

Secretary of State
Certificate and Order for Filing
TEMPORARY ADMINISTRATIVE RULES
A Statement of Need and Justification accompanies this form.

I certify that the attached copies* are true, full and correct copies of the TEMPORARY Rule(s) adopted on [upon filing] by the
Date prior to or same as filing date

Department of Human Services, Developmental Disabilities

411

Agency and Division	Administrative Rules Chapter Number
Kimberly Colkitt-Hallman 500 Summer Street NE, E-48 Salem, OR 97301-1074	(503) 945-6398

Rules Coordinator	Address	Telephone
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to become effective [January 1, 2016] through [June 28, 2016].
Date upon filing or later A maximum of 180 days including the effective date.

RULE CAPTION

ODDS: Support Services for Adults with Intellectual or Developmental Disabilities

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

List each rule number separately, 000-000-0000.
Secure approval of new rule numbers (Adopted rules) with the Administrative Rules Unit prior to filing

ADOPT:

AMEND:

411-340-0020; 411-340-0030; 411-340-0120; 411-340-0130; 411-340-0140;
411-340-0150; 411-340-0160; 411-340-0170.

SUSPEND:

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

Other Auth.:

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

RULE SUMMARY

The Department of Human Services, Office of Developmental Disabilities Services (Department) is temporarily amending the rules for support services for adults with intellectual or developmental disabilities in OAR chapter 411, division 340 to --

- Provide consistency across services by removing terms included in the general definitions rule, OAR 411-317-0000;
- Incorporate the most recent version of the In-Home Expenditure Guidelines;
- Align provider requirements associated with delivering in home attendant care and related services, and employment services, with other developmental disability services;
- Require an agency to obtain Medicaid certification and endorsement appropriate to each service delivered;
- Incorporate the adoption of the rules for home and community-based (HCB) services and settings and person-centered service planning in OAR chapter 411, division 004. The rules in OAR chapter 411, division 004 implement the regulations and expectations of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) by providing a foundation of standards to support the network of Medicaid-funded and private pay residential and non-residential HCB services and settings and person-centered service planning;
- Implement changes associated with the Fair Labor Standards Act by limiting payment to no more than 50 hours in a work week per personal support worker per individual;
- Incorporate guidelines for conflict free case management to prohibit individuals from receiving case management services from an entity that is affiliated with other direct service providers;
- Clarify the authorization and administration of State Plan private duty nursing services by the Medically Fragile Children's Unit to support an individual aged 18 through 20 in the family home; and
- Incorporate direct nursing services to support an adult with complex health management support needs in his or her home and community as described in OAR chapter 411, division 380.

Signed Lilia Teninty, Director, Developmental Disabilities

12/21/2015

Signature

Date

STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Department of Human Services, Developmental Disabilities

411

Agency and Division

Administrative Rules Chapter Number

In the Matter of: The temporary amendment of OAR 411-340-0020; 411-340-0030; 411-340-0120; 411-340-0130; 411-340-0140; 411-340-0150; 411-340-0160; and 411-340-0170 relating to support services for adults with intellectual or developmental disabilities.

Rule Caption: (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

ODDS - Support Services for Adults with Intellectual or Developmental Disabilities

Statutory Authority:

ORS 409.050, 427.402, 430.662

Other Authority:

Stats. Implemented:

ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

Need for the Temporary Rule(s):

Definitions

The Department needs to amend the following rules to provide consistency, streamline definitions across services, and incorporate the most recent version of the In-Home Expenditure Guidelines:

- OAR 411-340-0020 (Definitions); and
- OAR 411-340-0130 (Using Support Services Funds to Purchase Supports).

These rules are being amended to remove terms included in OAR 411-317-0000 (General Definitions) and incorporate the most recent version of the In-Home Expenditure Guidelines.

Provider Organization Requirements

The Department needs to amend the following rules to assure that only appropriately established and qualified providers are delivering services. These rules changes are necessary to demonstrate the state's commitment to the Employment First policy:

- OAR 411-340-0020 (Definitions);
- OAR 411-340-0030 (Certification of Support Services Brokerages and Provider Organizations); and
- OAR 411-340-0170 (Standards for Provider Organizations Paid with Support Services Funds).

These rules are being amended to --

- Align provider requirements associated with delivering in home attendant care and related services, and employment services, with other developmental disability services; and
- Require an agency to obtain Medicaid certification and endorsement appropriate to each service delivered.

HCB Services and Settings

The Department needs to amend the following rules to implement the regulations and expectations of CMS for Medicaid-funded and private pay residential and non-residential HCB services and settings and person-centered service planning:

- OAR 411-340-0020 (Definitions);
- OAR 411-340-0120 (Support Service Brokerage Services);
- OAR 411-340-0130 (Using Support Services Funds to Purchase Supports); and
- OAR 411-340-0140 (Using Support Services Funds for Certain Purchases is Prohibited).

These rules are being amended to incorporate the standards for HCB services and settings and person-centered service planning adopted in OAR chapter 411, division 004 by the Department on January 1, 2016.

Personal Support Workers

The Department needs to amend OAR 411-340-0130 (Using Support Services Funds to Purchase Supports) to implement changes associated with the Fair Labor Standards Act. OAR 411-340-0130 is being amended to limit payment to a single personal support worker per individual to no more than 50 hours in a work week unless the personal support worker is delivering relief care or an exception has been granted by the Brokerage or Department.

Conflict Free Case Management

The Department needs to amend the following rules to incorporate guidelines for conflict free case management to align the rules with federal expectations identified in regulations associated with the 1915(k) state plan amendment, 1915(c) waivers, and the home and community-based services regulations. The expectation is that assessment and developmental disability service authorization should not be done by an entity that is identified to provide developmental disability services:

- OAR 411-340-0020 (Definitions);
- OAR 411-340-0140 (Using Support Services Funds for Certain Purchases is Prohibited); and

- OAR 411-340-0150 (Standards for Support Services Brokerage Administration and Operations).

These rules are being amended to incorporate guidelines for conflict free case management to prohibit individuals from receiving case management services from an entity that is affiliated with other direct service providers.

Private Duty and Direct Nursing Services

The Department needs to amend the following rules to incorporate private duty and direct nursing services:

- OAR 411-340-0020 (Definitions); and
- OAR 411-340-0160 (Standards for Independent Providers Paid with Support Services Funds).

These rules are being amended to --

- Clarify the authorization and administration of State Plan private duty nursing services by the Medically Fragile Children's Unit to support an individual aged 18 through 20 in the family home; and
- Incorporate direct nursing services to support an adult with complex health management support needs in his or her home and community as described in OAR chapter 411, division 380.

Documents Relied Upon, and where they are available:

Justification of Temporary Rule(s):

Failure to act promptly and immediately update the rules in OAR chapter 411, division 340 will result in serious prejudice to --

- Individuals applying for, or receiving, developmental disability services;
- The parents, guardians, family members, and representatives of individuals receiving services;
- Brokerages;
- Providers; and
- The Department.

These rules need to be updated promptly to --

- Remove terms included in the general definitions rule, OAR 411-317-0000;
- Incorporate the most recent version of the In-Home Expenditure Guidelines;
- Align provider requirements associated with delivering in home attendant care and related services, and employment services, with other developmental disability services;

- Require an agency to obtain Medicaid certification and endorsement appropriate to each service delivered;
- Align with the new CMS standards relating to HCB services and settings and person-centered service planning adopted by the Department in OAR chapter 411, division 004;
- Implement changes associated with the Fair Labor Standards Act by limiting payment to no more than 50 hours in a work week per personal support worker per individual;
- Incorporate guidelines for conflict free case management to prohibit individuals from receiving case management services from an entity that is affiliated with other direct service providers; and
- Incorporate private duty and direct nursing services.

