

**907 KAR 12:010. New Supports for community living waiver service and coverage policies.**

RELATES TO: KRS 205.520, 205.5605, 205.5606, 205.5607, 42 C.F.R. 441 Subpart G, 42 U.S.C. 1396a, b, d, n

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.5606(1), 205.6317

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the service and coverage policies for the Supports for Community Living (SCL) waiver program. The SCL waiver program is federally authorized via a 1915(c) home and community based waiver that enables individuals with an intellectual or developmental disability to reside and receive services in a community setting rather than in an intermediate care facility for individuals with intellectual disabilities, including a participant directed services option pursuant to KRS 205.5606.

Section 1. Definitions. (1) "1915(c) home and community based waiver program" means a Kentucky Medicaid program established pursuant to, and in accordance with, 42 U.S.C. 1396n(c).

(2) "Abuse" is defined by KRS 209.020(8).

(3) "Adult day health care center" means an adult day health care center licensed in accordance with 902 KAR 20:066.

(4) "Adult foster care home" means a home:

(a) Not owned or leased by an SCL provider;

(b) In which a participant:

1. Is at least eighteen (18) years of age; and

2. Receives SCL services and resides in the family occupied (leased or owned) home; and

(c) In which the family:

1. Includes the participant in the family's household routines;

2. Provides training and supervision; and

3. Ensures that the participant's needs are met in accordance with the participant's person-centered service plan.

(5) "Advance directive" is defined by KRS 311.621(2).

(6) "Aversive technique" means:

(a) Withholding:

1. Food or hydration as a means to control or impose calm;

2. Access to a legal advocate or ombudsman;

3. Access to toilet, bath, or shower;

4. Access to personal belongings; or

5. Access to natural supports;

(b) Depriving medical attention or prescribed medication; or

(c) Depriving sleep.

(7) "Behavior intervention committee" or "BIC" means a group of individuals:

(a) Established to evaluate the technical adequacy of a proposed behavioral intervention for a participant; and

(b) That meets in accordance with the BIC policies established in Section 8 of this administrative regulation.

(8) "Board" means three (3) meals a day or other full nutritional regimen of a caregiver for the purpose of providing shared living services.

(9) "Case manager" means an individual who:

(a) Meets the requirements for a case manager established in Section 6 of this administrative regulation; and

(b) Meets all personnel and training requirements established in Section 3 of this administrative regulation.

(10) "Case manager supervisor" means an individual who:

(a) Provides professional oversight of case managers;

(b)1. Has a bachelor's or higher degree in a human service field from an accredited college or university;

2. Has a bachelor's degree in any other field from an accredited college or university with at least one (1) year of experience in the field of intellectual disability; or

3. Is a registered nurse;

(c) Has at least two (2) years of experience of case management responsibility in an organization that serves individuals with intellectual or developmental disabilities;

(d) Completes a case management supervisory training curriculum approved by DBHDID within six (6) months of beginning supervisory responsibilities; and

(e) Meets all personnel and training requirements established in Section 3 of this administrative regulation.

(11) "Certified nutritionist" is defined by KRS 310.005(12).

(12) "Certified psychologist" means an individual who is recognized as a certified psychologist in accordance with 201 KAR Chapter 26.

(13) "Certified psychologist with autonomous functioning" means a person licensed pursuant to KRS 319.056.

(14) "Certified school psychologist" means an individual certified by the Kentucky Education Professional Standards Board under 16 KAR 2:090.

(15) "Chemical restraint" means a drug or medication:

(a) Used to restrict an individual's:

1. Behavior; or

2. Freedom of movement; and

(b)1. That is not a standard treatment for the individual's condition; or

2. Dosage that is not an appropriate dosage for the individual's condition.

(16) "Community access specialist" means an individual who:

(a) Provides support and training that enables a participant to develop a network of natural supports to achieve a clearly defined and valued social role within the participant's community;

(b) Has:

1. Previously qualified or been credentialed by the department to provide community access services prior to the effective date of this administrative regulation; or

2.a. At least one (1) year of experience in the field of intellectual or developmental disabilities; and

b. Completed a department approved training program within one (1) year of application while providing community access services under the direct supervision of a community access specialist; and

(c) Meets the personnel and training requirements established in Section 3 or 10 of this administrative regulation.

(17) "Community guide" means an individual who:

(a) Has been selected by a participant to provide training, technical assistance, and support including individual budget development and implementation in aspects of participant direction;

and

(b) Has:

1. A bachelor's degree in a human services field from an accredited college or university;
2. A bachelor's degree in any other field from an accredited college or university plus at least one (1) year of experience in the field of intellectual or developmental disability; or
3. Experience in the field of intellectual or developmental disabilities that will substitute for the educational requirements stated in subparagraph 1. or 2. of this paragraph on a year-for-year basis;

(c) Meets the personnel and training requirements established in Sections 3 and 10 of this administrative regulation;

(d) Completes a community guide training curriculum approved by DBHDID within six (6) months of being employed by the first participant supported; and

(e) Provides services to a participant in accordance with Section 4 or 10 of this administrative regulation.

(18) "Controlled substance" is defined by KRS 218A.010(6).

(19) "Covered services and supports" is defined by KRS 205.5605(3).

(20) "DBHDID" means the Department for Behavioral Health, Developmental and Intellectual Disabilities.

(21) "DCBS" means the Department for Community Based Services.

(22) "Department" means the Department for Medicaid Services or its designee.

(23) "Developmental disability" means a disability that:

- (a) Is manifested prior to the age of twenty-two (22);
- (b) Constitutes a substantial disability to the affected individual; and
- (c) Is attributable either to an intellectual disability or a condition related to an intellectual disability that:

1. Results in an impairment of general intellectual functioning and adaptive behavior similar to that of a person with an intellectual disability; and

2. Is a direct result of, or is influenced by, the person's cognitive deficits.

(24) "Direct support professional" means an individual who:

(a) Provides services to a participant in accordance with Section 4 of this administrative regulation;

(b) Has direct contact with a participant when providing services to the participant;

(c) Is at least:

1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;

(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;

(e) Has the ability to:

1. Communicate effectively with a participant and the participant's family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant's person-centered team if requested by the participant; and

(f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant's person-centered service plan.

(25) "Direct support professional supervisor" means an individual who:

(a) Provides oversight of direct support professionals in the provision of services to participants;

(b) Is at least:

1. Eighteen (18) years old and has a high school diploma or GED; or
  2. Twenty-one (21) years old;
- (c) Meets the personnel and training requirements established in Sections 3 and 10 of this administrative regulation;
- (d) Has the ability to:
1. Communicate effectively with a participant and the participant's family;
  2. Read, understand, and implement written and oral instructions;
  3. Perform required documentation; and
  4. Participate as a member of the participant's person-centered team if requested by the participant;
- (e) Has at least two (2) years of experience in providing direct support to persons with a developmental disability;
- (f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant's person-centered service plan; and
- (g) Completes a supervisory training curriculum approved by DBHDID within six (6) months of beginning supervisory responsibilities.
- (26) "Drug paraphernalia" is defined by KRS 218A.500(1).
- (27) "Early and periodic screening, diagnostic, and treatment services" is defined by 42 U.S.C. 1396d(r).
- (28) "Electronic signature" is defined by KRS 369.102(8).
- (29) "Employee" means an individual who is employed by an SCL provider.
- (30) "Executive director" means an individual who shall:
- (a) Lead the design, development, and implementation of strategic plans for an SCL provider;
  - (b) Maintain responsibility for the day-to-day operation of the SCL provider organization;
  - (c) 1. Have a bachelor's or higher degree from an accredited institution; or
  2. Be a registered nurse;
  - (d) Have at least two (2) years of:
    1. Experience in the field of intellectual or developmental disabilities; and
    2. Administrative experience:
      - a. In an organization that served individuals with an intellectual or developmental disability; and
      - b. That includes experience in the execution of the overall administration of an agency including:
        - (i) Development, implementation, and maintenance of the agency's budget;
        - (ii) Development, review, implementation, and revisions as needed of the organization's policies and procedures; and
        - (iii) Supervision of employees including conducting performance evaluations;
  - (e) Meet all personnel and training requirements specified in Section 3 of this administrative regulation; and
  - (f) If providing professional oversight or supervision of employees, meet the supervisory qualifications specified for each service.
- (31) "Exploitation" is defined by KRS 209.020(9).
- (32) "Extended family member" means a relative of an individual by blood or marriage beyond the individuals included in the definition of immediate family member.
- (33) "Family home provider" means a home:
- (a) Not owned or leased by an SCL provider;
  - (b) In which a participant receives SCL services and resides in the family occupied (leased or owned) home; and

(c) In which the family:

1. Includes the participant in the family's household routines;
2. Provides training and supervision; and
3. Ensures that the participant's needs are met in accordance with the participant's person-centered service plan.

(34) "Financial management agency" means an agency contracted by the department that manages individual participant-directed service plans.

(35) "Functional assessment" means an assessment performed using evidenced based tools, direct observation, and empirical measurement to obtain and identify functional relations between behavioral and environmental factors.

(36) "Good cause" means a circumstance beyond the control of an individual that affects the individual's ability to access funding or services, which includes:

- (a) Illness or hospitalization of the individual that is expected to last sixty (60) days or less;
- (b) Required paperwork and documentation for processing in accordance with Section 2 of this administrative regulation has not been completed but is expected to be completed in two (2) weeks or less; or
- (c) The individual or his or her guardian has made diligent contact with a potential provider to secure placement or access services but has not been accepted within the sixty (60) day time period.

(37) "Group home" means a residential setting:

- (a) That is licensed in accordance with 902 KAR 20:078;
- (b) That is managed by a provider who meets the SCL provider requirements established in Section 3 of this administrative regulation; and
- (c) In which no more than eight (8) participants reside.

(38) "Guardian" is defined by KRS 387.010(3) for a minor and by KRS 387.812(3) for an adult.

(39) "Homicidal ideation" means thoughts about homicide that may range from vague ideas to detailed or fully formulated plans without taking action.

(40) "Human rights committee" means a group of individuals:

- (a) Comprised of representatives from home and community based waiver provider agencies in the community where a participant resides; and
- (b) Who meet:
  1. To ensure that the rights of participants are respected and protected through due process; and
  2. In accordance with the human rights committee requirements established in Section 7 of this administrative regulation.

(41) "Human services field" means:

- (a) Psychology;
- (b) Behavioral analysis;
- (c) Counseling;
- (d) Rehabilitation counseling;
- (e) Public health;
- (f) Special education;
- (g) Sociology;
- (h) Gerontology;
- (i) Recreational therapy;
- (j) Education;
- (k) Occupational therapy;
- (l) Physical therapy;

- (m) Speech-language pathology;
- (n) Social work; or
- (o) Family studies.
- (42) "ICF-IID" means an intermediate care facility for individuals with intellectual disabilities.
- (43) "Illicit substance" means:
  - (a) A drug, prescription or not prescription, used illegally or in excess of therapeutic levels;
  - (b) A prohibited drug; or
  - (c) A prohibited substance.
- (44) "Immediate family member" is defined by KRS 205.8451(3).
- (45) "Impact service" means a service designed to decrease the amount of paid supports a participant requires as the participant becomes:
  - (a) More independent; and
  - (b) Less reliant on an employee.
- (46) "Individual family service plan" or "IFSP" is defined by KRS 200.654(9).
- (47) "Integrated employment site" means the location of an activity or job that provides regular interaction with people without disabilities, excluding service providers, to the same extent that a worker without disabilities in a comparable position interacts with others.
- (48) "Integrated setting" means a setting that:
  - (a) Enables a participant to interact with nondisabled persons to the fullest extent possible;
  - (b) Includes access to community activities and opportunities at times, frequencies, and with persons of a participant's choosing; and
  - (c) Affords a participant choice in the participant's daily life activities.
- (49) "Intellectual disability" or "ID" means:
  - (a) A demonstration:
    1. Of significantly sub-average intellectual functioning and an intelligence quotient (IQ) of seventy (70) plus or minus five (5); and
    2. Of concurrent deficits or impairments in present adaptive functioning in at least two (2) of the following areas:
      - a. Communication;
      - b. Self-care;
      - c. Home living;
      - d. Social or interpersonal skills;
      - e. Use of community resources;
      - f. Self-direction;
      - g. Functional academic skills;
      - h. Work;
      - i. Leisure; or
      - j. Health and safety; and
  - (b) An intellectual disability that had an onset before eighteen (18) years of age.
- (50) "Legally responsible individual" means an individual who has a duty under state law to care for another person and includes:
  - (a) A parent (biological, adoptive, or foster) who provides care to the parent's minor child;
  - (b) A guardian who provides care to the guardian's minor child; or
  - (c) A spouse of a participant.
- (51) "Level of care determination" means a determination by the department that an individual meets patient status criteria for an intermediate care facility for individuals with intellectual disabilities as established in 907 KAR 1:022.
- (52) "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

- (53) "Licensed dietitian" is defined by KRS 310.005(11).
- (54) "Licensed marriage and family therapist" or "LMFT" is defined by KRS 335.300(2).
- (55) "Licensed medical professional" means
- (a) A physician;
  - (b) An advanced practice registered nurse;
  - (c) A physician assistant;
  - (d) A registered nurse;
  - (e) A licensed practical nurse; or
  - (f) A pharmacist.
- (56) "Licensed practical nurse" is defined by KRS 314.011(9).
- (57) "Licensed professional clinical counselor" or "LPCC" is defined by KRS 335.500(3).
- (58) "Licensed psychological associate" means an individual who:
- (a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and
  - (b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.
- (59) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.
- (60) "Licensed psychologist" means an individual who:
- (a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and
  - (b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.
- (61) "Life history" means an account of the series of events making up a participant's life including:
- (a) Developmental and historical information regarding family of origin, childhood experiences, and life events to present;
  - (b) History of supports received across the life span; and
  - (c) Life style practices that may lead to greater insight regarding a participant's current preferences, behavioral patterns, wants, and needs.
- (62) "Medical order for scope of treatment" is defined by KRS 311.621(12).
- (63) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
- (64) "MWMA" means the Kentucky Medicaid Waiver Management Application internet portal located at <http://chfs.ky.gov/dms/mwma.htm>.
- (65) "National Core Indicators" means:
- (a) A collaboration between the National Association of State Directors of Developmental Disability Services and the Human Services Research Institute;
  - (b) An effort by public developmental disabilities agencies to measure and track their own performance; and
  - (c) Standard measures:
    1. Used across states to assess the outcomes of services provided to individuals and families; and
    2. That address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.
- (66) "Natural supports" means assistance, relationships, or interactions that:
- (a) Allow a participant to be in the community;
  - (b) Include working in a job of the participant's choice in ways similar to people without disabilities; and
  - (c) Are based on ordinary social relationships at work and in the community.

