

STATE OF CONNECTICUT



HCBS CONSOLIDATED WAIVER OPERATIONS MANUAL APPENDIX

Issued October 11, 2005
Revised November, 2006

TABLE OF CONTENTS

Section	Subject / Form	Page #
A	PRAT Forms	
	Priority Checklist	A-1, 1-2
	Request for Service/Support	A-2, 1-3
B	PRAT Notification and Acknowledgement Letters	
	Notification of Resource Allocation Letter	B-1, 1-2
	Notification of Referral Letter	B-2
	Acknowledgment Form	B-3
	Instructions for Completion of Letters and Form	B-4
C	Waiver Application and Management Forms	
	DMR 219 Level of Care Determination	C-1
	DMR 222 HCBS Choice of Service Selection	C-2
	DMR 223 IFS Waiver Services	C-3
	DMR 225 PRAT Recommendation	C-4
	DSS W-1518 (Rev. 2/05)	C-5
	DMR 224 Inability or Refusal to Apply	C-6
	DSS W-1576 Change Report Form	C-7
D	Notice of Acceptance	D-1
E	Level of Need Assessment and Individual Plan Forms	
	Level of Need Assessment	See DMR Website
	Individual Plan	See DMR Website
F	IFS Budget, Instructions and Vendor Service Authorization	See Excel Files IFS FGP2
G	Comp Budget, Instructions and Vendor Service Authorization	See Excel Files Comp FGP1
H	DMR Cost Standards	H1-11
I	Individual Service Agreement	I1-7
J	Individual/Family Vendor Agreement	J1-2
K	Individual/Family Employee Agreement	K
L	Vendor Application and Instructions	L,1-4
M	Provider Training and Qualifications Verification Record	M,1-2
N	DMR Waiver Services: Codes-Units-Rates Table	N
O	Vendor Billing Invoice Forms: in Comp and IFS Excel Files FGP	See Excel Files FGP
P	Service Documentation Example – Staff	O
Q	Medicaid Provider Agreement	Q

Lives at home with family
Lives in own home
Lives in a CTH

Planning and Resource Allocation Team use only:
Priority assigned:
Date:

RESIDENTIAL SERVICES REQUEST - PRIORITY CHECKLIST

For People Living in Their Own or Family's Home or Community Training Home

Name: _____

Date: _____

DMR Number: _____

Completed by: _____
Signature/Title

Case Management Supervisor: _____

Signature/Date reviewed:

This form must be completed and attached to all requests for residential services for individuals living at home with their family, independently or in CTHs.

Circle the number next to the statement that best describes the individual or their situation for each of the eight areas.
Circle only one per section.

I. Identify the person or caregiver's expressed need or desire for services. The level of expressed need should be identified in the annual plan.	
1	The family is planning for the <u>future, 6-10 years.</u>
3	The family/individual is planning for the <u>future, 2-5 years.</u>
Inds. requesting future services will receive a P2 or P3 only.	
6	The individual/family wants services <u>soon, 3-12 months.</u> Would accept services if offered today.
8	The individual/family wants <u>immediate</u> services. They feel that they cannot wait more than a few days or weeks. And, they would accept the most appropriate services available if offered.

II. Age of Caregiver or self, if lives in own home:	
2	Is under 65.
5	Is 65 or older.

III. Physical and/or mental health of caregiver or self, if lives in own home:	
2	Is good or fair health.
5	Is in poor health.

IV. Identify the level of support/supervision the individual needs. Refer to the individual's <u>Waiting List Assessment</u> for the "Support Needed" – Minimal, Moderate or Comprehensive.	
2	<u>Minimal support</u> – can manage self-care without prompting, needs periodic assistance or drop-in supports, has routine care/supervision needs.
4	<u>Moderate support</u> e.g. prompting for self care, redirecting re: injurious behavior, 24 hour support must be available, has moderate medical, behavioral or physical needs.
8	<u>Comprehensive support</u> , e.g. 24 hour supervision, full personal care assistance, line of sight supervision at all times, has extensive medical, behavioral or physical needs.

V. Identify the support needs of the other members of the family household (includes parents, spouse/partner, siblings and children).	
1	The above individual is the only family member who requires ongoing supervision or support.
3	There is one other family member who requires ongoing support or supervision.
5	There are two or more other family members who require significant ongoing support or supervision.

VI. Resources available within the home			
2	Two or more adult caregivers who provide support	6	One adult caregiver who provides support or, Lives in own home and needs support within the home.
4	One adult caregiver who provides support and a network of family resources providing regular support	8	No Caregiver can't live in own without supports within the home.

Page 1 total: _____

VII. DMR Supports Received	
1	The individual/family <u>has regular access to OR</u> has declined offers of supports or services from DMR that provide periods of relief to the primary care provider. Supports and services may include Enhanced Family Support, full time Adult Day Supports, Birth to Three services, and other individual/family support such as weekly leisure services.
3	The individual/family has <u>access to some or periodic</u> supports and services that offer periods of relief for the caregiver and/or leisure/learning opportunities for the individual. Services may include temporary support, services or occasional leisure services, part-time work/day supports.
5	The individual/family requested and has not been able to access DMR individual or family supports. AND/OR The individual no longer receives education services and they are waiting for DMR day supports.

VIII. Other Sources of Support	
1	Caregiver has <u>regular access to OR</u> has declined offers of assistance and support from other family members, extended family, or other agencies such as extended school day, home health care, DCF, DPH or DSS community based services.
3	Caregiver/individual <u>has minimal access</u> to assistance and support from other family members, extended family, or agencies such as home health care, DCF, DPH or DSS community based services.
5	Caregiver/individual has <u>no access</u> to assistance and support from other family members, extended family, or agencies such as home health care, DCF, DPH or DSS community based services.

Scores: _____ + _____ = _____
 Page 1 Page 2 Total

Expressed need (Page1#1) is for: 2-5 years (Priority 2),
 6 or more years (Priority 3)

EXCEPTIONS

Emergency

Regardless of their total score, individuals with critical needs for services are considered an emergency if, and only if :
 (DESCRIBE BELOW)

There is an imminent risk of significant harm without DMR support.

- The individual may have frequent and severe self-injurious behavior that requires intervention and cannot be managed.
- The individual's behavior may place others at imminent risk of significant harm, either intentional or unintentional.
- The individual is homeless i.e., the person is in the hospital (or other temporary setting) and they cannot return home.
- Caregiver or individual is so ill (physically or mentally) that the individual cannot remain at home without DMR support
- The home environment is unstable and/or deteriorating to point where the person or family is at significant risk.

A. And, the individual/caregiver is willing to accept the most appropriate available resource.

Emergency – briefly describe the nature of the emergency.

Priority Adjustment

If any of the conditions below are placed on the individual/family's request for services or if services have been refused, the priority may be adjusted accordingly. (DESCRIBE BELOW)

- The individual/family will only accept a specific provider.
- The individual/family will only accept a specific program/location.
- The individual/family will only accept a specific type of service or support e.g. CLA, supported living, regional center.

Priority adjustment – describe any restriction placed on the request or refusal of services during the past 12 months.

PLANNING AND RESOURCE ALLOCATION TEAM

Request for Service/Support

Region: _____

<input type="checkbox"/> RESIDENTIAL: The following must be attached: → Priority Checklist → Waiting List Assessment

<input type="checkbox"/> DAY The following must be attached: → Priority Checklist

Name: _____

DMR #: _____

Date of Birth: _____

Current Supports:	Type	Support(s)	Provider/Address	Town
Residence				
Day				

Medicaid Eligible: No Pending Yes If YES, Medicaid Number: _____

If living in family home and requesting Residential Services or Support:

Name of Primary Care Giver (PCG): _____

(PCG) Relationship to individual: _____

(PCG) Date of Birth: _____

Reason for Request: New Request Priority Change Status Update
from _____ to _____

RESIDENTIAL REQUEST:

Support Type: CLA SL CTH RC
 ISO ISF Other _____

DAY REQUEST:

Support Type: DSO SEI GSE SHE ISD

Reason for request:

Date needed (Date of Graduation): _____

Submitted by: _____ Phone # _____ Date: _____

Reviewed by: _____ Date: _____

Name: _____

MR Level:	Other Diagnoses:
Vision: <input type="checkbox"/> No impairment <input type="checkbox"/> Impaired <input type="checkbox"/> Wears Glasses <input type="checkbox"/> Blind	Communication: <input type="checkbox"/> Verbal <input type="checkbox"/> Limited Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Alternative Communication: <input type="checkbox"/> Signs <input type="checkbox"/> Gestures <input type="checkbox"/> Uses Device
Hearing: <input type="checkbox"/> No impairment <input type="checkbox"/> Impaired <input type="checkbox"/> Uses Hearing Aide <input type="checkbox"/> Deaf	Mobility/Accessibility Needs: <input type="checkbox"/> None <input type="checkbox"/> Barrier Free <input type="checkbox"/> Full Accessibility
Describe Required Nursing Support and List Current Medication(s): _____ _____ _____ _____	
Describe Required Behavioral Support: _____ _____ _____ _____	
Supports Received: <input type="checkbox"/> Family Support <input type="checkbox"/> Respite <input type="checkbox"/> Grant \$ _____ <input type="checkbox"/> Other _____	Requesting Self-Determination? <input type="checkbox"/> Yes <input type="checkbox"/> No Current ISA in place? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: \$ _____ 620 \$ _____ 617
Other Agency Involvement: <input type="checkbox"/> BRS <input type="checkbox"/> BESB <input type="checkbox"/> DSS <input type="checkbox"/> DOC <input type="checkbox"/> DMH <input type="checkbox"/> DCF Voluntary <input type="checkbox"/> DCF Protective <input type="checkbox"/> DCF Voluntary Committed <input type="checkbox"/> DCF Committed <input type="checkbox"/> Home Health/VNA <input type="checkbox"/> Other _____	
Guardianship Status: <input type="checkbox"/> Own Guardian <input type="checkbox"/> Plenary Guardian <input type="checkbox"/> Limited Guardian for _____	
Guardian's Name _____ Relationship _____	
Signed Release enclosed in packet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Verbal permission for referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	

