

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

**CHAPTER 411
DIVISION 340**

**SUPPORT SERVICES FOR ADULTS WITH
INTELLECTUAL OR DEVELOPMENTAL DISABILITIES**

411-340-0010 Statement of Purpose

(Amended 12/28/2013)

(1) The rules in OAR chapter 411, division 340 prescribe standards, responsibilities, and procedures for support services brokerages to assist adults with intellectual or developmental disabilities to identify and address support needs and for providers paid with support services funds, including resources available through the state plan and waiver, to provide services so that an adult with an intellectual or developmental disability may live in his or her own home or in the family home.

(2) Services provided under these rules are intended to identify, strengthen, expand, and where required, supplement private, public, formal, and informal support available to adults with intellectual or developmental disabilities so that an adult with an intellectual or developmental disability may exercise self-determination in the design and direction of his or her life.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0020 Definitions

(Temporary Effective 07/01/2014 to 12/28/2014)

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 340:

(1) "Abuse" means "abuse of an adult" as defined in OAR 407-045-0260.

(2) "Abuse Investigation and Protective Services" means the reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required by OAR 407-045-0310.

(3) "ADL" means "activities of daily living". ADL are basic personal everyday activities, such as eating, using the restroom, grooming, dressing, bathing, and transferring.

(4) "Administrative Review" means "administrator review" as defined in this rule.

(5) "Administrator Review" means the Director of the Department reviews a decision upon request, including the documentation related to the decision, and issues a determination.

(6) "Adult" means an individual who is 18 years or older with an intellectual or developmental disability.

(7) "Alternative Resources" mean possible resources, not including support services, for the provision of supports to meet the needs of an individual. Alternative resources include, but are not limited to, private or public insurance, vocational rehabilitation services, supports available through the Oregon Department of Education, or other community supports.

(8) "Annual Plan" means the written summary a personal agent completes for an individual who is not enrolled in waiver or Community First Choice services. An Annual Plan is not an ISP and is not a plan of care for Medicaid purposes.

(9) "Assistive Devices" mean the devices, aids, controls, supplies, or appliances described in OAR 411-340-0130 that are necessary to enable an individual to increase the ability of the individual to perform ADL and IADLs or to perceive, control, or communicate with the environment in which the individual lives.

(10) "Assistive Technology" means the devices, aids, controls, supplies, or appliances described in OAR 411-340-0130 that are purchased to provide additional security for an individual and replace the need for direct

interventions to enable self direction of care and maximize independence of the individual.

(11) "Attendant Care" means assistance with ADL, IADL, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding as described in OAR 411-340-0130.

(12) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210.

(13) "Behavior Consultant" means a contractor with specialized skills who develops a Behavior Support Plan.

(14) "Behavior Support Plan" means the written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow to cause the challenging behaviors of an individual to become unnecessary and to change the behavior of a provider, adjust environment, and teach new skills.

(15) "Behavior Support Services" mean the services consistent with positive behavioral theory and practice that are provided to assist with behavioral challenges due to the intellectual or developmental disability of an individual that prevents the individual from accomplishing ADL, IADL, health related tasks, and cognitive supports to mitigate behavior. Behavior support services are provided in the home or community.

(16) "Brokerage" means an entity or distinct operating unit within an existing entity that uses the principles of self-determination to perform the functions associated with planning and implementation of support services for individuals with intellectual or developmental disabilities.

(17) "Brokerage Director" means the Director of a publicly or privately-operated brokerage who is responsible for administration and provision of services according to these rules, or the designee of the Brokerage Director.

(18) "Career Development Plan" means the part of an ISP that identifies the employment goals and objectives for an individual, the services and supports needed to achieve those goals, the people, agencies, and

providers assigned to assist the individual to attain those goals, the obstacles to the individual working in an individualized job in an integrated employment setting, and the services and supports necessary to overcome those obstacles.

(19) "Case Management" means the functions performed by a services coordinator or personal agent. Case management includes determining service eligibility, developing a plan of authorized services, and monitoring the effectiveness of services and supports.

(20) "Case Management Contact" means a reciprocal interaction between a personal agent and an individual or the legal or designated representative of the individual (as applicable).

(21) "CDDP" means "community developmental disability program" as defined in OAR 411-320-0020.

(22) "Certificate" means the document issued by the Department to a brokerage, or to a provider organization requiring certification under OAR 411-340-0170(2), that certifies the brokerage or provider organization is eligible to receive state funds for the provision of services.

(23) "Choice" means the expression of preference, opportunity for, and active role of an individual in decision-making related to services received and from whom including, but not limited to, case management, providers, services, and service settings. Personal outcomes, goals, and activities are supported in the context of balancing the rights, risks, and personal choices of the individual. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated orally, through sign language, or by other communication methods.

(24) "Choice Advising" means the impartial sharing of information about case management and other service delivery options available to individuals with intellectual or developmental disabilities provided by a person that meets the qualifications identified in OAR 411-340-0150(5).

(25) "Chore Services" mean the services described in OAR 411-340-0130 that are needed to restore a hazardous or unsanitary situation in the home of an individual to a clean, sanitary, and safe environment.

(26) "Collective Bargaining Agreement" means a contract based on negotiation between organized workers and their designated employer for purposes of collective bargaining to determine wages, hours, rules, and working conditions.

(27) "Community First Choice (K Plan)" means the state plan amendment authorized under section 1915(k) of the Social Security Act.

(28) "Community Nursing Services" mean the nursing services described in OAR 411-340-0130 that focus on the chronic and ongoing health and safety needs of an individual living in his or her own home. Community nursing services include an assessment, monitoring, delegation, training, and coordination of services. Community nursing services are provided according to the rules in OAR chapter 411, division 048 and the Oregon State Board of Nursing rules in OAR chapter 851.

(29) "Community Transportation" means the services described in OAR 411-340-0130 that enable an individual to gain access to community-based state plan and waiver services, activities, and resources. Community transportation is provided in the area surrounding the home of the individual that is commonly used by people in the same area to obtain ordinary goods and services. The area is not determined by the social or recreational groups or activities of an individual.

(30) "Complaint" means "complaint" as defined in OAR 411-318-0005.

(31) "Comprehensive Services" means developmental disability services and supports that include 24-hour residential services provided in a licensed home, foster home, or through a supported living program. Comprehensive services are regulated by the Department alone or in combination with an associated Department-regulated employment or day support activities program. Comprehensive services are in-home services provided to an individual with an intellectual or developmental disability when the individual receives case management services from a CDDP. Comprehensive services do not include support services for adults with intellectual or developmental disabilities enrolled in brokerages.

(32) "Cost Effective" means being responsible and accountable with Department resources by offering less costly alternatives when providing choices that adequately meet the support needs of an individual. Less

costly alternatives include other programs available from the Department, the utilization of assistive devices, natural supports, environmental modifications, and alternative resources. Less costly alternatives may include resources not paid for by the Department.

(33) "CPMS" means "Client Process Monitoring System". CPMS is the Department computerized system for enrolling and terminating services for individuals with intellectual or developmental disabilities.

(34) "Crisis" means "crisis" as defined in OAR 411-320-0020.

(35) "Crisis Diversion Services" mean the services authorized and provided according to OAR 411-320-0160 that are intended to maintain an individual at home or in the family home while the individual is in emergent status. Crisis diversion services include short-term residential placement services indicated on a Support Services Brokerage Crisis Addendum.

(36) "Day" means a calendar day unless otherwise specified in these rules.

(37) "Day Support Activities" means "day support activities" as defined in OAR 411-345-0020.

(38) "Delegation" means that a registered nurse authorizes an unlicensed person to perform nursing tasks and confirms that authorization in writing. Delegation may occur only after a registered nurse follows all steps of the delegation process as outlined in OAR chapter 851, division 047. Delegation by a physician is also allowed.

(39) "Department" means the Department of Human Services.

(40) "Designated Representative" means any adult, such as a parent, family member, guardian, advocate, or other person authorized in writing by an individual to serve as the representative of the individual in connection with the provision of funded supports, who is not also a paid provider for the individual. An individual is not required to appoint a designated representative.

(41) "Developmental Disability" means "developmental disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(42) "Director" means the Director of the Department of Human Services, Office of Developmental Disability Services, or the designee of the Director.

(43) "Discovery and Career Exploration" means "discovery and career exploration" as defined in OAR 411-345-0020.

(44) "Emergent Status" means an individual has been determined to be eligible for crisis diversion services according to OAR 411-320-0160.

(45) "Employer" means, for the purposes of obtaining in-home support through an independent provider as described in these rules, an individual or a person selected by the individual or the legal representative of the individual to act on the behalf of the individual to provide the employer responsibilities described in OAR 411-340-0135. An employer may also be a designated representative.

(46) "Employer-Related Supports" mean the activities that assist an individual, and when applicable the legal or designated representative or family members of an individual, with directing and supervising provision of services described in the ISP for the individual. Employer-related supports include, but are not limited to:

- (a) Education about employer responsibilities;
- (b) Orientation to basic wage and hour issues;
- (c) Use of common employer-related tools, such as job descriptions;
and
- (d) Fiscal intermediary services.

(47) "Employment Path Services" means "employment path services" as defined in OAR 411-345-0020.

(48) "Employment Services" means "employment services" as defined in OAR 411-345-0020.

(49) "Employment Specialist" means "employment specialist" as defined in OAR 411-345-0020.

(50) "Entry" means admission to a Department-funded developmental disability service.

(51) "Environmental Accessibility Adaptations" mean the physical adaptations described in OAR 411-340-0130 that are necessary to ensure the health, welfare, and safety of an individual in his or her own home, or that are necessary to enable the individual to function with greater independence around his or her own home.

(52) "Environmental Safety Modifications" mean the physical adaptations described in OAR 411-340-0130 that are made to the exterior of the home of an individual or the home of the family of the individual as identified in the ISP for the individual to ensure the health, welfare, and safety of the individual or to enable the individual to function with greater independence around the home.

(53) "Exit" means termination or discontinuance of a Department-funded developmental disability service by a licensed or certified provider organization.

(54) "Family":

(a) Means a unit of two or more people that includes at least one individual with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the individual with an intellectual or developmental disability by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

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

(iii) Joint responsibility for supporting the individual with an intellectual or developmental disability when the

individual is related to one of the partners by blood, marriage, or legal adoption.

(b) The term "family" is defined as described above for purposes of:

(A) Determining the eligibility of an individual for brokerage services as a resident in the family home;

(B) Identifying people who may apply, plan, and arrange for individual services; and

(C) Determining who may receive family training.

(55) "Family Training" means the training services described in OAR 411-340-0130 that are provided to the family of an individual to increase the capacity of the family to care for, support, and maintain the individual in the home of the individual.

(56) "Fiscal Intermediary" means a person or entity that receives and distributes support services funds on behalf of an individual, who employs a provider to provide services, supervision, or training to the individual in the home or community of the individual according to the ISP for the individual.

(57) "Founded Report" means the determination by the Department or Law Enforcement Authority (LEA), based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(58) "Functional Needs Assessment":

(a) Means the comprehensive assessment or re-assessment that:

(A) Documents physical, mental, and social functioning;

(B) Identifies risk factors, choices and preferences, service and support needs, strengths, and goals; and

(C) Determines the service level.

(b) The functional needs assessment for an adult is known as the Adult Needs Assessment. The Department incorporates Version B of the Adult Needs Assessment dated July 1, 2014 into these rules by this reference. The Adult Needs Assessment is maintained by the Department at: www.dhs.state.or.us/spd/tools/dd/cm/ANA_Adult_In-home.xls. Printed copies may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, Salem, OR 97301.

(59) "General Business Provider" means an organization or entity selected by an individual, or as applicable the legal or designated representative of the individual, and paid with support services funds that:

(a) Is primarily in business to provide the service chosen by the individual, or as applicable the legal or designated representative of the individual, to the general public;

(b) Provides services for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the person who actually provides support for the individual.

(60) "Hearing" means "hearing" as defined in OAR 411-318-0005.

(61) "Home" means the primary residence for an individual that is not under contract with the Department to provide services as a certified foster home or a licensed or certified residential care facility, assisted living facility, nursing facility, or other residential support program site.

(62) "Home and Community-Based Waiver Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with section 1915(c) and 1115 of the Social Security Act.

(63) "IADL" means "instrumental activities of daily living". IADL include activities other than ADL required to continue independent living such as:

(a) Meal planning and preparation;

- (b) Budgeting;
- (c) Shopping for food, clothing, and other essential items;
- (d) Performing essential household chores;
- (e) Communicating by phone or other media; and
- (f) Participating in the community.

(64) "ICF/IDD" means an intermediate care facility for individuals with intellectual disabilities.

(65) "Incident Report" means the written report of any injury, accident, act of physical aggression, use of protective physical intervention, or unusual incident involving an individual.

(66) "Independence" means the extent to which an individual exerts control and choice over his or her own life.

(67) "Independent Provider" means a person selected by an individual, or as applicable the legal or designated representative of the individual, and paid with support services funds to directly provide services to the individual.

(68) "Individual" means an adult with an intellectual or developmental disability applying for, or determined eligible for, developmental disability services.

(69) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other people;

(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which people without an intellectual or developmental disability participate, together with regular contact with people without an intellectual or developmental disability; and

(c) Individuals with intellectual or developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with people in the community.

(70) "Intellectual Disability" means "intellectual disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(71) "Intervention" means the action the Department or the designee of the Department requires when an employer fails to meet the employer responsibilities described in OAR 411-340-0135. Intervention includes, but is not limited to:

(a) A documented review of the employer responsibilities described in OAR 411-340-0135;

(b) Training related to employer responsibilities;

(c) Corrective action taken as a result of an independent provider filing a complaint with the Department, the designee of the Department, or other agency who may receive labor related complaints;

(d) Identifying an employer representative if an individual is not able to meet the employer responsibilities described in OAR 411-340-0135; or

(e) Identifying another representative if the current employer representative of an individual is not able to meet the employer responsibilities described in OAR 411-340-0135.

(72) "ISP" means "Individual Support Plan". An ISP includes the written details of the supports, activities, and resources required for an individual to achieve and maintain personal goals and health and safety. The ISP is developed at least annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The ISP reflects the services and supports that are important for the individual to meet the needs of the individual identified through a functional needs assessment as well as the preferences of the individual for service providers, delivery, and frequency of services and supports. The ISP is the

plan of care for Medicaid purposes and reflects whether services are provided through a waiver, state plan, or natural supports.

(73) "Job Coaching" means "job coaching" as defined in OAR 411-345-0020.

(74) "Job Development" means "job development" as defined in OAR 411-345-0020.

(75) "Legal Representative" means an attorney at law who has been retained by or for an individual, a power of attorney for an individual, or a person or agency authorized by a court to make decisions about services for an individual.

(76) "Level of Care" means an individual meets the following institutional level of care for an ICF/IDD:

(a) The individual has an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria in OAR 411-320-0080 for developmental disability services; and

(b) The individual has a significant impairment in one or more areas of adaptive behavior as determined in OAR 411-320-0080.

(77) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who, while acting in an official capacity, comes in contact with an adult with an intellectual or developmental disability and has reasonable cause to believe the adult has suffered abuse, or comes in contact with any person whom the public or private official has reasonable cause to believe abused the adult. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this definition, except that a psychiatrist, psychologist, clergy, or attorney is not required to report if the communication is privileged under ORS 40.225 to 40.295.

(78) "Natural Supports" means the voluntary resources available to an individual from the relatives, friends, significant others, neighbors, roommates, and the community of the individual that are not paid for by the Department.

(79) "Nursing Service Plan" means the plan that is developed by a registered nurse based on an initial nursing assessment, reassessment, or an update made to a nursing assessment as the result of a monitoring visit.

(a) The Nursing Service Plan is specific to an individual and identifies the diagnoses and health needs of the individual and any service coordination, teaching, or delegation activities.

(b) The Nursing Service Plan is separate from the ISP and any service plans developed by other health professionals.

(80) "OHP Plus" means only the Medicaid benefit packages provided under OAR 410-120-1210(4)(a) and (b).

(81) "OSIP-M" means "Oregon Supplemental Income Program-Medical" as described in OAR 461-001-0030. OSIP-M is Oregon Medicaid insurance coverage for individuals who meet the eligibility criteria described in OAR chapter 461.