(67) "Neglect" is defined by KRS 209.020(16).

(68) "Occupational therapist" is defined by KRS 319A.010(3).

(69) "Occupational therapy assistant" is defined by KRS 319A.010(4).

(70) "Office of Vocational Rehabilitation" means the agency mandated:

(a) By the Rehabilitation Act of 1973, as amended; and

(b) To provide individualized services to eligible individuals with disabilities with a substantial impediment to employment in order for the individual to gain and maintain employment.

(71) "Participant" means a Medicaid recipient who:

(a) Meets patient status criteria for an intermediate care facility for individuals with intellectual disabilities as established in 907 KAR 1:022;

(b) Is authorized by the department to receive SCL waiver services; and

(c) Utilizes SCL waiver services and supports in accordance with a person-centered service plan.

(72) "Participant-directed service" or "PDS" means an option established by KRS 205.5606 within the 1915(c) home and community based service waiver programs that allows recipients to receive non-medical services in which the individual:

(a) Assists with the design of the program;

(b) Chooses the providers of services; and

(c) Directs the delivery of services to meet his or her needs.

(73) "Person-centered coach" means a person who:

(a) Assists a participant and the participant's person-centered team in implementing and monitoring the effectiveness of the participant's person-centered service plan;

(b) Models person-centered thinking;

(c) Is responsible for training a participant, family, guardian, natural and unpaid supports, and other members of the person-centered team when barriers challenge the success of the participant in achieving his or her goals;

(d) Has:

1. A high school diploma or GED; and

2.a. Two (2) years of experience in the field of intellectual or developmental disabilities; or

b. Completed twelve (12) hours of college coursework in a human services field;

(e) Meets all personnel and training requirements established in Section 3 of this administrative regulation; and

(f) Performs documentation necessary to facilitate compliance with the documentation requirements established in Section 4(12)(d) of this administrative regulation.

(74) "Person-Centered Employment Plan" means a document that identifies the unique preferences, strengths, and needs of a participant in relation to the participant's work.

(75) "Person-centered service plan" means a written individualized plan of services for a participant that meets the requirements established in Section 5 of this administrative regulation.

(76) "Person-centered team" means a participant, the participant's guardian or representative, and other individuals who are natural or paid supports and who:

(a) Recognize that evidenced based decisions are determined within the basic framework of what is important for the participant and within the context of what is important to the participant based on informed choice;

(b) Work together to identify what roles they will assume to assist the participant in becoming as independent as possible in meeting the participant's needs; and

(c) Include providers who receive payment for services who shall:

1. Be active contributing members of the person-centered team meetings;

2. Base their input upon evidence-based information; and



3. Not request reimbursement for person-centered team meetings.

(77) "Physical restraint" means any manual method or physical or mechanical device, material, or equipment that:

(a) Immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely; and

(b) Does not include orthopedically prescribed devices or other devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a person for the purpose of:

1. Conducting routine physical examinations or tests;
2. Protecting the person from falling out of bed; or
3. Permitting the person to participate in activities without the risk of physical harm.

(78) "Physical therapist" is defined by KRS 327.010(2).

(79) "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.

(80) "Positive behavior support specialist" means an individual who;

(a) Provides evidence-based individualized interventions that assist a participant with acquisition or maintenance of skills for community living and behavioral intervention for the reduction of maladaptive behaviors;

(b) Has a master's degree in a behavioral science and one (1) year of experience in behavioral programming;

(c) Has at least one (1) year of direct service experience with individuals with intellectual or developmental disabilities; and

(d) Meets all personnel and training requirements established in Section 3 of this administrative regulation.

(81) "Prohibited drug" means a drug or substance that is illegal under KRS Chapter 218A or other statutes or administrative regulations of the Commonwealth of Kentucky.

(82) "Registered agent" means an individual meeting the requirements of KRS 14A.4-010(1)(b).

(83) "Registered nurse" is defined by KRS 314.011(5).

(84) "Registered office" means an office meeting the requirements of KRS 14A.4-010(1)(a).

(85) "Representative" is defined by KRS 205.5605(6).

(86) "Rights restriction" means any intervention that restricts a participant's:

(a) Movement;

(b) Access to other individuals, locations, or activities; or

(c) Rights.

(87) "Room" means the aggregate expense of housing costs for the purpose of providing shared living, including:

(a) Rent, lease, or mortgage payments;

(b) Real estate taxes;

(c) Insurance;

(d) Maintenance; and

(e) Utilities.

(88) "SCL intellectual disability professional" or "SCL IDP" means an individual who:

(a) Has at least one (1) year of experience working with persons with an intellectual or developmental disability;

(b) Meets all personnel and training requirements established in Section 3 of this administrative regulation; and

- (c)1. Is a doctor of medicine or osteopathy;
2. Is a registered nurse; or
3. Holds at least a bachelor's degree from an accredited institution in a human services field.

(89) "SCL provider" means an entity that meets the criteria established in Section 3 of this administrative regulation.

(90) "Seclusion" means the involuntary confinement of a participant alone in:

- (a) A room; or
- (b) An area from which the participant is physically prevented from leaving.

(91) "Serious medication error" means a medication error that requires or has the potential to require a medical intervention or treatment.

(92) "Shared living caregiver" means an unrelated individual who:

- (a) Resides with a participant in the participant's home;
- (b) Provides supervision and necessary personal assistance services as specified in the participant's person-centered service plan;

- (c)1. Is at least eighteen (18) years of age and has a high school diploma or GED; or
2. Is at least twenty-one (21) years old;

(d) Meets all personnel and training requirements established in Section 10 of this administrative regulation;

(e) Has the ability to:

1. Communicate effectively with a participant and the participant's family;
2. Read, understand, and implement written and verbal instructions; and
3. Perform documentation necessary to facilitate compliance with the documentation requirements established in Section 4(20)(j) of this administrative regulation;

(f) Has been determined by the participant's person-centered team, prior to being alone with the participant, to meet the following qualifications:

1. Demonstrate competence and knowledge on topics required to safely support the participant as described in the participant's person-centered service plan; and

2. Have the ability to participate as a member of the participant's person-centered team if requested by the participant; and

(g) Does not have any of the following relationships to the participant:

1. Immediate family member;
2. Extended family member;
3. Guardian; or
4. Legally responsible individual.

(93) "Speech-language pathologist" is defined by KRS 334A.020(3).

(94) "Staffed residence" means a residential setting:

(a) That is owned or leased by a provider who meets the SCL provider requirements established in Section 3 of this administrative regulation; and

(b) In which no more than three (3) participants reside.

(95) "State plan" is defined by 42 C.F.R. 430.10.

(96) "Subcontractor" means an entity or an individual:

- (a) Who is a currently credentialed professional or other service provider;
- (b) Who has signed an agreement with a certified SCL agency to provide SCL services and supports; and

(c) To whom the employee requirements in this administrative regulation apply.

(97) "Suicidal ideation" means thoughts about suicide that may range from being fleeting in nature to detailed planning.

(98) "Supported Employment Long-Term Support Plan" means a document that identifies

the amount and kind of support necessary for a participant to maintain employment and achieve individualized employment goals.

(99) "Supported employment specialist" means an individual who:

(a) Provides ongoing support services to eligible participants in supported employment jobs in accordance with Section 4 or 10 of this administrative regulation;

(b)1. Has previously qualified or been credentialed by the department to provide supported employment services prior to the effective date of this administrative regulation; or

2.a. Has at least one (1) year of experience in the field of intellectual or developmental disabilities; and

b. Has completed a department required training program within one (1) year of application while providing supported employment services under the direct supervision of a supported employment specialist; and

(c) Meets the personnel and training requirements established in Sections 3 and 10 of this administrative regulation.

(100) "Supports for Community Living" or "SCL" means home and community-based waiver services for an individual with an intellectual or developmental disability.

(101) "Supports Intensity Scale" or "SIS" means an assessment tool developed by the American Association on Intellectual and Developmental Disabilities that:

(a) Measures practical support requirements of individuals with intellectual or developmental disabilities in daily living, medical, and behavioral areas; and

(b) Is administered by a trained professional in the human services field as approved by the department.

Section 2. SCL Participant Eligibility, Enrollment, and Termination. (1) To be eligible to receive a service in the SCL program, an individual:

(a) Or individual's representative shall:

1. Apply for 1915(c) home and community based waiver services via the MWMA; and

2. Complete and upload into the MWMA a MAP - 115 Application Intake - Participant Authorization;

(b) Shall receive notification of potential SCL funding in accordance with Section 12 of this administrative regulation;

(c) Shall meet ICF-IID patient status requirements established in 907 KAR 1:022;

(d) Shall meet Medicaid eligibility requirements established in 907 KAR 20:010; and

(e) Upon receiving notification of potential SCL funding, shall upload the following into the MWMA:

1. A completed MAP – 350 Long Term Care Facilities and Home and Community Based Program Certification Form;

2. The results of a physical examination that was conducted within the last twelve (12) months;

3. A life history that has been completed within the past twelve (12) months; and

4. Documentation of a participant's status change.

(2)(a) To maintain eligibility as a participant:

1. A participant shall be administered a Supports Intensity Scale assessment by the department at least once every twenty-four (24) months from the level of care end date;

2. A participant shall maintain Medicaid eligibility requirements established in 907 KAR 20:010; and

3. An ICF-IID level of care determination shall be performed by the department at least once every twelve (12) months.

(b) The department shall:

1. Obtain the rights to use a Supports Intensity Scale; and
2. Use it in accordance with the terms and conditions required by the copyright associated with it.

(3) An SCL waiver service shall not be provided to an individual who is:

- (a) Receiving a service in another 1915(c) home and community based waiver program;
- (b) Receiving a duplicative service provided through another funding source; or
- (c) An inpatient of an ICF-IID or other facility.

(4) Involuntary termination and loss of an SCL waiver program placement shall be:

- (a) In accordance with 907 KAR 1:563; and
- (b) Initiated if:

1. An applicant fails to access an SCL waiver service within sixty (60) days of receiving notice of potential funding without receiving an extension based on demonstration of good cause; or

2. A participant:

- a. Fails to access any services outlined in the participant's service plan for a period greater than sixty (60) consecutive days without receiving an extension based on demonstration of good cause;

- b. Moves to a residence outside of the Commonwealth of Kentucky; or

- c. Does not meet ICF-IID patient status criteria in accordance with 907 KAR 1:022.

(5)(a) An involuntary termination of a service to a participant by an SCL provider shall require:

1. The SCL provider to simultaneously notify electronically or in writing the participant or participant's guardian, the participant's case manager, the department, and DBHDID at least thirty (30) days prior to the effective date of the termination; and

2. The participant's case manager, in conjunction with the SCL provider, to:

- a. Provide the participant or participant's guardian with the name, address, and telephone number of each current SCL provider in Kentucky;

- b. Provide assistance to the participant or participant's guardian in making contact with another SCL provider;

- c. Arrange and provide transportation for a requested visit to an SCL provider site;

- d. Provide a copy of pertinent information to the participant or participant's guardian;

- e. Ensure the health, safety, and welfare of the participant until an appropriate placement is secured;

- f. Continue to provide supports until alternative services or another placement is secured; and

- g. Provide assistance to ensure a safe and effective service transition.

(b) The notice referenced in paragraph (a)1. of this subsection shall include:

1. A statement of the intended action;

2. The basis for the intended action;

3. The authority by which the intended action is taken; and

4. The participant's right to appeal the intended action through the provider's appeal or grievance process.

(6)(a) DBHDID shall initiate an intent to discontinue a participant's participation in the SCL waiver program if the participant or participant's guardian submits a written notice of intent to discontinue services to:

1. The SCL provider; and

2. DBHDID.

(b) An action to terminate waiver participation shall not be initiated until thirty (30) calendar days from the date of the notice referenced in paragraph (a) of this subsection.

(c) A participant or guardian may reconsider and revoke the notice referenced in paragraph (a) of this subsection in writing during the thirty (30) calendar day period.

Section 3. Non-PDS Provider Participation Requirements. (1) An SCL provider shall comply with:

- (a) 907 KAR 1:671;
- (b) 907 KAR 1:672;
- (c) 907 KAR 1:673;
- (d) 902 KAR 20:078;
- (e) 907 KAR 7:005;

(f) The Health Insurance Portability and Accountability Act, 42 U.S.C. 1320d-2, and 45 C.F.R. Parts 160, 162, and 164;

(g) 42 U.S.C. 1320d to 1320d-8; and

(h) Local laws and ordinances governing smoke-free environments.

(2) In order to provide an SCL waiver service in accordance with Section 4 of this administrative regulation, an SCL provider shall:

(a) Be certified by the department prior to the initiation of a service;

(b) Be recertified at least biennially by the department;

(c) In accordance with KRS 273.182, maintain a registered agent and a registered office in Kentucky with the Office of the Secretary of State and file appropriate statement of change documentation with the filing fee with the Office of Secretary of State if the registered office or agent changes;

(d) Be in good standing with the Office of the Secretary of State of the Commonwealth of Kentucky pursuant to 30 KAR 1:010 and 30 KAR 1:020;

(e) Abide by the laws that govern the chosen business or tax structure of the SCL provider;

(f) Maintain policy that complies with this administrative regulation concerning the operation of the SCL provider and the health, safety, and welfare of all people supported or served by the SCL provider;

(g) Maintain an executive director who shall have the authority and responsibility for the management of the affairs of the SCL provider in accordance with written policy and procedures that comply with this administrative regulation; and

(h) Participate in the National Core Indicators' surveys and all department survey initiatives.