*****PLANNING AND RESOURCE ALLOCATION TEAM REVIEW*****

Name: _____

<p>RESIDENTIAL SUPPORT REQUEST:</p> <p>Target: <input type="checkbox"/>WL <input type="checkbox"/>AO <input type="checkbox"/>OLM <input type="checkbox"/>FOR <input type="checkbox"/>STS <input type="checkbox"/>NONE</p> <p>Target Sub Category: <input type="checkbox"/>DCF-COM <input type="checkbox"/>DCF-ComV <input type="checkbox"/>DCF Prot <input type="checkbox"/>DCF Vol <input type="checkbox"/>LEA <input type="checkbox"/>Pvt-Pay <input type="checkbox"/>DSS-MOU</p> <p>Priority: <input type="checkbox"/> Emergency (within 3 months) <input type="checkbox"/> 1 Needed within 1 year <input type="checkbox"/> 2 Needed within 2 - 5 years <input type="checkbox"/> 3 Needed within 6- 10 years</p> <p>Projected Placement Date: _____</p> <p>Residential Support Requested: <input type="checkbox"/>CLA <input type="checkbox"/>SL <input type="checkbox"/>CTH <input type="checkbox"/>ISO <input type="checkbox"/>ISF <input type="checkbox"/>RC <input type="checkbox"/>Other _____</p> <p>Self Determination <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Estimated Cost \$ _____</p>	<p>DAY SUPPORT REQUEST:</p> <p>Target: <input type="checkbox"/>GRAD <input type="checkbox"/>AO <input type="checkbox"/>FOR <input type="checkbox"/>STS <input type="checkbox"/>OLM <input type="checkbox"/>NONE</p> <p>Priority: <input type="checkbox"/> Emergency (within 3 months) <input type="checkbox"/> 1 Needed within 1 year <input type="checkbox"/> 2 Needed within 2 - 5 years <input type="checkbox"/> 3 Needed within 6 - 10 years</p> <p>Projected Placement Date: _____</p> <p>Day Support Requested: <input type="checkbox"/>DSO <input type="checkbox"/>SEI <input type="checkbox"/>GSE <input type="checkbox"/>SHE <input type="checkbox"/>ISD</p> <p>Self Determination <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Estimated Cost \$ _____</p>
--	---

RECOMMENDATION(S):

A. No current resource available. Request will be added to the Planning Document.

B. Referred for consideration to:

Provider	Program Type	Location
_____	_____	_____
_____	_____	_____

Person Responsible _____

C. Other: _____

Date of Review: _____
Planning and Resource Chair/Designee

Camris Tagged **Entered on Planning Document**

Comments _____

Dear _____ :

I am pleased to inform you that our region's Planning and Resource Allocation Team (PRAT) has awarded you funding for home and community based waiver supports. This funding decision is a result of your request for services and supports and is based upon your level of need information. It is available for you to purchase an array of supports and services. You can hire your own staff to provide these services through an Individual Support Agreement or you may wish to purchase your supports from a private provider.

DMR's ability to offer new funding and resources to consumers is contingent upon enrolling eligible applicants in the _____ waiver. Enrolling people in the _____ waiver means DMR gets federal revenue so that the state can continue to expand supports and services to individuals who are waiting for services or who are under-served.

Based on your assessed level of support needs, the range of new funding that will be available to you to begin the planning process is up to _____. The funding is anticipated to be accessed on or about _____.

By accepting this funding you understand and acknowledge that:

- You will participate in the application and enrollment process for Medicaid, if you are not currently enrolled in Medicaid, and will maintain Medicaid eligibility; and,
- You will participate in the application and enrollment process for the _____ waiver when that opportunity is presented to you by the department; and,
- Failure to participate in the application and enrollment process for Medicaid and the _____ waiver may result in the termination of your funding.

We are pleased to make these resources available to assist in providing safe and effective support for you to live in your home and/or community. These authorized waiver service funding levels may be adjusted based upon a change in your needs and/or circumstances.

I will contact you to begin the Individual Plan process. You and your support team will develop a plan that addresses needs and preferences for waiver services along with any other Medicaid or generic services you may have or need. If you seek to self-direct your services you also have the option to use part of your funding to purchase private Family and Individual Consultation and Support services, commonly known as Independent Broker services, to assist you in developing your plan. I will provide you with additional information regarding this option. If you and your support team develop a proposed service plan and budget to fund those supports that exceeds the funding range limit provided for in this letter I will submit the plan and budget to the Regional Planning and Resource Allocation Team for their consideration.

If you are dissatisfied by waiver service and resource determinations, now or in the future, and would like to initiate an administrative hearing, please let me know so that I can forward your request to the Regional Planning and Resource Allocation Team. If an agreement can not be reached between you and DMR about appropriate levels of service, a DMR form for Requesting a Hearing before the Department of Social Services to address any items of dispute (within the context of the HCBS waiver program) will be sent to you by the DMR Central Office Waiver Policy Unit.

This funding allocation will be released upon receipt by the department of the signed *Acknowledgment of DMR Assignment of Funding/Supports/Services* form. By signing this form you are indicating your desire to accept this funding and start the enrollment process. Please sign this attached form and return the signed form to me within **two weeks** so we can begin the planning process. If you do not return the signed form within two weeks these resources may be reallocated to another individual on the DMR Waiting List. If you have any questions regarding this process please contact me at (insert telephone number)

Sincerely,

DMR Case Manager

cc: Personal Representative
PRAT Coordinator
Supervisor of Case Management

Dear _____ :

I am pleased to inform you that our region's Planning and Resource Allocation Team (PRAT) has initiated a referral on your behalf for _____ service. This referral decision has been based on information available through the DMR waiting list as a result of your request for services and supports.

Your case manager will assist you in the referral process by arranging visits and gathering necessary information to determine if the referral will best meet your needs and preferences. This is a collaborative process and decision that will also involve the provider agency, as the agency will also assess your needs and preferences in relation to the other individuals supported in that setting, if applicable.

DMR also wishes to inform you that to be accepted for this service should a referral be successful, you understand and acknowledge that:

- You will participate in the application and enrollment process for Medicaid, if your family member is not currently enrolled in Medicaid, and will maintain Medicaid eligibility; and
- You will participate in the application and enrollment process for the _____ waiver when that opportunity is presented to you by the department; and
- Failure to participate in the application and enrollment process for Medicaid and the _____ waiver may result in the termination of your funding.

DMR's ability to offer new funding and resources to consumers is contingent upon enrolling eligible applicants in the _____ waiver. Enrolling people in the _____ waiver means DMR gets federal revenue so that the state can continue to expand supports and services to individuals who are waiting for services or who are under-served.

We are pleased to be able to offer this service option to you as a safe and effective way to support you in the community.

The referral process will be initiated upon receipt of the attached *Acknowledgment of DMR Assignment of Funding/Supports/Services* form. Please sign the attached form and return it to your Case Manager so we can begin the referral process with you and your family member.

Sincerely,

Regional Planning and Resource Allocation Team Coordinator

cc: Personal/Legal Representative
Case Manager



State of Connecticut
Department of Mental Retardation

**Acknowledgment of DMR Assignment
of Funding/Supports/Services**

The undersigned hereby acknowledges receipt of a letter from the Department of Mental Retardation (DMR), dated _____, confirming the assignment of funds or referral for _____ provided to assist _____ to live safely and effectively in his/her home and/or community. It is further acknowledged and understood that DMR's capacity to expand and enhance supports and services for _____ and others requires agreement to participate in the application and enrollment process for the _____ waiver when that opportunity is presented by DMR. The undersigned further agrees to enroll in Medicaid and/or maintain Medicaid eligibility. Finally, it is expressly acknowledged and understood that the failure to participate in the _____ waiver application and enrollment process, without reasonable cause, when presented by DMR may result in the termination of the funding/supports/services acknowledged herby.

Guardian/Representative

Individual/Consumer

Date

Date

Instructions for using the Resource Allocation letter or the Referral letter

B. PRAT

Upon initial decision to award a resource allocation or to submit a referral for a residential or day/vocational service on behalf of the individual, the Regional PRAT coordinator will complete the corresponding letter as notification to the individual and his/her legal representative. The letter serves to notify the individual of the award or referral and the associated requirements related to enrollment in a HCBS waiver if appropriate. The PRAT coordinator will complete the following:

- enter the individual's name and address
- enter the date
- enter the specific purpose of the resource allocation or referral, i.e. high school graduate funding for day/vocational supports; waiting list residential supports; group home living arrangement
- enter the amount of the initial PRAT approved resource allocation range
- enter the anticipated date that the funding will be available, i.e. in the summer of 2005, October, 2005
- enter which waiver the individual may be eligible for enrollment in
- in the cc: lines, enter the name of the legal representative, supervisor of case management and either the case manager (referral letter) **or the PRAT coordinator (allocation letter)**
- **sign the referral letter or** type the case manager's name on the allocation letter

Attach the Acknowledgment of DMR Assignment of Funding/Supports/Services form, mail it to the individual and legal representative, and copy the case manager and supervisor of case management. The PRAT coordinator should monitor the return receipt of the form.

C. Case Manager

The case manager will contact the individual and his/her representative upon receipt of the notice of resource allocation or referral. The case manager should be prepared to answer any questions the individual and his/her legal representative may have regarding the allocation, referral or waiver enrollment expectations. The signed Acknowledgment form must be given to the case manager prior to the initiation of the planning or referral process. The case manager will return the form to the PRAT as notification that the planning or referral will begin.

If the individual and his/her legal representative declines to accept the allocation of resources or referral due to Medicaid or HCBS waiver concerns that can not be addressed by the case manager, the case manager must complete Form 224, Reasons for not applying for Medicaid or a Medicaid waiver. The form is returned to PRAT. The individual and his/her legal representative is notified by the case manager at that time that:

- the resource allocation or referral will be withdrawn pending a written response to the individual and his/her legal representative with further guidance, information and/or additional questions for the individual and his/her legal representative to consider.