(82) "Person-Centered Planning":

(a) Means a timely and formal or informal process that is driven by an individual, includes people chosen by the individual, ensures that the individual directs the process to the maximum extent possible, and that the individual is enabled to make informed choices and decisions consistent with CFR 441.540.

(b) Person centered planning includes gathering and organizing information to reflect what is important to and for the individual and to help:

(A) Determine and describe choices about personal goals, activities, services, service providers, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(c) The methods for gathering information vary, but all are consistent with the cultural considerations, needs, and preferences of the individual.

(83) "Personal Agent" means a person who is a case manager for the provision of case management services, works directly with individuals and the legal or designated representatives and families of individuals to provide or arrange for support services as described in these rules, meets the qualifications set forth in OAR 411-340-0150(5), and is a trained employee of a brokerage or a person who has been engaged under contract to the brokerage to allow the brokerage to meet responsibilities in geographic areas where personal agent resources are severely limited. A personal agent is the person-centered plan coordinator of an individual as defined in the Community First Choice state plan amendment.

(84) "Personal Support Worker" means "personal support worker" as defined in OAR 411-375-0010.

(85) "Plan Year" means not more than 12 consecutive months that, unless otherwise set according to the conditions of OAR 411-340-0120, begins on the start date specified in the first authorized ISP for an individual after entry to a brokerage. Subsequent plan years begin on the anniversary of the start date of the initial ISP.

(86) "Policy Oversight Group" means the group that meets the requirements of OAR 411-340-0150(1) that is formed to provide individual-based leadership and advice to each brokerage regarding issues such as development of policy, evaluation of services, and use of resources.

(87) "Positive Behavioral Theory and Practice" means a proactive approach to behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abusive or demeaning interventions are never used;
and

(d) Evaluates the effectiveness of behavior interventions based on
objective data.

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

(89) "Productivity" as defined in ORS 427.005 means:

(a) Engagement in income-producing work by an individual that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual in work contributing to a household or community.

(90) "Progress Note" means a written record of an action taken by a personal agent in the provision of case management, administrative tasks, or direct services to support an individual. A progress note may also be a recording of information related to the services, support needs, or circumstances of the individual which is necessary for the effective delivery of support services.

(91) "Protection" means "protective services" as defined in this rule.

(92) "Protective Physical Intervention" means any manual physical holding of, or contact with, an individual that restricts freedom of movement.

(93) "Protective Services" mean the necessary actions taken as soon as possible to prevent subsequent abuse or exploitation of an individual, to prevent self-destructive acts, or to safeguard the person, property, and funds of an individual.

(94) "Provider" means a person, organization, or business selected by an individual, or as applicable the legal or designated representative of an individual, and paid with support services funds to provide support to an individual according to the ISP for the individual.

(95) "Provider Organization" means an entity selected by an individual, or as applicable the legal or designated representative of the individual, and paid with support services funds that:

(a) Is primarily in business to provide supports for individuals with intellectual or developmental disabilities;

(b) Provides supports for an individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the person who actually provides support for the individual.

(96) "Provider Organization Director" means the Director of a provider organization who is responsible for the administration and provision of services according to these rules, or the designee of the Director of the provider organization.

(97) "Psychotropic Medication" means a medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior including, but not limited to, anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(98) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services.

(99) "Regional Crisis Diversion Program" means "Regional Crisis Diversion Program" as defined in OAR 411-320-0020.

(100) "Relief Care" means the intermittent services described in OAR 411-340-0130 that are provided on a periodic basis for the relief of, or due to the temporary absence of, a person normally providing supports to an individual.

(101) "Self-Determination" means a philosophy and process by which individuals with intellectual or developmental disabilities are empowered to gain control over the selection of support services that meet their needs. The basic principles of self-determination are:

(a) Freedom. The ability for an individual with an intellectual or developmental disability, together with freely-chosen family and friends, to plan a life with necessary support services rather than purchasing a predefined program;

(b) Authority. The ability for an individual with an intellectual or developmental disability, with the help of a social support network if needed, to control resources in order to purchase support services;

(c) Autonomy. The arranging of resources and personnel, both formal and informal, that assists an individual with an intellectual or developmental disability to live a life in the community rich in community affiliations; and

(d) Responsibility. The acceptance of a valued role of an individual with an intellectual or developmental disability in the community through competitive employment, organizational affiliations, personal development, and general caring for others in the community, as well as accountability for spending public dollars in ways that are life-enhancing for the individual.

(102) "Self Direction" means that an individual, or as applicable the legal or designated representative of the individual, has decision-making authority over services and takes direct responsibility for managing services with the assistance of a system of available supports that promotes personal choice and control over the delivery of waiver and state plan services.

(103) "Service Level" means the amount of attendant care, hourly relief care, or skills training services determined necessary by a functional needs assessment and made available to meet the identified support needs of an individual.

(104) "Services Coordinator" means "services coordinator" as defined in OAR 411-320-0020.

(105) "Skills Training" means the activities described in OAR 411-340-0130 that are intended to maximize the independence of an individual through training, coaching, and prompting the individual to accomplish ADL, IADL, and health-related skills.

(106) "Social Benefit" means the service or financial assistance solely intended to assist an individual with an intellectual or developmental disability to function in society on a level comparable to that of a person who does not have an intellectual or developmental disability. Social benefits are pre-authorized by a personal agent and provided according to the description and limits written in an ISP.

(a) Social benefits may not:

(A) Duplicate benefits and services otherwise available to a person regardless of intellectual or developmental disability;

(B) Provide financial assistance with food, clothing, shelter, and laundry needs common to a person with or without an intellectual or developmental disability; or

(C) Replace other governmental or community services available to an individual.

(b) Assistance provided as a social benefit is reimbursement for an expense previously authorized in an ISP or prior payment in anticipation of an expense authorized in a previously authorized ISP.

(c) Assistance provided as a social benefit may not exceed the actual cost of the support required by an individual to be supported in the home of the individual.

(107) "Special Diet" means the specially prepared food or particular types of food described in OAR 411-340-0130 that are specific to the medical condition or diagnosis of an individual and in support of an evidence-based treatment regimen.

(108) "Specialized Medical Supplies" mean the medical and ancillary supplies described in OAR 411-340-0130, such as:

(a) Necessary medical supplies, specified in an ISP that are not available under the state plan;

(b) Ancillary supplies necessary to the proper functioning of items necessary for life support or to address physical conditions; and

(c) Supplies necessary for the continued operation of augmentative communication devices or systems.

(109) "State Plan" means Community First Choice or state plan personal care.

(110) "Substantiated" means an abuse investigation has been completed by the Department or the designee of the Department and the preponderance of the evidence establishes the abuse occurred.

(111) "Support" means the assistance that an individual requires, solely because of the affects of an intellectual or developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is subject to change with time and circumstances.

(112) "Support Services" mean the services of a brokerage listed in OAR 411-340-0120 as well as the uniquely determined activities and purchases arranged through the brokerage that:

(a) Complement the existing formal and informal supports that exist for an individual living in her or her own home or the family home;

(b) Are designed, selected, and managed by an individual or the legal or designated representative of the individual (as applicable);

(c) Are provided in accordance with the ISP for an individual; and

(d) May include purchase of supports as a social benefit required for an individual to live in his or her own home or the family home.

(113) "Support Services Brokerage Crisis Addendum" means the short-term plan that is required by the Department to be added to an ISP to describe crisis diversion services an individual is to receive while the individual is in emergent status.

(114) "Support Services Expenditure Guideline" means the guidelines that describe allowable uses for support services funds. The Department incorporates the expenditure guidelines into these rules by this reference. The expenditure guidelines are maintained by the Department at: (http://www.oregon.gov/dhs/dd/adults/ss_exp_guide.pdf). Printed copies may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, Salem, Oregon 97301.

(115) "Support Services Funds" mean the public funds designated by the brokerage for assistance with the purchase of supports according to an Individual Support Plan.

(116) "Supported Employment - Individual Employment Support" means "supported employment - individual employment support" as defined in OAR 411-345-0020.

(117) "Supported Employment - Small Group Employment Support" means "supported employment - small group employment support" as defined in OAR 411-345-0020.

(118) "These Rules" mean the rules in OAR chapter 411, division 340.

(119) "Transition Costs" mean the expenses described in OAR 411-340-0130, such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility or ICF/IDD to a community-based home setting where the individual resides.

(120) "Unusual Incident" means any incident involving an individual that includes serious illness or an accident, death, injury or illness requiring inpatient or emergency hospitalization, a suicide attempt, a fire requiring the services of a fire department, an act of physical aggression, or any incident requiring an abuse investigation.

(121) "Variance" means the temporary exception from a regulation or provision of these rules that may be granted by the Department as described in OAR 411-340-0090.

(122) "Vehicle Modifications" mean the adaptations or alterations described in OAR 411-340-0130 that are made to the vehicle that is the primary means of transportation for an individual in order to accommodate the service needs of the individual.

(123) "Waiver Services" means "home and community-based waiver services" as defined in this rule.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0030 Certification of Support Services Brokerages and Provider Organizations

(Amended 12/28/2013)

(1) CERTIFICATE REQUIRED.

(a) No person or governmental unit acting individually or jointly with any other person or governmental unit may establish, conduct, maintain, manage, or operate a brokerage without being certified by the Department under this rule.

(b) No person or governmental unit acting individually or jointly with any other person or governmental unit may establish, conduct, maintain, or operate a provider organization without either certification under this rule or current Department license or certification as described in OAR 411-340-0170(1).

(c) Certificates are not transferable or assignable and are issued only for the brokerage, or for the provider organization requiring certification under OAR 411-340-0170(2), and people or governmental units named in the application.

(d) Certificates issued on or after November 15, 2008 are effective for a maximum of five years.

(e) The Department shall conduct a review of the brokerage, or the provider organization requiring certification under OAR 411-340-0170(2), prior to the issuance of a certificate.

(2) CERTIFICATION. A brokerage, or a provider organization requiring certification under OAR 411-340-0170(2), must apply for an initial certificate and for a certificate renewal.

(a) The application must be on a form provided by the Department and must include all information requested by the Department.

(b) The applicant requesting certification as a brokerage must identify the maximum number of individuals to be served.

(c) To renew certification, the brokerage or provider organization must make application at least 30 days, but not more than 120 days, prior to the expiration date of the existing certificate. On renewal of brokerage certification, no increase in the maximum number of individuals to be served by the brokerage may be certified unless specifically approved by the Department.

(d) Application for renewal must be filed no more than 120 days prior to the expiration date of the existing certificate and extends the effective date of the existing certificate until the Department takes action upon the application for renewal.

(e) Failure to disclose requested information on the application or providing incomplete or incorrect information on the application may result in denial, revocation, or refusal to renew the certificate.

(f) Prior to issuance or renewal of the certificate, the applicant must demonstrate to the satisfaction of the Department that the applicant is capable of providing services identified in a manner consistent with the requirements of these rules.

(3) CERTIFICATION EXPIRATION, TERMINATION OF OPERATIONS, OR CERTIFICATE RETURN.

(a) Unless revoked, suspended, or terminated earlier, each certificate to operate a brokerage or provider organization expires on the expiration date specified on the certificate.

(b) If a certified brokerage or provider organization is discontinued, the certificate automatically terminates on the date operation is discontinued.

(4) CHANGE OF OWNERSHIP, LEGAL ENTITY, LEGAL STATUS, OR MANAGEMENT CORPORATION. The brokerage, or provider organization requiring certification under OAR 411-340-0170(2), must notify the Department in writing of any pending action resulting in a 5 percent or more change in ownership and of any pending change in the brokerage's or provider organization's legal entity, legal status, or management corporation.

(5) NEW CERTIFICATE REQUIRED. A new certificate for a brokerage or provider organization is required upon change in a brokerage's or provider organization's ownership, legal entity, or legal status. The brokerage or provider organization must submit a certificate application at least 30 days prior to change in ownership, legal entity, or legal status.

(6) CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may deny, revoke, or refuse to renew a certificate when the Department finds the brokerage or provider organization, the brokerage or provider organization director, or any person holding 5 percent or greater financial interest in the brokerage or provider organization:

(a) Demonstrates substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized and the brokerage or provider organization fails to correct the noncompliance within 30 calendar days of receipt of written notice of non-compliance;

(b) Has demonstrated a substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized during two inspections within a six year period (for the purpose of this rule, "inspection" means an on-site review of the service site by the Department for the purpose of investigation or certification);

(c) Has been convicted of a felony or any crime as described in OAR 407-007-0275;

(d) Has been convicted of a misdemeanor associated with the operation of a brokerage or provider organization;

(e) Falsifies information required by the Department to be maintained or submitted regarding services of individuals, program finances, or individuals' funds;

(f) Has been found to have permitted, aided, or abetted any illegal act that has had significant adverse impact on individual health, safety, or welfare; or

(g) Has been placed on the Office of Inspector General's list of excluded or debarred providers (<http://exclusions.oig.hhs.gov/>).

(7) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. Following a Department finding that there is a substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in section (6) of this rule has occurred, the Department may issue a notice of certificate revocation, denial, or refusal to renew.

(8) IMMEDIATE SUSPENSION OF CERTIFICATE. When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the certificate holder, immediately suspend a certificate without a pre-suspension hearing and the brokerage or provider organization may not continue operation.

(9) HEARING. An applicant for a certificate or a certificate holder may request a hearing pursuant to the contested case provisions of ORS chapter 183 upon written notice from the Department of denial, suspension, revocation, or refusal to renew a certificate. In addition to, or in lieu of a hearing, the applicant or certificate holder may request an administrative review by the Department's director. An administrative review does not preclude the right of the applicant or certificate holder to a hearing.

(a) The applicant or certificate holder must request a hearing within 60 days of receipt of written notice by the Department of denial, suspension, revocation, or refusal to renew a certificate. The request for a hearing must include an admission or denial of each factual matter alleged by the Department and must affirmatively allege a

short plain statement of each relevant, affirmative defense the applicant or certificate holder may have.

(b) In the event of a suspension pursuant to section (8) of this rule and during the first 30 days after the suspension of a certificate, the brokerage or provider organization may submit a written request to the Department for an administrative review. The Department shall conduct the review within 10 days after receipt of the request for an administrative review. Any review requested after the end of the 30-day period following certificate suspension is treated as a request for a hearing under subsection (a) of this section. If following the administrative review the suspension is upheld, the brokerage or provider organization may request a hearing pursuant to the contested case provisions of ORS chapter 183.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0040 Abuse and Unusual Incidents in Support Services Brokerages and Provider Organizations

(Amended 12/28/2013)

(1) ABUSE PROHIBITED. No adult or individual as defined in OAR 411-340-0020 shall be abused nor shall any employee, staff, or volunteer of the brokerage or provider organization condone abuse.

(a) Brokerages and provider organizations must have in place appropriate and adequate disciplinary policies and procedures to address instances when a staff member has been identified as an accused person in an abuse investigation as well as when the allegation of abuse has been substantiated.

(b) All employees of a brokerage or provider organization are mandatory reporters. The brokerage or provider organization must:

(A) Notify all employees of mandatory reporting status at least annually on forms provided by the Department; and

(B) Provide all employees with a Department-produced card regarding abuse reporting status and abuse reporting.

(2) INCIDENT REPORTS.

(a) A brokerage or provider organization must prepare an incident report for instances of potential or suspected abuse or an unusual incident as defined in OAR 411-340-0020, involving an individual and a brokerage or provider organization employee. The incident report must be placed in the individual's record and must include:

(A) Conditions prior to or leading to the potential or suspected abuse or unusual incident;

(B) A description of the potential or suspected abuse or unusual incident;

(C) Staff response at the time; and

(D) Review by the brokerage administration and follow-up to be taken to prevent recurrence of the potential or suspected abuse or unusual incident.

(b) A brokerage or provider organization must send copies of all incident reports involving potential or suspected abuse that occurs while an individual is receiving brokerage or provider organization services to the CDDP.

(c) A provider organization must send copies of incident reports of all potential or suspected abuse or unusual incidents that occur while the individual is receiving services from a provider organization to the individual's brokerage within five working days of the potential or suspected abuse or unusual incident.

(3) IMMEDIATE NOTIFICATION

(a) The brokerage must immediately report to the CDDP, and the provider organization must immediately report to the CDDP with notification to the brokerage, any incident or allegation of potential or suspected abuse falling within the scope of OAR 407-045-0260.

(A) When an abuse investigation has been initiated, the CDDP must provide notice according to OAR 407-045-0290.