(3) An SCL provider:

(a) Shall ensure that SCL waiver services shall not be provided to a participant by a staff person of the SCL provider who is a guardian, legally responsible individual, or immediate family member of the participant unless allowed for a participant-directed service in accordance with Section 4 of this administrative regulation;

(b) Shall not enroll a participant whose needs the SCL provider is unable to meet;

(c) Shall have and follow written criteria that comply with this administrative regulation for determining the eligibility of a participant for admission to services;

(d) Shall document:

1. A denial for a service; and

2. The reason for the denial;

(e) Shall maintain documentation of its operations including:

1. A written description of available SCL waiver services;

2. A current table of organization;

3. Any memorandum of understanding between a participant's case management agency and the participant's service providers;

4. Information regarding participants' satisfaction with services and the utilization of that in-

formation;

5. A quality improvement plan that:

a. Includes updated findings and corrective actions as a result of department and case management quality assurance monitoring; and

b. Addresses how the provider shall accomplish the following goals:

(i) Ensure that the participant receives person-centered SCL waiver services;

(ii) Enable the participant to be safe, healthy, and respected in the participant's community;

(iii) Enable the participant to live in the community with effective, individualized assistance; and

(iv) Enable the participant to enjoy living and working in the participant's community;

6. Evidence of continuous improvement of utilizing best practice standards toward meeting the critical strategic areas identified in the annual report released by the Kentucky National Core Indicators available at the Kentucky National Core Indicators Web site of <http://www.nationalcoreindicators.org/states/KY/>; and

7. A written plan of how the SCL provider shall participate in the:

a. Human rights committee in the area in which the SCL provider is located; and

b. Behavior intervention committee in the area in which the SCL provider is located;

(f) Shall maintain accurate fiscal information including documentation of revenues and expenses;

(g) Shall meet the following requirements if responsible for the management of a participant's funds:

1. Separate accounting shall be maintained for each participant or for the participant's interest in a common trust or special account;

2. Account balance and records of transactions shall be provided to the participant or the participant's guardian on a quarterly basis; and

3. The participant or the participant's guardian shall be notified if a balance is accrued that may affect Medicaid eligibility;

(h) Shall have a written statement of its mission and values, which shall:

1. Support participant empowerment and informed decision-making;

2. Support and assist participants to form and remain connected to natural support networks;

3. Promote participant dignity and self-worth;

4. Support team meetings that help ensure and promote the participant's right to choice, inclusion, employment, growth, and privacy;

5. Foster a restraint-free environment where the use of physical restraints, seclusion, chemical restraints, or aversive techniques shall be prohibited; and

6. Support the SCL program goal that all participants:

a. Receive person-centered waiver services;

b. Are safe, healthy, and respected in the participant's community;

c. Live in the community with effective, individualized assistance, and

d. Enjoy living and working in the participant's community;

(i) Shall have written policy and procedures for communication and interaction with a participant, family, or participant's guardian, which shall include:

1. A timely response to an inquiry;

2. The opportunity for interaction by direct support professionals;

3. Prompt notification of any unusual occurrence;

4. Visitation with the participant at a reasonable time, without prior notice, and with due regard for the participant's right of privacy;

5. Involvement in decision making regarding the selection and direction of the person-

centered service provided; and

6. Consideration of the cultural, educational, language, and socioeconomic characteristics of the participant and family being supported;

(j) Shall ensure the rights of a participant by:

1. Providing conflict free services and supports that are person-centered;
  2. Making available a description of the rights and means by which the rights can be exercised and supported including the right to:
    - a. Live and work in an integrated setting;
    - b. Time, space, and opportunity for personal privacy;
    - c. Communicate, associate, and meet privately with the person of choice;
    - d. Send and receive unopened mail;
    - e. Retain and use personal possessions including clothing and personal articles;
    - f. Private, accessible use of a telephone or cell phone;
    - g. Access accurate and easy-to-read information;
    - h. Be treated with dignity and respect and to maintain one's dignity and individuality;
    - i. Voice grievances and complaints regarding services and supports that are furnished without fear of retaliation, discrimination, coercion, or reprisal;
    - j. Choose among service providers;
    - k. Accept or refuse services;
    - l. Be informed of and participate in preparing the person-centered service plan and any changes in the person-centered service plan;
    - m. Be advised in advance of the:
      - (i) Provider or providers who will furnish services; and
      - (ii) Frequency and duration of services;
    - n. Confidential treatment of all information, including information in the participant's records;
    - o. Receive services in accordance with the current person-centered service plan;
    - p. Be informed of the name, business, telephone number, and business address of the person supervising the services and how to contact the person;
    - q. Have the participant's property and residence treated with respect;
    - r. Be fully informed of any cost sharing liability and the consequences if any cost sharing is not paid;
    - s. Review the participant's records upon request;
    - t. Receive adequate and appropriate services without discrimination;
    - u. Be free from and educated on mental, verbal, sexual, and physical abuse, neglect, exploitation, isolation, and corporal or unusual punishment, including interference with daily functions of living; and
    - v. Be free from mechanical, chemical, or physical restraints;
  3. Having a grievance and appeals system that includes an external mechanism for review of complaints;
  4. Ensuring access to participation in the local human rights committee in accordance with the human rights committee requirements established in Section 7 of this administrative regulation; and
  5. Ensuring access to participation in the local behavior intervention committee:
    - a. Established as a subset of the local human rights committee; and
    - b. In accordance with the behavior intervention committee requirements established in Section 8 of this administrative regulation;
- (k) Shall maintain fiscal records, service records, investigations, medication error logs, and incident reports for a minimum of six (6) years from the date that:
1. A covered service is provided; or

2. The participant turns twenty-one (21) years of age, if the participant is under the age of twenty-one (21);

(l) Shall make available all records, internal investigations, and incident reports:

1. To the:

a. Department;

b. DBHDID;

c. Office of Inspector General or its designee;

d. General Accounting Office or its designee;

e. Office of the Auditor of Public Accounts or its designee;

f. Office of the Attorney General or its designee;

g. DCBS;

h. Centers for Medicare and Medicaid Services; or

i. The Department of Aging and Independent Living; or

2. Pertaining to a participant to:

a. The participant, the participant's guardian, or the participant's case manager upon request; or

b. Protection and Advocacy upon written request;

(m) Shall cooperate with monitoring visits from monitoring agents;

(n) Shall maintain a record in the MWMA for each participant served that shall:

1. Contain all information necessary to support person-centered practices;

2. Be cumulative;

3. Be readily available;

4. Contain documentation that meets the requirements of Section 4 of this administrative regulation;

5. Contain the following:

a. The participant summary sheet;

b. The participant's name, Social Security number, and Medicaid identification number;

c. The Supports Intensity Scale Assessment profile;

d. The results of a department approved screening tool to assess health risk, which shall:

(i) Be administered by trained personnel using the department approved protocol at least annually and updated as needed; and

(ii) Assist in determining a participant's areas of vulnerability for a potential health risk;

e. The current person-centered service plan;

f. The goals and objectives identified by the participant and the participant's person-centered team that facilitates achievement of the participant's chosen outcomes as identified in the participant's person-centered service plan;

g. A list containing emergency contact telephone numbers;

h. The participant's history of allergies with appropriate allergy alerts;

i. The participant's medication record, including a copy of the signed or authorized current prescription or medical orders and the medication administration record if medication is administered at the service site;

j. A recognizable photograph of the participant;

k. Legally adequate consent, updated annually, and a copy of which is located at each service site for the provision of services or other treatment requiring emergency attention;

l. The participant's individual educational plan or individual family service plan, if applicable;

m. The participant's life history updated at least annually;

n. The results of an annual physical exam;

o. The results of an annual dental exam;

p. The MAP-350, Long Term Care Facilities and Home and Community Based Program



Certification Form updated annually in the MWMA;

- q. A psychological evaluation;
- r. A current level of care certification;
- s. The prior authorization notifications; and
- t. Incident reports, if any exist;

6. Be maintained by the provider in a manner that:

- a. Ensures the confidentiality of the participant's record and other personal information; and
- b. Allows the participant or guardian to determine when to share the information in accordance with law; and

7. Be safe from loss, destruction, or use by an unauthorized person ensured by the provider;

(o) Shall ensure that an employee or volunteer:

- 1. Behaves in a legal and ethical manner in providing a service;
- 2. Has a valid Social Security number or valid work permit if not a citizen of the United States of America; and
- 3. If responsible for driving a participant during a service delivery, has a valid driver's license with proof of current mandatory liability insurance for the vehicle used to transport the participant;

(p) Shall ensure that an employee or volunteer:

- 1. Completes a tuberculosis (TB) risk assessment performed by a licensed medical professional and, if indicated, a TB skin test with a negative result within the past twelve (12) months as documented on test results received by the provider within thirty (30) days of the date of hire or date the individual began serving as a volunteer; or
- 2. Who tests positive for TB or has a history of positive TB skin tests:
  - a. Shall be assessed annually by a licensed medical professional for signs or symptoms of active disease; and
  - b. If it is determined that signs or symptoms of active disease are present, in order for the person to be allowed to work or volunteer, is administered follow-up testing by his or her physician with the testing indicating the person does not have active TB disease;

(q) Shall maintain documentation:

- 1. Of an annual TB risk assessment or negative TB test for each employee who performs direct support or a supervisory function; or
- 2. Annually for each employee with a positive TB test that ensures no active disease symptoms are present;

(r) Shall provide a written job description for each staff person that describes the required qualifications, duties, and responsibilities for the person's job;

(s) Shall maintain an employee record for each employee that includes:

- 1. The employee's experience;
- 2. The employee's training;
- 3. Documented competency of the employee;
- 4. Evidence of the employee's current licensure or registration if required by law; and
- 5. An annual evaluation of the employee's performance;

(t) Shall require a background check:

- 1. And drug testing for each employee who is paid with funds administered by the department and who:
  - a. Provides support to a participant who utilizes SCL services; or
  - b. Manages funds or services on behalf of a participant who utilizes SCL services; or
- 2. For a volunteer recruited and placed by an agency or provider who has the potential to interact with a participant;

(u) Shall ensure that a volunteer placed by an agency or provider does not have unsupervised interaction with a participant;

(v) 1. Shall for a potential employee or volunteer obtain:

a. The results of a criminal record check from the Kentucky Administrative Office of the Courts and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment or volunteerism;

b. The results of a nurse aide abuse registry check as described in 906 KAR 1:100 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment or volunteerism;

c. The results of a caregiver misconduct registry check as described in 922 KAR 5:120 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment or volunteerism; and

d. Within thirty (30) days of the date of hire or initial date of volunteerism, the results of a central registry check as described in 922 KAR 1:470 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment or volunteerism; or

2. May use Kentucky's national background check program established by 906 KAR 1:190 to satisfy the background check requirements of subparagraph 1 of this paragraph;

(w) Shall for each potential employee obtain negative results of drug testing for illicit or prohibited drugs;

(x) Shall on an annual basis:

1. Randomly select and perform criminal history background checks, nurse aide abuse registry checks, central registry checks, and caregiver misconduct registry checks of at least twenty-five (25) percent of employees; and

2. Conduct drug testing of at least five (5) percent of employees;

(y) Shall not use an employee or volunteer to provide 1915(c) home and community based waiver services if the employee or volunteer:

1. Has a prior conviction of an offense delineated in KRS 17.165(1) through (3);

2. Has a prior felony conviction or diversion program that has not been completed;

3. Has a drug related conviction, felony plea bargain, or amended plea bargain conviction within the past five (5) years;

4. Has a positive drug test for prohibited drugs;

5. Has a conviction of abuse, neglect, or exploitation;

6. Has a Cabinet for Health and Family Services finding of:

a. Child abuse or neglect pursuant to the central registry; or

b. Adult abuse, neglect, or exploitation pursuant to the Caregiver Misconduct Registry; or

7. Is listed on the nurse aide abuse registry;

(z) Shall not permit an employee to transport a participant if the employee has a driving under the influence conviction, amended plea bargain, or diversion during the past year;

(aa) Shall maintain adequate staffing and supervision to implement services being billed;

(bb) Shall establish written guidelines that address and ensure the health, safety, and welfare of a participant, which shall include:

1. A basic infection control plan that includes:

a. Universal precautions;

b. Hand washing;

c. Proper disposal of biohazards and sharp instruments; and

d. Management of common illness likely to be emergent in the particular service setting;

2. Effective cleaning and maintenance procedures sufficient to maintain a sanitary and comfortable environment that prevents the development and transmission of infection;