Instructions for completing the Acknowledgment of DMR Assignment of Funding/Supports/Services form

The form is attached to the Resource Allocation letter or the Referral letter issued by the Regional PRAT at the time of the initial resource allocation or referral for the individual. The PRAT coordinator will complete the following:

- enter the date of the corresponding letter
- enter the specific purpose of the resource allocation or referral, i.e. high school graduate funding for day/vocational supports; waiting list residential supports; group home living arrangement
- enter the individual's name
- enter which waiver the individual may be eligible for enrollment in

The case manager will return the signed for to PRAT. PRAT will retain the form and designate the resource allocation or referral for the individual until the planning or referral process is completed and the waiver application is submitted for final approval.



**STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION
HOME AND COMMUNITY BASED SERVICES
SERVICE SELECTION FORM**

_____	_____	_____	_____
Recipient	Region	DMR #	Date
The purpose of this form is to document that when a recipient is determined to be likely to require the level of care provided in an ICF/MR, the recipient or his or her legal representative will be informed of any feasible alternatives under the Home and Community Based Services Waiver and given a choice of either institutional or home and community based services			
I have informed the recipient and/or legal representative of the feasible alternatives under the HCBS waiver.			
		_____	_____
		Regional Representative	Date
I believe the recipient to be:			
<input type="checkbox"/> legally competent (complete "A" below). <input type="checkbox"/> not legally competent and has legal representative (complete "B" below). <input type="checkbox"/> legally competent, but may not be able to make informed decisions (complete "C" below).			
		_____	_____
		Regional Representative	Date

A. I, the recipient, have been informed of the feasible alternatives for available services. I understand that I may change my selection at any time. At this time I would like to select the following: <input type="checkbox"/> Home and Community Based Services <input type="checkbox"/> Institutional (ICF/MR) Services	
_____	_____
Recipient	Date
B. I, the legal representative of the above named recipient, have been informed of the feasible alternatives for available services. I understand that I may change my selection at any time. At this time I would like to select the following: <input type="checkbox"/> Home and Community Based Services <input type="checkbox"/> Institutional (ICF/MR) Services	
_____	_____
Legal Representative	Date
C. The interdisciplinary team, which includes the recipient, believe that he or she, although legally competent, may not be able to make a fully informed decision regarding the selection of service delivery. The IDT, with the understanding that it may change the selection at any time, has recommended to the director that it is in the recipient's best interest to make the following selection: <input type="checkbox"/> Home and Community Based Services <input type="checkbox"/> Institutional (ICF/MR) Services	
_____	_____
IDT Chairperson	Date
<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	
_____	_____
Director	Date



DEPARTMENT OF MENTAL RETARDATION
Home and Community Based Services
WAIVER SERVICES FORM



Recipient	Region	DMR #	Address	
Case Manager	()		INITIAL	CHANGE
	Case Manager's Phone		DATE	DATE
The purpose of this form is to document the Individual and Family Support Waiver supports provided to a recipient who lives in their own home or with his/her family.				

COMMON SUPPORTS	COST/UNIT	ISA/MASTER CONTRACT/PROVIDER	UNIQUE SUPPORTS	COST/UNIT	ISA/MASTER CONTRACT/PROVIDER
Home and Community Supports			IFS WAIVER ONLY		
Supported Living			IS Habilitation		
Personal Support			Family Training		
Adult Companion					
Respite (Hrly or Daily)					
Personal Emergency Response System	/month				
Ancillary Supports					
Transportation (Mile or Trip)			COMPREHENSIVE WAIVER ONLY		
Consultative Service/Therapy			CLA		
Interpreter Services			CTH		
Other Supports – One Time Cost			Assisted Living		
Specialized Medical Equipment (Adaptive Aids)			Individual Directed Goods and Services		
Environment adaptations					
Vehicle Adaptations					
Family and Individual Consultation and Support					
Day and Vocational Supports					
Group Day Sheltered					
Group Day Support Options					
Supported Employment Individual					
Supported Employment Group					
Individualized Day - Rate Negotiated					

DMR Form 223 10.1.05

Funding Source			
New WL	<input type="checkbox"/>	Forensic	<input type="checkbox"/>
Age out	<input type="checkbox"/>	OTHER	<input type="checkbox"/>
Grad	<input type="checkbox"/>	Existing	<input type="checkbox"/>



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION

PRAT HCBS WAIVER RECOMMENDATION FORM

_____	_____	_____	_____	_____
Individual	DMR #	Region	Wait List Priority	Date of Birth

WAIVER ENROLLMENT REQUEST	<input type="checkbox"/> Individual and Family Support Waiver	<input type="checkbox"/> Comprehensive Waiver
Documentation indicates:		
Individual has Mental Retardation or Related Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No (<i>attach DMR 219</i>)
Individual meets ICF/MR Level of Care requirement	<input type="checkbox"/> Yes	<input type="checkbox"/> No (<i>attach DMR 219</i>)
Individual is eligible for Medicaid	Medicaid # _____	
Entitlements and income less than 3 times SSI	<input type="checkbox"/> Yes	<input type="checkbox"/> No (<i>If No attach form 224</i>)
Assets less than \$1600	<input type="checkbox"/> Yes	<input type="checkbox"/> No (<i>If No attach form 224</i>)
There are sufficient supports to meet needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Case Manager notified to begin enrollment process on date: _____		
Waiver services are included in the plan of care	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ADDITIONAL WAIVER SUPPORTS REQUESTED	<input type="checkbox"/> Individual and Family Support Waiver	<input type="checkbox"/> Comprehensive Waiver	
Type _____	Amount \$ _____	Type _____	Amount \$ _____
Type _____	Amount \$ _____	Type _____	Amount \$ _____
Describe why additional supports requested are <u>needed</u> (attach additional documentation if necessary):			
Basis for dispute of an Individual Plan and/or Budget:			

PRAT Recommendations:
Recommend: <input type="checkbox"/> Approval <input type="checkbox"/> Denial For enrollment in the DMR Comprehensive waiver
<input type="checkbox"/> Approval <input type="checkbox"/> Denial For enrollment in the DMR Individual and Family Support waiver
Recommend: <input type="checkbox"/> Approval <input type="checkbox"/> Denial For additional Comprehensive waiver supports as requested by the individual
<input type="checkbox"/> Approval <input type="checkbox"/> Denial For additional Individual and Family waiver supports as requested by the individual
Reason:

D. <u>PRAT Chair Signature and Date</u>
--

E. <u>Print Name</u>

**REASONS FOR DECLINING TO
SUBMIT MEDICAID AND/OR DMR
HCBS WAIVER APPLICATIONS**



Individual DMR # Region Date of Birth

The purpose of this form is to:
Record Reasons for inability to enroll in the DMR HCBS Waiver

INDIVIDUAL RESOURCES		
<u>Income</u>	<u>Assets</u>	<u>Trust fund</u>
Monthly unearned SSI \$ _____	Amount \$ _____	Amount \$ _____
SSDI \$ _____	Type (savings, property, stocks, etc.):	Trustee _____
Other \$ _____	_____	Address: _____
Monthly earned income \$ _____	_____	_____
Total Monthly Income \$ _____	Assets exceed \$1600: Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Income exceeds 3 x SSI: Yes <input type="checkbox"/> No <input type="checkbox"/>		Type of Trust: _____

OR: REFUSAL TO APPLY for Medicaid and/or the DMR HCBS Waiver

Date of decision: _____

Reason:

CM Signature and Date

REGIONAL STATUS:

Currently receiving DMR support but not on waiver and unable/ refusing to enroll

DMR supports withheld until notified by the Waiver Unit of the decision of the Commissioner or designee

Requesting response from Waiver Unit by _____ due to: _____

Comments

PRAT Chairperson Signature and Date

W-1576
(Rev. 2/99)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF MENTAL RETARDATION WAIVER CHANGE REPORT FORM

TO: _____
(DSS R.O.-Location)
FROM: DMR-CENTRAL OFFICE Region: _____
Client Name: _____ DMR No: _____
Medicaid Number: _____ DOB: _____

PLAN OF CARE CHANGE Effective Date: _____

Monthly Cost of Waiver Services: _____
Reason: (specify): _____

TRANSFER OF REGIONS Effective Date: _____

Client Transferred to DMR Region: _____ No.: _____

Address: _____

New Case Manager Name: _____ Telephone: _____

DISCHARGE FROM WAIVER Effective Date: _____

Discharge Reason (check one):

- Died
- Entered Hospital
- Became financially ineligible
- Became ineligible due to level of care
- Moved out of State
- Entered LTC facility due to health
- Entered LTC facility due to client choice
- Refused services-remained in community
- Lack of services
- Started new authorization segment/redetermination (DSS use only)
- Administrative error (DSS use only)
- Other (specify): _____

Comments: _____

DMR Representative: _____ Date: _____
DMR-Central Office Telephone: _____

Original to DSS Eligibility Worker. Copy to DMR Case Manager. Copy to DAS-Financial Services Center

**State of Connecticut
Department Of Mental Retardation
Waiver Operations Unit**

**Notice of Acceptance of Eligibility for Enrollment for
Home and Community Based Services Waiver Services**

Date:

Re: Application of _____
Date of Birth: _____

Materials necessary for determining eligibility for enrollment in the DMR waiver have been received and reviewed by the Waiver Operations Unit of the Department of Mental Retardation.

It is the determination of the DMR Waiver Operations Unit that you are eligible for enrollment in the DMR waiver at this time.

This finding may be contingent upon a Title 19 eligibility determination by DSS if you were not previously enrolled in Title 19.

Should further questions arise we will contact you and those acting on your behalf.

If you and those acting on your behalf have any questions or concerns, please contact:

Waiver Operations Unit

Andrew Wagner, Ed D., Director (860) 418-6027
Diane Libbey, Manager (860) 418-6019

**460 Capitol Avenue
Hartford, CT 06106**

Cc: Case manager

11/8/06

Appendix E Level of Need Assessment and Individual Plan forms

Click on the Link below to the DMR Website for the Level of Need Assessment and Screening Tool Forms and Individual Plan Forms.