(B) When an abuse investigation has been completed, the CDDP must provide notice of the outcome of the investigation according to OAR 407-045-0320.

(b) In the case of emergency overnight hospitalization due to illness or injury to an individual, the brokerage or provider organization must immediately notify:

(A) The individual's legal representative, parent, next of kin, designated contact person, or other significant person (as applicable); and

(B) In the case of a provider organization, the individual's brokerage.

(c) In the event of the death of an individual, the brokerage or provider organization must immediately notify:

(A) The Medical Director of the Department;

(B) The individual's legal representative, parent, next of kin, designated contact person, or other significant person (as applicable);

(C) The CDDP; and

(D) In the case of a provider organization, the individual's brokerage.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

**411-340-0050 Inspections and Investigations in Support Services
Brokerages and Provider Organizations**

(Amended 12/28/2013)

(1) Support services brokerages and provider organizations certified under these rules must allow the following types of investigations and inspections:

(a) Quality assurance and on-site inspections;

(b) Complaint investigations; and

(c) Abuse investigations.

(2) The Department, CDDP, or proper authority perform all inspections and investigations.

(3) Any inspection or investigation may be unannounced.

(4) All documentation and written reports required by this rule must be:

(a) Open to inspection and investigation by the Department, CDDP, or proper authority; and

(b) Submitted to the Department within the time allotted.

(5) When abuse is alleged or death of an individual has occurred and a law enforcement agency, the Department, or CDDP has determined to initiate an investigation, the brokerage or provider organization may not conduct an internal investigation without prior authorization from the Department. For the purposes of this rule, an "internal investigation" is defined as:

(a) Conducting interviews with the alleged victim, witness, the accused person, or any other person who may have knowledge of the facts of the abuse allegation or related circumstances;

(b) Reviewing evidence relevant to the abuse allegation, other than the initial report; or

(c) Any other actions beyond the initial actions of determining:

(A) If there is reasonable cause to believe that abuse has occurred;

(B) If the alleged victim is in danger or in need of immediate protective services;

(C) If there is reason to believe that a crime has been committed; or

(D) What, if any, immediate personnel actions must be taken.

(6) The Department or the CDDP shall conduct abuse investigations as set forth in OAR 407-045-0250 to OAR 407-045-0360 and shall complete an abuse investigation and protective services report according to OAR 407-045-0320.

(7) Upon completion of the abuse investigation by the Department, CDDP, or a law enforcement agency, a provider may conduct an investigation without further Department approval to determine if any other personnel actions are necessary.

(8) Upon completion of the abuse investigation and protective services report, in accordance with OAR 407-045-0330, the sections of the report that are public records and not exempt from disclosure under the public records law shall be provided to the appropriate brokerage or provider organization.

(9) The brokerage or provider organization may be required to submit to the Department a plan of improvement for any noncompliance found during an inspection pursuant to section (1)(a) of this rule.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0060 Complaints, Notification of Planned Action, and Hearings

(Temporary Effective 07/01/2014 to 12/28/2014)

(1) COMPLAINTS.

(a) Complaints must be addressed in accordance with OAR 411-318-0015.

(b) The brokerages must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015.

(c) Upon enrollment, request, and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual.

(2) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disability service is involuntarily denied, reduced, suspended, or terminated or voluntarily reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(3) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(b) An individual, or as applicable the legal or designated representative of the individual, may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025 for involuntary denials, reductions, suspensions, or terminations.

(c) Upon entry, request, and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

**411-340-0070 Support Services Brokerage and Provider Organization
Personnel Policies and Practices**

(Amended 12/28/2013)

(1) Brokerages and provider organizations must maintain up-to-date written position descriptions for all staff as well as a file, available to the

Department or CDDP for inspection that includes written documentation of the following for each staff:

- (a) Reference checks and confirmation of qualifications prior to hire;
- (b) Written documentation of an approved background check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370;
- (c) Satisfactory completion of basic orientation, including instructions for mandatory reporting and training specific to intellectual or developmental disabilities and skills required to carry out assigned work if the employee is to provide direct assistance to individuals;
- (d) Written documentation of employee notification of mandatory reporter status;
- (e) Written documentation of any founded report of child abuse or substantiated abuse;
- (f) Written documentation of any complaints filed against the staff and the results of the complaint process, including any disciplinary action; and
- (g) Legal eligibility to work in the United States.

(2) Any employee providing direct assistance to individuals must be at least 18 years of age and capable of performing the duties of the job as described in a current job description signed and dated by the employee.

(3) An application for employment at the brokerage or provider organization must inquire whether an applicant has had any founded reports of child abuse or substantiated abuse.

(4) Any employee of the brokerage or provider organization, or any subject individual defined by OAR 407-007-0210, who has or will have contact with an eligible individual of support services, must have an approved background check in accordance with OAR 407-007-0200 to 407-007-0370 and under ORS 181.534.

(5) Effective July 28, 2009, a person may not be authorized as a provider or meet qualifications as described in this rule if the person has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(6) Section (5) of this rule does not apply to employees of the brokerage or provider organization who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(7) Each brokerage and provider organization regulated by these rules must be a drug-free workplace.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0080 Support Services Brokerage and Provider Organization Records

(Amended 12/28/2013)

(1) CONFIDENTIALITY. Brokerage and provider organization records of services to individuals must be kept confidential in accordance with ORS 179.505, 45 CFR 205.50, 45 CFR 164.512 Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 HIPAA, and any Department rules or policies pertaining to individual service records.

(2) DISCLOSURE AND CONFIDENTIALITY. For the purpose of disclosure from individual medical records under these rules, brokerages, and provider organizations requiring certification under OAR 411-340-0170(2), are considered "providers" as defined in ORS 179.505(1) and ORS 179.505 is applicable.

(a) Access to records by the Department does not require authorization by an individual or an individual's legal or designated representative or family.

(b) For the purpose of disclosure of non-medical individual records, all or portions of the information contained in the non-medical individual records may be exempt from public inspection under the personal privacy information exemption to the public records law set forth in ORS 192.502(2).

(3) GENERAL FINANCIAL POLICIES AND PRACTICES. The brokerage or provider organization must:

(a) Maintain up-to-date accounting records consistent with generally accepted accounting principles that accurately reflect all revenue by source, all expenses by object of expense, and all assets, liabilities, and equities;

(b) As a provider organization, or as a brokerage offering services to the general public, establish and revise, as needed, a fee schedule identifying the cost of each service provided. Billings for Medicaid funds may not exceed the customary charges to private individuals for any like item or services charged by the brokerage or provider organization; and

(c) Develop and implement written statements of policy and procedure as are necessary and useful to assure compliance with any Department rule pertaining to fraud and embezzlement.

(4) RECORDS RETENTION. Records must be retained in accordance with OAR chapter 166, division 150, Secretary of State, Archives Division.

(a) Financial records, supporting documents, statistical records, and all other records (except individual records) must be retained for a minimum of three years after the close of the contract period.

(b) Individual records must be kept for a minimum of seven years.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0090 Support Services Brokerage and Provider Organization Request for Variance
(Amended 12/28/2013)

(1) Variances may be granted to a brokerage or provider organization:

- (a) If the brokerage or provider organization lacks the resources needed to implement the standards required in these rules;
- (b) If implementation of the proposed alternative services, methods, concepts, or procedures would result in services or systems that meet or exceed the standards in these rules; or
- (c) If there are other extenuating circumstances.

(2) Variances may not be granted to OAR 411-340-0130 and OAR 411-340-0140.

(3) The brokerage or provider organization requesting a variance must submit to the Department, in writing, an application that contains the following:

- (a) The section of the rule from which the variance is sought;
- (b) The reason for the proposed variance;
- (c) The proposed alternative practice, service, method, concept, or procedure;
- (d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and
- (e) If the variance applies to an individual's services, evidence that the variance is consistent with an individual's currently authorized ISP.

(4) The Department may approve or deny the variance request. The Department's decision shall be sent to the brokerage or provider organization and to all relevant Department programs or offices within 45 calendar days of the receipt of the variance request.

(5) The brokerage or provider organization may appeal the denial of a variance request by sending a written request for review to the Department's director, whose decision is final.

(6) The Department shall determine the duration of the variance.

(7) The brokerage or the provider organization may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0100 Eligibility for Support Services

(Temporary Effective 07/01/2014 to 12/28/2014)

(1) Individuals determined eligible according to this rule may not be denied brokerage services or otherwise discriminated against on the basis of age, diagnostic or disability category, race, color, creed, national origin, citizenship, income, or duration of Oregon residence.

(2) Eligibility for support services is determined by the CDDP of the county of residence of an individual according to OAR 411-320- 0110(8).

(3) Individuals are not eligible for services by more than one brokerage unless the concurrent eligibility:

(a) Is necessary to affect transition from one brokerage to another;

(b) Is part of a collaborative plan between the affected brokerages;
and

(c) Does not duplicate services and expenditures.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0110 Standards for Support Services Brokerage Entry and Exit

(Temporary Effective 07/01/2014 to 12/28/2014)

(1) The brokerage must make accurate, up-to-date, information about the brokerage available to individuals referred for services and the legal or designated representatives of individuals. This information must include:

- (a) A declaration of brokerage philosophy;
- (b) A brief description of the services provided by the brokerage, including typical timelines for activities;
- (c) A description of processes involved in using the services, including application and referral, assessment, planning, and evaluation;
- (d) A declaration of brokerage employee responsibilities as mandatory abuse reporters;
- (e) A brief description of individual responsibilities for use of public funds;
- (f) An explanation of the individual rights in OAR 411-318-0010, including the right of an individual to:
 - (A) Choose a brokerage from among Department-contracted brokerages in the county of residence of an individual that is serving less than the total number of individuals specified in the current contract between the brokerage and the Department;
 - (B) Choose a personal agent among those available in the selected brokerage;
 - (C) Select providers among those willing, available, and qualified according to OAR 411-340-0160, OAR 411-340-0170, and OAR 411-340-0180 to provide supports authorized through the ISP for the individual;
 - (D) Direct the services of providers; and
 - (E) Raise and resolve concerns about brokerage services, including specific rights to notification of planned action and hearings according to OAR 411-340-0060 and the rules in OAR chapter 411, division 318.

(g) Indication that additional information about the brokerage is available on request. The additional information must include, but not be limited to:

(A) A description of the organizational structure of the brokerage;

(B) A description of any contractual relationships the brokerage has in place, or may establish, to accomplish the brokerage functions required by rule; and

(C) A description of the relationship between the brokerage and the Policy Oversight Group of the brokerage.

(2) The brokerage must make the information required in section (1) of this rule available using language, format, and presentation methods appropriate for effective communication according to the needs and abilities of individuals.

(3) ENTRY INTO BROKERAGE SERVICES.

(a) To enter brokerage services:

(A) An individual must be determined eligible according to OAR 411-320-0110(8); and

(B) The individual, or as applicable the legal or designated representative of the individual, must choose to receive services from a selected brokerage.

(b) The Department may implement guidelines that govern entries when the Department has determined that such guidelines are prudent and necessary for the continued development and implementation of support services.

(c) The brokerage may not accept individuals for entry beyond the total number of individuals specified in the current contract between the brokerage and the Department.

(4) EXIT FROM A BROKERAGE.

(a) An individual must exit a brokerage:

(A) At the oral or written request of an individual, or as applicable the legal or designated representative of the individual, to end the service relationship;

(B) After an individual, or as applicable the legal or designated representative of the individual, either cannot be located or has not responded after 30 days of repeated attempts by brokerage staff to complete ISP development or monitoring activities;

(C) Upon the entry of an individual into CDDP case management services;

(D) When an individual is incarcerated or admitted to a medical hospital, psychiatric hospital, sub-acute facility, nursing facility, ICF/IDD, or other 24-hour residential program and it is determined that the individual is not returning home or is not returning home after 90 consecutive days; or

(E) When an individual does not reside in Oregon or resides in an area outside the geographic service area of the brokerage.

(b) In the event an individual exits a brokerage, a written Notification of Planned Action must be provided as described in OAR 411-340-0060 and OAR chapter 411, division 318.

(c) Each brokerage must have policies and procedures for notifying the CDDP of the county of residence of an individual when the individual plans to exit, or exits, brokerage services. Notification method, timelines, and content must be based on agreements between the brokerage and the CDDP of each county in which the brokerage provides services.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0120 Support Service Brokerage Services

(Temporary Effective 07/01/2014 to 12/28/2014)

(1) Each brokerage must provide or arrange for the following services as required to meet individual support needs:

(a) Assistance for individuals to determine needs and plan supports in response to needs;

(b) Case management;

(c) Assistance for individuals to find and arrange the resources to provide planned supports;

(d) Assistance with development and expansion of community resources required to meet the support needs of individuals served by the brokerage;

(e) Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct providers;

(f) Fiscal intermediary services in the receipt and accounting of support services funds on behalf of individuals in addition to making payment to providers with the authorization of an individual;

(g) Employer-related supports; and

(h) Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.

(2) SELF-DETERMINATION. Brokerages must apply the principles of self-determination to provision of services required in section (1) of this rule.

(3) PERSON-CENTERED PLANNING. A brokerage must use a person-centered planning approach to assist individuals to establish outcomes, determine needs, plan for supports, and review and redesign support strategies.

(4) HEALTH AND SAFETY ISSUES. The planning process must address basic health and safety needs and supports including, but not limited to:

- (a) Identification of risks including risk of serious neglect, intimidation, and exploitation;
- (b) Informed decisions by the individual, or as applicable the legal or designated representative of the individual, regarding the nature of supports or other steps taken to ameliorate any identified risks; and
- (c) Education and support to recognize and report abuse.

(5) PERSONAL AGENT SERVICES.

(a) An individual entered into brokerage services must be assigned a personal agent for case management services.

(b) INITIAL DESIGNATION OF PERSONAL AGENT.

(A) The brokerage must designate a personal agent for individuals newly entered in support services within 10 working days from the date entry becomes known to the brokerage.

(B) In the instance of an individual transferring into a brokerage from another brokerage, the brokerage must designate a personal agent within 10 days of entry to the new brokerage.

(C) The brokerage must send a written notice that includes the name, telephone number, and location of the personal agent or brokerage to the individual, and as applicable the legal or designated representative of the individual, within 10 working days from the date entry becomes known to the brokerage.

(D) Prior to implementation of the initial ISP for an individual, the brokerage must ask the individual, or as applicable the legal or designated representative of the individual, to identify any family and other advocates to whom the brokerage must provide the name, telephone number, and location of the personal agent.

(c) CHANGE OF PERSONAL AGENT. Changes of personal agents initiated by the brokerage must be kept to a minimum. If the brokerage must change personal agent assignments, the brokerage must notify the individual, or as applicable the legal or designated representative of the individual, and all current providers within 10 working days of the change. The notification must be in writing and include the name, telephone number, and address of the new personal agent, if known, or of a contact person at the brokerage.

(d) OSIP-M/OHP PLUS ELIGIBILITY. If an individual loses OSIP-M or OHP Plus eligibility, a personal agent must assist the individual in identifying why OSIP-M or OHP Plus eligibility was lost. Whenever possible, the personal agent must assist the individual in becoming eligible for OSIP-M or OHP Plus again. The personal agent must document efforts taken to assist the individual in becoming OSIP-M or OHP Plus eligible.

(e) CASE MANAGEMENT CONTACT. Every individual who has an ISP must have a case management contact no less than once every three months. Individuals with significant health and safety risks must have more frequent case management contact. At least one case management contact per year must be face to face. If an individual agrees, other case management contacts may be made by telephone or by other interactive methods. The outcome of the case management contact must be recorded in the progress note for an individual. The purpose of the case management contact is:

(A) To assure known health and safety risks are adequately addressed;

(B) To assure that the support needs of the individual have not significantly changed; and

(C) To assure that the individual is satisfied with the current supports.

(6) PARTICIPATION IN PROTECTIVE SERVICES. The brokerage and personal agent are responsible for the delivery of protective services, in cooperation with the CDDP when necessary, through the timely completion of activities necessary to address immediate health and safety concerns.

(7) CHOICE ADVISING. Choice advising regarding the provision of case management and other services must be provided to individuals who are eligible for, and desire, developmental disability services. Choice advising must be provided at least annually.

(8) LEVEL OF CARE DETERMINATION.