3. Ensuring that each site operated by the provider is equipped with:
  - a. An operational smoke detector placed in all bedrooms and other strategic locations; and
  - b. At least two (2) correctly charged fire extinguishers placed in strategic locations, at least one (1) of which shall be capable of extinguishing a grease fire and have a rating of 1A10BC;
4. Ensuring the availability of an ample supply of hot and cold running water with the water temperature complying with the safety limits established in the participant's person-centered service plan;
5. Establishing written procedures concerning the presence of deadly weapons as defined in KRS 500.080, which shall ensure:
  - a. Safe storage and use; and
  - b. That firearms and ammunition are permitted:
    - (i) Only in nonprovider owned or leased residences; and
    - (ii) Only if stored separately and under double lock;
6. Establishing written procedures concerning the safe storage of common household items;
7. Ensuring that the nutritional needs of a participant are met in accordance with the current recommended dietary allowance of the Food and Nutrition Board of the National Research Council or as specified by a physician;
8. Ensuring that an adequate and nutritious food supply is maintained as needed by the participant;
9. Ensuring a smoke-free environment for any participant who chooses a smoke-free environment including settings in which the participant is expected to spend any amount of time, including home, a day training site, a meeting site, or any other location;
10. Ensuring that:
  - a. Every case manager and any employee who will be administering medication, unless the employee is a currently licensed or registered nurse, has:
    - (i) Specific training provided by a registered nurse per a DBHDID medication administration approved curriculum; and
    - (ii) Documented competency on medication administration, medication cause and effect, and proper administration and storage of medication; and
  - b. An individual administering medication documents all medication administered, including self-administered and over-the-counter drugs, on a medication administration record, with the date, time, and initials of the person who administered the medication and ensuring that the medication shall:
    - (i) Be kept in a locked container;
    - (ii) If a controlled substance, be kept under double lock with a documented medication count performed every shift;
    - (iii) Be carried in a proper container labeled with medication and dosage pursuant to KRS 315.010(8) and 217.182(6);
    - (iv) Accompany and be administered to a participant at a program site other than the participant's residence if necessary; and
    - (v) Be documented on a medication administration record and properly disposed of, if discontinued; and
11. Adhering to policies and procedures for ongoing monitoring of medication administration;
  - (cc) Shall establish and follow written guidelines for handling an emergency or a disaster, which shall:
    1. Be readily accessible on site;
    2. Include instruction for notification procedures and the use of alarm and signal systems to alert a participant according to the participant's disability;

3. Include documentation of training and competency of staff and training of participants on emergency disaster drills;

4. Include an evacuation drill to be conducted in three (3) minutes or less, documented at least quarterly and, for a participant who receives residential support services, is scheduled to include a time when the participant is asleep; and

5. Mandate that the result of an evacuation drill be evaluated and if not successfully completed within three (3) minutes shall modify staffing support as necessary and repeat the evacuation drill within seven (7) days;

(dd) Shall provide orientation for each new employee, which shall include the mission, goals, organization, and practices, policies, and procedures of the agency;

(ee) Shall require documentation of all face-to-face training, which shall include:

1. The type of training provided;

2. The name and title of the trainer;

3. The training objectives;

4. The length of the training;

5. The date of completion;

6. The signature of the trainee verifying completion; and

7. Verification of competency of the trainee as demonstrated by post-training assessments, competency checklists, or post-training observations and evaluations;

(ff) Shall require documentation of Web-based training, which shall include:

1. Transcripts verifying successful completion of training objectives with scores of eighty-five (85) percent or higher; and

2. Competency checklist listing date of completion, signature of evaluator, and signature of trainee for all Phase I or Phase II Kentucky College of Direct Support modules within the timeframe specified;

(gg) Shall ensure that each case manager or employee prior to independent functioning and no later than six (6) months from the date of employment successfully completes training that shall include:

1. First aid and cardiopulmonary resuscitation certification by a nationally-accredited entity;

2.a. Department of Behavioral Health, Developmental and Intellectual Disabilities' crisis prevention and intervention training; or

b. Crisis prevention and intervention training that:

(i) Is competency based;

(ii) Is nationally accredited;

(iii) Excludes restraints; and

(iv) Is approved by the Department for Behavioral Health, Developmental and Intellectual Disabilities;

3. Successful completion of all Kentucky College of Direct Support Phase I training modules;

4. Individualized instruction about the person-centered service plan of the participant to whom the trainee provides supports; and

5. Verification of trainee competency as demonstrated by pre- and post-training assessments, competency checklists, and post-training observations or evaluations;

(hh) Shall ensure that all case managers or employees, unless the case manager or employee is a licensed professional providing a service governed by the licensure of the individual's profession, complete the Kentucky College of Direct Support Phase II training modules, no later than six (6) months from the date of employment or when the individual began providing services;

(ii) Shall ensure that each case manager complete DBHDID approved case management

training after three (3) months but within nine (9) months from the date of hire; and

(jj) Shall ensure that each adult family member residing in a level II residential adult foster care home or family home provider who may be left alone with the participant will receive training regarding the individualized needs of the participant.

(4) DBHDID shall:

(a) Obtain the rights to use the Kentucky College of Direct Support training modules required to be used by an SCL waiver provider pursuant to this administrative regulation; and

(b) Facilitate access to:

1. A screening tool to assess health risk required to be used by an SCL waiver provider of residential services pursuant to this administrative regulation; or

2. Kentucky College of Direct Support training modules required to be used by an SCL waiver provider pursuant to this administrative regulation.

(5) An SCL provider, employee, or volunteer shall:

(a) Not manufacture, distribute, dispense, be under the influence of, purchase, possess, use, or attempt to purchase or obtain, sell, or transfer any of the following in the workplace or while performing work duties:

1. An alcoholic beverage;

2. A controlled substance except an SCL provider, employee, or volunteer may use or possess a medically necessary and legally prescribed controlled substance;

3. An illicit drug;

4. A prohibited drug or prohibited substance;

5. Drug paraphernalia; or

6. A substance that resembles a controlled substance, if there is evidence that the individual intended to pass off the item as a controlled substance; and

(b) Not possess a prescription drug for the purpose of selling or distributing it.

Section 4. Covered Services. (1)(a) An SCL waiver service shall:

1. Be prior authorized by the department; and

2. Be provided to a participant pursuant to the participant's person-centered service plan by an individual who meets the requirements established in Section 3 of this administrative regulation.

(b) Any combination of day training, community access, personal assistance, or any hours of paid community employment or on-site supported employment service shall not exceed sixteen (16) hours per day.

(2) SCL covered services shall include:

(a) Case management;

(b) Community access services;

(c) Community guide services;

(d) Community transition services;

(e) Consultative clinical and therapeutic services;

(f) Day training;

(g) Environmental accessibility adaptation services;

(h) Goods and services;

(i) Natural supports training;

(j) Person-centered coaching;

(k) Personal assistance services;

(l) Positive behavior supports;

(m) Residential support services, which may include:

1. Level I residential supports;

2. Technology assisted residential services; or

3. Level II residential supports;

(n) Respite;

(o) Shared living;

(p) Specialized medical equipment and supplies;

(q) Supported employment;

(r) Transportation services; or

(s) Vehicle adaptation.

(3) Case management requirements shall be as established in Section 6 of this administrative regulation.

(4) A community access service:

(a) Shall be provided by a community access specialist;

(b) Shall be designed to support a participant to participate in meaningful routines, events, and activities through various community organizations;

(c) Shall be designed to empower a participant in developing natural supports;

(d) May be participant directed;

(e) If participant directed, may be provided by an immediate family member, guardian, or legally responsible individual of the participant in accordance with Section 10 of this administrative regulation;

(f) Shall stress training that empowers a participant in acquiring, practicing, utilizing, and improving skills related to:

1. Connecting with others;

2. Independent functioning;

3. Self advocacy;

4. Socialization;

5. Community participation;

6. Personal responsibility;

7. Financial responsibility; and

8. Other skills related to optimal well-being as defined in the participant's person-centered service plan;

(g) Shall be designed to result in an increased ability to develop natural supports and access community resources including educational, recreational, religious, civic, or volunteer opportunities with an outcome of:

1. Less reliance on formal supports; and

2. Greater reliance on natural or unpaid supports as established in the participant's person-centered service plan;

(h) Shall have an emphasis on the development of personal social networks, membership opportunities, friendships, and relationships for the participant as established in the participant's person-centered service plan;

(i) Shall be provided outside the participant's home or residential setting and occur during the day, in the evening, or on weekends;

(j) Shall not duplicate residential support or day training services, or authorized therapies;

(k) Shall be provided to a participant with a:

1. One (1) to one (1) staff to participant ratio; or

2. Ratio of one (1) staff to no more than two (2) participants according to the participant's person-centered service plan, if the participant invites a friend;

(l) Shall occur in an integrated community setting;

(m) Shall be an impact service and the participant's person-centered service plan shall define steps to decrease the provision of the service as the participant becomes more independ-

ent in accessing and becoming part of the community;

(n) Shall be documented in the MWMA by:

1. A note documenting each contact, which shall include:

a. A full description of each service rendered;

b. Evidence of training or service to support outcomes designated in the participant's person-centered service plan;

c. The date of the service;

d. The location of the service;

e. The beginning and ending times of the service;

f. The signature and title of the individual providing the service; and

g. The date the entry was made in the record; and

2. A monthly summary note, which shall include:

a. The month and year for the time period the note covers;

b. An analysis of progress toward the participant's outcome or outcomes;

c. Identification of barriers to achievement of outcomes;

d. Projected plan to achieve the next step in achievement of outcomes;

e. The signature and title of the community access specialist completing the note; and

f. The date the note was written; and

(o) Shall not exceed 160 fifteen (15) minute units per week alone or in combination with community access group services.

(5)(a) A community guide service shall:

1. Be provided by a community guide who meets the personnel and training requirements established in Sections 3 and 10 of this administrative regulation;

2. Be designed to empower a participant to define and direct the participant's services;

3. Only be for a participant who chooses participant-directed supports for some or all of the participant's support services;

4. Include:

a. Direct assistance to a participant in meeting his or her participant-directed responsibilities;

b. Information and assistance that helps the participant in:

(i) Problem solving;

(ii) Decision making;

(iii) Developing supportive community relationships; and

(iv) Accessing resources that promote implementation of the participant's person-centered service plan; and

c. Information to ensure that the participant understands the responsibilities involved with directing the participant's services;

5. Be documented in the MWMA by:

a. A note documenting each contact, which shall include:

(i) A full description of each service rendered;

(ii) The date of the service;

(iii) The location of the service;

(iv) The beginning and ending times of the service;

(v) The signature and title of the community guide providing the service; and

(vi) The date the entry was made in the record; and

b. A completed monthly summary note, which shall include:

(i) The month and year for the time period the note covers;

(ii) An analysis of the efficacy of the service provided including recommendations and identification of additional support needs;

(iii) The signature and title of the community guide completing the note; and

(iv) The date the note was written; and

6. Be limited to 576 fifteen (15) minute units per one (1) year authorized person-centered service plan period.

(b)1. A participant and the participant's person-centered team shall determine the community guide services to be received.

2. The community guide services to be received by a participant shall be specified in the participant's person-centered service plan.

(c) If needed, directed assistance provided by a community guide:

1. Shall be based on the needs of the participant; and

2. May include assistance with:

a. Recruiting, hiring, training, managing, evaluating, and changing employees;

b. Scheduling and outlining the duties of employees;

c. Developing and managing the individual budget;

d. Understanding provider qualifications; or

e. Recordkeeping and other program requirements.

(d) A community guide service shall not duplicate a case management service.

(e) A community guide providing community guide services to a participant shall not provide other direct waiver services to any participant.

(f) A community guide shall not be employed by an agency that provides other direct waiver services to the participant.

(6) Community transition services:

(a) Shall be nonrecurring set-up expenses for a participant who is transitioning from an institutional or other provider-operated living arrangement to a living arrangement in a private residence where the participant is directly responsible for his or her own living expenses;

(b) Shall be expenses that are necessary to enable a participant to establish a basic household that do not constitute room and board;

(c) May include:

1. A security deposit that is required to obtain a lease on an apartment or home;

2. Essential household furnishings or moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens;

3. A one (1) time set-up fee or deposit for utility or service access, including telephone, electricity, heating, or water;

4. A service necessary for the participant's health and safety including pest eradication or one (1) time cleaning prior to occupancy;

5. A necessary home accessibility adaptation; or

6. An activity to assess a need and arrange for and procure needed resources;

(d) Shall be furnished only:

1. To the extent that the service is reasonable and necessary;

2. As clearly identified in the participant's person-centered service plan; and

3. If the service cannot be obtained from other sources;

(e) Shall not include:

1. Monthly rental or mortgage expense;

2. Food;

3. Regular utility charges;

4. Items that are intended for purely diversional or recreational purposes; or

5. Furnishings for living arrangements that are owned or leased by an SCL provider;

(f) Shall be coordinated and documented in the MWMA by the participant's case manager by:



1. Description or itemized line item of purchase and cost;
2. A receipt for a procurement including date of purchase;
3. The signature and title of the case manager; and
4. The date the entry was made in the record; and
- (g) Shall not exceed \$2,000 per approved transition.
- (7) A consultative clinical and therapeutic service shall:
  - (a) Be provided by a person who:
    1. Meets the personnel and training requirements established in Section 3 of this administrative regulation; and
    2. Is a:
      - a. Certified nutritionist;
      - b. Licensed dietitian;
      - c. Licensed marriage and family therapist;
      - d. Licensed professional clinical counselor;
      - e. Licensed psychological associate;
      - f. Licensed psychologist;
      - g. Licensed psychological practitioner;
      - h. Licensed clinical social worker; or
      - i. Positive behavior support specialist;
    - (b) Include:
      1. Professional consultation, evaluation, and assessment of the participant, the environment and the system of support, and written summary of findings and recommendations for the participant and the participant's person-centered team;
      2. Providing treatment that:
        - a. Is consistent with assessment results and diagnosis;
        - b. Is evidence based or current best practice; and
        - c. Encompasses psychological treatment or counseling as indicated by the condition of the participant;
      3. Coordinating program wide support, as needed, that addresses the assessed needs, conditions, or symptoms affecting a participant's ability to fully participate in the participant's community;
      4. Participating in developing and revising, as needed, home treatment or support plans as components of a participant's person-centered service plan;
      5. Providing training and technical assistance to carry out recommendations and plans that shall occur within the settings in which the recommendations, home treatment, or support plans are to be carried out;
      6. Monitoring:
        - a. Of the fidelity of data reporting and participant's person-centered service plan implementation;
        - b. Of the effectiveness of the participant's person-centered service plan;
        - c. Of the impact of the participant's person-centered service plan on the participant, and the participant's environment and system of supports; and
        - d. That shall be conducted:
          - (i) In the settings where the participant's person-centered service plan is implemented;
          - (ii) Through discussions and observations of people implementing the participant's person-centered service plan; and
          - (iii) Through reporting data;
      7. A functional assessment, which shall:
        - a. Be conducted by a person who meets the personnel and training requirements estab-

lished in Section 3 of this administrative regulation and is a:

- (i) Licensed psychologist;
- (ii) Certified psychologist with autonomous functioning; or
- (iii) Positive behavior support specialist;

b. Include:

(i) A description of the behavior patterns identified through the functional assessment and the goals of intervention; and

(ii) Modifications to the social or physical environment that may prevent the behavior or increase the likelihood of alternative adaptive behaviors; and

c. Identify specific skills to be taught or reinforced that shall:

- (i) Achieve the same function as the behavior of concern;
- (ii) Allow the participant to cope more effectively with circumstances; and
- (iii) Be documented when they occur;

8. Documentation in the MWMA of each contact, which shall include:

a. A full description of each service rendered;

b. An analysis of the efficacy of the service provided including any recommendation or identification of additional support needs if needed;

c. The date of the service;

d. The location of the service;

e. The beginning and end times of the service;

f. The signature and title of the professional providing the service;

g. The date the entry was made in the record; and

(c) Not exceed 160 fifteen (15) minute units per one (1) year authorized person-centered service plan period.