<http://www.dmr.state.ct.us/>

Select Publications

- Click on Private Provider Forms
- Level of Need Assessment and Screening Tool

Or

<http://www.dmr.state.ct.us/>

Select Publications

- Click on Private Provider Forms
- Individual Plan Forms

Appendix F Budget Form
See Comprehensive and IFS Excel File

**Appendix G Vendor Authorization Form
See Comprehensive and IFS Excel File**

The Department of Mental Retardation
Individual Support Agreements
Accounting and Reporting Requirements
(COST STANDARDS)
Introduction

1. This document supplements the department's procedures relative to Individual Supports and establishes the accounting requirements for determining, documenting, and reporting the costs of Individual Support Agreements (ISA) funded by the Department of Mental Retardation (DMR).
These requirements are designed to provide department staff, Fiscal Intermediaries (FIs) that contract with the DMR and the recipients of support funding through ISAs, the guidelines, and standards required to assure the appropriate use of State funds, and that costs submitted for Federal reimbursement are appropriate and allowable by the applicable Federal Standards and regulations.
2. These requirements are applicable to recipients of Individual Support Agreements from the Department of Mental Retardation, to the Fiscal Intermediaries that administer the disbursement and financial reporting of Individual Support Agreement Funds and the department staff responsible for the development, review and approval of ISAs, individual budgets and management of Fiscal Intermediary Service contracts.
3. The accounting principles and related policy guides are set forth in the following Attachments:
 - Attachment A - Basic Considerations
 - A. Factors affecting allowability of costs
 - B. Documentation of costs
 - C. Prior Approval
 - D. Expenditure of ISA Funds
 - E. Budget Revisions (either amendments or adjustments)
 - F. Financial Reporting Requirements
 - G. Definitions
 - Attachment B - Selected Items of Cost
 - Attachment C - Home and Community Based Waiver Requirements
 - Attachment D - Reasonable Rate Guidelines
 - Attachment E - State Rate for Meals
 - Attachment F – Abbreviated Attachment B and D
5. The provisions of this document are effective May 1, 2004 and will be incorporated into the provisions of new agreements made on and after the effective date. These requirements should be kept in the DMR Manual in the section for Individual Support procedures and used in conjunction with these procedures.
6. Further information concerning this document may be obtained by contacting your Self Determination Director who will consult with the Director of the DMR Operation Center and/or the Central Office Director of Individual and Family Support, as necessary.

ATTACHMENT A

BASIC CONSIDERATIONS

- A. **Factors affecting allowability of costs.** Individuals are expected to access resources traditionally available from family, friends, and community prior to seeking State assistance. For example: services that can otherwise be obtained through other community resources such as vocational technical schools, or other community organizations. To be allowable under an agreement, costs must meet the following general criteria:
1. Costs must be applicable to the services rendered directly to or on behalf of the individual named in the ISA.
 2. Hourly rates of service must be reasonable in comparison with similar programs available in the State of Connecticut (See Attachment D Reasonable Rates Guidelines). Rates paid to family members performing under the ISA must comply with related party requirements in Attachment B and must show qualifications to perform the work as required by state or federal law or DMR policy and procedure (e.g. license, certification).
 - Total costs of individual expenditures must be reasonable. Documentation of competitive bidding is required for individual expenditures for goods in excess of \$2,500.
 - Documentation of the determination of competitive bidding must be available to support costs funded by the ISA
 3. Expenditures must be necessary, required, reasonable, and documented in the individual's plan. Costs must be identified in the individual budget that supports the signed ISA.
 4. Expenditures must conform to any limitations or exclusions set forth in these principles and in the agreement as to types or amount of cost items. **The cost items in this document are not account (SID) specific.**
 5. Costs must be adequately documented.
 6. Cost items must not be funded by other sources, including but not limited to:
 - a. Participants personal funds, income and assets,
 - b. Private insurance,
 - c. Insurance settlements and insurance awards,
 - d. Other state or federal agencies such as Bureau of Rehabilitation Services (BRS), the Department of Social Services (DSS), Board of Education and Services for the Blind (BESB), or the Department of Mental Health and Addiction Services (DMHAS), or
 - e. Medicare, and/or Medicaid (state plan services).
 7. Cost items must not be funded by waivers administered by DSS, including but not limited to Katie Becket, Connecticut Homecare Program for Elders, Acquired Brain Injury, and Personal Care Attendant, except with prior approval.

B. Documentation of costs.

1. Allowable costs must be adequately documented by original documentation and/or any other forms of documentation evidencing a cost was incurred, the nature and description of items or services purchased, a disbursement of funds was made, and substantiating a cost was incurred during the contract period. Original documentation includes store and vendor bills and receipts, time sheets and time cards signed by both the individual performing the service and the designated person knowledgeable that the hours or work have been provided, and cancelled checks from individuals who are seeking reimbursement of costs.
2. Supporting documentation must demonstrate the cost was incurred to directly support the individual named in the ISA funded by the Department of Mental Retardation.
3. The absence of adequate supporting documentation may render a cost unallowable and not funded by the Department of Mental Retardation, and may result in a requirement for reimbursement to the Department.

4. Documentation may be demonstrated in various ways for instance: receipts, a log of purchases or miles traveled, responses to bids, the purchased item's appropriateness for the individual is based on such things as age, disability needs, individual plan.
- C. **Prior Approval.** Prior approval must be secured before a **cost item requiring prior approval in Attachment B** may be entered in to the individual's plan/budget. No action may be taken until approval has been secured. Documentation of this approval must be submitted and filed with the ISA. (Refer to the Prior Approval Procedure in the DMR Manual for details) **Any one or a combination of the following items can be approved through the regional approval process when it meets the prior approval criteria, up to a maximum of \$1,000 per year as a one-time or annualized expense:**
 - **Cleaning supplies # 5 page 9,**
 - **Clothing # 6 page 9**
 - **Household maintenance #24 page 13**
 - **Household furnishings #25 page 13,**
 - **Household repairs #26 page 13**

Requests over \$1,000 per year, as a one-time or annualized expense, for a single item or a combination of these items, requires a Central Office Prior Approval.

The approval will last for the duration of the ISA and approvals of ongoing costs do not require approval for renewal. **Appeals will be reviewed by the Deputy Commissioner. The individual or family can use the PAR process after an appeal decision has been rendered.**

- D. **Expenditure of ISA Funds** The expenditure of ISA funds will be in accordance with approved ISA budgets and comply with applicable Individual Support procedures. Copies of the ISA budget will be provided Fiscal Intermediaries. Fiscal Intermediaries are only authorized to process payments for items of costs that have been identified in the approved ISA budget (original or amendment), or have been identified in a budget adjustment approved by the Regional Self Determination Director.
- E. **Budget Revisions (either amendments or adjustments)** must comply with applicable Individual Support procedures. ISAs must be supported by budgets disclosing how funds will be expended. Refer to Procedure No. I.C.2.PR.008 "Individual Support Agreement Fiscal Management" for details.
- F. **Financial Reporting Requirements** Fiscal Intermediaries must comply with the terms of the their contracts and the applicable department Individual Support procedures. Costs incurred and funded by an ISA must be reported to the Department of Mental Retardation on the financial report forms designated and provided by the Department. Costs incurred as part of an ISA that are reported to the Department must be accurately classified and reported on the expenditure report based upon the type of expenditure that was incurred in order to ensure that financial reports accurately report the costs of the ISA. Expenditure of ISA funds are to be reported based upon classification of the expenditure, not the availability of funds in the ISA award budget.

Expenditures of ISA funds must be disclosed and reported based upon the nature of the expenditure. Specifically as examples, food must be reported as food, not as program or recreational supplies; cellular phones must be reported as cellular phones, not as personal safety backup.

G. **Definitions:**

1. **Allowable ISA Costs** Allowable ISA costs are those costs that have been incurred to directly serve the individual named in the ISA. These are costs that have been specifically identified in the budget that supports the agreement. Costs that exceed the range of reasonable must have prior approval.
2. **Amendments** are revisions of the plan and budget that change the total amount of the ISA. The rules for amendments are in the DMR procedures for ISAs
3. **Applicable credits.** The term applicable credits refers to refunds, vendor or store credits, or reduction of expenditures in any manner that reduces the actual cost incurred by the ISA. Typical examples of such transactions are: purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds, and adjustments of overpayments for erroneous charges. To the extent that such credits received for services or other items funded by the ISA, the cost to the ISA and ultimately the cost to the Department of Mental Retardation must be reduced to reflect the reduction of the cost. Refunds or credits received in a current contract period, applicable to a prior period must be applied to the current period.
4. **Compensation** for personal services includes all compensation paid or accrued for services of employees rendered during the period of the ISA award. Compensation includes and is limited to, salaries, wages, and fringe benefits. Any other type of compensation, **such as stipends**, must have prior approval.
5. **Individual** For the purpose of this document refers the person identified and funded by the ISA
6. **Prior approval** Prior approval in this context means securing the department's permission in advance to incur cost for those items typically designated as not allowed or requiring prior approval by this document, DMR procedures or directives.
7. **Reasonable costs.** A cost is reasonable if, by its nature or by its amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs. Or simply, the cost is that which a typical person would be willing to spend with his or her own money.
8. **Reasonable rates.** A rate would be reasonable if, by its nature or by its amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs. See Attachment D for Reasonable Rates
9. **Related Party Transactions.** Related party transactions are transactions between the individual with the ISA and persons or organizations that are related to that individual, through marriage, ability to control, ownership, family or business association. Past exercise or influence or control needs not be shown, only the potential or ability to directly or indirectly exercise influence or control. Related party transactions include housing rentals between the individual and other family members.
10. **Total costs.** The total cost of an Individual Support Agreement (ISA) is the sum of the allowable costs less any applicable credits.