Failure to immediately update these rules --

- Prevents these rules from aligning with OAR chapter 411, division 004 (HCB Services and Settings and Person-Centered Service Planning); OAR 411-317-0000 (Definitions); OAR chapter 411, division 323 (Agency Certification and Endorsement); 411-350-0055 (Private Duty Nursing); OAR chapter 411, division 375 (Personal Support Workers); and OAR chapter 411, division 380 (Direct Nursing Services);
- Prevents the Department from streamlining operations to provide consistency across services and incorporating the most recent version of the In-Home Expenditure Guidelines;
- Prevents the Department from assuring that only appropriately established and qualified providers deliver services;
- Risks non-compliance with the Fair Labor Standards Act, Employment First Policy, and the new CMS standards relating to HCB services and settings and person-centered service planning; and
- Prevents individuals with complex health needs from accessing private duty and direct nursing services.

Signed Lilia Teninty, Director, Developmental Disabilities

12/21/2015

Signature

Date

DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 340

SUPPORT SERVICES FOR ADULTS WITH
INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

411-340-0020 Definitions

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" 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.~~

~~(31) "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 state plan 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 home and community 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 support 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 as described in OAR 411-340-0160 who conducts functional assessments and 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 primary caregiver or provider to follow in order to reduce the frequency and intensity of the challenging behaviors of an individual and to modify the behavior of the primary caregiver or 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 provides cognitive supports to mitigate behavior. Behavior support services are provided in the home or community.~~

(162) "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.

(173) "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:~~

~~(a) The employment goals and objectives for an individual;~~

~~(b) The services and supports needed to achieve those goals;~~

~~(c) The people, agencies, and providers assigned to assist the individual to attain those goals;~~

~~(d) The obstacles to the individual working in an individualized job in an integrated employment setting; and~~

~~(e) The services and supports necessary to overcome those obstacles.~~

~~(19) "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).~~

(204) "CDDP" means "cCommunity dDevelopmental dDisability pProgram" as defined in OAR 411-320-0020.

(215) "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.

~~(22) "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. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated through a variety of methods, including orally, through sign language, or by other communication methods.~~

(23) "Choice Advising" means the impartial sharing of information to individuals with intellectual or developmental disabilities provided by a person that meets the qualifications in OAR 411-340-0150(5) about:

- (a) Case management;
- (b) Service options;
- (c) Service setting options; and
- (d) Provider types.

~~(24) "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.~~

(7) "Clinical Criteria" means the criteria used by the Department or the Medically Fragile Children's Unit as described in OAR 411-350-0055 to assess the private duty nursing support needs of an individual aged 18 through 20.

~~(25) "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.~~

~~(26) "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.~~

~~(27) "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 that are not medical in nature. 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.~~

~~(28) "Completed Application" means completed application as defined in OAR 411-320-0020.~~

~~(29) "Comprehensive Services" means developmental disability services and supports that include 24-hour residential services and attendant care 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 program for employment. 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.~~

~~(30) "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 and the utilization of assistive devices, natural supports, environmental modifications, and alternative resources. Less costly alternatives may include resources not paid for by the Department.~~

~~(31) "CPMS" means "Client Process Monitoring System". CPMS is the Department computerized system for enrolling and terminating services for individuals with intellectual or developmental disabilities.~~

~~(32) "Crisis" means "crisis" as defined in OAR 411-320-0020.~~

(~~339~~) "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.

~~(34) "Delegation" is the process by which 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.~~

(~~35~~10) "Department" means the Department of Human Services.

~~(36) "Designated Representative" means any adult, such as a parent, family member, guardian, advocate, or other person, who is chosen by an individual or the legal representative of the individual, not a paid provider for the individual, and authorized by the individual or the legal representative of the individual to serve as the representative of the individual or the legal representative of the individual in connection with the provision of funded supports. An individual or a legal representative of the individual is not required to appoint a designated representative.~~

~~(37) "Developmental Disability" means "developmental disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.~~

(~~38~~11) "Director" means the Director of the Department of Human Services, Office of Developmental Disability Services or Office of Licensing and Regulatory Oversight, or the designee of the Director.

~~(12) "Direct Nursing Services" mean the nursing services described in OAR chapter 411, division 380 that are determined medically necessary to support an adult with complex health management support needs in his or her home and community. Direct nursing services are provided on a shift staffing basis.~~

(~~39~~13) "Discovery and Career Exploration" means "discovery and career exploration" as defined in OAR 411-345-0020.

~~(40) "Emergent Status" means an individual has been determined to be eligible for crisis diversion services according to OAR 411-320-0160.~~

~~(41) "Employer" means, for the purposes of obtaining in-home support through a personal support worker 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 or the legal representative of the individual to conduct the employer responsibilities described in OAR 411-340-0135. An employer may also be a designated representative.~~

~~(42) "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 may 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 service agreements; and~~

~~(d) Fiscal intermediary services.~~

~~(4314) "Employment Path Services" means "employment path services" as defined in OAR 411-345-0020.~~

~~(4415) "Employment Services" means "employment services" as defined in OAR 411-345-0020.~~

~~(4516) "Employment Specialist" means "employment specialist" as defined in OAR 411-345-0020.~~

(17) "Endorsement" means the authorization to provide program services issued by the Department to a certified agency that has met the qualification criteria outlined in these rules, the corresponding program rules, and the rules in OAR chapter 411, division 323.

(18) "Entity" means a person, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation of a state.

~~(46) "Entry" means admission to a Department-funded developmental disability service.~~

~~(47) "Environmental Modifications" 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 or lead to a substitution for, or decrease in, direct human assistance to the extent expenditures would otherwise be made for human assistance.~~

~~(48) "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 or lead to a substitution for, or decrease in, direct human assistance to the extent expenditures would otherwise be made for human assistance.~~

~~(49) "Exit" means termination or discontinuance of a Department-funded developmental disability service by a licensed or certified provider organization.~~

(5019) "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.

~~(51) "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.~~

~~(52) "Fiscal Intermediary" means a person or entity that receives and distributes support services funds on behalf of an employer.~~

~~(5320)~~ "Functional Needs Assessment":

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

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

(B) Identifies risk factors and support needs; and

(C) Determines the service level.

(b) The functional needs assessment for an adult enrolled in a support services brokerage is known as the Adult Needs Assessment (ANA). ~~Effective December 31, 2014, t~~The Department incorporates Version C of the ANA into these rules by this reference. The ANA is maintained by the Department at:

~~<http://www.dhs.state.or.us/spd/tools/dd/ANAAadultInhome.xls>~~

~~<http://www.dhs.state.or.us/spd/tools/dd/cm/>. A Pprinted copies copy~~ of a blank ANA may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

~~(54) "General Business Provider" means an organization or entity selected by an individual and paid with support services funds that:~~

~~(a) Is primarily in business to provide the service chosen by 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.~~

~~(55) "Hearing" means a contested case hearing subject to OAR 137-003-0501 to 137-003-0700, which results in a Final Order.~~

~~(56) "Home" means the primary residence for an individual that is not under contract with the Department to provide services as a certified or licensed foster home, residential care facility, assisted living facility, nursing facility, or other residential support program site.~~

~~(5721) "Home Delivered Meals" means "Home Delivered Meals" as defined in OAR 411-040-0010.~~

~~(5822) "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) Managing personal finances;~~

~~(c) Shopping for food, clothing, and other essential items;~~

~~(d) Performing essential household chores;~~

~~(e) Communicating by phone or other media; and~~

~~(f) Traveling around and participating in the community.~~

(5923) "ICF/ID" means an intermediate care facility for individuals with intellectual disabilities.

(6024) "In-Home Expenditure Guidelines" mean the guidelines published by the Department that describe allowable uses for support services funds. Effective January 1, ~~2015~~2016, the Department incorporates Version ~~24~~.0 of the In-home Expenditure Guidelines into these rules by this reference. The In-home Expenditure Guidelines are maintained by the Department at: (~~http://www.dhs.state.or.us/spd/tools/dd/cm/ss_exp_guide.pdf~~~~http://www.oregon.gov/dhs/dd/adults/ss_exp_guide.pdf~~). A printed copy may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(25) "Incident of Ownership" means an ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interest.