(8) Day training:

(a) Shall be provided by a direct support professional;

(b) Shall include:

1. Providing regularly scheduled activities in a non-residential setting that are designed to foster the acquisition of skills, build positive social behavior and interpersonal competence, and foster greater independence and personal choice;

2. Career planning or pre-vocational activities to develop experiential learning opportunities and career options consistent with the participant's skills and interests that:

a. Are person-centered and designed to support employment related goals;

b. Provide active training designed to prepare a participant to transition from school to adult responsibilities, community integration, and work;

c. Enable each individual to attain the highest level of work in the most integrated setting with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities; and

d. Include:

(i) Skill development to communicate effectively with supervisors, co-workers, and customers;

(ii) Generally accepted community workplace conduct and dress;

(iii) Workplace problem solving skills and strategies;

(iv) General workplace safety;

(v) The ability to follow directions;

(vi) The ability to attend tasks; or

(vii) Mobility training;

3. Supported retirement activities including:

a. Altering schedules to allow for more rest time throughout the day; or

b. Support to participate in hobbies, clubs, or other activities in the participant's community;  
or

4. Training and supports designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills;

(c) Shall include required informational sessions sponsored by the provider at least annually for the participant regarding community involvement or employment services and arrangement of opportunities for the participant to explore community integration, supported employment, and other employment opportunities in the community;

(d) Shall, if provided in an adult day health care center, only be available for a participant who:

1. Is at least twenty-one (21) years of age; and

2. Requires skilled nursing services or nursing supervision in a licensed adult day health care center as outlined in the participant's person-centered service plan;

(e) Shall include environments that:

1. Are not diversional in nature; and

2. Occur in a variety of settings in the community and shall not be limited to fixed-site facilities;

(f) May be participant directed and if participant directed, may be provided by an immediate family member, guardian, or legally responsible individual of the participant in accordance with Section 10 of this administrative regulation;

(g) Shall not be reimbursable if vocational in nature and for the primary purpose of producing goods or performing services;

(h) Shall include documentation in the MWMA that shall be:

1. A note for each contact, which shall include:

a. A full description of each service rendered;

b. The date of the service;

c. The location of the service;

d. The beginning and ending times of the service;

e. The signature and title of the individual providing the service; and

f. The date the entry was made in the record; and

2. A completed monthly summary note, which shall include:

a. The month and year for the time period the note covers;

b. An analysis of the efficacy of the service provided including recommendations and identification of additional support needs;

c. The signature and title of the individual completing the note; and

d. The date the note was written; and

(i) Shall be limited to:

1. Five (5) days per week excluding weekends; and

2. 160 fifteen (15) minute units per week for day training alone or in combination with any hours of paid community employment or on-site supported employment service.

(9)(a) An environmental accessibility adaptation service:

1. Shall be:

a. Designed to enable participants to interact more independently with their environment thereby enhancing their quality of life and reducing their dependence on physical support from others; and

b. A physical adaptation to a participant's or family's home, which shall be necessary to:

(i) Ensure the health, welfare, and safety of the participant; or

(ii) Enable the participant to function with greater independence in the home and without which the participant would require institutionalization;

2. May include the following if necessary for the welfare of a participant:
  - a. Installation of a ramp or grab-bar;
  - b. Widening of a doorway;
  - c. Modification of a bathroom facility; or
  - d. Installation of a specialized electric and plumbing system, which shall be necessary to accommodate the medical equipment or supplies necessary for the welfare of the participant;
3. Shall not include:
  - a. An adaptation or improvement to a home that is not of direct medical or remedial benefit to a participant;
  - b. An adaptation that adds to the total square footage of a home except if necessary to complete an adaptation; and
  - c. An adaptation to a provider-owned residence;
4. Shall be provided:
  - a. In accordance with applicable state and local building codes; and
  - b. By a vendor who shall be in good standing with the Office of the Secretary of State of the Commonwealth of Kentucky pursuant to 30 KAR 1:010 and 30 KAR 1:020; and
5. Shall be coordinated and documented in the MWMA by a case manager by:
  - a. A description of each adaptation purchased;
  - b. A receipt for every adaptation made, which shall include the:
    - (i) Date of purchase;
    - (ii) Description of the item;
    - (iii) Quantity and per unit price; and
    - (iv) Total amount of the purchase;
  - c. The signature and title of the case manager; and
  - d. The date the entry was made in the record.
- (b) An immediate family member, guardian, or legally responsible individual of a participant shall not be eligible to be a vendor or provider of an environmental accessibility adaptation service for the participant.
- (c) A home accessibility modification shall not be furnished to a participant who receives residential habilitation services except if the services are furnished in the participant's own home.
- (d) A request shall be documented in a participant's person-centered service plan and include cost of adaptations.
- (10)(a) Goods and services shall:
  1. Be services, equipment, or supplies that are individualized to a participant who chooses to use participant-directed services;
  2. Be utilized to reduce the need for personal care or to enhance independence within a participant's home or community;
  3. Not be a good or service available to a recipient outside of the department's SCL waiver program;
  4. Meet the following requirements:
    - a. The good or service shall decrease the need for other Medicaid services;
    - b. The good or service shall promote participant inclusion in the community;
    - c. The good or service shall increase a participant's safety in the home environment; and
    - d. The participant shall not have the funds to purchase the good or service;
  5. If participant directed and purchased from a participant-directed budget, be prior authorized;
  6. Not include experimental or prohibited treatments;
  7. Be clearly linked to a participant need that has been documented in the participant's per-

son-centered service plan;

8. Be coordinated and documented in the MWMA by a case manager by:

- a. Description or itemized line item of purchase and cost;
- b. Receipts for procurements that include the date of purchase;
- c. The signature and title of the case manager; and
- d. The date the entry was made in the record; and

9. Not exceed \$1,800 per one (1) year authorized person-centered service plan period.

(b) A purchase of a good or service shall not circumvent other restrictions on SCL waiver services:

1. Established in this administrative regulation; and
2. Including the prohibition against claiming for the costs of room and board.

(c) An immediate family member, guardian, or legally responsible individual of a participant shall not be a provider of participant-directed goods and services to the participant.

(d) A case manager shall submit reimbursement documentation to the financial management agency.

(e) Equipment purchased as a good shall become the property of the participant.

(11)(a) Natural supports training shall:

1. Be provided by a qualified entity as identified in the person-centered service plan;
2. Be participant directed and include:
  - a. Training and education to individuals who provide unpaid support, training, companionship, or supervision to participants;
  - b. Instruction about treatment regimens and other services specified in the participant's person-centered service plan;
  - c. Instruction on current best practices;
  - d. The costs of registration and training fees associated with formal instruction in areas relevant to the participant's needs identified in the participant's person-centered service plan; or
  - e. Training provided by a member of the participant's community regarding specific interests of the participant and how the natural support network shall support the participant's inclusion in activities and events surrounding the area of interest;
3. Be individualized, direct training of families and natural support networks for acquisition or enhancement of their ability to support the participant;
4. Relate to needs identified in a participant's person-centered service plan and be tied to a specific goal in the person-centered service plan;
5. Not duplicate or occur simultaneously with any education or training provided through:
  - a. State plan physical therapy services;
  - b. State plan occupational therapy services;
  - c. State plan speech-language pathology services;
  - d. Consultative clinical and therapeutic services; or
  - e. Positive behavior support services;
6. Be provided in:
  - a. A participant's own home or a participant's family's home; or
  - b. Community setting specific to community-based natural supports training goals specified in the participant's person-centered service plan;
7. Not include:
  - a. Services reimbursable by any other support;
  - b. Training paid caregivers;
  - c. Costs of travel, meals, or overnight lodging to attend a training event or conference; or
  - d. Services not related to the needs of the participant; and
8. Be coordinated and documented in the MWMA by a case manager by:

- a. The specific training provided;
- b. The date and the beginning and ending time when the service was provided;
- c. The service location;
- d. The receipts or verification of service provision, including first and last name and title (if applicable) of the person providing the service and the signature of the person providing the service;
- e. Verification of registration and certificate of attendance at any formal training; and
- f. The progress made in moving the participant towards independence as reflected in goals and the participant's person-centered service plan.

(b) An immediate family member, guardian, or legally responsible individual of a participant shall not be eligible to be a participant-directed provider of natural supports training services for the participant.

(c) For purposes of natural supports training, an individual shall be defined as any person, family member, neighbor, friend, companion, or coworker who provides uncompensated care, training, guidance, companionship, or support to the participant who utilizes natural supports training.

(d) A case manager shall submit reimbursement documentation to the financial management agency.

(12)(a) Person-centered coaching shall:

- 1. Be provided by a person-centered coach who shall:
    - a. Operate independently of a residential or day training provider;
    - b. Work under the direction of a positive behavior support specialist or other licensed professional in the settings where the person-centered service plan is implemented; and
    - c. Meet the personnel and training requirements specified in Section 3 of this administrative regulation;
  - 2. Be an individualized service to be utilized when a barrier challenges the success of a participant in achieving the participant's goals;
  - 3. Include:
    - a. The provision of training developed in conjunction with certified or licensed professionals from the participant's person-centered team, to the participant, family, guardian, natural and paid supports on implementation of all or designated components of the participant's person-centered service plan;
    - b. Monitoring the effectiveness of person-centered planning as demonstrated by the support system's implementation of the person-centered service plan or designated components across the array of service settings and reporting of required and pertinent data; and
    - c. Data collection that shall be utilized by the participant's person-centered team to modify the environment or person-centered service plan as needed;
  - 4. Not duplicate case management or any other service;
  - 5. Not supplant an educational service available under the Individuals with Disabilities Education Act (20 U.S.C. 101 et seq.); and
  - 6. Be limited to 1,320 fifteen (15) minute units per year.
- (b) Person-centered coaching shall be outcome-based with a plan for the gradual withdrawal of the services.
- (c) A person-centered coach shall not be considered as part of a staffing ratio, plan, or pattern.
- (d) Documentation of a person-centered coaching service shall be entered in the MWMA and shall include:
- 1. A note documenting each contact, which shall include:
    - a. A full description of each service rendered;

- b. The date of the service;
  - c. The location of the service;
  - d. The beginning and ending time of the service;
  - e. The signature and title of the person-centered coach providing the service; and
  - f. The date the entry was made in the record; and
2. A completed monthly summary note, which shall include:
- a. The month and year for the time period the note covers;
  - b. A summary of the service provided including recommendations and identification of additional support needs if any exist;
  - c. The signature and title of the individual completing the note;
  - d. The date the note was written; and
  - e. The signature, title, and date of review of documentation by the positive behavior specialist or other licensed professional directing the work of the person-centered coach.
- (13) Personal assistance services:
- (a) Shall be provided by a direct support professional;
  - (b) Shall enable a participant to accomplish tasks that the participant normally would do for himself or herself if the participant did not have a disability;
  - (c) Shall be available only to a participant who lives in the participant's own residence or in the participant's family residence;
  - (d) May be participant directed and if participant directed, may be provided by an immediate family member, guardian, or legally responsible individual of the participant in accordance with Section 10 of this administrative regulation;
  - (e) Shall include:
    - 1. Hands-on assistance (performing a task for a participant);
    - 2. Reminding, observing, guiding, or training a participant in activities of daily living;
    - 3. Reminding, observing, guiding, or training a participant in instrumental activities of daily living;
    - 4. Assisting a participant in managing the participant's medical care including making medical appointments and accompanying the participant to medical appointments; or
    - 5. Transportation, which is not otherwise available under the Medicaid Program, to access community services, activities, and appointments;
  - (f) Shall take place in a participant's home or in the community as appropriate to the participant's need;
  - (g) Shall not be available to a participant:
    - 1. Receiving paid residential supports; or
    - 2. Under the age of twenty-one (21) if medically necessary personal assistance is available as an early and periodic screening, diagnostic, and treatment service;
  - (h) Shall not supplant an educational service available under the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); and
  - (i) Shall be documented in the MWMA by:
    - 1. A note for each contact, which shall include:
      - a. A full description of each service rendered;
      - b. Evidence of training or service to support outcomes designated in the participant's person-centered service plan as appropriate;
      - c. The date of the service;
      - d. The location of the service;
      - e. The beginning and ending time of the service;
      - f. The signature and title of the direct support professional providing the service; and
      - g. The date the entry was made in the record; and

2. A detailed monthly summary note, which shall include:
  - a. The month and year for the time period the note covers;
  - b. Evidence of progress toward the participant's outcome or outcomes;
  - c. Identification of barriers to achievement of outcome or outcomes;
  - d. Projected plan to achieve the next step in achievement of outcome or outcomes;
  - e. The signature and title of the direct support professional completing the note; and
  - f. The date the note was written.