ATTACHMENT B

SELECTED ITEMS OF COST

Table of Contents

1. Administrative and General
2. Advertising
3. Alcoholic beverages
4. Bad debts
5. Cleaning supplies
6. Clothing Costs
7. Communication costs e.g. phones, fax machines postage
8. Compensation of personal services
 - a. Definition
 - b. Allowability
 - c. Fringe Benefits
9. Computers and computer software
10. Contingency provisions
11. Contributions
12. Damages
13. DMR funded/contracted Day Program costs.
14. Direct care provided by family members
15. Education
16. Equipment, materials and supplies
17. Equipment – therapeutic
18. Fines and Penalties
19. Fringe Benefits
20. Furniture
21. Goods and services – used by persons other than the individual named
in the ISA
22. Homemaker services
23. Home Renovation and modification costs
24. Housing Maintenance
25. Household furnishings
26. Household repairs
27. Insurance
28. Legal and advocate fees
29. Losses on awards
30. Personal Care Items
31. Personal Items
32. Professional service costs
33. Recreation/Entertainment costs
34. Related Party transactions
35. Respite Support
36. Room and board related expenses
37. Service coordination
38. Service agreement administration – expenditures
39. Taxes
 - a. Property
 - b. Sales
40. Transportation costs
 - a. Mileage Reimbursement
 - b. Vehicle Repairs and Vehicle Modifications
 - c. Purchase/Leasing
41. Travel costs
42. Vacations
43. Day Program Wages

ATTACHMENT B

SELECTED ITEMS OF COST Allowability, Unallowable and Prior Approval

This section provides the requirements to be applied when determining the allowability of certain items of cost. Determination as to allowability in each case should be based on the nature and the type of the cost, and/or the accounting principles provided for similar or related items of cost. Expenditures must be necessary, required, reasonable, and documented in the individual's plan. Costs must be identified in the individual budget that supports the signed ISA.

Prior approval may be required for certain costs. Items/services requiring prior approval must be reviewed and documented in accordance with the "Prior Approval" procedure located in the DMR Manual under Individual Supports.

The following alphabetical list of cost items is not intended to be all-inclusive. If an item is not there, the reader should apply the concepts laid out for similar cost item(s) and request prior approval if warranted.

1. **Administrative and General.** Administrative and general costs (A&G/overhead costs) are unallowable costs. To the extent services funded by an ISA Agreement are purchased from a private service organization, that service organization's administrative costs/overhead is allowable as part of the overall rate charged by the services organization for the services to be rendered under the ISA Agreement.
2. **Advertising.** The only allowable advertising costs are those which are solely for the recruitment of personnel required for the performance of the ISA
3. **Alcoholic beverages.** Costs of alcoholic beverages are unallowable.
4. **Bad debts.** Bad debts, including losses (whether actual or estimated) arising from uncollectible accounts and other claims, related collection costs, and related legal costs, are unallowable.
5. **Cleaning Supplies.** Household cleaning supplies are room and board related costs. Cleaning supplies that are needed as a result of the person's disability are allowable subject to prior approval criteria, **and can be approved through the regional approval process under the limits and the conditions in section C on page 4 of this document.**
6. **Clothing costs.** Clothing is a personal item funded by the personal funds individuals receive through awards from State and Federal sources. Clothing required as a result of the individual's disability is allowable subject to prior approval, **and can be approved through the regional approval process under the limits and conditions in section C on page 4 of this document.**
7. **Communication costs.** Costs incurred for telephone services, local and long distance telephone calls, cell phones, fax costs, postage are allowable subject to prior approval and they are related directly to the care of the individual, they are reasonable, and they are budgeted as part of the ISA. Costs are allowable only for that portion of the expense that relates directly to the individual's care, separate from costs incurred by other members of the household. Cell phone costs can be approved up to \$20 a month under the regional approval process for emergency support, calling back up staff, or for health, medical, and behavioral needs that meet the prior approval criteria. Requests over \$20 a month require a Central Office Prior Approval. The cost of the phone is not allowable.
8. **Compensation for personal services.**
 - a. **Definition.** Compensation for personal services includes all compensation paid or accrued for services of employees rendered during the period of the ISA award. Compensation includes and is limited to, salaries, wages, and fringe benefits. Any type of compensation beyond wages and fringe benefits, **such as stipends**, must have prior approval.
 - b. **Allowability.** Compensation is allowable to the extent that:
 - (1) Total compensation, and rates of payment to individual employees are reasonable for the services rendered, and reasonable based upon the rates the Department of Mental Retardation funds for similar services.

- (2) Charges to agreements are supported and documented by time sheets indicating the days services were rendered, the time periods during each day the services were rendered, and the total hours per day. In order for compensation to be an allowable expenditure, the time sheets must be signed by the employee, and signed by an agreed upon designated individual knowledgeable that the hours of service paid by the ISA were provided.

c. Fringe benefits.

- (1) Fringe benefits in the form of employer contributions or expenses for social security, governmental payroll related taxes, employee insurance, workmen's compensation insurance, pension plan costs and the like, are allowable, provided such benefits are part of the budget that supports the ISA.
 - (2) Fringe benefits in the form of regular compensation paid to employees during periods of authorized absences from the job, such as vacation leave and/or sick leave are allowable. Any other type of compensation must have prior approval.
- 9. Computers and computer software.** Computers and computer software unrelated to the disability of the individual named in the ISA are unallowable. Therapeutic computers and software are addressed under equipment (See paragraph 17 Therapeutic Equipment).
- 10. Contingency provisions.** Contributions to a contingency reserve or any similar provision made for events the occurrence of which cannot be foretold with certainty as to time, intensity, or with an assurance of their happening, are unallowable. Payments or any form of accounting entries and/or charges to accounts for unexpended funds during the award period are unallowable.
- 11. Contributions.** Contributions and donations are unallowable.
- 12. Damages.** Expenditures for damages that result from the actions or are the result of the disability of the individual named in the ISA require prior approval. Normal wear and tear type damages are not allowable.
- 13. Day Program Wages.** Day Program Wages as an expense in the ISA to compensate the individual supported by the ISA, requires Prior Approval.
- 14. DMR funded/contracted Day Program costs.** Does not include supports provided by staff hired by the individual/family. Refer to Compensation for these costs.
- a) **ISA's will not be used to purchase contracted agency day programs; these services will be purchased through the DMR Private Division's contracting system. This is applicable for new ISA's, and is not intended to affect any existing ISA's that purchase center based or group day programs from agencies. Exceptions will be reviewed at the regional level.**
 - b) **For existing ISA's with agency day programs, there will be no profits or markups added onto the day program costs *by the day program provider for day program costs* funded by the ISA.**
- 15. Direct care provided by family members.** Direct care provided by family members for routine care and supervision that would be expected to be provided by a family member is unallowable. Exceptions may be made when it can be demonstrated that the service is not a typical family support function, **such as support for intensive medical, behavioral, or supervision needs**, the family member is qualified to perform the service, and **if the family member has reduced their income in order to provide the service.** Family member includes mother, father or spouse, and siblings residing within the home. Parents of a child under age 18 may not be paid for services to the child.
- 16. Education.** Costs related to Special education and related services as defined in the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA (20 U.S.C. 1401), are allowable. Education costs available under a program funded by IDEA (20 U.S.C. 1401) are unallowable. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the section 110 of the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Act.

17. Equipment, materials and supplies. Equipment and/or materials and supplies that are directly related to the individual's disability and do not have another funding source are allowable to the extent the items of equipment are included in the budget that supports the ISA and the equipment is under the physical control of the individual. Physical control means in their residence or other locations where the individual has access to the equipment and access and use of the equipment is limited and restricted to use only by the individual named in the ISA. Equipment purchased for use in the day program under the physical control of the day program provider, and is available for use by other day program participants is a day program expense unallowable as an ISA expense.

In determining the allowability of the items of equipment, documentation must be available to disclose that the equipment, and/or materials and supplies is not funded by other sources, typically, private insurance, Medicare, and/or Medicaid.

Equipment costs not directly related to the disability of the individual named in the ISA are unallowable.

18. **Equipment – Therapeutic**, such as a hospital bed or other therapeutic equipment needed that is directly related to disability of the individual named in the ISA, is allowable to the extent that it is not funded by other sources, typically private insurance, Medicare and/or Medicaid. The therapeutic equipment must be recommended by a licensed professional **which include physicians, therapists, counselors, psychiatrists, nurses, occupational therapists, physical therapists, and vocational rehabilitation counselors.** All equipment items should be transferred with the individual if they move to another residential setting. The allowable cost is limited to the cost of the equipment item from an equipment vendor. Equipment that acquired through a third party, i.e. a day or residential program provider must be reported at the cost the provider pays its vendor.
19. **Fines and penalties.** Costs of fines and penalties resulting from violations of, or failure to comply with Federal, State, and local laws and regulations are unallowable.
20. **Fringe benefits.** See **subparagraph 7.c.**
21. **Furniture.** Furniture costs unrelated to the disability of the individual named in the ISA are limited to a maximum one time expense of \$1000 and will be tracked in the Department's ISA database. Furniture costs that are related to the disability of the individual named in the ISA must be purchased as therapeutic equipment (See paragraph 17 Therapeutic Equipment).
22. **Goods or services - used by persons other than the individual.** Costs of goods or services for personal use of individuals other than the individual named in the ISA are unallowable except those costs that may be required and are related to the care of the individual with the ISA that are incurred for individuals other than individuals named in the ISA. The costs of goods or services for use by individuals compensated under the ISA must have prior approval. Personal living expenses for individuals other than the individual named in the ISA are subject to prior approval.
23. **Homemaker services.** Costs including cleaning services, homemaker services, and laundry services are unallowable except if these costs are related to the disability of the individual named in the ISA and cannot be performed by another resident in the household. **Homemaker services can be approved through the regional approval process under the conditions above when the costs are competitive.**