(a) The brokerage must assure that an individual who is eligible for services identified in OAR 411-340-0130(7) or who becomes eligible for the services after entry into the brokerage:

(A) Receives a level of care determination;

(B) Is offered the choice between home and community-based services or institutional care;

(C) Is provided a notice of fair hearing rights; and

(D) Has the level of care determination reviewed annually or at any time there is a significant change in a condition that qualified the individual for the level of care.

(b) A level of care determination may be made by a services coordinator or a personal agent.

(c) The level of care determination must be documented in a progress note in the record for the individual. The level of care determination must be completed no more than two months prior to the authorization of the ISP for the individual and no more than 60 days prior to the annual reauthorization of the ISP.

(9) FUNCTIONAL NEEDS ASSESSMENT. The brokerage or CDDP must complete a functional needs assessment initially and at least annually for any individual who is enrolled in waiver or Community First Choice services.

(a) A functional needs assessment must be completed:

(A) Prior to the development of an initial ISP;

(B) Within 60 days prior to the annual renewal of an ISP; and

(C) Within 45 days from the date an individual, or as applicable the legal or designated representative of the individual, requests a functional needs assessment.

(b) Individuals must be notified of the need for re-assessment at least 14 days prior to the expiration of the most recent assessment.

(c) The assessment must be conducted face to face.

(d) An individual, or as applicable the legal or designated representative of the individual, must participate in a functional needs assessment and provide information necessary to complete the functional needs assessment and re-assessments within the time frame required by the Department.

(A) Failure to participate in the functional needs assessment or provide information necessary to complete the functional needs assessment or re-assessment within the applicable time frame results in a denial of service eligibility. In the event service eligibility is denied, a written Notification of Planned Action must be provided as described in OAR 411-340-0060 and OAR chapter 411, division 318.

(B) The Department may allow additional time if circumstances beyond the control of the individual, or as applicable the legal or designated representative of the individual, prevent timely participation in the functional needs assessment or timely submission of information necessary to complete the functional needs assessment.

(10) INDIVIDUAL SUPPORT PLANS.

(a) An individual who is accessing waiver or Community First Choice services must have an authorized ISP.

(A) The ISP must be facilitated, developed, and authorized by a personal agent.

(B) The initial ISP must be authorized ;

(i) No more than 90 days from the date of eligibility determination made by the CDDP according to OAR 411-320-0080; or

(ii) No later than the end of the month following the month in which the level of care determination was made.

(C) The brokerage must provide a written copy of the most current ISP to the individual and the legal or designated representative of the individual (as applicable).

(b) PERSON-CENTERED ISP REQUIREMENTS. The person-centered ISP must reflect the services and supports that are important for the individual to meet the needs of the individual identified through a Department approved assessment, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual and the scope of services and supports, the ISP must include:

(A) The name of the individual and the name of the legal or designated representative of the individual (as applicable);

(B) A description of the supports required that is consistent with support needs identified in the assessment of the individual, including the reason the support is necessary;

(C) The projected dates of when specific supports are to begin and end;

(D) A list of personal, community, and public resources that are available to the individual and how the resources may be applied to provide the required supports. Sources of support may include waiver services, state plan services, state general funds, or natural supports;

- (E) The manner in which services are delivered and the frequency of services;
- (F) The providers of supports to be purchased with support services funds or the type of provider, such as an independent provider, provider organization, or general business provider, when the provider is unknown or is likely to change frequently;
- (G) The setting in which the individual resides as chosen by the individual;
- (H) The strengths and preferences of the individual;
- (I) Individually identified goals and desired outcomes;
- (J) The services and supports (paid and unpaid) to assist the individual to achieve identified goals and the providers of the services and supports, including voluntarily provided natural supports;
- (K) The risk factors and the measures in place to minimize the risk factors, including back up plans;
- (L) The identity of the person responsible for case management and monitoring the ISP;
- (M) A provision to prevent unnecessary or inappropriate care;
- (N) The alternative settings considered by the individual;
- (O) Schedule of ISP reviews;
- (P) Any changes in support needs identified in an assessment; and
- (Q) Any revisions to the ISP that may alter:
 - (i) The amount of support services funds required;

- (ii) The amount of support services required;
- (iii) Types of support purchased with support services funds; and
- (iv) The type of support provider.

(c) **ISP SCHEDULE.** The schedule of the support services ISP, developed in compliance with this rule after an individual enters a brokerage, may be adjusted with the consent of, or at the request of, an individual or the legal or designated representative of the individual (as applicable).

(A) An adjustment may only occur one time per individual upon ISP renewal.

(B) An ISP date adjustment must be clearly documented in the ISP.

(d) **ISP AUTHORIZATION.**

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

(B) A revision to an initial or annual ISP that involves the types of support purchased with support services funds must be authorized prior to implementation.

(C) A revision to an initial or annual ISP that does not involve the types of support purchased with support services funds does not require authorization. Documented verbal agreement to the revision by the individual, or as applicable the legal or designated representative of the individual, is required prior to implementation of the revision.

(D) An ISP is authorized when:

- (i) The signature of the individual, or as applicable the legal or designated representative of the individual, is present on the ISP or documentation is present explaining

the reason an individual who does not have a legal or designated representative may be unable to sign the ISP.

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

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

(III) In the case of a revision to an initial or annual ISP that is in response to immediate, unexpected change in circumstance, and is necessary to prevent injury or harm to the individual, documented verbal agreement may substitute for a signature for no more than 10 working days.

(ii) The signature of the personal agent involved in the development of, or revision to, the ISP is present on the ISP; and

(iii) A designated brokerage representative has reviewed the ISP for compliance with Department rules and policy.

(E) For an individual transferring from in-home comprehensive services, the CDDP ISP may be used as authorization for available support services for up to 90 days.

(e) PERIODIC REVIEW OF ISP AND RESOURCES.

(A) A personal agent must conduct and document reviews of the ISP and resources for an individual with the individual and the legal or designated representative of the individual (as applicable).

(B) At least annually, as part of preparation for a new ISP, the personal agent must:

(i) Evaluate the progress of the individual toward achieving the purposes of the ISP and assess and revise goals as needed;

(ii) Note effectiveness of the use of support services funds based on personal agent observation as well as individual satisfaction; and

(iii) Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports.

(11) ANNUAL PLANS. An Annual Plan must be completed for individuals who do not access waiver or Community First Choice services.

(a) A personal agent must complete an Annual Plan within 60 days of the enrollment of an individual into support services, and annually thereafter if the individual is not enrolled in any waiver or Community First Choice services.

(b) A written Annual Plan must be documented as an Annual Plan or as a comprehensive progress note in the record for the individual and consist of:

(A) A review of the current living situation of the individual;

(B) A review of any personal health, safety, or behavioral concerns;

(C) A summary of the support needs of the individual; and

(D) Actions to be taken by the personal agent and others.

(12) PROFESSIONAL OR OTHER SERVICE PLANS.

(a) A Nursing Service Plan must be present when support services funds are used to purchase services requiring the education and training of a licensed professional nurse.

(b) A Support Services Brokerage Crisis Addendum, or other document prescribed by the Department for use in these circumstances, must be attached to the ISP when an individual enrolled in a brokerage is in emergent status in a short-term, out-of-home, residential placement as part of the crisis diversion services for the individual.

(c) As of July 1, 2014, a Career Development Plan must be attached to the ISP of an adult in accordance with OAR 411-345-0160.

(13) CASE MANAGEMENT TRANSITION TO ANOTHER BROKERAGE OR TO A CDDP. At the request of an individual enrolled in brokerage services, or as applicable the legal or designated representative of the individual, who has selected another brokerage or CDDP, the brokerage must collaborate with the receiving brokerage or CDDP of the county of residence of the individual to transition case management and other authorized services.

(a) If an individual requests case management services from a CDDP, the brokerage must notify the local CDDP of the request within five working days. A transfer of case management services must occur within ten working days of the request unless a later date is mutually agreed upon by the individual, the brokerage, and the CDDP.

(b) An individual may request case management services from another brokerage when the selected brokerage has capacity available within the limits of the contract between the brokerage and the Department.

(c) If an individual requests case management services from an available brokerage, the brokerage must notify the local CDDP of the request within five working days. A transfer of case management services to the available brokerage must occur within ten working days of the request unless a later date is mutually agreed upon by the individual, the brokerage, and the CDDP of the county of residence of the individual.

(d) If the Department has designated and contracted funds solely for the support of the transitioning individual, the brokerage must notify

the Department to consider transfer of the funds for the individual to the receiving brokerage.

(e) The ISP in place at the time of request for transfer may remain in effect 90 days after entry to the new brokerage while a new ISP is developed and authorized.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0125 Crisis Supports in Support Services

(Amended 12/28/2013)

(1) The brokerage must, in conjunction with its Regional Crisis Diversion Program, attempt to provide supports that mediate a crisis risk factor for adults who are:

(a) Entered in support services; and

(b) Determined to be in crisis as described in section (2) of this rule.

(2) CRISIS DETERMINATION.

(a) An individual enrolled in support services is eligible for crisis diversion services when:

(A) A brokerage has referred an individual to the Regional Crisis Diversion Program because the brokerage has determined that one or more of the following crisis risk factors, not primarily related to a significant mental or emotional disorder or substance abuse, are present and for which no appropriate alternative resources are available:

(i) An individual is not receiving necessary supports to address life-threatening safety skill deficits;

(ii) An individual is not receiving necessary supports to address life-threatening issues resulting from behavioral or medical conditions;

(iii) An individual currently engages in self-injurious behavior serious enough to cause injury that requires professional medical attention;

(iv) An individual undergoes, or is at imminent risk of undergoing, loss of primary caregiver due to the primary caregiver's inability to provide supports;

(v) An individual experiences a loss of home due to a protective service action; or

(vi) An individual is not receiving the necessary supports to address significant safety risks to others, including but not limited to:

(I) A pattern of physical aggression serious enough to cause injury;

(II) Fire-setting behaviors; or

(III) Sexually aggressive behaviors or a pattern of sexually inappropriate behaviors.

(B) The Regional Crisis Diversion Program has determined crisis eligibility according to OAR 411-320-0160; and

(C) The individual's ISP has been revised to address the identified crisis risk factors and the revisions:

(i) May resolve the crisis; and

(ii) May not contribute to new or additional crisis risk factors.

(b) A functional needs assessment must be completed for any individual determined to be in crisis as described in this section of this rule.

(3) CRISIS SUPPORTS.

(a) An ISP for an individual in emergent status may authorize short-term, out-of-home, residential placement. Residential placement does not exit an individual from support services.

(b) The individual's personal agent must:

(A) Participate with the Regional Crisis Diversion Program staff in efforts to stabilize supports and return costs to the individual's benefit level;

(B) Assist with the identification of qualified providers who may be paid in whole, or in part, using crisis diversion funding except in the case of short-term, out-of-home, residential placements with a licensed or certified provider;

(C) Complete and coordinate the Support Services Brokerage Crisis Addendum when an individual in emergent status requires a short-term, out-of-home, residential placement; and

(D) Monitor the delivery of supports provided, including those provided through crisis funding.

(i) Monitoring is done through contact with the individual, any providers, and the individual's legal or designated representative and family (as applicable).

(ii) Monitoring is done to collect information regarding supports provided and progress toward outcomes that are identified as necessary to resolve the crisis.

(iii) The personal agent must document the information described in subparagraph (ii) of this paragraph in the individual's record and report to the Regional Crisis Diversion Program or CDDP as required.

(c) Support services provided during emergent status are subject to all requirements of this rule.

(d) All supports authorized in an ISP continue during the crisis unless prohibited by other rule, policy, or the supports contribute to new or additional crisis risk factors.

(4) **TRANSITION TO COMPREHENSIVE SERVICES.** When an individual eligible for crisis supports may have long-term support needs that may not be met through support services:

(a) The brokerage must immediately notify the CDDP of the individual's county of residence;

(b) The brokerage must coordinate with the CDDP and the Regional Crisis Diversion Program to facilitate a timely exit from support services and entry into appropriate, alternative services; and

(c) The brokerage must assure that information required for a potential provider of comprehensive services is available as needed for a referral to be made.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0130 Using Support Services Funds to Purchase Supports
(Temporary Effective 07/01/2014 to 12/28/2014)

(1) Support services funds may be used to assist individuals to purchase supports defined in OAR 411-340-0130(7), in accordance with an ISP when:

(a) The supports are necessary for an individual to live in the individual's own home or in the individual's family home or meet individual support needs;

(b) For Community First Choice services, the support will address a need that has been determined to be necessary by a functional needs assessment;

(c) An enrolled individual meets the criteria for level of care;

(d) The individual is eligible for home and community-based waiver services or Community First Choice state plan services;

(e) Cost-effective arrangements for obtaining the required supports, applying public, private, formal, and informal resources available to the eligible individual are specified in the individual's ISP;

(A) Support services funds are not intended to replace the resources available to an individual from the individual's natural supports. Support services funds may be authorized only when the individual's natural supports are unavailable, insufficient, or inadequate to meet the needs of the individual.

(B) Support services funds are not available when an individual's support needs may be met by alternative resources. Support services funds may be authorized only when alternative resources are unavailable, insufficient, or inadequate to meet the needs of the individual.

(f) The ISP has been authorized for implementation.

(2) A brokerage may use support services funds to assist individuals that do not meet the criteria in section (1)(d) of this rule when, up to the individual's 18th birthday, the individual was receiving children's intensive in-home services as described in OAR chapter 411, division 300 or in-home supports as described in OAR chapter 411, division 308.

(3) An individual is no longer eligible to access support services funds when the individual is eligible for support services funds based on section (2) of this rule and --

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

(b) The Social Security Administration or the Department's Presumptive Medicaid Disability Determination Team finds that the individual does not have a qualifying disability; or

(c) The individual is determined by the state of Oregon to be ineligible for OHP Plus or OSIP-M.

(4) Goods and services purchased with support services funds on behalf of individuals are provided only as social benefits.

(5) SERVICE LIMITS. The use of support services funds to purchase individual supports is limited to:

(a) The individual's service level as determined by the functional needs assessment. The functional needs assessment determines a total number of hours available to meet identified needs. This amount may not be exceeded without prior approval from the Department. The types of services that contribute to the total of hours used are; Attendant Care, Hourly Relief Care, Skills Training. Attendant Care and Skill Training hours that constitute Day Support Activities contribute to the total of hours used.

(b) Other services and supports determined by the personal agent to be necessary to meet identified support needs.

(c) An average of 108.3 hours per month of Employment Path Services and Individual Supported Employment - Small Group Employment Support individually or combined.

(d) 40 hours per week of Supported Employment -Individual Employment Support, not including Job Development. If an individual is receiving less than 25 hours per week of Supported Employment - Individual Employment Support, the individual may also receive any combination of Small Group Employment Support, and Employment Path Services, the total of which (including the Supported Employment - Individual Employment services) shall not exceed an annual average of 108.3 hours per month.

(6) AMOUNT, METHOD, AND SCHEDULE OF PAYMENT.

(a) The brokerage must disburse, or arrange for disbursement of, support services funds to qualified providers on behalf of individuals in the amount required to implement an authorized ISP. The brokerage is specifically prohibited from reimbursement of individuals or individuals' families for expenses related to services and from

advancing funds to individuals or individuals' families to obtain services.

(b) The method and schedule of payment must be specified in written agreements between the brokerage and the individual or the individual's legal or designated representative (as applicable).

(7) TYPES OF SUPPORTS. Supports eligible for purchase with support services funds must be consistent with published Expenditure Guidelines and are limited to:

(a) Community First Choice services. An individual who is eligible for OHP Plus and meets Level of Care may access Community First Choice services.

(b) Effective October 1, 2014, an individual receiving medical benefits under OAR 410-200 requesting Medicaid coverage for services in a nonstandard living arrangement (see OAR 461-001-0000) is subject to the rules regarding transfer of assets (see OAR 461-140-0210 to 461-140-0300) in the same manner as if they were requesting these services under OSIPM. This includes, but is not limited to, the following assets:

(A) An annuity is evaluated according to OAR 461-145-0022;

(B) A transfer of property when an individual retains a life estate is evaluated according to OAR 461-145-0310;

(C) A loan made by an individual is evaluated according to OAR 461-145-0330;

(D) An Irrevocable trust is evaluated according to OAR 461-145-0540.

(c) When an individual will be disqualified for a transfer of assets they must receive a notice meeting the requirements of OAR 461-175-0310 in the same manner as if they were requesting services under OSIPM.