~~(61) "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.~~

~~(62) "Independence" means the extent to which an individual exerts control and choice over his or her own life.~~

~~(63) "Independent Provider" means a person selected by an individual and paid with support services funds to directly provide services to the individual.~~

(26) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in another entity. Indirect ownership interest includes an ownership interest in an entity that has an indirect ownership interest in another entity.

~~(64) "Individual" means an adult with an intellectual or developmental disability applying for, or determined eligible for, Department-funded services. Unless otherwise specified, references to individual also include the legal or designated representative of the individual, who has the ability to act for the individual and to exercise the rights of the individual.~~

~~(65) "Integration" as defined in ORS 427.005 means:~~

~~(a) 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 disabilities participate, together with regular contact with people without disabilities; and~~

~~(c) Residence by individuals with intellectual or developmental disabilities in homes or in home-like settings that are in proximity to community resources, together with regular contact with people without disabilities in their community.~~

~~(66) "Intellectual Disability" means "intellectual disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.~~

~~(6727) "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 the 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 that is driven by the individual. The ISP reflects 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 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, Community First Choice state plan,~~

~~natural supports, or alternative resources. The ISP includes the Career Development Plan.~~

(~~6828~~) "Job Coaching" means "job coaching" as defined in OAR 411-345-0020.

(~~6929~~) "Job Development" means "job development" as defined in OAR 411-345-0020.

~~(70) "Legal Representative" means an attorney at law who has been retained by or for an individual, a person acting under the authority granted in a power of attorney, or a person or agency authorized by a court to make decisions about services for an individual.~~

(~~7130~~) "Level of Care" means an individual meets the following institutional level of care for an ICF/ID:

(a) The individual has a 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.

~~(72) "Natural Supports" means the voluntary resources available to an individual from the individual's relatives, friends, significant others, neighbors, roommates, and the community that are not paid for by the Department.~~

~~(73) "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 as well as any service plans developed by other health professionals.~~

(31) "OHA" means the "Oregon Health Authority".

(~~7432~~) "OHP Plus" means only the Medicaid benefit packages provided under OAR 410-120-1210(4)(a) and (b). This excludes individuals receiving Title XXI benefits.

(~~7533~~) "OSIPM" means "Oregon Supplemental Income Program-Medical" as described in OAR 461-001-0030. OSIPM is Oregon Medicaid insurance coverage for individuals who meet the eligibility criteria described in OAR chapter 461.

(34) "Owner" means a person with an ownership interest.

(35) "Ownership Interest" means the possession of equity in the capital, stock, or profits of an entity.

~~(76) "Person-Centered Planning":~~

~~(a) Means a timely and formal or informal process driven by an individual, includes people chosen by the individual, ensures the individual directs the process to the maximum extent possible, and the individual is enabled to make informed choices and decisions consistent with 42 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, providers, service settings, 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.~~

(~~77~~36) "Personal Agent" means a person who:

~~(a) is~~ a case manager for the provision of case management services;

~~(b) Is the person-centered plan coordinator for an individual as defined in the Community First Choice state plan amendment;~~

~~(c) works~~ Works directly with individuals and, if applicable, the legal or designated representatives and families of individuals, ~~if applicable~~, to provide or arrange for support services as described in these rules;

~~(d) meets~~ Meets the qualifications set forth in OAR 411-340-0150(5) and

~~(e) 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.~~

~~(78) "Personal Support Worker" means "personal support worker" as defined in OAR 411-375-0010.~~

(~~79~~37) "Plan Year" means 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.

(~~80~~38) "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.

~~(81) "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 intrusive intervention possible;~~

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

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

~~(82) "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.~~

(39) "Private Duty Nursing Services" mean the State Plan nursing services described in OAR chapter 410, division 132 (OHA, Private Duty Nursing Services) and OAR 411-350-0055 that are determined medically necessary to support an individual aged 18 through 20.

~~(83) "Productivity" as defined in ORS 427.005 means regular engagement in income-producing work, preferable competitive employment with supports and accommodations to the extent necessary, by an individual that is measured through improvements in income level, employment status, or job advancement or engagement by an individual in work contributing to a household or community.~~

~~(84) "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.~~

~~(85) "Protective Services" mean the necessary actions offered to an individual as soon as possible to prevent subsequent abuse or exploitation~~

~~of the individual, to prevent self-destructive acts, or to safeguard the person, property, and funds of the individual.~~

~~(86) "Provider" means a person, agency, organization, or business selected by an individual that provides recognized Department-funded services and is approved by the Department or other appropriate agency to provide Department-funded services.~~

~~(87) "Provider Organization" means an entity, licensed or certified by the Department, selected by an 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 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.~~

~~(88) "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.~~

~~(89) "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.~~

~~(90) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services.~~

~~(9140) "Regional Crisis Diversion Program" means "Regional Crisis Diversion Program" as defined in OAR 411-320-0020.~~

~~(92) "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.~~

~~(93) "Scope of Work" means the written statement of all proposed work requirements for an environmental modification which may include dimensions, measurements, materials, labor, and outcomes necessary for a contractor to submit a proposal to complete such work. The scope of work is specific to the identified tasks and requirements necessary to address the needs outlined in the supplemental assessment, referenced in the ISP, and relating to the ADL, IADL, and health-related tasks of the individual as discussed by the individual, homeowner, personal agent, and ISP team.~~

~~(94) "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, 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 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 to live a life in the community rich in community affiliations; and~~

~~(d) Responsibility. The acceptance of a valued role of an individual 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.~~

~~(95) "Self-Direction" means that an 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.~~

~~(96) "Service Agreement":~~

~~(a) Is the written agreement consistent with an ISP that describes, 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 their own safety and the individual is missing while in the community under the service of a contractor or provider organization.~~

~~(b) For employed personal support workers, the service agreement serves as the written job description.~~

~~(97) "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.~~

~~(98) "Services Coordinator" means "services coordinator" as defined in OAR 411-320-0020.~~

~~(99) "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.~~

~~(100) "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.~~

~~(101) "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.~~

~~(102) "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 through state plan or alternative resources;~~

~~(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.~~

~~(103) "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.~~

(10441) "Support Services" mean the services of a brokerage listed in OAR 411-340-0120 ~~as well as and~~ 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~~his or her own home or the family home;
- (b) Are designed, selected, and managed by an individual;
- (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.

(10542) "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.

(10643) "Support Services Funds" mean the public funds designated by the brokerage for assistance with the purchase of supports according to an ISP.

(10744) "Supported Employment - Individual Employment Support" means "supported employment - individual employment support" as defined in OAR 411-345-0020.

(10845) "Supported Employment - Small Group Employment Support" means "supported employment - small group employment support" as defined in OAR 411-345-0020.

(10946) "These Rules" mean the rules in OAR chapter 411, division 340.

~~(110) "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/ID to a community-based home setting where the individual resides.~~

~~(111) "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.~~

(11247) "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.

~~(113) "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.~~

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

(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 granted certification under OAR 411-340-0170(2), and people or governmental units named in the application.

(d) Certificates, including those issued on or after November 15, 2008 before January 1, 2016 are effective for a maximum of five two years.

(e) The Department shall conduct a review of the brokerage, or the provider organization requiring granted certification under OAR 411-340-0170(2), or requiring certification and endorsement as set forth in OAR chapter 411 division 323, prior to the issuance of a certificate or endorsement.

(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 provider organization requesting certification under these rules must apply before January 1, 2016.

(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. A certificate for a provider organization that was issued under these rules before January 1, 2016 may not be renewed. On and after January 1, 2016, the provider organization must apply for certification and endorsement as set forth in OAR chapter 411, division 323.

(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~~Before 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 or two years from the date the certificate was issued, whichever is sooner.

(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~~five 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 of the brokerage or provider organization.