24. **Home Renovation and modification costs.** Costs applicable to renovation and/or modifications to the primary residence the individual lives are allowable but cannot exceed \$10,000. Physical adaptations to the home are allowable if they are required by the individual's plan of care, are necessary to ensure the health, welfare, and safety of the individual, enable the individual to function with greater independence in the home and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, and are not typically of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home must be noted on the ISA.
- Home renovation and modification costs must have prior approval (see Prior Approval, 3.a. definitions). As part of the prior approval, all home improvements and renovation projects must document through a submission of a proposal to obtain the prior approval that includes (1) the disclosure of the full scope of the project including a budget that identifies the cost for the entire project, (2) documentation that the project has the approvals from local building inspectors and fire marshals, (3) the documentation that the project has been competitively bid with the documentation of bids are from three qualified bidders, that each bidder is currently licensed with the State of Connecticut's Department of Consumer Protection to perform the work, craft, or skill for the portion of the project they are bidding, that the bidders are insured, and that all bids must be competitive and the bids are comparable. Comparable bids means each bidder was bidding on the same scope of work.
25. **Housing Maintenance.** Costs of housing (e.g., maintenance including grass cutting services, landscaping, snow removal services etc.) and housing allowances that are disability related are allowable subject to prior approval. **Housing Maintenance can be approved through the regional approval process under the limits and conditions in section C on page 4 of this document.**
26. **Household furnishings.** Household furnishings including but not limited to kitchen appliances (including refrigerators, dishwashers, etc.), washing machines, dryers, window dressings, wallpaper and the range of wall decorations, lights, lamps, quilts, pillow shams, etc. are unallowable unless they are part of the one time set up cost. Exceptions may be granted if the item is disability related and meets prior approval criteria. **Household furnishings can be approved through the regional approval process under the limits and conditions in section C on page 4 of this document.**
27. **Household repairs.** Household repairs including but not limited to plumbing, electrical, repair of household furnishings and items such as dishwashers, refrigerators, washers, dryers are unallowable unless disability related, documented, and has prior approval. **Household repairs can be approved through the regional approval process under the limits and conditions in section C on page 4 of this document.**
28. **Insurance.** The additional cost of automobile insurance resulting from the "employee" of the ISA or non-family member who will have access to and be driving the family's vehicles is an allowable cost. However, the allowable insurance cost is only the additional cost to the policy for this reason. Any other insurance costs are unallowable.
29. **Legal and Advocate Fees.** Fees and other costs associated with attorneys and advocates are unallowable costs.
30. **Losses on awards.** Any excess of costs of the ISA is unallowable as a cost of award in another fiscal period.
31. **Personal Care Items.** Costs for personal care such as diapers, formulas are allowable if required as a result of the individual's disability, are not items normally used for an individual at that age and are not covered by private insurance coverage, Medicaid, Medicare, other State funded programs, or other sources

32. **Personal Items.** The ordinary and necessary items that fall under the category of “personal items” are unallowable costs of an ISA. Personal items are typically funded by the awards individuals receive from their various State and Federal sources and entitlements. The ordinary and necessary items include but are not limited to food/snacks to the extent not considered a room and board cost, clothing, hair care including barber and hairdresser costs, toiletries, the various forms of entertainment such as bowling, tickets to movies and theaters, meals out at restaurants and fast foods, etc. To the extent there are extraordinary personal expenses related to the individual named in the ISA, and those expenses have been included in the ISA budget supporting the award, the budgeted personal expenses are allowable, subject to the disclosure and documentation of the extraordinary conditions that exist that require the ISA to fund these personal costs.
33. **Professional service costs.** Costs of professional and consultant services rendered by persons who are licensed members of a particular profession or possess a special skill are allowable when reasonable and necessary for the care of the individual named in the ISA, are included in the budget that supports the ISA and are not covered by private insurance, Medicare or Medicaid, other State funded programs, or other sources.
34. **Recreation/Entertainment costs.** The cost of amusements, diversions, organized social or recreational activities and related costs such as meals, lodging, rentals, transportation and gratuities may be an allowable expense if it can be demonstrated that it is a necessary part of the plan **and does not exceed \$1200.**
35. **Related Party Transactions.** Transactions between the individual with the ISA and persons or organizations that are related to that individual, through marriage, ability to control, ownership, family or business association are allowable to the extent the amount charged the ISA is the related party’s actual cost, the transaction has been disclosed in writing to the Department identifying the nature of the relationship and the cost benefit of the transaction to the ISA, and the goods and services provided are required, they are necessary, they are reasonably and competitively priced, and they are included in the budget for the ISA.
36. **Respite Support.** Respite supports are “services given to individuals unable to care for themselves and provided on a short-term basis because of the absence or need for relief of those persons normally providing care. Respite supports are allowable.
37. **Room and board related expenses.** Costs applicable to the basic room and board needs for the individual named in the ISA are not allowable. Room and board related costs are funded by the entitlements the individual receives from State and Federal sources. Room and board related costs include but are not limited to food, rent, mortgage payments, utilities, repairs and maintenance, furniture, except for allowable setup costs, and home entertainment equipment.
38. **Service coordination.** The value of, or the fees for, service coordination function provided by family members or non-family members of individuals receiving ISAs is allowable.
39. **Service agreement administration-expenditures** The value of, or the fees for, financial/employer type administrative functions provided by family members or non-family members of individuals that are not administered by a Fiscal Intermediary are unallowable.
40. **Taxes.**
- a) **Property Taxes** on assets funded by the ISA are allowable.
Property taxes on assets not funded by the ISA are unallowable.
 - b) **Sales Taxes** on items funded by the ISA are allowable. Sales taxes on items not funded by the ISA are unallowable.
41. **Transportation costs.** Whenever possible, family, neighbors, friends, or community agencies that can provide these services without charge will be utilized.
- a. Mileage Reimbursement** The maximum mileage reimbursement is limited to the mileage reimbursement rate recognized by the IRS. To be allowable, the mileage must be documented by the dates of travel, the number of miles, and the purpose of the travel.

a. **Vehicle Repairs and Vehicle Modifications** are unallowable without prior approval.

b **Purchase/Leasing** The transportation costs applicable to the individual named in the ISA are allowable to the extent that the vehicle is needed due to the disability of the individual named in the ISA, are approved under prior approval and costs are included in the budget supporting the ISA. Allowable transportation costs related to the purchase or leasing of wheelchair vans, not to exceed the typical lease expenses for wheelchair vans and only when the primary use of the van is for the person with the disability named in the ISA. To be allowable the travel costs must be documented and disclose the dates of travel, the number of miles, and the purpose of the travel. Personal use of the vehicle purchased or leased with the ISA will be reimbursed to the State. **The decision to purchase or lease depends on the cost to buy versus the cost to lease and the factors affecting this. These factors include, the percentage of time the vehicle will be used for the individual versus the caretaker or family, the miles driven, the length of time the vehicle will be held, and the maintenance costs of the vehicle.**

42. **Travel costs.** Travel costs **including air, train, and bus fares** applicable to the individual named in the ISA are allowable to the extent that the travel costs are approved under prior approval, and costs are included in the budget supporting the ISA.

43. **Vacations.** The costs associated with vacations and any form of travel related costs related to vacations or time away from the individual's residence is unallowable costs. These costs are funded from the various awards and entitlements individuals receive from State and Federal sources.

DEPARTMENT OF MENTAL RETARDATION
INDIVIDUAL SUPPORT AGREEMENT

Region: _____ **Broker/Case Manager** _____

FY _____ Original: _____ Amendment # : _____ Renewal _____

This agreement is to clarify the terms for receipt of Individual Supports from the Department of Mental Retardation including the department funding, the supports and services to be provided or purchased, the proposed support providers, the payment authorization mechanisms, and the documented accounting requirements.

TERMS OF AGREEMENT

Recipient or Sponsoring Family Member	Social Security #
Address	City, State, Zip Code
Person for Whom Funds are Requested	DMR #

I hereby agree to receive Individual Supports and adhere to the following:

- I understand that I will be required to be an active participant in the development and implementation of the Individual Support Plan Summary as follows:

The Plan Summary is a concise one-page overview document that highlights the supports agreed upon in the person-centered planning process.

The Plan Summary is submitted with the ISA (Individual Support Agreement) and the Individual Budget. Please indicate if the ISA is a **new** agreement, a **renewal**, an **adjustment**, or an **amendment**. Also indicate the date and the name of the person who prepared the plan summary.

The Plan Summary will consist of the following:

1. **Current Situation:** A brief description of the person’s current situation including where the person is living, working, or going to school. If the Agreement is a renewal, include a description of the accomplishments of the past year.
2. **Vision:** A brief statement of the person’s dream or vision for the future. The person’s dream includes all areas of their life – home, work/school, and relationships, and community life.
3. **This Year’s Action Plan/Rationale:** Describe the pieces of the dream that the person and their circle are working on this year and the outcomes the person hopes to achieve. The action plan describes:
 - ❖ **type of support the person will receive** to move closer to his/her desired future
 - ❖ **why the support is important** (*what needs will be addressed*)
 - ❖ **how much support (hours, frequency)** will be provided
 - ❖ **who will provide the support,**
 - ❖ and if the support is **paid or non-paid**.

Include all supports the person will receive including case manager/broker, home and community supports, day support, respite, family support, and rent subsidy. Be sure to address supports that ensure the person's health and welfare.

The automated budget included with the Individual Support Agreement packet further delineates DMR-funded supports.

4. **Who Contributed to the Plan:** Identify by name and role (broker, relative, friend, agency staff) who contributed to the development of the plan and will assist the person in reviewing and modifying the plan in the future. This must be done at least annually.
5. **Waiver Enrollment Status:** Indicate if the individual is enrolled in the waiver or the status of the enrollment application if in process. If the individual is not enrolled in the waiver, please state the reason.
 - I understand that any significant changes to the Individual Support Plan Summary must be approved by the department.
 - I understand that I will be an active participant in the selection and ongoing monitoring of supports and services.
 - I agree to enroll in the Home and Community Based Services Waiver, if eligible.
 - I understand that my participation may affect the receipt of other services from the department that I or my sponsoring family member currently receive.
 - I understand that it is my responsibility to ensure that support workers are properly trained to protect the recipient's health and welfare as they provide the specified supports and services.
 - I understand that if payments for supports and services are made by a fiscal intermediary, I must also adhere to the requirements identified on Schedule A of this agreement.
 - I understand that if I receive a cash subsidy from the department, I must also adhere to the requirements identified on Schedule B of this agreement.
 - I understand that if the department makes payments for supports and services through a contract with a provider, I must also adhere to the requirements identified on Schedule C of this agreement.
 - I understand that if I am participating in the DMR/DSS Home Care Pilot Program, I must also adhere to the requirements identified on Schedules A and D of this agreement.