(14)(a) Positive behavior supports shall include:

1. The utilization of evidenced based and best practices in behavioral techniques, interventions, and methods to assist a participant with significant, intensive challenges that interfere with activities of daily living, social interaction, or work;

2. Evidenced based or best practices regarding treatment of a behavioral health condition that shall be the primary support services if supplemental behavioral interventions are needed; and

3. A positive behavior support plan, which shall:

- a. Be clearly based upon the information, data collected, and recommendations from the functional assessment;

- b. Meet the primary purpose of having the participant acquire or maintain skills for community living while behavioral interventions are delivered for the reduction of significant challenges that interfere with activities of daily living, social interaction, or work;

- c. Be developed with the participant and participant's person-centered team;

- d. Be related to goals of interventions, such as greater participation in activities, or enhanced coping or social skills;

- e. Identify strategies for managing consequences to maximize reinforcement of adaptive or positive behavior and minimize that for target behavior;

- f. Delineate goals of intervention and specific replacement behavior or skills that are incorporated into the participant's total service plan;

- g. If necessary to ensure safety and rapid de-escalation of a targeted behavior, outline the de-escalation techniques and scaled response with criteria for use and documentation requirements;

- h. Include specific criteria for how data including rate, frequency, duration, and intensity shall be recorded;

- i. Include specific criteria for re-evaluation when the data does not demonstrate progress;

- j. Clarify in measurable terms the frequency, intensity, and duration of the target behaviors:

- (i) That will signify that a reduction in services is in order; and

- (ii) When services are at an end;

- k. Be revised whenever necessary and submitted for review to the local behavior intervention committee along with:

- (i) The participant's person-centered service plan;

- (ii) The participant's functional assessment;

- (iii) The participant's life history;

- (iv) The participant's medical assessment; and

- (v) Any other appropriate assessment;

- l. Be submitted to the local human rights committee if rights restrictions are recommended; and

- m. Be implemented across service settings by the various people, both paid and natural supports, assisting a participant to reach the participant's goals and dreams.

- (b) Positive behavior supports shall be provided by a positive behavior support specialist.

- (c) Behavioral health treatment and positive behavioral supports shall be utilized in a collab-



orative manner.

(d) One (1) unit of positive behavior supports shall equal one (1) plan.

(e) Positive behavior supports shall be billed in accordance with 907 KAR 12:020.

(15)(a) Residential support services shall:

1. Be authorized for a participant based upon information from the participant's Supports Intensity Scale assessment, a screening tool that assesses health risk, and an approved person-centered service plan; and

2. Ensure that the participant has:

a. Privacy in the sleeping or living unit in a residential setting;

b. An option for a private unit in a residential setting;

c. A unit with lockable entrance doors and with only the individual and appropriate staff having keys to those doors;

d. A choice of roommates or housemates;

e. The freedom to furnish or decorate the participant's sleeping or living units within the lease or other agreement;

f. Visitors of the participant's choosing at any time and access to a private area for visitors; and

g. Physical accessibility defined as being easy to approach, enter, operate, or participate in a safe manner and with dignity by a person with or without a disability.

(b) To be considered physically accessible, a setting shall meet the Americans with Disabilities Act, 42 U.S.C. Chapter 126, standards of accessibility for all participants served in the setting.

(c) All communal areas shall be accessible to all participants as well as having a means to enter the building, such as a key or security code.

(d) Bedrooms shall be accessible to the appropriate persons.

(e) Any modification of the additional residential conditions, except for the setting being physically accessible requirement, shall be supported by a specific assessed need and justified in the person-centered service plan.

(f) The following shall be documented in the participant's person-centered service plan:

1. Identification of a specific and individualized assessed need;

2. Documentation of any positive intervention or support used prior to any modifications to the person-centered service plan;

3. Documentation of any less intrusive method of meeting the participant's needs that has been tried but did not work;

4. A clear description of the condition that is directly proportionate to the specific assessed need;

5. Regular collection and review of data to measure the ongoing effectiveness of the modification;

6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

7. The informed consent of the participant; and

8. An assurance that interventions and supports will cause no harm to the participant.

(g) Residential support services shall:

1. Include:

a. Level I residential supports;

b. Technology assisted residential supports; or

c. Level II residential supports; and

2. Be documented in the MWMA by a:

a. Daily note, which shall include:

(i) Information about how a participant spent the day including any effort toward meeting any outcome identified in the participant's person-centered service plan;

(ii) The date of the service;

(iii) The location of the service;

(iv) The signature and title of the individual providing the service; and

(v) The date the entry was made in the record; and

b. Detailed monthly summary note, which shall include:

(i) The month and year for the time period covered by the note;

(ii) An analysis of progress toward a participant's outcome or outcomes;

(iii) A projected plan to achieve the next step in achievement of an outcome or outcomes;

(iv) Information regarding events that occurred that had an impact on the participant's life;

(v) The signature and title of the direct support professional writing the note; and

(vi) The date the note was written;.

(16)(a) Level I residential supports shall:

1. Be furnished in a provider-owned or leased residence that complies with the Americans with Disabilities Act based upon the needs of each participant receiving a support in the residence;

2. Be for a participant who requires a twenty-four (24) hour a day, intense level of support;

3. Include no more than five (5) unsupervised hours per day per participant:

a. To promote increased independence; and

b. That shall be based on the:

(i) Needs of the participant as determined by the participant's person-centered team; and

(ii) Participant's person-centered service plan;

4. Include:

a. Adaptive skill development;

b. Assistance with activities of daily living including bathing, dressing, toileting, transferring, or maintaining continence;

c. Community inclusion;

d. Adult education supports;

e. Social and leisure development;

f. Protective oversight or supervision;

g. Transportation;

h. Personal assistance; and

i. The provision of medical or health care services that are integral to meeting the participant's daily needs; and

5. Be outlined in a participant's person-centered service plan with an accurate reflection of the responsibilities of the residential provider.

(b) Level I residential supports shall be provided by a:

1. Staffed residence that:

a. Has been certified:

(i) By the department to be an SCL waiver provider; and

(ii) By DBHDID to provide level I residential supports; and

b. Shall have no more than three (3) participants receiving publicly-funded supports in a home leased or owned by the provider; or

2. Group home that:

a. Has been certified:

(i) By the department to be an SCL waiver provider; and

(ii) By DBHDID to provide level I residential supports; and

b. Shall have no more than eight (8) participants in the group home.

(c)1. For a participant approved for unsupervised time, a safety plan shall be included in the participant's person-centered service plan based upon the participant's assessed needs.

2. A participant's case manager and other person-centered team members shall ensure that a participant is able to implement a safety plan.

3. A participant's case manager shall provide ongoing monitoring of the safety plan, procedures, or assistive devices required by a participant to ensure relevance, the participant's ability to implement the safety plan, and the functionality of the devices if required.

(d) If a participant experiences a change in support needs or status, the participant's person-centered team shall meet to make the necessary adjustments in the:

1. Participant's person-centered service plan; and
2. Residential services to meet the participant's needs.

(e) A level I residential support provider shall employ staff who shall be a:

1. Direct support professional; or
2. Direct support professional supervisor if providing supervision.

(17)(a) Technology assisted residential services shall:

1. Be furnished in a participant's residence:
  - a. That complies with the Americans with Disabilities Act based upon the needs of each participant receiving a support in the residence; and
  - b. To three (3) or fewer participants who, through the use of technology assisted residential services, reduce the amount of in-home staff support;

2. Be for a participant who:

- a. Requires up to twenty-four (24) hours a day of support; and
  - b. Is able to increase his or her level of independence with a reduced need for onsite staff;
3. Include, to the extent required for a participant:

- a. Protective oversight or supervision;
- b. Transportation;
- c. Personal assistance; or

d. The provision of medical or health care services that are integral to meeting the participant's daily needs;

4. Increase a participant's independence without undue risk to the participant's health or safety;

5. Be a real-time monitoring system with a two (2) way method of communication linking a participant to a centralized monitoring station; and

6. Be allowed to include:

- a. An electronic sensor;
- b. A speaker or microphone;
- c. A video camera, which shall not be located in a bedroom or a bathroom;
- d. A smoke detector; or
- e. A personal emergency response system.

(b)1. A device listed in paragraph (a)6. of this subsection shall link a participant's residence to remote staff employed to provide electronic support.

2. A technology assisted residential service provider shall have a plan established to ensure that staff is available twenty-four (24) hours a day, seven (7) days a week for a participant or participants receiving services from the provider.

(c) Technology shall be used by the technology assisted residential service provider to assist a participant in residing in the most integrated setting appropriate to the participant's needs.

(d) The level and types of technology assisted residential services provided to a participant shall be:

1. Determined by a participant's person-centered team; and
2. Outlined in a participant's person-centered service plan.

(e) A participant's person-centered team shall give careful consideration to the participant's medical, behavioral, and psychiatric condition in determining the level and types of technology assisted residential services needed for a participant.

(f) The use of technology to reduce a participant's need for residential staff support in a residence may be utilized if there is an individualized person-centered service plan that has been developed to promote a participant's increased independence:

1. Based on the participant's needs as indicated in the scores and results of the Supports Intensity Scale assessment and a screening tool that assesses health risk; and
2. As recommended by the participant's person-centered team.

(g)1. If a participant experiences a change in support need or status, the technology assisted residential service provider shall:

a. Immediately adjust the participant's supervision to meet any acute need of the participant; and

b. Reassess the appropriateness of technology assisted residential services and make any adjustment, if needed, to meet any chronic support need of the participant.

2. Any adjustment shall be made in collaboration with the participant's case manager and person-centered team if the adjustment is to be implemented for a period longer than what was determined by the participant's person-centered team when developing the participant's person-centered service plan.

(h) A technology assisted residential service provider shall:

1. Be responsible for arranging or providing a participant's transportation between the participant's residence and any other service site or community location;

2. Employ staff who:

a. Shall be a:

(i) Direct support professional; or

(ii) Direct support professional supervisor if providing supervision; and

b. Demonstrate:

(i) Proficiency in the individual's ability to operate all monitoring devices utilized in technology assisted residential services; and

(ii) The ability to respond appropriately to the needs of participants in a timely manner; and

3. Have daily contact with the participant.

(18)(a) Level II residential supports shall:

1. Be for a participant who requires up to a twenty-four (24)-hour level of support;

2. Be a support tailored to a participant to:

a. Assist the participant with acquiring, retaining, or improving skills related to living in a community; and

b. Promote increased independence;

3. Be designed and implemented to assist a participant to reside in the most integrated setting appropriate to the participant's needs;

4. Provide support for a participant up to twenty-four (24) hours a day;

5. Be furnished in:

a. An adult foster care home;

b. A family home provider; or

c. A participant's own home;

6. Be based on the:

a. Needs of the participant as determined by the participant's person-centered team; and

b. Participant's person-centered service plan; and

7. Include:
  - a. Adaptive skill development;
  - b. Assistance with activities of daily living including bathing, dressing, toileting, transferring, or maintaining continence;
  - c. Community inclusion;
  - d. Adult education supports;
  - e. Social and leisure development;
  - f. Protective oversight or supervision;
  - g. Transportation;
  - h. Personal assistance; and
  - i. The provision of medical or health care services that are integral to meeting the participant's daily needs.

(b) Level II residential supports shall be provided by:

1. An adult foster care provider that:

a. Has been certified:

- (i) By the department to be an SCL waiver provider; and
- (ii) By DBHDID to provide level II residential supports; and

b. Shall have no more than three (3) participants who are:

- (i) Aged eighteen (18) years or older; and
- (ii) Receiving publicly-funded supports and living in the home; or

2. A family home provider that:

a. Has been certified:

- (i) By the department to be an SCL waiver provider; and
- (ii) By DBHDID to provide level II residential supports; and

b. Shall have no more than three (3) participants receiving publicly-funded supports living in the home.

(c) A level II residential support provider shall employ staff who shall be a:

1. Direct support professional; or
2. Direct support professional supervisor if providing supervision.

(d) If a participant experiences a change in support need or status, the level II residential services provider shall adjust services provided to the participant to meet the participant's altered need or status.

(e) For a participant approved for unsupervised time, a safety plan shall:

1. Be included in the participant's person-centered service plan based upon the participant's assessed needs; and

2. Ensure that:

a. The participant's case manager and other person centered service plan team members ensure that the participant is able to implement the safety plan; and

b. The participant's case manager provides ongoing monitoring of the safety plan, procedures, or assistive devices required by the participant to ensure:

- (i) Relevance;
- (ii) The participant's ability to implement the safety plan; and
- (iii) The functionality of the devices if required.

(f) If a participant experiences a change in support needs or status, the participant's person-centered team shall meet to make the necessary adjustments in the:

1. Participant's person-centered service plan; and
2. Residential services to meet the participant's needs.

(19) Respite:

(a) Shall:

1. Be provided to a participant who:
  - a. Does not receive residential services;
  - b. Resides in the participant's own home or family's home; and
  - c. Is unable to independently administer self-care;
2. Be provided:
  - a. In a variety of settings;
  - b. By a direct support professional; and
  - c. On a short-term basis due to the absence or need for relief of a non-paid primary caregiver;
3. Be documented in the MWMA by a contact note, which shall include:
  - a. The date of the service;
  - b. The beginning and ending time of the service;
  - c. A full description of each service rendered;
  - d. The signature and title of the individual providing the service; and
  - e. The date the entry was made in the record; and
4. Not exceed 830 hours per each one (1) year authorized person-centered service plan period; and

(b) May be participant directed and if participant directed, may be provided by an immediate family member or guardian of the participant in accordance with Section 10 of this administrative regulation.

(20)(a) Shared living shall be a participant-directed service designed to:

1. Be an alternative to residential support services; and
2. Be provided by a shared living caregiver who provides some of the participant's supports in exchange for the caregiver's share of room and board expenses.