(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~~ the ownership, legal entity, or legal status of a brokerage or provider organization. The brokerage or provider organization must apply for a certificate as described in section (2) of this rule ~~submit a certificate application~~ at least 30 days ~~prior to~~before the 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~~five 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~~

411-340-0120 Support Service Brokerage Services

(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 the 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 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 business 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 business 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 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, and as applicable the legal or designated representative of the individual, and all current providers within 10 business 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) OSIPM/OHP PLUS ELIGIBILITY. If an individual loses OSIPM or OHP Plus eligibility, a personal agent must assist the individual in identifying why OSIPM or OHP Plus eligibility was lost. Whenever possible, the personal agent must assist the individual in becoming eligible for OSIPM or OHP Plus again. The personal agent must document efforts taken to assist the individual in becoming OSIPM 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 as identified in the ISP 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 notes. 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.

(a) 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. Documentation of the discussion must be included in the service record for the individual.

(b) Beginning no later than July 1, 2016, in accordance with the rules for home and community-based services and settings in OAR chapter 411, division 004, an individual, or as applicable the legal or designated representative of the individual, must be advised regarding the available residential and non-residential settings, including non-disability specific settings and an option for a private unit in a residential setting. The settings options must be:

(A) Identified and documented in the ISP as described in section (10) of this rule;

(B) Based on the needs and preferences of the individual;

(C) For residential settings, the available resources of the individual for room and board; and

(D) For employment and non-residential day services, a non-disability specific setting option must be presented and documented in the ISP.

(8) LEVEL OF CARE DETERMINATION.

(a) The brokerage must assure that an individual who is eligible for OHP Plus or OSIPM or who becomes eligible after entry into the brokerage:

(A) Receives a level of care determination prior to accessing services and prior to an initial functional needs assessment;

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

(C) Is provided a notice of fair hearing rights (Notification of Rights SDS 0948); and

(D) Has the level of care determination reviewed annually not more than 60 days prior to the renewal of the ISP, 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 assessment must be documented in a progress note in the record for the individual.

(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, or is expected to enroll in, waiver or Community First Choice state plan services.

(a) A functional needs assessment must be completed:

(A) Not more than 45 days from the date ~~that~~ the individual submitted a completed application to the CDDP or the date the individual became eligible for OHP Plus or OSIPM;

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

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

(D) Within 45 days from the date an individual requests a functional needs re-assessment.

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

(c) An individual, and 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 reassessment 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 reassessment within the applicable time frame results in the 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 prevent timely participation in the functional needs assessment or reassessment or timely submission of information necessary to complete the functional needs assessment or reassessment.

(d) No fewer than 14 days prior to conducting a functional needs assessment, the brokerage must mail a notice of the assessment process to the individual to be assessed. The notice must include a description and explanation of the assessment process and an explanation of the process for appealing the results of the assessment.

(10) INDIVIDUAL SUPPORT PLANS.

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

(A) The personal agent must facilitate and develop an ISP through a person-centered service planning process. ~~must be facilitated, developed, and authorized by a personal agent.~~

(B) The initial ISP must be authorized; by the personal agent --

(i) No more than 90 days from the date a completed application is submitted to 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 or no more than 45 days from the date the level of care determination was made.

~~(DC)~~ A-The personal agent must review and revise the ISP for ~~the~~ an individual ~~--~~

(i) Upon reassessment of functional needs as required every 12 months;

(ii) When the circumstances or needs of the individual change; or

(iii) as needed if a revision of the ISP is requested by the individual or legal representative of the individual. The revision of the ISP must be completed within 30 days from the date of the request of the individual.

(GD) 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, t~~The written ISP must include, but not be limited to, the following:

(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;~~

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

(C) Home and community-based service and setting options --

(i) Based on the needs and preferences of the individual, and for residential settings, the available resources of the individual for room and board;

(ii) Chosen by the individual; and

(iii) Integrated in and support full access to the greater community;

(D) Opportunities to seek employment and work in competitive integrated employment settings for those individuals who desire to work.

(i) If the individual wishes to pursue employment, a non-disability specific setting option must be presented and documented in the ISP.

(ii) Individuals working in sheltered workshops shall be encouraged to use services in integrated settings.

(E) Opportunities to engage in community life, control personal resources, and receive services in the community to the same degree of access as people not receiving home and community-based services;

(F) The strengths and preferences of the individual;

(G) The service and support needs of the individual;

(H) The goals and desired outcomes of the individual;

(I) The providers of services and supports, including unpaid supports provided voluntarily;

(J) Risk factors and measures in place to minimize risk;

(K) Individualized backup plans and strategies, when needed;

(L) People important in supporting the individual;

(M) The person responsible for monitoring the ISP;

(N) Language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual receiving services and the people important in supporting the individual;

(O) The written informed consent of the individual or, if applicable, the legal or designated representative of the individual;

(P) Signatures of the individual, or if applicable the legal or designated representative of the individual, and all people and providers with whom the ISP was shared in its entirety, or as described below in subsection (d) of this section;

(Q) Self-directed supports; and

(R) Provisions to prevent unnecessary or inappropriate services and supports.

(c) The individual, or if applicable the legal or designated representative of the individual, decides on the level of information in the ISP that is shared with providers. To effectively provide services, providers must have access to necessary information from the ISP that the provider is responsible for implementing. A provider identified to deliver a service or support included in an ISP must acknowledge through a signature on a written agreement receipt of the necessary information.

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

~~(D) A list of personal, community, and alternative 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, Community First Choice state plan services, other state plan services, state general funds, or natural supports;~~

~~(E) The manner in which services are delivered and the frequency of services;~~

~~(F) Provider type;~~

~~(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 for assistance with support and service needs;~~

~~(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) The ISP must be made available using language, format, and presentation methods appropriate for effective communication~~

~~according to the needs and abilities of the individual receiving services and the people important in supporting the individual.~~

(d) 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.

(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.

(e) After September 1, 2018, the brokerage must only authorize services delivered in a home and community-based setting that meets the qualities described in OAR 411-004-0020 and non-residential employment service and day service settings that are consistent with OAR 411-004-0020(1), as implemented in OAR chapter 411, division 345:

(A) The setting must be integrated in and support the same degree of access to the greater community as people not receiving home and community-based services, including opportunities for individuals enrolled in or utilizing home and community-based services to:

(i) Seek employment and work in competitive integrated employment settings. Employment service settings must, at minimum, provide interaction with the general public (including opportunities to work with customers and coworkers who do not have disabilities or use home and community-based services). Non-residential day service settings must, at minimum, be used to facilitate going out into the broader community and away from a provider site;

(ii) Engage in community life;

(iii) Control personal resources; and

(iv) Receive services in the community.

(B) The setting must ensure individual rights of privacy, dignity, respect, and freedom from coercion and restraint;

(C) The setting must optimize but not regiment individual initiative, autonomy, self-direction, and independence in making life choices including, but not limited to, daily activities, physical environment, and with whom to interact; and

(D) The setting must facilitate individual choice regarding services and supports, and who provides the services and supports.

(f) An ISP must not authorize any single personal support worker to be paid for more than 50 hours in a work week per individual unless --

(A) The personal support worker is delivering daily relief care; or

(B) An exception has been granted by the brokerage or Department.

(eg) 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 oral 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 oral agreement may substitute for a signature for no more than 10 business 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 to a brokerage, the CDDP ISP may be used as authorization for available support services for up to 90 days.

(fh) PERIODIC REVIEW OF ISP AND RESOURCES.

(A) A personal agent must facilitate 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 state plan services.

(a) A personal agent must complete an Annual Plan within 60 days of the entry of an individual into support services, and annually thereafter if the individual is not enrolled in any waiver or Community First Choice state plan 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 are authorized for the provision of the following:

(A) Community nursing services as described in OAR chapter 411, division 048;

(B) Private duty nursing services as described in OAR 411-350-0055; and

(C) Direct nursing services as described in OAR chapter 411, division 380. ~~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.

Employment service providers, including Vocational Rehabilitation, must have a copy of the Career Development Plan.