(d) An individual found to have transferred assets is not eligible for Community First Choice Services.

(e) Community First Choice services include:

(A) Community nursing services as described in section (8) of this rule;

(B) Chore services as described in section (9) of this rule;

(C) Attendant care as described in section (10) of this rule;

(D) Skills training as described in section (11) of this rule;

(E) Community transportation as described in section (12) of this rule;

(F) Assistive Devices as described in section (13) of this rule;

(G) Assistive Technology as described in section (14) of this rule;

(H) Relief care as described in section (15) of this rule;

(I) Behavior support services as described in section (16) of this rule;

(J) Environmental accessibility adaptations as described in section (17) of this rule; and

(K) Transition costs as described in section (18) of this rule.

(f) Home and Community Based Waiver Services. Individuals who are eligible for OSIP-M and meet Level of Care may access Community First Choice Services and the following services:

(A) Case management as defined in OAR 411-340-0020;

(B) Employment Services as described in section (19) of this rule that include:

(i) Supported employment - Individual Employment Support ;

(ii) Supported Employment - Small Group Employment Support;

(iii) Employment Path Services;

(iv) Discovery/Career Exploration Services.

(C) Family training as described in section (20) of this rule;

(D) Special diets as described in section (21) of this rule;

(E) Environmental Safety Adaptations as described in section (22) of this rule;

(F) Vehicle modifications as described in section (23) of this rule; and

(G) Specialized Medical Supplies as described in section (24) of this rule.

(g) State Plan personal care as described in OAR chapter 411, division 034.

(8) COMMUNITY NURSING SERVICES.

(a) Community nursing services include:

(A) Evaluation, including medication reviews, and identification of supports that minimize health risks while promoting an individual's autonomy and self-management of healthcare;

(B) Collateral contact with a personal agent regarding an individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered ISP; and

(C) Delegation and training of nursing tasks to an individual's provider so the provider may safely perform health related tasks.

(b) Community nursing services exclude direct nursing care.

(c) Community nursing services are not covered by other Medicaid spending authorities.

(9) CHORE SERVICES. Chore services may be provided only in situations where no one else is responsible or able to perform or pay for the services.

(a) Chore services include heavy household chores such as --

(A) Washing floors, windows, and walls;

(B) Tacking down loose rugs and tiles; and

(C) Moving heavy items of furniture for safe access and egress.

(b) Chore services may include yard hazard abatement to ensure the outside of the home is safe for the individual to traverse and enter and exit the home.

(10) ATTENDANT CARE SERVICES.

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

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

(B) Toileting, bowel, and bladder care -- assisting to and from the bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, managing menses, cleansing an individual or adjusting clothing related to toileting, emptying a catheter drainage bag or assistive device, ostomy care, or bowel care;

(C) Mobility, transfers, and repositioning -- assisting with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(D) Nutrition -- preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with adaptive utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(E) Medication and medical equipment including but not limited to assisting with ordering, organizing, and administering medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring an individual for choking while taking medications, assisting with the administration of medications, maintaining equipment, or monitoring for adequate medication supply; and

(F) Delegated nursing tasks.

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

(A) Light housekeeping -- tasks necessary to maintain an individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and laundry;

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

(C) Assistance with necessary medical appointments, including help scheduling appointments, arranging medical transportation services, accompaniment to appointments, follow up from appointments, or assistance with mobility, transfers, or cognition in getting to and from appointments;

(D) Observation of an individual's status and reporting of significant changes to physicians, health care professionals, or other appropriate people;

(E) First aid and handling emergencies, including addressing medical incidents related to conditions such as seizures, aspiration, constipation, or dehydration or responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(F) Cognitive assistance or emotional support provided to an individual due to an intellectual or developmental disability, including helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive functions.

(G) Social support in the community around socialization, and participation in the community.

(i) Support with socialization includes assisting participants in acquiring, retaining, and improving self-awareness and self-control, social responsiveness, social amenities, and interpersonal skills.

(ii) Support with community participation, includes assisting individuals in acquiring, retaining, and improving skills to use available community resources, facilities, or businesses.

(H) Support with communication provided to assist individuals in acquiring, retaining, and improving expressive and receptive skills in verbal and non-verbal language and the functional application of acquired reading and writing skills.

(c) Attendant care services means an individual requires assistance with ADLs. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require

verbal reminding to complete any of the tasks described in subsection (b) of this section.

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

(B) "Hands-on" means a provider physically performs all or parts of an activity because an individual is unable to do so.

(C) "Monitoring" means a provider observes an individual to determine if assistance is needed.

(D) "Reassurance" means to offer an individual encouragement and support.

(E) "Redirection" means to divert an individual to another more appropriate activity.

(F) "Set-up" means the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment so that an individual may perform an activity.

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

(11) **SKILLS TRAINING.** Skills training is specifically tied to the functional needs assessment and ISP and is a means for an individual to acquire, maintain, or enhance independence in supports otherwise provided through state plan or waiver services.

(a) Skills training may be applied to the use and care of assistive devices and technologies.

(b) Skills training is authorized when:

(A) The anticipated outcome of the skills training, as documented in the ISP, is measurable;

(B) Timelines for measuring progress towards the anticipated outcome are established in the ISP; and

(C) Progress towards the anticipated outcome are measured and the measurements are evaluated by a personal agent no less frequently than every six months, based on the start date of the initiation of the skills training.

(c) When anticipated outcomes are not achieved, the personal agent must reassess the use of skills training with the individual.

(12) COMMUNITY TRANSPORTATION.

(a) Community transportation services include but are not limited to --

(A) Community transportation provided by common carriers, taxicab, or bus in accordance with standards established for these entities;

(B) Reimbursement on a per-mile basis for transporting an individual to accomplish ADL, IADL, health related task or employment goal identified on an ISP; or

(C) Assistance with the purchase of a bus pass.

(b) Community transportation services exclude medical transportation, purchase of individual or family vehicles, routine vehicle maintenance and repair, ambulance services, payment to the spouse of an individual receiving support services, and costs for transporting a person other than the individual.

(c) Mileage reimbursement must be limited to those destinations where other members of the individual's local community would typically get similar services.

(d) Community transportation is not provided by the Department to obtain medical or non-medical items that may be delivered by a supplier or sent by mail order without cost to the eligible individual.

(e) Community transportation must be prior authorized by an individual's personal agent and documented in the individual's service plan. The Department does not pay any provider under any circumstances for more than the total number of hours, miles, or rides prior authorized by the brokerage and documented in the individual's service plan.

(A) Personal support workers who use their own personal vehicle for community transportation are reimbursed according to the terms defined in their Collective Bargaining Agreement between the Home Care Commission and Service Employees International Union, Local 503, OPEU.

(B) The Department or brokerage does not authorize reimbursement for travel to or from the residence of a personal support worker. The Department or brokerage only authorizes community transportation and mileage from the home of an eligible individual to the destination necessary to meet the goal stated in the individual's service plan and back to the individual's home.

(13) Assistive Devices. When assistive devices are primarily and customarily used to serve a medical purpose, the purchase, rental, or repair of assistive devices with support service funds must be limited to the types of equipment that are not excluded under OAR 410-122-0080.

(a) Assistive devices may include the purchase of devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the individual's ability to perform and support ADLs and IADLs or to perceive, control, or communicate with the environment in which the individual lives.

(b) Assistive devices may be purchased with support service funds when an individual's intellectual or developmental disability otherwise prevents or limits the individual's independence in areas identified in a functional needs assessment.

(c) Assistive devices that may be purchased for the purpose described in subsection (b) of this section must be of direct benefit to the individual and may include:

(A) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders, alert systems for ADL or IADL supports, or mobile electronic devices;

(B) Assistive devices, not covered by other Medicaid programs, to assist and enhance an individual's independence in performing ADLs or IADLs, such as durable medical equipment, mechanical apparatus, electrical appliances, or information technology devices.

(i) Expenditures for assistive devices are limited to \$5,000 per plan year without Department approval.

(ii) Any single device or assistance costing more than \$500 must be approved by the Department prior to expenditure.

(d) Assistive devices may not include items not of direct medical or remedial benefit to the individual.

(e) Assistive devices must meet applicable standards of manufacture, design, and installation.

(f) To be authorized by a services coordinator, Assistive devices must be:

(A) In addition to any medical equipment and supplies furnished under OHP and private insurance;

(B) Determined necessary to the daily functions of the individual; and

(C) Directly related to the disability of the individual.

(g) Assistive devices exclude:

(A) Items that are not necessary or of direct medical or remedial benefit to the individual;

(B) Assistive devices intended to supplant similar items furnished under OHP or private insurance;

(C) Items available through the family, community, or other governmental resources;

(D) Items that are considered unsafe for an individual;

(E) Equipment and furnishings of general household use.

(14) ASSISTIVE TECHNOLOGY Assistive technology to provide additional security and replace the need for direct interventions to enable self direction of care and maximize independence, such as motion or sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems;

(a) Expenditures for assistive technology are limited to \$5,000 per plan year without Department approval.

(b) Any single purchase costing more than \$500 must be approved by the Department prior to expenditure.

(15) RELIEF CARE.

(a) Relief care includes two types of care, neither of which may be characterized as daily or periodic services provided to allow an individual's primary caregiver to attend school or work.

(A) Twenty-four hour relief care must be provided in segments of 24-hour units that may be sequential but may not exceed 7 consecutive days without permission from the Department.

(B) Hourly relief care is substitute work for the usual attendant care provider.

(b) Relief care may include both day and overnight services that may be provided in:

(A) The home of the individual;

(B) A licensed or certified setting;

(C) The home of a qualified provider. If relief care is provided in the home of a qualified provider, the personal agent and the individual, or the representative of the individual, must document that the home of the qualified provider is a safe setting for the individual;

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

(16) BEHAVIOR SUPPORT SERVICES.

(a) Behavior support services consist of:

(A) Assessing an individual or the needs of the individual's family and the environment;

(B) Developing positive behavior support strategies, including a Behavior Support Plan if needed;

(C) Implementing the Behavior Support Plan with an individual's provider or family; and

(D) Revising and monitoring the Behavior Support Plan as needed.

(b) Behavior support services may include:

(A) Training, modeling, and mentoring an individual's family;

(B) Developing visual communication systems as behavior support strategies; and

(C) Communicating as authorized by an individual, or as applicable the individual's legal or designated representative, with school, medical, or other professionals about the strategies and outcomes of the Behavior Support Plan.

(c) Behavior support services exclude:

(A) Mental health therapy or counseling;

(B) Health or mental health plan coverage;

(C) Educational services, including, but not limited to consultation and training for classroom staff;

(D) Adaptations to meet needs of an individual at school;

(E) An assessment in a school setting;

(F) Attendant Care;

(G) Skills Training; or

(H) Relief Care.

(17) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

- (F) Protective covering for smoke alarms, light fixtures, and appliances;
- (G) Sound and visual monitoring systems;
- (H) Installation of ramps, grab-bars, and electric door openers;
- (I) Adaptation of kitchen cabinets and sinks;
- (J) Widening of doorways;
- (K) Handrails;
- (L) Modification of bathroom facilities;
- (M) Individual room air conditioners for an individual whose temperature sensitivity issues create behaviors or medical conditions that put the individual or others at risk;
- (N) Installation of non-skid surfaces;
- (O) Overhead track systems to assist with lifting or transferring;
- (P) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual; and
- (Q) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

- (A) Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, and central air conditioning;
- (B) Adaptations that add to the total square footage of the home except for ramps that attach to the home for the purpose on entry or exit;

(C) Adaptations outside of the home; and

(D) General repair or maintenance and upkeep required for the home, including repair of damage caused by the individual.

(c) Environmental accessibility adaptations are limited to \$5,000 per modification. A personal agent may request approval for additional expenditures through the Department prior to expenditure. Approval is based on the individual's service and support needs and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental accessibility adaptations must be tied to supporting ADL, IADL, and health-related tasks as identified in the individual's ISP.

(e) Environmental accessibility adaptations must be completed by a state licensed contractor. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the provider's file prior to payment.

(f) Environmental accessibility adaptations must be made within the existing square footage of the home, except for external ramps, and may not add to the square footage of the home.

(g) Payment to the contractor is to be withheld until the work meets specifications.

(18) TRANSITION COSTS.

(a) Transition costs are limited to individuals transitioning from a nursing facility, ICF/IDD, or acute care hospital, to a home or community-based setting where the individual resides.

(b) Transition costs are based on an individual's assessed need determined during the person-centered service planning process and must support the desires and goals of the individual receiving services and supports. Final approval for transition costs must be through the Department prior to expenditure. The Department's

approval is based on the individual's need and the Department's determination of appropriateness and cost-effectiveness.

(c) Financial assistance for transition costs is limited to:

(A) Moving and move-in costs, including movers, cleaning and security deposits, payment for background or credit checks (related to housing), or initial deposits for heating, lighting, and phone;

(B) Payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishings, such as a bed; and

(C) Other items necessary to re-establish a home.

(d) Transition costs are provided no more than twice annually.

(e) Transitions costs for basic household furnishings and other items are limited to one time per year.

(19) Employment services must be:

(a) Delivered according to OAR 411-345-0025; and

(b) Provided by an employment specialist meeting the requirements described in OAR 411-345-0030.

(20) FAMILY TRAINING. Family training services are provided to an individual's family to increase the family's capability to care for, support, and maintain the individual in the home.

(a) Family training services include:

(A) Instruction about treatment regimens and use of equipment specified in an individual's ISP;

(B) Information, education, and training about an individual's disability, medical, and behavioral conditions; and

(C) Organized conferences and workshops specifically related to an individual's disability, identified support needs, or specialized medical or behavioral support needs.

(b) Family training services exclude:

(A) Mental health counseling, treatment, or therapy;

(B) Training for paid care providers;

(C) Legal fees;

(D) Training for families to carry out educational activities in lieu of school;

(E) Vocational training for family members; and

(F) Paying for training to carry out activities that constitute abuse of an adult.

(c) Prior authorization by the brokerage is required for attendance by family members at organized conferences and workshops funded with support services funds.

(21) SPECIAL DIET. Special diets are specially prepared food or particular types of food, ordered by a physician and periodically monitored by a dietician, specific to an individual's medical condition or diagnosis that are needed to sustain an individual in the individual's home. Special diets are supplements and are not intended to meet an individual's complete daily nutritional requirements.

(22) ENVIRONMENTAL SAFETY ADAPTATIONS.

(a) Materials must be of the most cost effective type and decorative additions will not be considered.

(b) Fencing will be limited to 200 linear feet without approval from DHS to exceed the limit. Large gates such as automobile gates are excluded. Costs for paint and stain are excluded.

(23) VEHICLE MODIFICATIONS. Vehicle modification does not include:

(a) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;

(b) Purchase or lease of a vehicle; or

(c) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

(24) SPECIALIZED MEDICAL SUPPLIES. Specialized Medical supplies will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid state plan services.

(25) Day support activities must be provided according to OAR 411-345-0025.

(26) EDUCATIONAL SERVICES. Educational services such as professional instruction, formal training, and tutoring in communication, socialization, and academic skills, are not allowable expenses covered by support services funds.

(27) CONDITIONS OF PURCHASE. The brokerage must arrange for supports purchased with support services funds to be provided:

(a) In settings and under contractual conditions that enable the individual to freely choose to receive supports and services from another qualified provider;

(A) Individuals who choose to combine support services funds to purchase group services must receive written instruction from the brokerage about the limits and conditions of such arrangements;

(B) Combined support services funds may not be used to purchase existing, or create new, comprehensive services;

(C) Individual support expenses must be separately projected, tracked, and expensed, including separate contracts, employment agreements, and timekeeping for staff working with more than one individual; and

(D) Combined arrangements for residential supports must include a plan for maintaining an individual at home after the loss of roommates.

(b) In a manner consistent with positive behavioral theory and practice and where behavior intervention is not undertaken unless the behavior:

(A) Represents a risk to health and safety of the individual or others;

(B) Is likely to continue and become more serious over time;

(C) Interferes with community participation;

(D) Results in damage to property; or

(E) Interferes with learning, socializing, or vocation.