(b) A payment for the portion of the costs of rent or food attributable to an unrelated personal caregiver shall be routed through the financial management agency specifically for reimbursing the participant.

(c) If two (2) participants choose to live together in a home, the two (2) may share a caregiver.

(d) Depending upon the need of a participant, a caregiver may provide:

1. Assistance with the acquisition, retention, or improvement in skills related to activities of daily living; or
2. Supervision required for safety or the social and adaptive skills necessary to enable the participant to reside safely and comfortably in the participant's own home.

(e) Shared living services shall:

1. Address a participant's needs identified in the participant's person-centered planning process;
2. Be outlined in the participant's person-centered service plan;
3. Be specified in a contractual agreement between the participant and the caregiver; and
4. Complement other services the participant receives and enhance increased independence for the participant.

(f) A participant's person-centered team shall decide and ensure that the individual who will serve as the participant's caregiver has the experience, skills, training, and knowledge appropriate to the participant and the type of support needed.

(g) A participant's caregiver shall meet the participant-directed services provider requirements established in Section 10 of this administrative regulation.

(h) Room and board expenses for an unrelated caregiver living with a participant shall be:

1. Reflected in the participant's person-centered service plan; and
2. Specified in the contractual agreement between the participant and the caregiver.

(i) A payment shall not be made if a participant lives in the caregiver's home or in a residence that is owned or leased by an SCL provider.

(j) Documentation shall:

1. Be maintained by a participant's case manager in the MWMA; and

2. Include:

a. A dated monthly summary note that is written by the case manager and details how services were provided according to the contractual agreement and the participant's person-centered service plan;

b. A monthly receipt for the caregiver's room and board expenses that were reimbursed to the participant;

c. The signature and title of the case manager writing the note;

d. The date the note was written;

e. A signed and dated statement from the participant or the participant's guardian indicating that the participant is satisfied with the services provided by the caregiver; and

f. The signature, title and date of documentation review by the case manager supervisor who is supervising the case manager.

(k) Shared living shall be based on a prior authorized amount not to exceed \$600 per month.

(21)(a) Specialized medical equipment and supplies shall:

1. Include a device, control, or appliance specified in a participant's person-centered service plan that shall:

a. Be necessary to ensure the health, welfare, and safety of the participant; or

b. Enable the participant to function with greater independence in the home;

2. Include assessment or training needed to assist a participant with mobility, seating, bathing, transferring, security, or other skills including operating a wheelchair, a lock, a door opener, or a side lyre;

3. Include a computer necessary for operating communication devices, a scanning communicator, a speech amplifier, a control switch, an electronic control unit, a wheelchair, a lock, a door opener, or a side lyre;

4. Include customizing a device to meet a participant's needs;

5. Include partial nutrition supplements, special clothing, an enuresis protective chuck, or another authorized supply that is specified in the participant's person-centered service plan;

6. Include an ancillary supply necessary for the proper functioning of an approved device;

7. Be identified in a participant's person-centered service plan;

8. Be recommended by a person whose signature shall verify the type of specialized equipment or supply that is necessary to meet the participant's need; and who:

a. Meets the personnel and training requirements established in Section 3 of this administrative regulation; and is:

(i) An occupational therapist;

(ii) A physical therapist; or

(iii) A speech-language pathologist; or

b. Is a certified or licensed practitioner whose scope of practice includes the evaluation and recommendation of specialized equipment or supplies;

9. Not include equipment, a supply, an orthotic, prosthetic, service, or item covered under the department's:

a. Durable medical equipment program pursuant to 907 KAR 1:479;

b. Hearing services program pursuant to 907 KAR 1:038 or 907 KAR 1:039; or

c. EPSDT program pursuant to 907 KAR 11:034 or 907 KAR 11:035; and

10. Be coordinated and documented in the MWMA by a case manager by:

- a. A description or itemized line item of purchase and cost;
- b. Receipts for procurements that include the date of purchase;
- c. The signature and title of the case manager;
- d. The date the entry was made in the record; and
- e. The signature, title, and date of the documentation review by the case manager supervisor providing supervision to the case manager.

(b) Equipment purchased pursuant to this subsection for a participant shall become the property of the participant.

(22)(a) Supported employment shall be funded by the Rehabilitation Act of 1973 (29 U.S.C. Chapter 16) or Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.) for a participant if funding is available under either act for the participant.

(b) If the funding referenced in paragraph (a) of this subsection is not available for a participant, SCL waiver funding may be accessed for the participant for all defined supported employment services if there has been no change in the impact of the participant's disability on the participant's employment.

(c) Supported employment shall:

1. Be services that enable a participant to engage in paid work that occurs in an integrated community setting with competitive wages and benefits commensurate to the job responsibilities;

2. Be covered for a participant if no change in the impact of a participant's disability on the participant's employment has occurred and:

a. A Supported Employment Long-Term Support Plan has been completed, incorporated into the participant's person-centered service plan, and uploaded into the MWMA; or

b. There is documentation of the payment of the supported employment individual outcome placement fee indicating closure of the case by the Office of Vocational Rehabilitation;

3. Be participant directed, if a participant chooses this option;

4. Be provided:

a. In a variety of settings; and

b. By a supported employment specialist who:

(i) Meets the personnel and training requirements established in Section 3 of this administrative regulation; and

(ii) Works for an SCL certified provider that is a vendor of supported employment services for the Office of Vocational Rehabilitation;

5. Be delivered on a one (1) to one (1) basis with a participant or indirectly on behalf of a participant;

6. Exclude work performed directly for the supported employment provider or other service provider; and

7. Be coordinated with other applicable 1915(c) home and community based waiver services, if applicable, in support of the participant's employment outcome.

(d) Supported employment services delivered on a one-to-one basis and the hours spent by a participant performing paid employment and day training shall not exceed:

1. Forty (40) hours per week; or

2. 160 units per week.

(e) A supported employment service shall:

1. Be provided and documented as required by this subsection; and

2. Include the components established in this subsection.

(f)1. Supported employment shall include person-centered job selection discovery that shall:

a. Be a respectful way to get to know a participant who is seeking a job and break past conceived notions about what a participant can or cannot do; and



b. Include developing a Person Centered Employment Plan based upon the participant's:

- (i) Life experiences;
- (ii) Interests;
- (iii) Talents;
- (iv) Contributions;
- (v) Impact of disability;
- (vi) Vulnerabilities; and
- (vii) Support needs.

2. The Person-Centered Employment Plan shall be completed by the employment specialist, entered into the MWMA, and updated as needed.

3. A participant may access up to 120 units of person-centered job selection funding.

4. Prior to receiving employment services and job development, a participant and the participant's person-centered team shall review the content of the Person-Centered Employment Plan and ensure that the plan:

- a. Represents an accurate description of the participant's interests, goals, and objectives;
- b. Is based upon the development of a career rather than short-term employment; and
- c. Is incorporated into the participant's person-centered service plan.

5.a. Person-centered job selection shall conclude with a meeting at which parties supporting the participant provide:

(i) Suggestions of places in the participant's area where the participant might be able to perform the job tasks identified in the Person-Centered Employment Plan in return for at least minimum wage; and

(ii) Contacts, if available, for the places referenced in subclause (i) of this clause.

b. Information gathered at the job planning meeting shall be documented in the participant's individual plan for employment.

6.a. Job development and analysis shall:

(i) Be conducted to determine the skills that the participant will need to successfully contribute in a specific workplace;

(ii) Include deciding how to talk about the impact of the participant's disability in relation to the contributions that the participant can offer the employer;

(iii) Include facilitating the development of natural supports based on ordinary social relationships at work; and

(iv) Include matching job tasks that need to be completed for potential employers with the interests, skills, and abilities established in the participant's Person-Centered Employment Plan beginning with the leads provided during the job planning meeting.

b. A participant and the participant's employment specialist may access up to ninety (90) units of job development services.

7.a. Job acquisition with support shall be the actual acceptance of a position by the participant.

b. Stabilization services shall include becoming as independent as is possible in the workplace through assistance from natural supports.

c. The expectation shall be for systemic fading of the supported employment specialist to begin as soon as possible without jeopardizing the job and continuing until the participant receives only monitoring, career planning, and crisis assistance.

d. A participant and the participant's supported employment specialist may access up to 800 units of job acquisition and stabilization services.

8. Prior to initiating long-term support and follow-up services, the participant and the participant's person-centered team shall review the supported employment long-term support plan and ensure that the:

- a. Participant is functioning well in the job in terms of general satisfaction, number of hours worked, and performance of job duties;
- b. Participant is comfortable in interacting with coworkers and supervisors, and performs job duties through the use of natural supports; and
- c. Long-term support plan has been completed and integrated into the participant's person-centered service plan.

9.a. Long-term support and follow-up shall be provided to help a participant maintain the job and experience continued success after the:

- (i) Participant is fully integrated into the workplace; and
- (ii) Supported employment specialist is no longer needed on a regular basis.

b. The supported employment specialist shall continue to be available for the participant if and when needed for support or assistance with any job change or job advancement.

c.(i) The participant and the participant's supported employment specialist may access twenty-four (24) units of supported employment each month.

(ii) Any increase in supported employment units shall be justified in the long-term employment support plan and approved by the participant and the participant's person-centered team.

10. A person-centered employment plan activity note, notes regarding a participant's job development activity, notes regarding a participant's job acquisition or stabilization activity, and notes regarding a participant's long-term employment support activity shall:

a. Be completed, and uploaded into the MWMA, by a participant's supported employment specialist to document each contact with the participant or action provided on behalf of the participant; and

b. Contain:

- (i) The date of the service;
- (ii) The beginning time of the service;
- (iii) The ending time of the service;
- (iv) A description of the activity that was conducted;
- (v) The justification of the activity;
- (vi) The results of the activity;
- (vii) The anticipated content of the next activity; and
- (viii) The signature of the supported employment specialist who provided the service.

(23)(a) A transportation service shall:

1. Enable a participant who chooses to use participant-directed services to gain access to integrated waiver and other community services, activities, resources, and organizations typically utilized by the general population;

2. Only be provided when transportation is not:

a. Otherwise and customarily available through natural supports including family, friends, neighbors, or community agencies; or

b. Included as an element of another SCL waiver service;

3. Include nonemergency travel;

4. Be clearly described in a participant's person-centered service plan, which shall include information regarding the unavailability of other transportation services or resources;

5. Be reimbursable based upon the assessed needs of a participant as specified in the participant's person-centered service plan;

6. Be provided by a driver who:

a. Is at least eighteen (18) years of age and legally licensed to operate the transporting vehicle to which the individual is assigned or owns;

b. Has proof of current liability insurance for the vehicle in which the participant will be transported; and

c. Is an individual or other public transit resource including a local cab or bus service; and

7. Not:

a. Include transporting a participant to school (through the twelfth grade);

b. Be available to a participant who:

(i) Receives transportation as an element of another covered service;

(ii) Is receiving a residential service via the SCL waiver program;

(iii) Has access to transportation under the Individuals with Disabilities Education Act; or

(iv) Customarily receives transportation from a relative.

(b) A participant shall not contract with an individual to provide transportation if the individual has a driving under the influence conviction within the past twelve (12) months.

(c) A transportation service may be provided by an immediate family member, guardian, or legally responsible individual of the participant in accordance with Section 10 of this administrative regulation.

(d) A case manager shall:

1. Coordinate transportation services; and

2. Ensure that the following documentation is completed and submitted to the financial management agency for direct payment to the approved vendor:

a. The specific type and purpose of transportation provided;

b. The date and the beginning and ending time when the service was provided;

c. The location of origin of the transportation service, destination of the transportation service, and the mileage incurred from point to point;

d. Verification of service delivery, including the first and last name and title (if applicable) of the individual providing the service; and

e. A receipt from the driver if a bus, taxicab, or similar type of transportation service in which the participant directly purchases the service is utilized.

(24)(a) A vehicle adaptation shall:

1. Be a device, control, or service that enables a participant to:

a. Increase the participant's independence and physical safety; and

b. Interact more independently with the participant's environment and reduce the participant's dependence on physical support from others;

2. Be made to a participant's or a participant's family's privately owned vehicle;

3. Include:

a. A hydraulic lift;

b. A ramp;

c. A special seat; or

d. An interior modification to allow for access into and out of the vehicle as well as safety while the vehicle is moving;

4. Be limited to \$6,000 per five (5) years per participant;

5. Be prior authorized by the department in order to be reimbursable by the department; and

6. Be coordinated and documented in the MWMA by a case manager by:

a. Documenting an estimate from a vendor determined to be qualified to complete vehicle modifications by the Office of Vocational Rehabilitation;

b. Documentation from the Office of Vocational Rehabilitation that the participant is not qualified to receive a vehicle modification from the Office of Vocational Rehabilitation;

c. A description or itemized line item of purchase and cost;

d. A receipt for procurements that shall include the date of purchase;

e. Verification by the case manager that the work is complete, adequate, and satisfactory within ten (10) business days of completion before payment is requested and issued;

f. The signature and title of the case manager; and

- g. The date the entry was made in the record.
- (b) The department's SCL program shall be the payer of last resort for a vehicle adaptation.
- (c) The need for a vehicle adaptation shall:
  1. Be documented in a participant's person-centered service plan; and
  2. Include an assessment from an occupational therapist or physical therapist specializing in vehicle modifications that result in specific recommendations for the type of modification to meet the needs of the participant.
- (d) The department shall not reimburse for the repair or replacement costs of a vehicle adaptation of a vehicle owned by an SCL provider.
- (e) A vehicle adaptation vendor shall be in good standing with the Office of the Secretary of State of the Commonwealth of Kentucky pursuant to 30 KAR 1:010 and 30 KAR 1:020.
- (f) An immediate family member, guardian, or legally responsible individual of the participant shall not be eligible to be a vendor or provider of a vehicle adaptation service for the participant.
- (g) A case manager shall submit reimbursement documentation to the financial management agency.