(13) TRANSITION TO ANOTHER BROKERAGE OR TO A CDDP. At the request of an individual enrolled in brokerage services who has selected another brokerage or CDDP to provide case management and to arrange services, the brokerage must collaborate with the receiving brokerage or CDDP of the county of origin 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 business days. Planning for a transfer of case management services must begin within ~~ten~~ 10 business 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 business days. Planning for a transfer of case management services to the available brokerage must begin within ~~ten~~ 10 business days of the request unless a later date is mutually agreed upon by the individual, the brokerage, and the CDDP of the county of origin 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 the 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

411-340-0130 Using Support Services Funds to Purchase Supports

(1) Support services funds may be used to assist individuals to purchase supports described in section (8) of this rule, in accordance with an ISP when the following conditions are met:

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

(b) For Community First Choice state plan services, the support ~~shall~~ addresses 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 the services as described in section (8) of this rule;
- (e) Cost-effective arrangements for obtaining the required supports, applying public, private, formal, and informal-alternative resources available to the eligible individual are specified in the ISP for the individual;

(A) Support services funds are not intended to replace the resources available to an individual from the voluntarily provided natural supports of the individual.

(B) Support services funds are not available when the support needs of an individual 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; and

(g) After September 1, 2018, the supports are delivered in a home and community-based setting that meets the qualities described in OAR 411-004-0020.

(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 18th birthday of the individual, 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 18th birthday of the individual;

(b) The Social Security Administration or the Presumptive Medicaid Disability Determination Team of the Department 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 and OSIPM.

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

(5) POST ELIGIBILITY TREATMENT OF INCOME. Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

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

(a) The service level for an individual as determined by a functional needs assessment. The functional needs assessment determines the total number of hours available to meet identified needs. The total number of hours may not be exceeded without prior approval from the Department. The types of services that contribute to the total of hours used include:

(A) Attendant care;

(B) Hourly relief care;

(C) Skills training; and

(D) State plan personal care services as described in OAR chapter 411, division 034.

(b) Other services and supports determined by a personal agent to be necessary to meet the support needs identified through a person-centered planning process and consistent with the In-home Expenditure Guidelines; and

(c) Employment services and payment for employment services are limited to:

(A) An average of 25 hours per week for any combination of job coaching, small group employment support, and employment path services; and

(B) 40 hours in any one week for job coaching if job coaching is the only service utilized.

(d) Payment for no more than 50 hours in a work week by a single personal support worker per individual unless --

(A) The personal support worker is delivering daily relief care; or

(B) An exception has been granted by the brokerage or Department.

(7) 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 families of individuals for expenses related to services and from advancing funds to individuals or families of individuals to obtain services.

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

(8) TYPES OF SUPPORTS. Supports eligible for purchase with support services funds must be consistent with the In-home Expenditure Guidelines and are limited to:

(a) Community First Choice state plan services. An individual who is eligible for OHP Plus and meets the Level of Care may access Community First Choice state plan services when supported by an assessed need.

(b) Transfer of Assets.

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

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

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

(iii) A loan made evaluated according to OAR 461-145-0330; or

(iv) An irrevocable trust evaluated according to OAR 461-145-0540.

(B) When an individual is considered ineligible due to a disqualifying transfer of assets, the individual must receive a notice meeting the requirements of OAR 461-175-0310 in the same manner as if the individual was requesting services under OSIPM.

(c) Community First Choice state plan services include:

(A) Behavior support services as described in section (9) of this rule;

(B) Community nursing services as described in section (10) of this rule;

(C) Environmental modifications as described in section (11) of this rule; and

(D) Attendant care as described in section (12) of this rule;

- (E) Skills training as described in section (13) of this rule;
- (F) Relief care as described in section (14) of this rule;
- (G) Assistive devices as described in section (15) of this rule;
- (H) Assistive technology as described in section (16) of this rule;
- (I) Chore services as described in section (17) of this rule;
- (J) Community transportation as described in section (18) of this rule;
- (K) Transition costs as described in section (19) of this rule; and
- (L) Home delivered meals as described in OAR chapter 411, division 040.

(d) Individuals who are eligible for OSIPM and meet the Level of Care may access Community First Choice state plan services and the following home and community-based waiver services:

- (A) Case management as defined in OAR 411-340-0020;
- (B) Employment services as described in section (20) of this rule that include:
 - (i) Supported employment - individual employment support;
 - (ii) Supported employment - small group employment support;
 - (iii) Employment path services; and
 - (iv) Discovery and career exploration services.
- (C) Family training as described in section (21) of this rule;

(D) Special diets as described in section (22) of this rule;

(E) Environmental safety modifications as described in section (23) of this rule;

(F) Vehicle modifications as described in section (24) of this rule; ~~and~~

(G) Specialized medical supplies as described in section (25) of this rule; ~~and~~

(H) Direct nursing services for individuals 21 years of age and over as described in OAR chapter 411, division 380.

(e) State Plan private duty nursing services under OAR chapter 410, division 132 (OHA, Private Duty Nursing Services), for individuals aged 18 through 20 that meet the clinical criteria described in OAR 411-350-0055.

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

(9) BEHAVIOR SUPPORT SERVICES.

(a) Behavior support services consist of:

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

(B) Developing positive behavior support strategies, including a Behavior Support Plan, by a qualified behavior consultant as described in OAR 411-340-0160, if needed;

(C) Implementing the Behavior Support Plan with the 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 the family of an individual;

(B) Developing a visual communication system as a strategy for behavior support; and

(C) Communicating, as authorized by an individual, 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 the needs of an individual at school;

(E) An assessment in a school setting;

(F) Attendant care;

(G) Skills training; or

(H) Relief care.

(10) COMMUNITY NURSING SERVICES.

(a) Community nursing services include:

(A) Nursing assessments, including medication reviews;

(B) Care coordination;

(C) Monitoring;

(D) Development of a Nursing Service Plan;

(E) Delegation and training of nursing tasks to a provider and primary caregiver;

(F) Teaching and education of the provider and primary caregiver and identifying supports that minimize health risks while promoting the autonomy of an individual and self-management of healthcare; and

(G) Collateral contact with a services coordinator regarding the community health status of an individual to assist in monitoring safety and well-being and to address needed changes to the ISP for the individual.

(b) Community nursing services exclude direct nursing care.

(c) A Nursing Service Plan must be present when support services funds are used for community nursing services. A personal agent must authorize the provision of community nursing services as identified in an ISP.

(d) After an initial nursing assessment, a nursing re-assessment must be completed every six months or sooner if a change in a medical condition requires an update to the Nursing Service Plan.

(11) ENVIRONMENTAL MODIFICATIONS.

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

(b) Environmental modifications exclude:

- (A) Adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, and central air conditioning, unless directly related to the assessed health and safety needs of the individual and identified in the ISP for the individual;
- (B) Adaptations that add to the total square footage of the home except for ramps that attach to the home for the purpose of entry or exit;

(C) Adaptations outside of the home; and

(D) General repair or maintenance and upkeep required for the home.

(c) Environmental modifications must be tied to supporting assessed ADL, IADL, and health-related tasks as identified in the needs assessment and ISP for an individual.

(d) Environmental modifications are limited to \$5,000 per modification. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-effectiveness. In addition, separate environmental modification projects that cumulatively total up to over \$5,000 in a plan year must be submitted to the Department for review.

(e) Environmental modifications must be completed by a state licensed contractor with a minimum of \$1,000,000 liability insurance. 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 file for the contractor prior to payment.

(f) Environmental modifications 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.

(h) A scope of work as defined in OAR 411-340-0020 must be completed for each identified environmental modification project. All contractors submitting bids must be given the same scope of work.

(i) Personal agents must follow the processes outlined in the In-home Expenditure Guidelines for contractor bids and the awarding of work.

(j) All dwellings must be in good repair and have the appearance of sound structure.

(k) The identified home may not be in foreclosure or be the subject of legal proceedings regarding ownership.

(l) Environmental modifications must only be completed to the primary residence of the individual.

(m) Upgrades in materials that are not directly related to the health and safety needs of the individual are not paid for or permitted.

(n) Environmental modifications are subject to Department requirements regarding materials and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials, manuals, and industry and risk management publications.

(o) RENTAL PROPERTY.

(A) Environmental modifications to rental property may not substitute or duplicate services otherwise the responsibility of the landlord under the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.