(c) In accordance with applicable state and federal wage and hour regulations in the case of personal services, training, and supervision;

(d) In accordance with applicable state or local building codes in the case of environmental accessibility adaptations to the home;

(e) In accordance with Oregon Board of Nursing rules in OAR chapter 851 when services involve performance of nursing services or delegation, teaching, and assignment of nursing tasks;

(f) In accordance with OAR 411-340-0160 through 411-340-0180 governing provider qualifications and responsibilities; and

(g) In accordance with the Department's Support Services Expenditure Guidelines.

(28) INDEPENDENT PROVIDER, PROVIDER ORGANIZATION, AND GENERAL BUSINESS PROVIDER AGREEMENTS AND RESPONSIBILITIES. When support services funds are used to purchase services, training, supervision, or other personal assistance for individuals, the brokerage must require and document that providers are informed of:

- (a) Mandatory reporter responsibility to report suspected abuse;
- (b) Responsibility to immediately notify the people, if any, specified by the individual, or as applicable the individual's legal or designated representative, of any injury, illness, accident, or unusual circumstance that occurs when the provider is providing individual services, training, or supervision that may have a serious effect on the health, safety, physical or emotional well-being, or level of services required;
- (c) Limits of payment:
 - (A) Support services fund payments for the agreed-upon services are considered full payment and the provider under no circumstances may demand or receive additional payment for these services from the individual, the individual's family, or any other source unless the payment is a financial responsibility (spend-down) of an individual under the Medically Needy Program; and
 - (B) The provider must bill all third party resources before using support services funds unless another arrangement is agreed upon by the brokerage and described in an individual's ISP.
- (d) The provisions of section (31) of this rule regarding sanctions that may be imposed on providers; and
- (e) The requirement to maintain a drug-free workplace.

(29) PROVIDER TERMINATION.

- (a) A personal support worker's provider enrollment may be inactivated or terminated consistent with OAR 411-375-0070.

(b) An Independent Provider who is not a Personal Support Worker.

(A) The provider enrollment for a personal support worker may be inactivated in the following circumstances:

(i) The provider has not provided any paid in-home services to an individual within the last previous 12 months;

(ii) The provider informs the Department, CDDP, CIIS, or Support Services Brokerage that the personal support worker is no longer providing in-home services in Oregon;

(iii) The background check for a provider results in a closed case pursuant to OAR 407-007-0325;

(iv) Services to an individual, is being investigated by Adult or Child Protective Services for suspected abuse that poses imminent danger to current or future individuals; or

(v) Provider payments, all or in part, for the provider have been suspended based on a credible allegation of fraud or has a conviction of for fraud pursuant to federal law under 42 CFR 455.23.

(B) An independent provider who is not a personal support worker may have their provider enrollment terminated when the brokerage or Department determines that, at some point after the provider's initial qualification and authorization to provide supports purchased with support services funds, the provider has:

(i) Been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of service;

(ii) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

- (iii) Surrendered his or her professional license or had his or her professional license suspended, revoked, or otherwise limited;
- (iv) Failed to safely and adequately provide the authorized services;
- (v) Had a founded report of child abuse or substantiated abuse;
- (vi) Failed to cooperate with any Department or brokerage investigation or grant access to, or furnish, records or documentation, as requested;
- (vii) Billed excessive or fraudulent charges or been convicted of fraud;
- (viii) Made a false statement concerning conviction of crime or substantiated abuse;
- (ix) Falsified required documentation;
- (x) Failed to comply with the provisions of section (30) of this rule or OAR 411-340-0140;
- (xi) Been suspended or terminated as a provider by the Department or Oregon Health Authority;
- (xii) Violates the requirement to maintain a drug-free work place;
- (xiii) Fails to provide services as required;
- (xiv) Fails to provide a tax identification number or social security number that matches the independent provider's legal name, as verified by the Internal Revenue Service or Social Security Administration; or

(xv) Has been excluded or debarred by the Office of the Inspector General.

(C) If the brokerage or Department makes a decision to terminate a provider's enrollment, the brokerage or Department must issue a written notice that shall include --

(i) An explanation of the reason for termination of the provider enrollment;

(ii) The alleged violation as listed in subsection (b) of this section; and

(iii) The independent provider's appeal rights, including where to file the appeal.

(iv) For terminations based on substantiated protective services allegations, the notice may only contain the limited information allowed by law. In accordance with ORS 124.075, 124.085, 124.090, and OAR 411-020-0030, complainants, witnesses, the name of the alleged victim, and protected health information may not be disclosed.

(v) The effective date of the termination.

(D) The provider may appeal a termination within 30 days of the date the termination notice was mailed to the provider. The provider must appeal a termination separately from any appeal of audit findings and overpayments.

(i) A provider of Medicaid services may appeal a termination by requesting an administrator's review by the Department's director or their designee.

(ii) For an appeal regarding provision of Medicaid services to be valid, written notice of the appeal must be received by the Department within 30 days of the date the termination notice was mailed to the provider.

(E) At the discretion of the Department, providers who have previously been terminated or suspended by the Department or by the Oregon Health Authority may not be authorized as providers of Medicaid services.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0135 Standards for Employers

(Temporary Effective 07/01/2014 to 12/28/2014)

(1) An employer of record is required when a personal support worker who is not an independent contractor is selected by the family to provide supports. The Department may not act as the employer of record.

(2) JOB DESCRIPTION. The employer is responsible for creating and maintaining a job description for potential independent providers that is in coordination with the services authorized in the ISP.

(3) PERSONAL SUPPORT WORKER BENEFITS. The only benefits available to independent providers are for those who are personal support workers and negotiated in the collective bargaining agreement and provided in Oregon Revised Statute. The collective bargaining agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Independent providers, including personal support workers, are not state or brokerage employees.

(4) EMPLOYER RESPONSIBILITIES.

(a) For an individual to be eligible for support provided by an independent provider, an employer must demonstrate the ability to:

(A) Locate, screen, and hire a qualified independent provider;

(B) Supervise and train the independent provider;

(C) Schedule work, leave, and coverage;

(D) Track the hours worked and verify the authorized hours completed by the independent provider;

(E) Recognize, discuss, and attempt to correct, with the independent provider, any performance deficiencies and provide appropriate, progressive, disciplinary action as needed; and

(F) Discharge an unsatisfactory independent provider.

(b) Indicators that an employer may not be meeting the employer responsibilities described in subsection (4)(a) of this section include but are not limited to:

(A) Independent provider complaints;

(B) Multiple complaints from an independent provider requiring intervention from the Department or Brokerage;

(C) Frequent errors on time sheets, mileage logs, or other required documents submitted for payment that results in repeated coaching from the Department or Brokerage;

(D) Complaints to Medicaid Fraud involving the employer; or

(E) Documented observation by the Brokerage of services not being delivered as identified in the individual's ISP.

(c) The Department or the Brokerage may require intervention as defined in OAR 411-340-0020 when an employer has demonstrated difficulty meeting the employer responsibilities described in subsection (4)(a) of this section.

(d) After appropriate intervention and assistance, an individual unable to meet the employer responsibilities described in subsection (4)(a) of this section may be determined ineligible for support provided by an independent provider.

(A) An individual determined ineligible to be an employer of an independent provider and unable to designate an employer

representative, may not request support provided by an independent provider until the individual's next annual ISP. Improvements in health and cognitive functioning may be factors in demonstrating the individual's ability to meet the employer responsibilities described in section (4)(a) of this rule. If an individual is able to demonstrate the ability to meet the employer responsibilities sooner than the next annual ISP, the individual may request the waiting period be shortened.

(B) An individual determined ineligible to be an employer of an independent provider is offered other available service options that meet the individual's service needs, including support through a contracted qualified provider organization or general business provider when available.

(5) DESIGNATION OF EMPLOYER RESPONSIBILITIES.

(a) An individual not able to meet all of the employer responsibilities described in section (4)(a) of this rule must:

(A) Designate an employer representative in order to receive or continue to receive in home support; or

(B) Select other available services.

(b) An individual able to demonstrate the ability to meet some of the employer responsibilities described in section (4)(a) of this rule must:

(A) Designate an employer representative to fulfill the responsibilities the individual is not able to meet to receive or continue to receive support from an independent provider; and

(B) On a Department approved form, document the specific employer responsibilities performed by the individual and the employer responsibilities performed by the individual's employer representative.

(c) When an individual's employer representative is not able to meet the employer responsibilities described in section (4)(a) or the qualifications in section (6)(c) of this rule, an individual must:

(A) Designate a different employer representative to receive or continue to receive in home support; or

(B) Select other available services.

(6) EMPLOYER REPRESENTATIVE.

(a) An individual, or the individual's legal representative, may designate an employer representative to act on behalf of the individual, to meet the employer responsibilities described in section (4)(a) of this rule. An individual's legal or designated representative may be the employer.

(b) An employer who is also an individual's independent provider of support must seek an alternate employer for purposes of the independent provider's employment. The alternate employer must:

(A) Track the hours worked and verify the authorized hours completed by the independent provider; and

(B) Document the specific employer responsibilities performed by the employer on a Department approved form.

(c) The Department or the Brokerage may suspend, terminate, or deny an individual's request for an employer representative if the requested employer representative has:

(A) A history of substantiated abuse of an adult as described in OAR 411-045-0250 to 411-045-0370;

(B) A history of founded abuse of a child as described in ORS 419B.005;

(C) Participated in billing excessive or fraudulent charges; or

(D) Failed to meet the employer responsibilities in section (4)(a) or (6)(b) of this rule, including previous termination as a result of failing to meet the employer responsibilities in section (4)(a) or (6)(b).

(d) An individual is given the option to select another employer representative if the Department or Brokerage suspends, terminates, or denies an individual's request for an employer representative for the reasons described in subsection (6)(c) of this section.

(7) APPEALS.

(a) The Department or the Brokerage, respectively, shall mail a notice identifying the individual and if applicable the individual's employer representative and legal or designated representative, when:

(A) The Department or the Brokerage denies, suspends, or terminates an employer from performing the employer responsibilities described in sections (4)(a) or (6)(b) of this rule; and

(B) The Department or the Brokerage denies, suspends, or terminates an employer representative from performing the employer responsibilities described in section (4)(a) or (6)(b) of this rule because the employer representative does not meet the qualifications in section (6)(c) of this rule.

(b) **BROKERAGE ISSUED NOTICES.** An individual receiving support from an independent provider, or as applicable the individual's legal or designated representative or employer representative, may appeal a notice issued by the Brokerage by requesting a review by the Brokerage's director.

(A) For an appeal regarding denial, suspension, or termination of an employer to be valid, written notice of the appeal and request for review must be received by the Brokerage within 45 calendar days of the date of the notice.

(B) The Brokerage director shall complete a review and issue a decision within 30 calendar days of the date the written appeal was received by the Brokerage.

(C) If an individual, or as applicable the individual's legal or designated representative or employer representative, is

dissatisfied with the Brokerage director's decision, the individual, or as applicable the individual's legal or designated representative or employer representative, may request an administrator review by the Department's director or the Department's designee.

(D) For an appeal of the Brokerage's decision to be valid, written notice of the appeal and request for an administrator review must be received by the Department within 15 calendar days of the date of the Brokerage's decision.

(E) The Department's director or the Department's designee shall complete an administrator review within 30 calendar days of the date the written appeal was received by the Department.

(F) The Department's decision of an administrator review is considered final.

(c) DEPARTMENT ISSUED NOTICES. An individual receiving support from an independent provider, or as applicable the individual's legal or designated representative, may appeal a notice issued by the Department by requesting an administrator review by the Department's director or the Department's designee.

(A) For an appeal regarding denial, suspension, or termination of an employer to be valid, written notice of the appeal and request for an administrator review must be received by the Department within 45 calendar days of the date of the notice.

(B) The Department's director or Department's designee shall complete an administrator review and issue a decision within 30 calendar days of the date the written appeal was received by the Department.

(C) The Department's decision of an administrator review is considered final.

(d) An individual has appeal rights as described in OAR 411-340-0060 when the denial, suspension, or termination of the employer

results in the Department or CDDP denying, suspending, or terminating an individual from support services.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0140 Using Support Services Funds for Certain Purchases Is Prohibited

(Amended 12/28/2013)

(1) Effective July 28, 2009, support services funds may not be used to support, in whole or in part, a provider in any capacity who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(2) Section (1) of this rule does not apply to employees of individuals, individuals' legal representatives, employees of general business providers, or employees of provider organizations, who were hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(3) Support services funds may not be used to pay for:

(a) Services, materials, or activities that are illegal;

(b) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 407-045-0260;

(c) Materials or equipment that has been determined unsafe for the general public by recognized consumer safety agencies;

(d) Individual or family vehicles;

(e) Health and medical costs that the general public normally must pay, including but not limited to:

(A) Medications;

(B) Health insurance co-payments;

(C) Dental treatments and appliances;

(D) Medical treatments;

(E) Dietary supplements, including but not limited to vitamins and experimental herbal and dietary treatments; or

(F) Treatment supplies not related to nutrition, incontinence, or infection control.

(f) Ambulance services;

(g) Legal fees;

(h) Vacation costs for transportation, food, shelter, and entertainment that are normally incurred by a person on vacation, regardless of disability, and are not strictly required by the individual's need for personal assistance in all home and community-based settings;

(i) Individual services, training, or supervision that has not been arranged according to applicable state and federal wage and hour regulations;

(j) Services, activities, materials, or equipment that are not necessary, cost-effective, or do not meet the definition of support or social benefits as defined in OAR 411-340-0020;

(k) Educational services for school-age individuals over the age of 18, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills, and post-secondary educational services such as those provided through two- or four-year colleges for individuals of all ages;

(l) Services provided in a nursing facility, correctional institution, or hospital;

(m) Services, activities, materials, or equipment that may be obtained by the individual or the individual's family through alternative resources or natural supports;

(n) Unless under certain conditions and limits specified in Department guidelines, employee wages or contractor charges for time or services when the individual is not present or available to receive services, including but not limited to employee paid time off, hourly "no show" charge, and contractor travel and preparation hours;

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

(p) Notwithstanding abuse as defined in OAR 407-045-0260, services when there is sufficient evidence to believe that an individual, or as applicable the individual's legal or designated representative, has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the individual's ISP, refused to accept or delegate record keeping required to use brokerage resources, or otherwise knowingly misused public funds associated with brokerage services

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0150 Standards for Support Services Brokerage Administration and Operations

(Temporary Effective 07/01/2014 to 12/28/2014)

(1) POLICY OVERSIGHT GROUP. The brokerage must develop and implement procedures for incorporating the direction, guidance, and advice of individuals and family members of individuals in the administration of the organization.

(a) The brokerage must establish and utilize a Policy Oversight Group, of which the membership majority must be individuals with intellectual or developmental disabilities and family members of individuals with intellectual or developmental disabilities.

(b) Brokerage procedures must be developed and implemented to assure the Policy Oversight Group has the maximum authority that may be legally assigned or delegated over important program operational decisions, including such areas as program policy development, program planning and goal setting, budgeting and

resource allocation, selection of key personnel, program evaluation and quality assurance, and complaint resolution.

(c) If the Policy Oversight Group is not also the governing body of the brokerage, then the brokerage must develop and implement a written procedure that describes specific steps of appeal or remediation to resolve conflicts between the Policy Oversight Group and the governing body of the brokerage.

(d) A Policy Oversight Group must develop and implement operating policies and procedures.

(2) FULL-TIME BROKERAGE DIRECTOR REQUIRED. The brokerage must employ a full-time director who is responsible for the daily operations of the brokerage in compliance with these rules and who has authority to make budget, staffing, policy, and procedural decisions for the brokerage.

(3) DIRECTOR QUALIFICATIONS. In addition to the general staff qualifications of OAR 411-340-0070(1) and (2), the brokerage director must have:

(a) A minimum of a bachelor's degree and two years experience, including supervision, in the field of intellectual or developmental disabilities, social services, mental health, or a related field; or

(b) Six years of experience, including supervision, in the field of intellectual or developmental disabilities, social services, or mental health.

(4) FISCAL INTERMEDIARY REQUIREMENTS.

(a) A fiscal intermediary must:

(A) Demonstrate a practical understanding of laws, rules, and conditions that accompany the use of public resources;

(B) Develop and implement accounting systems that operate effectively on a large scale as well as track individual budgets;

(C) Establish and meet the time lines for payments that meet individuals' needs;

(D) Develop and implement an effective payroll system, including meeting payroll-related tax obligations;

(E) Generate service, management, and statistical information and reports required by the brokerage director and Policy Oversight Group to effectively manage the brokerage and by individuals to effectively manage supports;

(F) Maintain flexibility to adapt to changing circumstances of individuals; and

(G) Provide training and technical assistance to individuals as required and specified in the individuals' ISPs.

