

___ Based on CMS Form 2082 (relevant pages attached).

___ Based on CMS form 372 for years _____ of Waiver # _____, which serves a similar

___ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

X Other (specify):

This number is estimated based on the percentage of D' to Total D+D' in the approved RENEWAL DD WAIVER #0336.

State:	California
Date	3/26/08

APPENDIX J-5
FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the Waiver, were the Waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this Waiver request.

Factor G is computed as follows:

___ Based on institutional cost trends shown by CMS Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

X Based on the data in the approved RENEWAL DD WAIVER #0336. Following pages are from the Waiver, except that 2007-08 data has been adjusted from 12 to 7 months to coincide with the first year of SDS services.

___ Based on actual case histories of individuals institutionalized for this disease or condition at this LOC. Documentation attached.

___ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

___ Other (specify):

If institutional respite care is provided as a service under this Waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

State:	California
Date	3/26/08

APPENDIX J-6
FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

The estimated annual average per capita Medicaid cost for all services other than those

Included in Factor G' are the following:

The cost of all State plan services furnished while the individual was institutionalized.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution), which began after the person's first day of institutional services.

Costs of institutional respite care are provided as a service under this Waiver under Factor D. Such costs are not duplicated in the calculation of Factor G'.

Factor G' is computed as follows (check one):

___ Based on CMS Form 2082 (relevant pages attached).

X Based on approved RENEWAL DD WAIVER #0336.

___ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

___ Other (specify):

APPENDIX J-7
DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1					
FACTOR D:		$17,674		FACTOR G:	$ 68,062
FACTOR D':		7,079		FACTOR G':	4,914
TOTAL		$24,753	≤		$72,976

YEAR 2					
FACTOR D:		$19,903		FACTOR G:	$ 73,918
FACTOR D':		7,972		FACTOR G':	5,484
TOTAL		$27,875	≤		$79,402

YEAR 3					
FACTOR D:	$	20,333		FACTOR G:	$ 77,161
FACTOR D':		8,145		FACTOR G':	5,610
TOTAL		$28,478	≤		$82,771

YEAR 4					
FACTOR D:	$	21,984		FACTOR G:	$ 79,625
FACTOR D':		8,806		FACTOR G':	5,739
TOTAL		$30,790	≤		$85,364

YEAR 5					
FACTOR D:	$	22,578		FACTOR G:	$ 82,154
FACTOR D':		9,044		FACTOR G':	88,025
TOTAL		$31,622	≤		$170,179

State:	California
Date	3/26/08