(B) Environmental modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.

(C) The Department does not fund work to restore the rental structure to the former condition of the rental structure.

(12) ATTENDANT CARE SERVICES. Attendant care services include direct support provided to an individual in the home of the individual or community by a qualified personal support worker or provider organization. ADL and IADL services provided through attendant care must support the individual to live as independently as possible, and be based on the identified goals, preferences, and needs of the individual. ~~(e)~~ Assistance with ADLs, IADLs, and health-related tasks may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance.

Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete any ~~of the IADL tasks described in subsection (b) of this section.~~

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

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

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

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

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

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

(~~Gg~~) "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.

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

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

~~(B) Toileting, bowel, and bladder care - 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 -- 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) Delegated nursing tasks;~~

~~(F) First aid and handling emergencies -- addressing medical incidents related to the conditions of an individual, such as seizure, aspiration, constipation, or dehydration, responding to the call of the individual for help during an emergent situation, or for unscheduled needs requiring immediate response;~~

~~(G) Assistance with necessary medical appointments -- 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; and~~

~~(H) Observation of the status of an individual and reporting of significant changes to a physician, health care provider, or other appropriate person.~~

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

~~(A) Light housekeeping tasks necessary to maintain an individual in a healthy and safe environment -- 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) Meal preparation and special diets;~~

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

~~(E) Medication and medical equipment -- 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) Support in the community around socialization and participation in the community.~~

~~(i) Support with socialization -- assisting an individual in acquiring, retaining, and improving self-awareness and self-control, social responsiveness, social amenities, and interpersonal skills;~~

~~(ii) Support with community participation -- assisting an individual in acquiring, retaining, and improving skills to use available community resources, facilities, or businesses; and~~

~~(iii) Support with communication -- assisting an individual 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.~~

(13) SKILLS TRAINING. Skills training is specifically tied to accomplishing ADL, IADL, and other health-related tasks as identified by the functional needs assessment and ISP and is a means for an individual to acquire, maintain, or enhance independence.

(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 within the timeframe outlined in the ISP, the personal agent must reassess or redefine the use of skills training with the individual for that particular goal.

(14) RELIEF CARE.

(a) Relief care may not be characterized as daily or periodic services provided solely to allow the primary caregiver to attend school or work. Daily relief care may be provided in segments that are sequential but may not exceed seven consecutive days without permission from the Department. No more than 14 days of relief care in a plan year are allowed without approval from the Department.

(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, chosen by the individual or the representative of the individual, that is a safe setting for the individual; or

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

(15) ASSISTIVE DEVICES. Assistive devices are primarily and customarily used to meet an ADL, IADL, or health-related support need. The purchase, rental, or repair of assistive devices with support service funds must be limited to the types of equipment and supplies 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 ability of the individual to perform and support ADLs and IADLs or to perceive, control, or communicate within the home and community environment in which the individual lives.

(b) Assistive devices may be purchased with support service funds when the intellectual or developmental disability of an individual otherwise prevents or limits the independence of the individual 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) 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; and

(B) Assistive devices, not provided by any other funding source, to assist and enhance the independence of an individual in performing ADLs or IADLs, such as durable medical equipment, mechanical apparatus, or electronic devices.

(d) Expenditures for assistive devices are limited to \$5,000 per plan year without Department approval. Any single purchase costing more than \$500 must be approved by the Department prior to expenditure. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and a determination by the Department of appropriateness and cost-effectiveness.

(e) Devices must be limited to the least costly option necessary to meet assessed need of an individual.

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

(g) To be authorized by a personal agent, assistive devices must be:

(A) In addition to any assistive devices, medical equipment, and supplies furnished under OHP, the state plan, private insurance, or alternative resources;

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

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

(h) Assistive devices exclude:

(A) Items that are not necessary or of direct medical benefit to the individual or do not address the underlying need for the device;

(B) Items intended to supplant similar items furnished under OHP, private insurance, or alternative resources;

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

(D) Toys or outdoor play equipment; and

(E) Equipment and furnishings of general household use.

(16) ASSISTIVE TECHNOLOGY Assistive technology is primarily and customarily used to provide additional safety and support and replace the need for direct interventions, to enable self-direction of care, and maximize independence. Assistive technology includes, but is not limited to, motion or sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinence and fall sensors, or other electronic backup systems, including the expense necessary for the continued operation of the assistive technology;

(a) Expenditures for assistive technology are limited to \$5,000 per plan year without Department approval. Any single purchase costing more than \$500 must be approved by the Department prior to expenditure. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and a determination by the Department of appropriateness and cost-effectiveness.

(b) Payment for on-going electronic back-up systems or assistive technology costs must be paid to providers each month after services are received.

(A) Ongoing costs do not include electricity or batteries.

(B) Ongoing costs may include minimally necessary data plans and the services of a company to monitor emergency response systems.

(17) 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.

(18) COMMUNITY TRANSPORTATION.

(a) Community transportation includes, but is not limited to:

(A) Community transportation provided by a common carrier, 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, a health-related task, or employment goal identified in an ISP; or

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

(b) Community transportation may only be authorized when natural supports or volunteer services are not available and one of the following is identified in the ISP of the individual:

(A) The individual has an assessed need for ADL, IADL, or health-related task during transportation; or

(B) The individual has either an assessed need for ADL, IADL, or health-related task at the destination or a need for waiver funded services at the destination;

(c) Community transportation must be provided in the most cost effective manner, which meets the needs identified in the ISP for the individual.

(d) Community transportation expenses exceeding \$500 per month must be approved by the Department.

(e) Community transportation must be prior authorized by a personal agent and documented in an ISP. 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 ISP. Personal support workers who use their own personal vehicles for community transportation are reimbursed as described in OAR chapter 411, division 375.

(f) Community transportation services exclude:

- (A) Medical transportation;
- (B) Purchase or lease of a vehicle;
- (C) Routine vehicle maintenance and repair, insurance, and fuel;
- (D) Ambulance services;
- (E) Costs for transporting a person other than the individual;
- (F) Transportation for a provider to travel to and from the workplace of the provider;
- (G) Transportation that is not for the sole benefit of the individual;
- (H) Transportation to vacation destinations or trips for relaxation purposes;
- (I) Transportation provided by family members who are not personal support workers and are not simultaneously providing other paid supports at the time of the transportation;
- (J) Payment to the spouse of an individual receiving support services;
- (K) Reimbursement for out-of-state travel expenses; and
- (L) Mileage reimbursement for the vehicle of the supported individual.

(19) TRANSITION COSTS.

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

(b) Transition costs are based on the assessed need of an individual 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 approval of the Department is based on the need of an individual and the determination by the Department 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.

(20) EMPLOYMENT SERVICES. 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.

(21) FAMILY TRAINING. Family training services are provided to the family of an individual to increase the abilities of the family to care for, support, and maintain the individual in the home of the individual.

(a) Family training services include:

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

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

(C) Registration fees for organized conferences and workshops specifically related to the intellectual or developmental disability of the individual or the identified, specialized, medical, or behavioral support needs of the individual.

(i) Conferences and workshops must be prior authorized by a personal agent, directly relate to the intellectual or developmental disability of the individual, and increase the knowledge and skills of the family to care for and maintain the individual in the home of the individual.

(ii) Conference and workshop costs exclude:

(I) Travel, food, and lodging expenses;

(II) Services otherwise provided under OHP or available through other resources; or

(III) Costs for ~~individual-a~~ family members who is a paid provider ~~are employed to care for the individual.~~

(b) Family training services exclude:

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

(B) Training for a paid provider;

(C) Legal fees;

(D) Training for a family 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.

(22) 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 the medical condition or diagnosis of an individual that are needed to sustain the individual in the home of the individual. Special diets are supplements and are not intended to meet the complete daily nutritional requirements of the individual. Special diet supplies must be supported by an evidence-based treatment regimen.

(23) ENVIRONMENTAL SAFETY MODIFICATIONS.

(a) Environmental safety modifications must be made from materials of the most cost effective type and may not include decorative additions.