The Department of Mental Retardation hereby agrees to the following:

- The Department of Mental Retardation will work with the fiscal intermediary of your choice, provide a cash subsidy, or arrange supports and services under contract with a provider as outlined in the approved individual support plan summary attached to this agreement.

Individual Support Plan Summary

The individual support plan summary as described on page one of this agreement should be attached.

Budget

The total amount of funds covered under this agreement is up to: \$_____. A copy of the automated budget should be attached and describe the funding amount, the planned distribution of funds, the agreed upon payment process and schedules, the payment authorization process to be used for direct payments to support providers, any special conditions of payment and expenditure reporting requirements.

The following is the distribution of funds covered by this agreement:

Schedule A				
<input type="checkbox"/>	Fiscal Intermediary	Account	Fiscal Intermediary	\$ Amount
<input type="checkbox"/>	Fiscal Intermediary	Account	Fiscal Intermediary	\$ Amount
Schedule B				
<input type="checkbox"/>	Subsidy	Account	Recipient/Sponsoring Family Member	\$ Amount
Schedule C				
<input type="checkbox"/>	Contract	Account	Provider	\$ Amount

This agreement is effective from: ____ / ____ / ____ to ____ / ____ / ____.

Signed: _____
 ____ / ____ / ____
 Recipient or Sponsoring Family Member

Date:

Signed: _____
 ____ / ____ / ____
 Regional Director

Date:

Approved: _____
 ____ / ____ / ____
 Commissioner or Designee

Date:

This agreement shall become effective upon written approval by the Commissioner or Designee of the Department of Mental Retardation and shall supersede any previous agreements entered into by both parties. This agreement may be terminated without cause upon thirty days' written notice by either party. The department has the right to terminate this agreement upon 24 hours' notice when the department deems the health or welfare of the person receiving supports is endangered. All unexpended funds must be returned at the request of the department.

SCHEDULE A

This schedule should be attached to all agreements that include plans to make payments for supports and services through a fiscal intermediary.

I hereby agree to work with a fiscal intermediary and to adhere to the following:

- I agree to enter into an agreement with a fiscal intermediary that is under contract with the department.
- I agree to enter into an agreement with the provider agency/agencies or individual support worker(s) I hire. The agreement must identify the specific supports and services that will be provided according to the Individual Support Agreement and will include the type, amount, and cost of supports and services including the hours of support to be provided and the agreed upon fee.
- I agree to notify the DMR regional office if I intend to purchase supports, services, or goods from a party that is related to me through family, marriage, or business association.
- I understand that any payments made by the fiscal intermediary under this agreement may be used only for items or services as outlined in the individual support plan summary and budget.
- I understand that I am responsible to seek or negotiate reasonable fees for services and reasonable costs for items, goods, or equipment. I agree to obtain three bids for purchases of items, equipment, or home modifications over \$2,500.
- I understand that any special equipment, furnishings, or items purchased under this agreement are the property of the service recipient and will be transferred to his or her new place of residence or activity at such time as there is a change of residence or day services or supports.
- I understand that the fiscal intermediary will assist me to make any required payments for mandatory employment benefits such as FICA, FUTA, and Unemployment Compensation if I hire an employee with funds provided by the Department of Mental Retardation.
- I understand that I must submit timesheets, receipts, invoices, expenditure reports, or other documentation that services were provided or supports were purchased to the fiscal intermediary on a monthly basis/within the agreed upon timeframe.
- I understand that the fiscal intermediary will provide monthly reports of expenditures made under this agreement.
- I understand that the fiscal intermediary will assist me to complete any required employer forms or documents.
- I understand that any funds held by the fiscal intermediary that are not expended under the terms of this agreement must be returned to the department, upon request.
- I agree to provide feedback to the department regarding the performance of the fiscal intermediary if requested.

Recipient or Sponsoring Family Member

Date: ____/____/____

SCHEDULE B

This schedule should be attached to all agreements that include cash subsidies to service recipients or their sponsoring family member.

I hereby agree to receive a cash subsidy to purchase supports and services and to adhere to the following:

- I understand that any funds received under this agreement may be used only for items or services as outlined in the individual support plan summary and budget.
- I agree to notify the DMR regional office if I intend to purchase supports, services, or goods from a party that is related to me through family, marriage, or business association.
- I understand that I am responsible to seek or negotiate reasonable fees for services and reasonable costs for items or equipment. I agree to obtain three bids for purchases of items, equipment, or home modifications over \$2,500.
- I understand that any special equipment, furnishings, or items purchased under this individual support agreement are the property of the service recipient and will be transferred to his or her new home or activity at such time as there is a change of residence or day service.
- I understand that I am responsible for making any required payments for mandatory state and federal employment benefits such as FICA, FUTA, and Unemployment Compensation if I hire a support provider with subsidy funds provided by the Department of Mental Retardation.
- I understand that receipt of a cash subsidy may affect other state or federal benefits or entitlements that I currently receive, such as Supplemental Security Income (SSI) and Medicaid (Title XIX), or may affect state or federal benefits and entitlements that my sponsoring family member currently receives such as (TANF), Medicaid, or Section 8 Housing. Resolution of these issues will be handled on a case by case basis with the support of DMR staff.
- I understand that with the receipt of a cash subsidy I must submit expenditure reports for the purpose of documenting the accounting requirements. The annual amount of the cash subsidy will determine the frequency and the information to include in the expenditure report as outlined below.
 1. 0 - \$3,000 Expenditure reports must be submitted quarterly and include:
 - a. A list of purchases or services used during the quarter
 - b. Service recipient and/or family should maintain receipts or supporting documentation of expenditures for their personal records.
 2. \$3,001 - \$7,000 Expenditure reports must be submitted quarterly and include:
 - a. An itemized list and costs of supports and services used during the quarter
 - b. A separate checking account is required. Submit copies of checkbook ledger and bank statements for the quarter
 - c. Invoices, receipts, time sheets of service hours provided, or other documents that substantiate services were rendered during the quarter.
- I understand that, with the receipt of a cash subsidy, expenditure reports are due to the regional designee monthly when required or on October 15, January 15, April 15, or July 15 during the time period covered under this agreement.
- I understand that subsequent cash subsidy payments may be withheld if expenditure reports are not received by due dates.
- I understand that, upon request, I must return any subsidy funds provided by the department that are not expended during the terms of this agreement or in accordance with the individual plan summary and budget.

Recipient or Sponsoring Family Member

Date: ____/____/____

SCHEDULE C

This schedule should be attached to all agreements that include plans for the department to enter into a contract with a private provider chosen by the recipient or his or her sponsoring family member to provide supports and services as identified in the individual support plan.

I hereby agree to receive supports and services from the provider I select and to adhere to the following:

- I agree to enter into an agreement with the provider that identifies the specific supports and services the provider will be responsible for as identified in the individual support plan. The agreement will include the type, amount, and cost of supports and services including the hours of support to be provided and the agreed upon fee.
- I understand that any payments made to the provider under this agreement may be used only for supports or services as outlined in the individual support plan.
- I understand that payments for supports and services made by the department under contracts or other payment authorizations will be processed according to standard procedures and time frames, and that providers will be required to adhere to established monitoring and reporting requirements.
- I agree to provide feedback to the department regarding my satisfaction with the performance of the provider.
- I understand that supports and services paid for by the department under contract with a provider may be changed at the request of the service recipient or family upon 30 days notice to the department.

Recipient or Sponsoring Family Member

Date: ____/____/____

SCHEDULE D

This schedule should be attached to all agreements for participants of the DMR/DSS Home Care pilot program. The DMR/DSS Home Care pilot program transfers DSS Medicaid funds to DMR for the purpose of enabling families to direct the purchase of home care for their children. The DMR/DSS Home Care pilot program is limited to eligible children who are under 18 years of age and who:

- ◆ **Are authorized for over 20 hours per week of Medicaid Home Health Aide or Nursing services**
- ◆ **Have a documented history of inability to gain access to a sufficient amount of authorized home care**
- ◆ **Are enrolled in the DMR Home and Community-Based Services waiver.**

I hereby agree to adhere to the following:

- I agree to access home care supports and services from the person(s) or provider agency I select as described in the individual support plan summary.
- I agree to discontinue Medicaid covered home health aides or nursing funded through the traditional DSS Medicaid payment system.
- I agree to notify my DMR case manager or support broker of the date on which I will discontinue Medicaid covered home health services and will begin to direct the purchase of individual supports for my child.
- I agree to enroll my child in the DMR Home and Community-Based Services waiver as a requirement of participation in the DMR/DSS Home Care pilot program.
- I agree to provide feedback to the department regarding my satisfaction with the DMR/DSS Home Care pilot program, upon request.
- I agree to work with a fiscal intermediary and to adhere to the requirements described in Schedule A of this Individual Support Agreement.

Date: _____/_____/_____

Recipient or Sponsoring Family Member

Individual/Family Agreement with Vendor

Name and Address of Individual/Sponsoring Person:

(First Name)
(Last Name)

(Street) (City)
(State) (Zip Code)

Name of person services will be provided to:

(First Name) (Last Name)

Name of Case Manager:

(First name) (last Name)
(Phone Number)

Effective date of Agreement:

Name and Address of Agency:

(Name) (Address)
(City) (State)

Contact Person:

(Name)
(Phone Number)

Fiscal Intermediary:

Check appropriate box:

Negotiated Rate

Agency with Choice

Both

Type of support:

Hourly Rate of Pay: \$

Days/Hours of Work:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours							

Billing Method: Invoices sent directly to FI Invoices sent directly to family

Terms for Discontinuation of Service (can be negotiated up to a maximum of 30 days):

Agency With Choice

Role of the Individual in Selecting & Dismissing staff:

I agree to provide the services and supports identified in this agreement and to ensure staff, prior to working alone with individual, are provided standard training and specific training identified in the individual plan.