(b) A fiscal intermediary may not recruit, hire, supervise, evaluate, dismiss, or otherwise discipline those employed to provide services described in an individual's authorized ISP.

(c) FISCAL INTERMEDIARY QUALIFICATIONS.

(A) A fiscal intermediary may not:

(i) Be a provider of support services paid using support services funds; or

(ii) Be a family member or other representative of an individual for whom they provide fiscal intermediary services.

(B) The brokerage must obtain and maintain written evidence that:

(i) Contractors providing fiscal intermediary services have sufficient education, training, or work experience to effectively and efficiently perform all required activities; and

(ii) Employees providing fiscal intermediary services have sufficient education, training, or work experience to effectively and efficiently perform all required activities prior to hire or that the brokerage has provided requisite education, training, and experience.

(5) PERSONAL AGENT QUALIFICATIONS.

(a) Each personal agent must have knowledge of the public service system for developmental disability services in Oregon and at least:

(A) A bachelor's degree in a behavioral science, social science, or a closely related field; or

(B) A bachelor's degree in any field and one year of human services related experience, such as work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or

(C) An associate's degree in a behavioral science, social science, or a closely related field and two years of human services related experience such as work providing assistance to individuals and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or

(D) Three years of human services related experience.

(b) A brokerage must submit a written variance request to the Department prior to employing a person not meeting the minimum qualifications for a personal agent set forth in subsection (a) of this section. The variance request must include:

(A) An acceptable rationale for the need to employ a person who does not meet the qualifications; and

(B) A proposed alternative plan for education and training to correct the deficiencies.

(i) The proposal must specify activities, timelines, and responsibility for costs incurred in completing the alternative plan.

(ii) A person who fails to complete the alternative plan for education and training to correct the deficiencies may not fulfill the requirements for the qualifications.

(6) **PERSONAL AGENT TRAINING.** The brokerage must provide or arrange for personal agents to receive training needed to provide or arrange for brokerage services, including but not limited to:

- (a) Principles of self-determination;
- (b) Person-centered planning processes;
- (c) Identification and use of alternative support resources;
- (d) Fiscal intermediary services;
- (e) Basic employer and employee roles and responsibilities;
- (f) Developing new resources;
- (g) Major public health and welfare benefits;
- (h) Constructing and adjusting individualized support plans; and
- (i) Assisting individuals to judge and improve quality of personal supports.

(7) **INDIVIDUAL RECORD REQUIREMENTS.** The brokerage must maintain current, up-to-date records for each individual receiving services and must make these records available to the Department upon request. The individual or the individual's legal representative may access any portion of the individual's record upon request. Individual records must include at minimum:

- (a) Application and eligibility information received from the referring CDDP;
- (b) An easily-accessed summary of basic information, including the individual's name, family name (if applicable), individual's legal or designated representative (if applicable), address, telephone number, date of entry into the program, date of birth, sex, marital status, individual financial resource information, and plan year anniversary date;
- (c) Documents related to determining eligibility for brokerage services;
- (d) Records related to receipt and disbursement of funds, including expenditure authorizations, expenditure verification, copies of CPMS expenditure reports, and verification that providers meet the requirements of OAR 411-340-0160 through 411-340-0180;
- (e) Documentation, signed by the individual, or as applicable the individual's legal or designated representative, that the individual, or as applicable the individual's legal or designated representative, has been informed of responsibilities associated with the use of support services funds;
- (f) Incident reports;
- (g) The completed functional needs assessment and other assessments used to determine supports required, preferences, and resources;
- (h) ISP and reviews. If an individual is unable to sign the ISP, the individual's record must document that the individual was informed of the contents of the ISP and that the individual's agreement to the ISP was obtained to the extent possible;
- (i) Names of those who participated in the development of the ISP. If an individual was not able to participate in the development of the ISP, the individual's record must document the reason;

(j) Written service agreements. A written service agreement must be consistent with the individual's ISP and must describe at a minimum:

(A) Type of service to be provided;

(B) Hours, rates, location of services, and expected outcomes of services; and

(C) Any specific individual health, safety, and emergency procedures that may be required, including action to be taken if an individual is unable to provide for the individual's own safety and the individual is missing while in the community under the service of a contractor or provider organization.

(k) A written job description for all services to be delivered by an employee of the individual or the individual's legal or designated representative (as applicable). The written job description must be consistent with the individual's ISP and must describe at a minimum:

(A) Type of service to be provided;

(B) Hours, rates, location, duration of services, and expected outcomes of services; and

(C) Any specific individual health, safety, and emergency procedures that may be required, including action to be taken if an individual is unable to provide for the individual's own safety and the individual is missing while in the community under the service of an employee of the individual.

(l) Personal agent correspondence and notes related to resource development and plan outcomes;

(m) Progress notes. Progress notes must include documentation of the delivery of services by a personal agent to support each case service provided. Progress notes must be recorded chronologically and documented consistent with brokerage policies and procedures. All late entries must be appropriately documented. Progress notes must, at a minimum, include:

(A) The month, day, and year the services were rendered and the month, day, and year the entry was made if different from the date service was rendered;

(B) The name of the individual receiving services;

(C) The name of the brokerage, the person providing the service (i.e., the personal agent's signature and title), and the date the entry was recorded and signed;

(D) The specific services provided and actions taken or planned, if any;

(E) Place of service. Place of service means the name of the brokerage and where the brokerage is located, including the address. The place of service may be a standard heading on each page of the progress notes; and

(F) The names of other participants (including titles and agency representation, if any) in notes pertaining to meetings with or discussions about the individual.

(n) Information about individual satisfaction with personal supports and the brokerage's services.

(8) SPECIAL RECORD REQUIREMENTS FOR SUPPORT SERVICES FUND EXPENDITURES.

(a) The brokerage must develop and implement written policies and procedures concerning use of support services funds. These policies and procedures must include but may not be limited to:

(A) Minimum acceptable records of expenditures:

(i) Itemized invoices and receipts to record purchase of any single item;

(ii) A trip log indicating purpose, date, and total miles to verify vehicle mileage reimbursement;

(iii) Itemized invoices for any services purchased from independent contractors, provider organizations, and professionals. Itemized invoices must include:

(I) The name of the individual to whom services were provided;

(II) The date of the services; and

(III) A description of the services.

(iv) Pay records, including timesheets signed by both employee and employer, to record employee services; and

(v) Documentation that services provided were consistent with an individual's authorized ISP.

(B) Procedures for confirming the receipt, and securing the use of, assistive devices, environmental safety modifications, and environmental accessibility adaptations.

(i) When an assistive device is obtained for the exclusive use of an individual, the brokerage must record the purpose, final cost, and date of receipt.

(ii) The brokerage must secure use of equipment or furnishings costing more than \$500 through a written agreement between the brokerage and the individual or the individual's legal representative that specifies the time period the item is to be available to the individual and the responsibilities of all parties if the item is lost, damaged, or sold within that time period.

(iii) The brokerage must ensure that projects for environmental accessibility adaptations and environmental safety modifications involving renovation or new construction in an individual's home or property costing \$5,000 or more per single instance or cumulatively over several modifications:

(I) Are approved by the Department before work begins and before final payment is made;

(II) Are completed or supervised by a contractor licensed and bonded in Oregon; and

(III) That steps are taken as prescribed by the Department for protection of the Department's interest through liens or other legally available means.

(iv) The brokerage must obtain written authorization from the owner of a rental structure before any environmental accessibility adaptations are made to the rental structure.

(b) Any goods purchased with support services funds that are not used according to an individual's ISP or according to an agreement securing the state's use may be immediately recovered.

(c) Failure to furnish written documentation upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, Centers for Medicare and Medicaid Services, or their authorized representatives, immediately or within timeframes specified in the written request, may be deemed reason to recover payments or deny further assistance.

(9) QUALITY ASSURANCE.

(a) The Policy Oversight Group must develop a Quality Assurance Plan and review the plan at least twice a year. The Quality Assurance Plan must include a written statement of values, organizational outcomes, activities, and measures of progress that:

(A) Uses information from a broad range of individuals, legal or designated representatives, professionals, and other sources to determine community support needs and preferences;

(B) Involves individuals in ongoing evaluation of the quality of their personal supports; and

(C) Monitors:

(i) Customer satisfaction with the services of the brokerage and with individual plans in areas such as individual access to supports, sustaining important personal relationships, flexible and unique support strategies, individual choice and control over supports, responsiveness of the brokerage to changing needs, and preferences of the individuals; and

(ii) Service outcomes in areas such as achievement of personal goals and effective use of resources.

(b) The brokerage must participate in statewide evaluation, quality assurance, and regulation activities as directed by the Department.

(10) BROKERAGE REFERRAL TO AFFILIATED ENTITIES.

(a) When a brokerage is part of, or otherwise directly affiliated with, an entity that also provides services that an individual may purchase using private or support services funds, brokerage staff may not refer, recommend, or otherwise encourage the individual to utilize this entity to provide services unless:

(A) The brokerage conducts a review of provider options that demonstrates that the entity's services are cost-effective and best-suited to provide the services determined by the individual to be the most effective and desirable for meeting needs and circumstances represented in the individual's ISP; and

(B) The entity is freely selected by the individual and is the clear choice by the individual among all available alternatives.

(b) The brokerage must develop and implement a policy that addresses individual selection of an entity that the brokerage is a part of, or otherwise directly affiliated, to provide services purchased with private or support services funds. This policy must address, at minimum:

(A) Disclosure of the relationship between the brokerage and the potential provider;

(B) Provision of information about all other potential providers to the individual, or as applicable the individual's legal or designated representative, without bias;

(C) A process for arriving at the option for selecting a provider;

(D) Verification of the fact that the providers were freely chosen among all alternatives;

(E) Collection and review of data on services purchased by an individual enrolled in the brokerage by an entity that the brokerage is a part of or otherwise directly affiliated; and

(F) Training of personal agents and individuals in issues related to the selection of providers.

(11) GENERAL OPERATING POLICIES AND PRACTICES. The brokerage must develop and implement such written statements of policy and procedure in addition to those specifically required by this rule as are necessary and useful to enable the brokerage to accomplish the brokerage's objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0160 Standards for Independent Providers Paid with Support Services Funds

(Temporary Effective 07/01/2014 to 12/28/2014)

(1) PERSONAL SUPPORT WORKER QUALIFICATIONS. Each personal support worker must meet the qualifications described in OAR chapter 411, division 375.

(2) INDEPENDENT PROVIDER QUALIFICATIONS. Each independent provider who is paid as a contractor or a self-employed person, who is not

a personal support worker, selected to provide the services and supports in OAR 411-340-0130 must:

(a) Be at least 18 years of age;

(b) Have approval to work based on current Department policy and a background check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370. A subject individual as defined in OAR 407-007-0210 may be approved for one position to work with multiple individuals statewide when the subject individual is working in the same employment role. The Department's Background Check Request form must be completed by the subject individual to show intent to work statewide;

(A) Prior background check approval for another Department provider type is inadequate to meet background check requirements for personal support worker enrollment.

(B) Background check approval is effective for two years from the date a personal support worker is hired or contracted with to provide in-home services, except in the following circumstances:

(i) Based on possible criminal activity or other allegations against the personal support worker, a new fitness determination is conducted resulting in a change in approval status; or

(ii) The background check approval has ended because the Department has inactivated or terminated the provider enrollment for the personal support worker.

(c) Effective July 28, 2009, not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275;

(d) Be legally eligible to work in the United States;

(e) Not be the spouse of an individual receiving services;

(f) Demonstrate by background, education, references, skills, and abilities that he or she is capable of safely and adequately performing the tasks specified in an individual's ISP, with such demonstration confirmed in writing by the individual, or as applicable the individual's legal or designated representative, and including:

(A) Ability and sufficient education to follow oral and written instructions and keep any records required;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the provider has knowledge of emergency procedures specific to the individual receiving services.

(g) Hold a current, valid, and unrestricted appropriate professional license or certification where services and supervision requires specific professional education, training, and skill;

(h) Understand requirements of maintaining confidentiality and safeguarding individual information;

(i) Not be on the Office of Inspector General's list of excluded or debarred providers (<http://exclusions.oig.hhs.gov/>); and

(j) If providing transportation, have a valid driver's license and proof of insurance, as well as any other license or certification that may be required under state and local law, depending on the nature and scope of the transportation service.

(k) Sign a Medicaid provider agreement and be enrolled as a Medicaid provider prior to delivery of any services.

(3) Section (1)(c) of this rule does not apply to employees of individuals, individuals' legal or designated representatives, employees of general business providers, or employees of provider organizations, who were

hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(4) All providers must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and OAR 407-007-0290. The provider must notify the Department or the Department's designee within 24 hours.

(5) BEHAVIOR CONSULTANTS. Behavior consultants are not Personal Support Workers. Behavior consultants providing specialized supports must:

(a) Have education, skills, and abilities necessary to provide behavior consultation services, including knowledge and experience in developing Behavior Support Plans based on positive behavioral theory and practice;

(b) Have received at least two days of training in the Oregon Intervention Services Behavior Intervention System, and have a current certificate; and

(c) Submit a resume to the brokerage indicating at least one of the following:

(A) A bachelor's degree in special education, psychology, speech and communication, occupational therapy, recreation, art or music therapy, or a behavioral science field, and at least one year of experience with individuals who present difficult or dangerous behaviors; or

(B) Three years experience with individuals who present difficult or dangerous behaviors and at least one year of that experience includes providing the services of a behavior consultant.

(6) NURSE. A nurse providing community nursing services is not a personal support worker. The nurse must:

(a) Have a current Oregon nursing license;

(b) Be enrolled in the Long Term Care Community Nursing Program as described in OAR chapter 411, division 048; and

(c) Submit a resume to the brokerage indicating the education, skills, and abilities necessary to provide nursing services in accordance with state law, including at least one year of experience with individuals.

(7) DIETICIANS. Dieticians providing special diets must be licensed according to ORS 691.415 through 691.465.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0170 Standards for Provider Organizations Paid with Support Services Funds

(Temporary Effective 07/01/2014 to 12/28/2014)

(1) PROVIDER ORGANIZATIONS WITH CURRENT LICENSE OR CERTIFICATION. A provider organization certified, licensed, and endorsed under OAR chapter 411, division 325 for 24-hour residential services, or licensed under OAR chapter 411, division 360 for adult foster homes, or certified and endorsed under OAR chapter 411, division 345 for employment and alternatives to employment services or OAR 411-328-0550 to 411-328-0830 for supported living services, may not require additional certification as an organization to provide relief care, attendant care, skill training, community transportation, or behavior consultation.

(a) Current license, certification, or endorsement is considered sufficient demonstration of ability to:

(A) Recruit, hire, supervise, and train qualified staff;

(B) Provide services according to ISPs; and

(C) Develop and implement operating policies and procedures required for managing an organization and delivering services, including provisions for safeguarding individuals receiving services.

(b) Provider organizations must assure that all people directed by the provider organization as employees, contractors, or volunteers to provide services paid for with support services funds meet the standards for qualification of independent providers described in OAR 411-340-0160.

(c) Provider organizations developing new sites, owned or leased by the provider organization, that are not reviewed as a condition of the current license or certification and where individuals are regularly present and receiving services purchased with support services funds, must meet the conditions of section (2)(f) of this rule in each such site.

(2) PROVIDER ORGANIZATIONS REQUIRING CERTIFICATION. A provider organization without a current license or certification as described in section (1) of this rule must be certified as a provider organization according to OAR 411-340-0030 prior to selection for providing the services listed in OAR 411-340-0130 and paid for with support services funds.

(a) The provider organization must develop and implement policies and procedures required for administration and operation in compliance with these rules, including but not limited to:

(A) Policies and procedures required in OAR 411-340-0040, OAR 411-340-0050, OAR 411-340-0070, OAR 411-340-0080, and OAR 411-340-0090 related to abuse and unusual incidents, inspections and investigations, personnel policies and practices, records, and variances.

(B) Individual rights. The provider organization must have, and implement, written policies and procedures that protect the individual rights described in OAR 411-318-0010 and that:

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

(ii) Protect individuals during hours of service from financial exploitation that may include but is not limited to:

(I) Staff borrowing from or loaning money to individuals;

(II) Witnessing wills in which the staff or provider organization is beneficiary; or

(III) Adding the staff member's or provider organization's name to the individual's bank account or other personal property without approval of the individual or the individual's legal representative (as applicable).