(b) Fencing may not exceed 200 linear feet without approval from the Department.

(c) Environmental safety modifications exclude:

(A) Large gates, such as automobile gates;

(B) Costs for paint and stain;

(C) Adaptations or improvements to the home that are of general utility and are not for the direct safety or long-term

benefit to the individual or do not address the underlying environmental need for the modification; and

(D) Adaptations that add to the total square footage of the home.

(d) Environmental safety modifications must be tied to supporting ADL, IADL, and health-related tasks as identified in the ISP.

(e) Environmental safety modifications are limited to \$5,000 per modification. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-effectiveness. In addition, separate environmental safety modification projects that cumulatively total up to over \$5,000 in a plan year must be submitted to the Department for review.

(f) Environmental safety modifications must be completed by a state licensed contractor with a minimum of \$1,000,000 liability insurance. 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 file for the contractor prior to payment.

(g) Environmental safety modifications must be made within the existing square footage of the home and may not add to the square footage of the home.

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

(i) A scope of work as defined in OAR 411-340-0020 must be completed for each identified environmental safety modification project. All contractors submitting bids must be given the same scope of work.

(j) A personal agent must follow the processes outlined in the In-home Expenditure Guidelines for contractor bids and the awarding of work.

(k) All dwellings must be in good repair and have the appearance of sound structure.

(l) The identified home may not be in foreclosure or the subject of legal proceedings regarding ownership.

(m) Environmental safety modifications must only be completed to the primary residence of the individual.

(n) Upgrades in materials that are not directly related to the health and safety needs of the individual are not paid for or permitted.

(o) Environmental safety modifications are subject to Department requirements regarding material and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials manuals, and industry and risk management publications.

(p) RENTAL PROPERTY.

(A) Environmental safety modifications to rental property may not substitute or duplicate services otherwise the responsibility of the landlord under the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.

(B) Environmental safety modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.

(C) The Department does not fund work to restore the rental structure to the former condition of the rental structure.

(24) VEHICLE MODIFICATIONS.

(a) Vehicle modifications may only be made to the vehicle primarily used by an individual to meet the unique needs of the individual. Vehicle modifications may include a lift, interior alterations to seats, head and leg rests, belts, special safety harnesses, other unique

modifications to keep the individual safe in the vehicle, and the upkeep and maintenance of a modification made to the vehicle.

(b) Vehicle modifications exclude:

(A) Adaptations or improvements to a vehicle that are of general utility and are not of direct medical benefit to the individual or do not address the underlying need for the modification;

(B) The purchase or lease of a vehicle; or

(C) Routine vehicle maintenance and repair.

(c) Vehicle modifications are limited to \$5,000 per modification. A personal agent must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-effectiveness. In addition, separate vehicle modification projects that cumulatively total up to over \$5,000 in a plan year must be submitted to the Department for review.

(d) Vehicle modifications must meet applicable standards of manufacture, design, and installation.

(25) SPECIALIZED MEDICAL SUPPLIES. Specialized medical supplies do not cover services ~~which~~ that are otherwise available to an individual under Vocational Rehabilitation and Other Rehabilitation Services, 29 U.S.C. 701-7961, as amended, or the Individuals with Disabilities Education Act, 20 U.S.C. 1400 as amended. Specialized medical supplies may not overlap with, supplant, or duplicate other services provided through a waiver, OHP, or Medicaid state plan services.

(26) 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) Provided in settings and under contractual purchasing arrangements and 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, service 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) After September 1, 2018, delivered in a home and community-based setting that meets the qualities described in OAR 411-004-0020;

(bc) Provided 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.

(ed) Provided in accordance with the following:

(A) aApplicable state and federal wage and hour regulations in the case of personal services, training, and supervision;

(dB) ~~In accordance with a~~Applicable state or local building codes in the case of environmental modifications to the home;

(eC) ~~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;

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

(gE) ~~In accordance with t~~The In-home 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 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 family of the individual,

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 the ISP for an individual.

(d) The provisions of section (29) 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) The provider enrollment for a personal support worker is terminated as described in OAR chapter 411, division 375.

(b) An independent provider who is not a personal support worker may have their provider enrollment terminated in the following circumstances:

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

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

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

(D) 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

(E) 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.

(c) Provider enrollment may be terminated when the brokerage or Department determines that, at some point after the initial qualification and authorization of the provider to provide supports purchased with support services funds, the provider has:

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

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

(C) Surrendered his or her professional license or had his or her professional license suspended, revoked, or otherwise limited;

(D) Notwithstanding abuse as defined in OAR 407-045-0260, failed to safely and adequately provide the authorized services;

(E) Had a founded report of child abuse or substantiated adult abuse;

(F) Failed to cooperate with any Department or brokerage investigation or grant access to, or furnish, records or documentation, as requested;

(G) Billed excessive or fraudulent charges or been convicted of fraud;

(H) Made a false statement concerning conviction of crime or substantiated abuse;

(I) Falsified required documentation;

(J) Failed to comply with the provisions of section (28) of this rule or OAR 411-340-0140;

(K) Been suspended or terminated as a provider by the Department or Oregon Health Authority;

(L) Violated the requirement to maintain a drug-free work place;

(M) Failed to provide services as required;

(N) Failed to provide a tax identification number or social security number that matches the legal name of the independent provider, as verified by the Internal Revenue Service or Social Security Administration; or

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

(d) If the brokerage or Department makes a decision to terminate provider enrollment, the Department must issue a written notice that includes:

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

(B) The alleged violation as listed in subsection (b) and (c) of this section; ~~and~~

(C) The appeal rights of the individual, including where to file the appeal; ~~and~~

(D) For terminations based on substantiated abuse allegations, only 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; ~~and~~

(E) The effective date of the termination.

(e) The provider may appeal a termination within 30 days from 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.

(A) A provider of Medicaid services may appeal a termination by requesting an administrator review by the Director of the Department.

(B) 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 from the date the termination notice was mailed to the provider.

(f) 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

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

(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) After September 1, 2018, services delivered in a home and community-based setting that is not in compliance with the qualities of a home and community based setting described in OAR 411-004-0020;

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

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

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

(de) Individual or family vehicles;

(ef) 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.

(fg) Ambulance services;

(gh) Legal fees;

(hi) 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;

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

(~~jk~~) 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;

(~~kl~~) 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;

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

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

(~~no~~) 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;

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

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

(~~qr~~) Any purchase that is not generally accepted by the relevant mainstream professional or academic community as an effective means to address an identified support need; ~~or~~

(~~fs~~) Services, supplies, or supports that are illegal, experimental, or determined unsafe for the general public by recognized consumer safety agencies-; or

(t) After June 30, 2016, services provided by an entity affiliated with the brokerage authorizing 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

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

(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, gender, 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) Personal agent correspondence and notes related to resource development and plan outcomes;

(l) 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.

(m) 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 modifications.

(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 modifications 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; and

(II) Are completed or supervised by a contractor licensed and bonded in Oregon; ~~and.~~

(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~~ his or her 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 REFFERRAL 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. An affiliated entity may not be authorized by a brokerage to provide services. If an individual served by the brokerage was receiving services from an affiliated entity on December 31, 2015, the individual may continue to have those services provided by the affiliated entity until June 30, 2016, at which time the individual must either receive services from another service provider or receive case management from another brokerage or a CDDP. An entity is affiliated with the brokerage when the entity or the brokerage has an incident of ownership in the other. 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

(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 not a personal support worker who is paid as a contractor or a self-employed person that is 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 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 independent provider enrollment.

(B) Background check approval is effective for two years from the date an independent provider is contracted with to provide in-home support, except in the following circumstances:

(i) Based on possible criminal activity or other allegations against the independent provider, 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 independent provider.

(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 the 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.

(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 list of excluded or debarred providers maintained by the Office of the Inspector General (<http://exclusions.oig.hhs.gov/>);

(j) If transporting an individual, have a valid license to drive 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; and

(k) Sign a Medicaid provider agreement and be enrolled as a Medicaid provider prior to delivery of any services.