Agency Representative

Signature: _____

Date: _____

Employer

Signature: _____

Date: _____

Individual/Family Agreement with Employee

Name and Address of Employer:

(First Name) (Last Name)

(Street) (City) (State) (Zip Code)

Name of person services will be provided to:

(First Name) (Last Name)

Name of Case Manager:

(First Name) (last Name) (phone Number)

Effective Date of Agreement:

Name and Address of Employee:

(Name) (Address) (City) (State) (zip code)

Type of support:

(Attach Qualifications for Support Type)

Days/Hours of Work:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours							

Rate of Pay: \$ _____ Workman's Compensation Insurance: Yes No Other: _____

Specific Training from individual plan required before working alone with Individual: _____

Conditions of Employment/Work Rules: _____

Name & Phone Number of person to contact if unable to report to work: _____

Employee Emergency Contact: _____
(Name) (Phone Number) (Relationship to employee)

I agree to provide the services and supports identified in this agreement, and prior to working alone with individual complete the standard training and specific training identified in the individual plan.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

3. Type of application:

Initial Enrollment
 Reapplication/Re-enrollment

The applicant (check one) () is () is not a current DMR
 Service provider

The applicant (check one) () is () is not a current CT
 Medicaid provider

For initial enrollment or reapplication/re-enrollment, use **X** to indicate services the provider agency will provide under each program. Use **X** to specify which region(s) or locations where service will be provided.

Provide Service	Service	North Region	South Region	West Region	Out of State	Specific Towns (if not region wide)
	Personal Support					
	Respite Care					
	Supported Employment					
	IS Habilitation					
	Group Day Services					
	Individualized Day Support					
	Environmental Modifications					
	Vehicle Modifications					
	Transportation					
	Specialized Medical Equipment and Supplies					
	Personal Emergency Response System (PERS)					
	Adult Companion Services					
	Consultative Services: Psychology					
	Dietician/Nutrition					
	Counseling					
	Behavior Management					
	Interpreter Service					
	Family and Individual Consultation and Support (FICS)					
	Residential Habilitation: CLA					
	CTH					
	Supported Living					
	Assisted Living: Level 1					
	Level 2					
	Level 3					
	Level 4					
	Core Services					

Beginning Date Medicaid Services will be provided: ____/____/____

4. Provider Agency Acknowledgement

I understand that the provider agency is responsible for submitting to DMR verification and documentation of its qualifications to render the Waiver Services indicated on this application

Signature of Authorized Agent for Provider Agency

Typed or Printed Name and Title of Authorized Agent

Date: _____

Instructions:

- 1) A completed "Department of Mental Retardation Application for Vendor Participation" form with attachments should be submitted to:

Peter Mason
Operations Manager
Department of Mental Retardation
460 Capitol Avenue
Hartford, Connecticut 06106

- 2) Attachments:

Signed Assurance Agreement
Documentation (see attached Document Guidelines)
Licenses and qualifications of all consultants

- 3) The DMR will notify the Qualified Vendor applicant in writing within 30 days if the application is complete and identify what information is missing or incomplete. The applicant will be given a time frame to provide the missing information.
- 4) The DMR will notify a Qualified Vendor applicant in writing whether the application has been accepted within 60 days of the receipt of a complete application.



**State Of Connecticut
Department Of Mental Retardation**

PROVIDER QUALIFICATIONS AND TRAINING VERIFICATION RECORD
For Employees Hired Directly by Individuals and Families

Name of Employee:	Name of Individual Receiving Services:
Case Manager:	

Waiver Services To Be Provided (please check all that apply:)

<input type="checkbox"/> Personal Support <input type="checkbox"/> Respite <input type="checkbox"/> Supported Employment <input type="checkbox"/> IS Habilitation <input type="checkbox"/> Individualized Day Support <input type="checkbox"/> Comp Supported Living	<input type="checkbox"/> Adult Companion Services <input type="checkbox"/> Consultative Services <input type="checkbox"/> Interpreter Services <input type="checkbox"/> Transportation <input type="checkbox"/> Family and Individual Consultation Support (FICS) <input type="checkbox"/> Individual Directed Goods and Services
---	--

PART 1: STANDARD REQUIREMENTS

Requirement Timeframe	Standard Qualifications, Competence or Training Required	Date Met	Employer Initials	Employee Initials
PRIOR TO EMPLOYMENT	18 Years of Age *			
	16 Years of Age (<i>Respite only</i>)*			
	21 Years of Age (FICS)			
	Criminal Background Check *			
	DMR Abuse and Neglect Registry Check *			
	Ability to Complete Record Keeping			
	Ability to Communicate Effectively with the Individual and Family			
	Proficient in English and other languages as required, understands cultural nuances and emblems, understands interpreter role (<i>Interpreter Services Only</i>)			
	Professional Licensure/Certification or Appropriate Training as Required (<i>Consultative Services Only</i>)*			
Family and Individual Consultation Support (FICS) Requirements as Applicable				

* *Verified by the Fiscal Intermediary*

PRIOR TO BEING ALONE WITH THE INDIVIDUAL OR WITHIN 30 DAYS OF EMPLOYMENT	Abuse/Sexual Abuse and Neglect Prevention and Reporting			
	Human Rights			
	Confidentiality			
	Handling Fire and Other Emergencies			
	Incident Reporting			
	Medication Administration (if required in the Individual Plan)			
	Approved and Prohibited Physical Management Techniques			
Person-centered Planning/Circle Participation <i>(IS Habilitation, Supported Employment, Individualized Day Support Services Only)</i>				

PART 2: ADDITIONAL AND SPECIFIC REQUIREMENTS (As Identified In The Individual Plan)

Additional and Specific Competence or Training Required	Requirement Timeframe (✓)				Date Met	Employer Initials	Employee Initials
	Prior To/ Alone	Within 15 days	Within 30 days	Other: Specify			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

The signatures below verify that required qualifications and training for the elements indicated above are met and the employee understands his/her responsibilities relating to the elements.

Signature of the Employer

Date

Signature of the Employee

Date

Please Attach this Form to the Individual/Family Agreement with Employee

Waiver Services
Codes Units and Rates

Service	Procedure Codes	Units/ Smallest unit increment	Vendor Rate
Residential Habilitation (SL)	T 2016	Contract	DMR Contract
Supported Living - Comp Waiver	97535	Hour / 15 minutes	31.26/hour
Individual Support Habilitation (IS) – IFS Waiver	97535	Hour / 15 minutes	31.26/hour
Personal Support	T 1019	Hour / 15 minutes	26.04/hour
Adult Companion	S 5135	Hour / 15 minutes	16.44/hour
Supported Employment Individual	T 2019	Hour / 15 minutes	56.43/hour
Supported Employment Group	T 2019	Hour / 15 minutes	10.58/hour
Supported Employment Group w/B	T2019B	Hour / 15 minutes	11.07/hour
Group Day – Day Support Option (DSO)	T 2021	Hour / 15 minutes	15.42/hour
Group Day – Shelter Workshop (SHE)	T2021	Hour / 15 minutes	7.49/hour
Group Day – SHE w/B	T2021B	Hour / 15 minutes	7.84/hour
Individualized Day	97537	Hour / 15 minutes	Negotiated (Cap of 31.26/hour)
Respite Individual (in home) Daily	S 5151	1 day	290.35/day
Respite Individual (in home) Hourly	S 5150	Hour / 15 minutes	24.20/hour
Respite Individual (out of home) Daily	S 5151	1 day	316.67/day
Respite Individual (out of home) Hourly	S 5150	Hour / 15 minutes	25.29/hour
Respite Group (in / out of home) Daily	S 5151	1 day	123.10/day
Respite Group (in / out of home) Hourly	S 5150	Hour / 15 minutes	9.16/hour
Personal Emergency Response System (Install)	1222 Z	One Time	33.98/install
Personal Emergency Response System (2 way)	1223 Z	1 month	56.63/month
Transportation	S 0215	1 mile	.42/mile
Transportation – one way trip		Trip	
Specialized Medical Equipment	T 2029	1 Unit	
Consultative Services			
Behavioral	H 2019	Hour / 15 minutes	68.95/hour
Counseling	S 9482	Hour / 15 minutes	68.95/hour
Nutrition	S 9470	Hour / 15 minutes	68.95/hour
Interpreter Services	T 1013	Hour / 15 minutes	53.04/hour
Family and Individual Consultation and Support (FICS)	T 2040	Hour / 15 minutes	50.01/hour
Intensive Staffing Support (Group Day & Respite Only)	Group Day Procedure Code + “Sup”	Hour / 15 minutes	11.08/hour
Assisted Living Com Waiver only	DSS Codes		
Level 1	1430Z	Per Diem/Daily	17.31/day
Level 2	1431Z	Per Diem/Daily	33.81/day
Level 3	1432Z	Per Diem/Daily	50.42/day
Level 4	1433Z	Per Diem/Daily	70.32/day
Core Services	1434Z	Per Diem/Daily	4.32/day
Individual Directed Goods and Services-Comp Waiver only	T2025	Manual entry/unit	Negotiated

APPENDIX O

VENDOR BILLING INVOICE FORM

**SEE Comprehensive EXCEL FILE
and
IFS EXCEL FILE**



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

Provider Agreement

Date: _____

Agreement between the Connecticut Department of Social Services (DSS) and

Provider _____

G. Address

Phone _____ Fax _____

The provider agrees to accept check(s) for item(s) or service(s) purchased for individuals served through the DMR Individual and Family Support Waiver or the DMR Comprehensive Waiver. Financial management, for these purchases, is provided by _____, which is not a Connecticut government agency. Acceptance and endorsement of the check(s) will signify that the provider agrees to the following terms and conditions:

- a. Accept payment, in form of check(s), from _____ doing business in _____.
- b. Agree to keep records of the service(s) or purchase(s).
- c. Provide only the service(s) or item(s) authorized on the check(s).
- d. Accept the check(s) as payment in full for the service(s) or item(s) purchased.
- e. No additional charges will be made or accepted from clients.
- 6. Upon request, provide DSS or its designee information regarding the service(s) or purchase(s) for _____ which payment was made.

DSS Representative

Provider Representative