(C) Complaints.

(i) Complaints must be addressed in accordance with OAR 411-318-0015.

(ii) The provider organization must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015.

(iii) Upon enrollment, request, and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual. (D) Policies and procedures appropriate to scope of service, including but not limited to those required to meet minimum standards set forth in subsections (f) to (k) of this section and consistent with written service agreements for individuals currently receiving services.

(b) The provider organization must deliver services according to a written service agreement.

(c) The provider organization must maintain a current record for each individual receiving services. The record must include:

(A) The individual's name, current home address, and home phone number;

(B) A current written service agreement, signed and dated by the individual or the individual's legal or designated representative (as applicable);

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

(D) Contact information for the brokerage assisting the individual to obtain services; and

(E) Records of service provided, including type of services, dates, hours, and personnel involved.

(d) Staff, contractors, or volunteers who provide services to individuals must meet independent provider qualifications in OAR 411-340-0160. Additionally, those staff, contractors, or volunteers must have current CPR and first aid certification obtained from a recognized training agency prior to working alone with an individual.

(e) The provider organization must ensure that employees, contractors, and volunteers receive appropriate and necessary training.

(f) Provider organizations that own or lease sites, provide services to individuals at those sites, and regularly have individuals present and receiving services at those sites, must meet the following minimum requirements:

(A) A written emergency plan must be developed and implemented and must include instructions for staff and volunteers in the event of fire, explosion, accident, or other emergency including evacuation of individuals served.

(B) Posting of emergency information:

(i) The telephone numbers of the local fire, police department, and ambulance service, or "911" must be posted by designated telephones; and

(ii) The telephone numbers of the provider organization director and other people to be contacted in case of emergency must be posted by designated telephones.

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

(D) The provider organization must train all individuals when the individuals begin attending the service site to leave the site in response to an alarm or other emergency signal and to cooperate with assistance to exit the site.

(i) Each provider organization must conduct an unannounced evacuation drill each month when individuals are present.

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

(iii) Any individual failing to evacuate the service site unassisted within the established time limits set by the local fire authority for the site must be provided specialized training or support in evacuation procedures.

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

(I) The date and time of the drill;

(II) The location of the simulated fire;

(III) The last names of all individuals and staff present at the time of the drill;

(IV) The amount of time required by each individual to evacuate if the individual needs more than the established time limit; and

(V) The signature of the staff conducting the drill.

(v) In sites providing services to individuals who are medically fragile or have severe physical limitations, requirements of evacuation drill conduct may be modified. The modified plan must:

(I) Be developed with the local fire authority, the individual or the individual's legal or designated representative (as applicable), and the provider organization director; and

(II) Be submitted as a variance request according to OAR 411-340-0090.

(E) The provider organization must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(F) At least once every three years, the provider organization must conduct a health and safety inspection.

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

(ii) The inspection must be performed by:

(I) The Oregon Occupational Safety and Health Division;

(II) The provider organization's worker's compensation insurance carrier; or

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

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

(iii) The inspection must cover:

(I) Hazardous material handling and storage;

(II) Machinery and equipment used at the service site;

(III) Safety equipment;

(IV) Physical environment; and

(V) Food handling, when necessary.

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

(G) The provider organization must ensure that each service site has received initial fire and life safety inspections performed by the local fire authority or a Deputy State Fire Marshal. The documented results of the inspection, including documentation of recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider for five years.

(H) Direct service staff must be present in sufficient number to meet health, safety, and service needs specified in the individual written agreements of the individuals present. When individuals are present, staff must have the following minimum skills and training:

- (i) At least one staff member on duty with CPR certification at all times;
- (ii) At least one staff member on duty with current First Aid certification at all times;
- (iii) At least one staff member on duty with training to meet other specific medical needs identified in the individual service agreement; and
- (iv) At least one staff member on duty with training to meet other specific behavior intervention needs as identified in individual service agreements.

(g) Provider organizations providing services to individuals that involve assistance with meeting health and medical needs must:

(A) Develop and implement written policies and procedures addressing:

- (i) Emergency medical intervention;
- (ii) Treatment and documentation of illness and health care concerns;
- (iii) Administering, storing, and disposing of prescription and non-prescription drugs, including self-administration;
- (iv) Emergency medical procedures, including the handling of bodily fluids; and
- (v) Confidentiality of medical records;

(B) Maintain a current written record for each individual receiving assistance with meeting health and medical needs that includes:

- (i) Health status;

(ii) Changes in health status observed during hours of service;

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

(iv) A description of any restrictions on activities due to medical limitations.

(C) If providing medication administration when an individual is unable to self-administer medications and there is no other responsible person present who may lawfully direct administration of medications, the provider organization must:

(i) Have a written order or copy of the written order, signed by a physician or physician designee, before any medication, prescription or non-prescription, is administered;

(ii) Administer medications per written orders;

(iii) Administer medications from containers labeled as specified per physician written order;

(iv) Keep medications secure and unavailable to any other individual and stored as prescribed;

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

(vi) Not administer unused, discontinued, outdated, or recalled drugs; and

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

(D) Maintain a MAR (if required). The MAR must include:

- (i) The name of the individual;
- (ii) The brand name or generic name of the medication, including the prescribed dosage and frequency of administration as contained on physician order and medication;
- (iii) Times and dates the administration or self-administration of the medication occurs;
- (iv) The signature of the staff administering the medication or monitoring the self-administration of the medication;
- (v) Method of administration;
- (vi) Documentation of any known allergies or adverse reactions to a medication;
- (vii) Documentation and an explanation of why a PRN, or "as needed", medication was administered and the results of such administration; and
- (viii) An explanation of any medication administration irregularity with documentation of a review by the provider organization director.

(E) Provide safeguards to prevent adverse medication reactions, including:

- (i) Maintaining information about the effects and side-effects of medications the provider organization has agreed to administer;
- (ii) Communicating any concerns regarding any medication usage, effectiveness, or effects to the individual or the individual's legal or designated representative (as applicable); and

(iii) Prohibiting the use of one individual's medications by another individual or person.

(F) Maintain a record of visits to medical professionals, consultants, or therapists if facilitated or provided by the provider organization.

(h) Provider organizations that own or operate vehicles that transport individuals must:

(A) Maintain the vehicles in safe operating condition;

(B) Comply with Department of Motor Vehicles laws;

(C) Maintain insurance coverage on the vehicles and all authorized drivers;

(D) Carry a fire extinguisher and first aid kit in each vehicle; and

(E) Assign drivers who meet applicable Department of Motor Vehicles requirements to operate vehicles that transport individuals.

(i) If assisting with management of funds, the provider organization must have and implement written policies and procedures related to the oversight of the individual's financial resources that include:

(A) Procedures that prohibit inappropriately expending an individual's personal funds, theft of an individual's personal funds, using an individual's funds for staff's own benefit, commingling an individual's personal funds with the provider organization's or another individual's funds, or the provider organization becoming an individual's legal or designated representative; and

(B) The provider organization's reimbursement to the individual of any funds that are missing due to theft or mismanagement on the part of any staff of the provider organization, or of any funds within the custody of the provider organization that are

missing. Such reimbursement must be made within 10 working days of the verification that funds are missing.

(j) Additional standards for assisting individuals to manage difficult behavior.

(A) The provider organization must have, and implement, a written policy concerning behavior intervention procedures. The provider organization must inform the individual, and as applicable the individual's legal or designated representative, of the behavior intervention policy and procedures prior to finalizing the individual's written service agreement.

(B) Any intervention to alter an individual's behavior must be based on positive behavioral theory and practice and must be:

(i) Approved in writing by the individual or the individual's legal or designated representative (as applicable); and

(ii) Described in detail in the individual's record.

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

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

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

(k) Additional standards for supports that involve protective physical intervention.

(A) The provider organization must only employ protective physical intervention:

(i) As part of an individual's ISP;

(ii) As an emergency measure, but only if absolutely necessary to protect the individual or others from immediate injury; or

(iii) As a health-related protection prescribed by a physician, but only if necessary for individual protection during the time that a medical condition exists.

(B) Provider organization staff members who need to apply protective physical intervention under an individual's service agreement must be trained by a Department-approved trainer and documentation of the training must be maintained in the staff members' personnel file.

(C) Protective physical intervention in emergency situations must:

(i) Be only used until the individual is no longer a threat to self or others;

(ii) Be authorized by the provider organization director or the individual's physician within one hour of application of the protective physical intervention;

(iii) Result in the immediate notification of the individual's legal or designated representative (as applicable); and

(iv) Prompt a review of the individual's written service agreement, initiated by the provider organization, if protective physical intervention is used more than three times in a six month period.

(D) Protective physical intervention must be designed to avoid physical injury to an individual or others and to minimize physical and psychological discomfort.

(E) All use of protective physical intervention must be documented and reported according to procedures described in OAR 411-340-0040. The report must include:

(i) The name of the individual to whom the protective physical intervention is applied;

(ii) The date, type, and length of time of the application of protective physical intervention;

(iii) The name and position of the person authorizing the use of the protective physical intervention;

(iv) The name of the staff member applying the protective physical intervention; and

(v) Description of the incident.

(l) Additional standards for supports that involve employment services are found in OAR 411-345-0160.

(3) CERTIFICATE ADMINISTRATIVE SANCTION. An administrative sanction may be imposed for non-compliance with these rules. An administrative sanction includes one or more of the following actions:

(a) Conditions;

(b) Denial, revocation, or refusal to renew a certificate; or

(c) Immediate suspension of a certificate.

(4) CERTIFICATE CONDITIONS.

(a) The Department may attach conditions to a certificate that limit, restrict, or specify other criteria for operation of the agency. The type of condition attached to a certificate shall directly relate to a risk of harm or potential risk of harm to individuals. The Department may attach a condition to a certificate upon a finding that:

(A) Information on the application or initial inspection requires a condition to protect the health, safety, or welfare of individuals;

(B) A threat to the health, safety, or welfare of an individual exists;

(C) There is reliable evidence of abuse, neglect, or exploitation;
or

(D) The agency is not being operated in compliance with these rules.

(b) Conditions that the Department may impose on a certificate include but are not limited to:

(A) Restricting the total number of individuals that may be served;

(B) Restricting the number of individuals allowed within program services based upon the capacity of the agency and staff to meet the health and safety needs of all individuals;

(C) Restricting the support level of individuals allowed within program services based upon the capacity of the agency and staff to meet the health and safety needs of all individuals;

(D) Requiring additional staff or staff qualifications;

(E) Requiring additional training;

(F) Restricting the agency from allowing persons on the premises who may be a threat to an individual's health, safety, or welfare;

(G) Requiring additional documentation; or

(H) Restricting admissions.

(c) NOTICE OF CERTIFICATE CONDITIONS. The Department shall notify the agency in writing of any conditions imposed, the reason for the conditions, and the opportunity to request a hearing under ORS chapter 183. Conditions take effect immediately upon issuance of the notice, or at such later date as indicated on the notice, and shall continue until removed by the Department.

(d) HEARING. The agency may request a contested case hearing in accordance with ORS chapter 183 and this rule upon written notice from the Department of the imposition of conditions.

(A) The agency must request a hearing within 21 days of receipt of the Department's written notice of certificate conditions.

(B) In addition to, or in-lieu of a hearing, an agency may request an administrator review as described in section (7) of this rule. The administrator review does not diminish an agency's right to a hearing.

(e) The agency may send a written request to the Department to remove a condition if the agency believes the situation that warranted the condition has been remedied.

(5) CERTIFICATE DENIAL, REFUSAL TO RENEW, OR REVOCATION.

(a) The Department may deny, refuse to renew, or revoke a certificate when the Department finds the agency, or any person holding 5 percent or greater ownership interest in the agency:

(A) Demonstrates substantial failure to comply with these rules or the corresponding program services rules such that the health, safety, or welfare of individuals is jeopardized and the agency fails to correct the non-compliance within 30 calendar days of receipt of written notice of non-compliance;

(B) Has demonstrated a substantial failure to comply with these rules or the corresponding program services rules such that the health, safety, or welfare of individuals is jeopardized;

(C) Has been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of service;

(D) Has been convicted of a misdemeanor associated with the operation of an agency or program services;

(E) Falsifies information required by the Department to be maintained or submitted regarding individual services, program services finances, or individuals' funds;

(F) Has been found to have permitted, aided, or abetted any illegal act that has had significant adverse impact on individual health, safety, or welfare; or

(G) Has been placed on the current Centers for Medicare and Medicaid Services list of excluded or debarred providers.

(b) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may issue a notice of denial, refusal to renew, or revocation of the certificate following a Department finding that there is a substantial failure to comply with these rules or such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in subsection (a) of this section has occurred.

(c) HEARING. An applicant for a certificate or a certified agency, as applicable, may request a contested case hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for 24-hour residential services, upon written notice from the Department of denial, refusal to renew, or revocation of the certificate.

(A) DENIAL. The applicant must request a hearing within 60 days of receipt of the Department's written notice of denial.

(B) REFUSAL TO RENEW. The agency must request a hearing within 60 days of receipt of the Department's written notice of refusal to renew.

(C) REVOCATION. The agency must request a hearing within 21 days of receipt of the Department's written notice of revocation. In addition to, or in-lieu of a hearing, the agency may request an administrator review as described in section (7) of this rule. The administrator review does not diminish the agency's right to a hearing.

(6) IMMEDIATE SUSPENSION OF CERTIFICATE.

(a) When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for

such findings, the Department may, by written notice to the agency, immediately suspend a certificate without a pre-suspension hearing and the agency may not continue operation.

(b) HEARING. The agency may request a contested case hearing in accordance with ORS chapter 183 and this rule upon written notice from the Department of the immediate suspension of the certificate.

(A) The agency must request a hearing within 21 days of receipt of the Department's written notice of suspension.

(B) In addition to, or in-lieu of a hearing, the agency may request an administrator review as described in section (7) of this rule. The administrator review does not diminish the agency's right to a hearing.

(7) ADMINISTRATOR REVIEW.

(a) The agency, in addition to the right to a contested case hearing, may request an administrator review by the Department's Director or designee.

(b) The request for administrator review must be received by the Department within 10 days from the date of the Department's notice of suspension, revocation, or imposition of conditions. The agency may submit, along with the request for administrator review, any additional written materials the agency wishes to have considered during the administrator review.

(c) The Department shall conduct the administrator review and issue a decision within 10 days from the date of receipt of the request for administrator review, or by a later date as agreed to by the agency.

(d) If the decision of the Department is to affirm the suspension, revocation, or condition, the agency may appeal the decision to a contested case hearing as long as the request for a contested case hearing was received by the Department within 21 days of the original written notice of suspension, revocation, or imposition of conditions.

(8) **INFORMAL CONFERENCE.** After the Department has received a request for hearing, the Department shall offer the applicant or the agency an opportunity for an informal conference unless an administrator review has been completed as described in section (7) of this rule.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

411-340-0180 Standards for General Business Providers Paid with Support Services Funds

(Amended 12/28/2013)

(1) General business providers providing services to individuals and paid with support services funds must hold any current license appropriate to function required by the state of Oregon or federal law or regulation, including but not limited to:

- (a) For a home health agency, a license under ORS 443.015;
- (b) For an in-home care agency, a license under ORS 443.315;
- (c) For providers of environmental accessibility adaptations involving building modifications or new construction, a current license and bond as a building contractor as required by either OAR chapter 812 (Construction Contractor's Board) or OAR chapter 808 (Landscape Contractors Board);
- (d) For environmental accessibility consultants, a current license as a general contractor as required by OAR chapter 812, including experience evaluating homes, assessing the needs of an individual, and developing cost-effective plans to make homes safe and accessible;
- (e) For public transportation providers, the established standards;
- (f) For private transportation providers, a business license and drivers licensed to drive in Oregon;

(g) For vendors and medical supply companies providing specialized equipment and supplies, a current retail business license including enrollment as Medicaid providers through the Division of Medical Assistance Programs if vending medical equipment;

(h) A current business license for providers of personal emergency response systems; and

(i) Retail business licenses for vendors and supply companies providing special diets.

(2) Services provided and paid for with support services funds must be limited to the services within the scope of the general business provider's license.

Stat. Auth.: ORS 409.050, 427.402, and 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695