(3) Section (2)(c) of this rule does not apply to employees of 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 designee of the Department within 24 hours.

(5) Independent providers, including personal support workers, are not employees of the state, CDDP, or Brokerage.

(6) BEHAVIOR CONSULTANTS. Behavior consultants are not personal support workers. Behavior consultants may include, but are not limited to, autism specialists, licensed psychologists, or other behavioral specialists. Behavior consultants providing specialized supports must:

(a) Have education, skills, and abilities necessary to provide behavior support services as described in OAR 411-340-0130;

(b) Have received current certification demonstrating completion of OIS training; and

(c) Submit a resume or the equivalent 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 as described in OAR 411-340-0130.

(7) NURSE. A nurse ~~providing community nursing services~~ is not a personal support worker. ~~The nurse must:~~

~~(a) Have a current Oregon nursing license;~~

~~(ba) A nurse providing community nursing services must:~~

~~(A) Be enrolled in the Long Term Care Community Nursing Program as described in OAR chapter 411, division 048; and~~

~~(B) Meet the qualifications described in OAR 411-048-0210;
and~~

~~(c) Submit a resume to the CDDP indicating the education, skills, and abilities necessary to provide nursing services in accordance with Oregon law, including at least one year of experience with individuals with intellectual or developmental disabilities.~~

~~(b) A nurse providing direct nursing services must be an enrolled Medicaid Provider and meet the qualifications described in OAR 411-380-0080.~~

~~(c) A nurse providing private duty nursing services must be an enrolled Medicaid Provider as described in OAR 410-132-0200 (OHA, Provider Enrollment).~~

(8) 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

(1) PROVIDER ORGANIZATIONS WITH CURRENT LICENSE OR CERTIFICATION. A provider organization ~~certified, licensed, and certified or applying for certification prior to January 1, 2016 according to OAR 411-340-0030, certified and endorsed as set forth in OAR chapter 411, division 323, under OAR chapter 411, division 325 for a 24-hour residential setting, or licensed under OAR chapter 411, division 360 for an adult foster home, or certified and endorsed under OAR chapter 411, division 345 for employment services or OAR chapter 411, division 328 for a supported living setting, or licensed under OAR chapter 411, division 360 for an adult foster home,~~ does not require additional certification or endorsement as an organization to provide relief care, attendant care, skills 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, or endorsement~~ as described in section (1) of this rule must be certified, ~~or applied for certification~~, as a provider organization according to OAR 411-340-0030 ~~before January 1, 2016, and must be granted a certificate~~ prior to selection for providing the services listed in OAR 411-340-0130(12), (13), (14) or (18) and paid for with support services funds. ~~A provider organization that was certified or had applied for certification according to OAR 411-340-0030 before January 1, 2016 may also provide employment services when the organization also meets the requirements in OAR 411-345-0030. When granted after January 1, 2016, certification as set forth in OAR chapter 411 division 323, with an endorsement to these rules, is not sufficient qualification for a provider organization to deliver employment services. To be certified or to receive an endorsement under these rule:~~

(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 services to individuals;

(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 name of the staff member or provider organization to the bank account or other personal property of the individual without approval of the individual or the legal representative of the individual (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 entry and 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 name, current home address, and home phone number of the individual;

(B) A current written service agreement signed and dated by the individual;

(C) Contact information for the legal or designated representative of the individual (as applicable) and any other people designated by the individual 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 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 business 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 e~~Only be used until the individual is no longer a threat to self or others;

(ii) Be authorized by the provider organization director or the physician of the individual 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 provider organization. The type of condition attached to a certificate must directly relate to the risk of harm or potential risk of harm to individuals.

(b) 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 provider organization is not being operated in compliance with these rules.

(c) Conditions that the Department may impose on a certificate include, but are not limited to:

(A) Restricting the total number of individuals to whom a provider organization may provide services;

(B) Restricting the total number of individuals to whom a provider organization may provide services based upon the capability and capacity of the provider organization and staff to meet the health and safety needs of all individuals;

(C) Restricting the type of support and services the provider organization may provide to individuals based upon the capability and capacity of the provider organization 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 provider organization from allowing a person on the premises who may be a threat to the health, safety, or welfare of an individual;

(G) Requiring additional documentation; or

(H) Restricting admissions.

(d) NOTICE OF CERTIFICATE CONDITIONS. The Department issues a written notice to the provider organization when the Department imposes conditions on the certificate of the provider organization. The written notice of certificate conditions includes the conditions imposed by the Department, the reason for the conditions,

and the opportunity to request a hearing under ORS chapter 183. Conditions take effect immediately upon issuance of the written notice of certificate conditions or at a later date as indicated on the notice and are a Final Order of the Department unless later rescinded through the hearing process. The conditions imposed remain in effect until the Department has sufficient cause to believe the situation that warranted the condition has been remedied.

(e) HEARING. The provider organization may request a hearing in accordance with ORS chapter 183 and this rule upon receipt of written notice of certificate conditions. The request for a hearing must be in writing.

(A) The provider organization must request a hearing within 21 days of receipt of the written notice of certificate conditions.

(B) In addition to, or in-lieu of a hearing, a provider organization may request an administrative review as described in section (7) of this rule. The administrative review does not diminish a provider organization's right to a hearing.

(f) The provider organization may send a written request to the Department to remove a condition if the provider organization 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 provider organization, or any person holding five percent or greater ownership interest in the provider organization:

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

(B) Has demonstrated a substantial failure to comply with these rules or the corresponding program 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 services;

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

(E) Falsifies information required by the Department to be maintained or submitted regarding individual services, provider organization finances, or funds belonging to the individuals;

(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 maintained by the Office of the Inspector General.

(b) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may issue a notice of denial, refusal to renew, or revocation of a certificate following a Department finding that there is a substantial failure to comply with these rules or the corresponding program rules 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 provider organization, as applicable, may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential setting, upon written notice from the Department of denial, refusal to renew, or revocation of the certificate. The request for a hearing must be in writing.

(A) DENIAL. The applicant must request a hearing within 60 days from the receipt of the written notice of denial.

(B) REFUSAL TO RENEW. The provider organization must request a hearing within 60 days from the receipt of the written notice of refusal to renew.

(C) REVOCATION. The provider organization must request a hearing within 21 days from the receipt of the written notice of revocation.

(i) In addition to, or in-lieu of a hearing, the provider organization may request an administrative review as described in section (7) of this rule.

(ii) The administrative review does not diminish the right of the provider organization 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 provider organization, immediately suspend a certificate without a pre-suspension hearing and the provider organization may not continue operating.

(b) HEARING. The provider organization may request a hearing in accordance with ORS chapter 183 and this rule upon written notice from the Department of the immediate suspension of the certificate. The request for a hearing must be in writing.

(A) The provider organization must request a hearing within 21 days from the receipt of the written notice of suspension.

(B) In addition to, or in-lieu of a hearing, the provider organization may request an administrative review as described in section (7) of this rule. The request for an administrative review must be in writing. The administrative review does not diminish right of the provider organization to a hearing.

(7) ADMINISTRATIVE REVIEW.

(a) The provider organization, in addition to the right to a hearing, may request an administrative review. The request for an administrative review must be in writing.

(b) The Department must receive a written request for an administrative review within 10 business days from the receipt of the notice of suspension, revocation, or imposition of conditions. The provider organization may submit, along with the written request for an administrative review, any additional written materials the provider organization wishes to have considered during the administrative review.

(c) The determination of the administrative review is issued in writing within 10 business days from the receipt of the written request for an administrative review, or by a later date as agreed to by the provider organization.

(d) The provider organization may request a hearing if the decision of the Department is to affirm the suspension, revocation, or condition. The request for a hearing must be in writing. The Department must receive the written request for a hearing within 21 days from the receipt of the original written notice of suspension, revocation, or imposition of conditions.

(8) INFORMAL CONFERENCE. Unless an administrative review has been completed as described in section (7) of this rule, a provider organization requesting a hearing may have an informal conference with the Department.

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