Section 5. Person-centered Service Plan Requirements. (1) A person-centered service plan shall:

- (a) Be established for each participant;
- (b) Be developed by:
  1. The participant, the participant's guardian, or the participant's representative;
  2. The participant's case manager;
  3. The participant's person-centered team; and
  4. Any other individual chosen by the participant if the participant chooses any other individual to participate in developing the person-centered service plan;
- (c) Use a process that:
  1. Provides the necessary information and support to empower the participant, the participant's guardian, or participant's representative to direct the planning process in a way that empowers the participant to have the freedom and support to control the participant's schedules and activities without coercion or restraint;
  2. Is timely and occurs at times and locations convenient for the participant;
  3. Reflects cultural considerations of the participant;
  4. Provides information:
    - a. Using plain language in accordance with 42 C.F.R. 435.905(b); and
    - b. In a way that is accessible to an individual with a disability or who has limited English proficiency;
  5. Offers an informed choice defined as a choice from options based on accurate and thorough knowledge and understanding to the participant regarding the services and supports to be received and from whom;
  6. Includes a method for the participant to request updates to the person-centered service plan as needed;
  7. Enables all parties to understand how the participant:
    - a. Learns;
    - b. Makes decisions; and
    - c. Chooses to live and work in the participant's community;
  8. Discovers the participant's needs, likes, and dislikes; and
  9. Empowers the participant's person-centered team to create a person-centered service plan that:

- a. Is based on the participant's:
  - (i) Assessed clinical and support needs;
  - (ii) Strengths;
  - (iii) Preferences; and
  - (iv) Ideas;
- b. Encourages and supports the participant's:
  - (i) Rehabilitative needs;
  - (ii) Habilitative needs; and
  - (iii) Long term satisfaction;
- c. Is based on reasonable costs given the participant's support needs;
- d. Includes:
  - (i) The participant's goals;
  - (ii) The participant's desired outcomes; and
  - (iii) Matters important to the participant;
- e. Includes a range of supports including funded, community, and natural supports that shall assist the participant in achieving identified goals;
- f. Includes:
  - (i) Information necessary to support the participant during times of crisis; and
  - (ii) Risk factors and measures in place to prevent crises from occurring;
- g. Assists the participant in making informed choices by facilitating knowledge of and access to services and supports;
- h. Records the alternative home and community-based settings that were considered by the participant;
- i. Reflects that the setting in which the participant resides was chosen by the participant;
- j. Is understandable to the participant and to the individuals who are important in supporting the participant;
- k. Identifies the individual or entity responsible for monitoring the person-centered service plan;
- l. Is finalized and agreed to with the informed consent of the participant or participant's representative in writing with signatures by each individual who will be involved in implementing the person-centered service plan;
- m. Shall be distributed to the individual and other people involved in implementing the person-centered service plan;
- n. Includes those services that the individual elects to self direct; and
- o. Prevents the provision of unnecessary or inappropriate services and supports; and
- (d) Include in all settings the ability for the participant to:
  - 1. Have access to make private phone calls, texts, or emails at the participant's preference or convenience; and
  - 2.a. Choose when and what to eat;
  - b. Have access to food at any time;
  - c. Choose with whom to eat or whether to eat alone; and
  - d. Choose appropriating clothing according to the:
    - (i) Participant's preference;
    - (ii) Weather; and
    - (iii) Activities to be performed.
  - (2) If a participant's person-centered service plan includes ADHC services, the ADHC services plan of treatment shall be addressed in the person-centered service plan.
  - (3)(a) A participant's person-centered service plan shall be:
    - 1. Entered into the MWMA by the participant's case manager; and

2. Updated in the MWMA by the participant's case manager.

(b) A participant or participant's authorized representative shall complete and upload into the MWMA a MAP - 116 Service Plan - Participant Authorization prior to or at the time the person-centered service plan is uploaded into the MWMA.

Section 6. Case Management Requirements. (1) A case manager shall:

(a) Have a bachelor's degree from an accredited institution in a human services field and be supervised by:

1. An SCL intellectual disability professional;
2. A registered nurse who has at least two (2) years of experience working with individuals with an intellectual or a development disability;
3. An individual with a bachelor's degree in a human services field who has at least two (2) years of experience working with individuals with an intellectual or a developmental disability;
4. A licensed clinical social worker who has at least two (2) years of experience working with individuals with an intellectual or a developmental disability;
5. A licensed marriage and family therapist who has at least two (2) years of experience working with individuals with an intellectual or a developmental disability;
6. A licensed professional clinical counselor who has at least two (2) years of experience working with individuals with an intellectual or a developmental disability;
7. A certified psychologist or licensed psychological associate who has at least two (2) years of experience working with individuals with an intellectual or a developmental disability; or
8. A licensed psychological practitioner or certified psychologist with autonomous functioning who has at least two (2) years of experience working with individuals with an intellectual or a developmental disability;

(b) Be a registered nurse;

(c) Be a licensed clinical social worker;

(d) Be a licensed marriage and family therapist;

(e) Be a licensed professional clinical counselor;

(f) Be a licensed psychologist; or

(g) Be a licensed psychological practitioner.

(2) A case manager shall:

(a) Communicate in a way that ensures the best interest of the participant;

(b) Be able to identify and meet the needs of the participant;

(c)1. Be competent in the participant's language either through personal knowledge of the language or through interpretation; and

2. Demonstrate a heightened awareness of the unique way in which the participant interacts with the world around the participant;

(d) Ensure that:

1. The participant is educated in a way that addresses the participant's:

a. Need for knowledge of the case management process;

b. Personal rights; and

c. Risks and responsibilities as well as awareness of available services; and

2. All individuals involved in implementing the participant's person-centered service plan are informed of changes in the scope of work related to the person-centered service plan as applicable;

(e)1. Lead the person-centered service planning team; and

2. Coordinate services through team meetings with representatives of all agencies involved in implementing a participant's person-centered service plan;

(f)1. Include the participant's participation or representative's participation in the case man-

agement process; and

2. Make the participant's preferences and participation in decision making a priority;

(g) Document:

1. A participant's interactions and communications with other agencies involved in implementing the participant's person-centered service plan; and

2. Personal observations;

(h) Advocate for a participant with service providers to ensure that services are delivered as established in the participant's person-centered service plan;

(i) Assess the quality of services, safety of services, and cost effectiveness of services being provided to a participant in order to ensure that implementation of the participant's person-centered service plan is successful and done so in a way that is efficient regarding the participant's financial assets and benefits;

(j) Document services provided to a participant by entering into the MWMA a monthly contact note, which shall include:

1. The month and year for the time period the note covers;

2. An analysis of progress toward the participant's outcome or outcomes;

3. Identification of barriers to achievement of outcomes;

4. A projected plan to achieve the next step in achievement of outcomes;

5. The signature and title of the case manager completing the note; and

6. The date the note was generated;

(k) Accurately reflect in the MWMA if a participant is:

1. Terminated from the SCL waiver program;

2. Admitted to an intermediate care facility for individuals with intellectual disabilities;

3. Admitted to a hospital;

4. Admitted to a skilled nursing facility;

5. Transferred to another Medicaid 1915(c) home and community based waiver service program; or

6. Relocated to a different address;

(l) Provide information about participant-directed services to the participant or the participant's guardian:

1. At the time the initial person-centered service plan is developed;

2. At least annually thereafter; and

3. Upon inquiry from the participant or participant's guardian; and

(m) Be supervised by a case management supervisor.

(3)(a) Case management for any individual who begins receiving SCL services after the effective date of this administrative regulation shall be conflict free except as allowed in paragraph (b) of this subsection.

(b)1. Conflict free case management shall be a scenario in which a provider including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider who renders case management to a participant shall not also provide another 1915(c) home and community based waiver service to that same participant unless the provider is the only willing and qualified SCL provider within thirty (30) miles of the participant's residence.

2. An exemption to the conflict free case management requirement shall be granted if:

a. A participant requests the exemption;

b. The participant's case manager provides documentation of evidence to DBHDID, that there is a lack of a qualified case manager within thirty (30) miles of the participant's residence;

c. The participant or participant's representative and case manager signs a completed MAP - 531 Conflict-Free Case Management Exemption; and

d. The participant, participant's representative, or case manager uploads the completed MAP - 531 Conflict-Free Case Management Exemption into the MWMA.

3. If a case management service is approved to be provided despite not being conflict free, the case management provider shall document conflict of interest protections, separate case management and service provision functions within the provider entity, and demonstrate that the participant is provided with a clear and accessible alternative dispute resolution process.

4. An exemption to the conflict free case management requirement shall be requested upon reassessment or at least annually.

(c) A participant who receives SCL services prior to the effective date of this administrative regulation shall transition to conflict free case management when the participant's next level of care determination occurs.

(d) During the transition to conflict free case management, any case manager providing case management to a participant shall educate the participant and members of the participant's person-centered team of the conflict free case management requirement in order to prepare the participant to decide, if necessary, to change the participant's:

1. Case manager; or
2. Provider of non-case management SCL services.

(4) Case management shall include:

(a) Initiation, coordination, implementation, and monitoring of the assessment, reassessment, evaluation, intake, and eligibility process;

(b) Assisting a participant in the identification, coordination, and arrangement of the person centered team and person centered team meetings;

(c) Facilitating person-centered team meetings that assist a participant to develop, update, and monitor the person-centered service plan, which shall be distributed or made available to all members of the person-centered team within five (5) business days of development;

(d) Assisting a participant to gain access to and maintain employment, membership in community clubs and groups, activities, and opportunities at the times, frequencies, and with the people the participant chooses;

(e) Coordinating and monitoring all 1915(c) home and community based waiver services and non-waiver services including having monthly face-to-face contacts with the participant to determine if the participant's needs are being met.

1. Contact shall be at a location where the participant is engaged in services.

2. A case manager shall utilize the MWMA to:

a. Ensure that the participant's health, safety, and welfare are not at risk;

b. Gather data regarding the participant's satisfaction with the services for use in guiding the person centered planning process;

c. Address how the person-centered team will address the following:

(i) Expanding and deepening the participant's relationships;

(ii) Increasing the participant's presence in local community life; and

(iii) Helping the participant have more choice and control; and

d. Generate monthly summary notes.

3. Coordinating and monitoring shall include:

a. Initiating person-centered team meetings and receiving prior authorization within fourteen (14) days of a contact visit if the results of a monthly contact visit indicate that different or additional services or other changes in the participant's person-centered service plan are required to meet the participant's needs;

b. Assisting with participant-directed services including:

(i) Assisting the participant in identifying, if necessary, a community guide and a representative who shall work with the participant on the development of a person-centered service plan,



budget, and emergency back-up plan;

(ii) Assisting the participant in identifying strategies for recruiting and managing employees; and

(iii) Assigning modules within the Kentucky College of Direct Supports for training purposes and assisting the participant, the community guide, or the representative in monitoring the completion of training within timeframes specified in Section 10 of this administrative regulation;

c. Monitoring the provision of services and submission of required documentation to the financial management agency; and

d. Monitoring and reporting identified deficiencies to appropriate agencies;

(f) Assisting a participant in planning resource use and assuring protection of resources to include:

1. Clearly outlining the participant's insurance options and availability; and

2. Exploring the potential availability of other resources and social service programs for which the participant may qualify;

(g) Monitoring to ensure that services continue if a participant has been terminated from any service until an alternate provider, if needed, has been chosen by the participant and services have been approved;

(h) Providing a participant and the participant's team members twenty-four (24) hour telephone access to a case management staff person;

(i) Documentation, uploaded into the MWMA, of services by a detailed monthly summary note, which shall include:

1. The month and year for the time period the note covers;

2. An analysis of progress toward the participant's outcome or outcomes;

3. Identification of barriers to achievement of outcomes;

4. A projected plan to achieve the next step in achievement of outcomes;

5. The signature and title of the case manager completing the note; and

6. The date the note was generated;

(j) Person-centered team meetings, which shall not constitute the required monthly face-to-face visit with a participant; and

(k) Supervision duties performed by the case manager supervisor who provides supervision in accordance with a DBHDID approved case manager supervisor training.

(5)(a) One (1) unit of case management shall equal one (1) month.

(b) A provider shall bill for a case management service in accordance with 907 KAR 12:020.

(6) Case management shall involve:

(a) A constant recognition of what is and is not working regarding a participant; and

(b) Changing what is not working.

Section 7. Human Rights Committee. (1) A human rights committee shall meet on a routine, scheduled basis, no less than quarterly to ensure that the rights of participants utilizing SCL services are respected and protected through due process.

(2) A human rights committee shall include at least:

(a) At least one (1) self-advocate;

(b) At least one (1) member from the community at large with experience in human rights issues or in the field of intellectual or developmental disabilities;

(c) At least one (1) appointed guardian or family member of a waiver participant;

(d) One (1) professional in the medical field; and

(e) At least one (1) professional with:

1. A bachelor's degree from an accredited college or university; and

2. Three (3) years of experience in the field of intellectual or developmental disabilities.

(3) Each SCL provider shall:

(a) Actively participate in the human rights committee process of the local human rights committee; and

(b) Provide the necessary documentation to the local human rights committee for review and approval prior to implementation of any rights restrictions or positive behavior support plans involving rights restrictions.

(4) A human rights committee meeting shall have a quorum of at least three (3) members, including at least one (1) self-advocate and one (1) community at large member.

(5) A human rights committee shall:

(a) Maintain a record of each meeting; and

(b) Send a summary of each person-centered service plan reviewed to the:

1. Relevant participant; or

2. Participant's guardian and case manager.

(6) Each member of a human rights committee shall:

(a) Complete an orientation approved by DBHDID;

(b) Sign a confidentiality agreement; and

(c) Function in accordance with the Health Insurance Portability and Accountability Act codified as 45 C.F.R. Parts 160, 162, and 164.

(7)(a) A human rights committee shall ensure that any restriction imposed on a participant is:

1. Temporary in nature;

2. Defined with specific criteria outlining how the restriction is to be imposed;

3. Paired with learning or training components to assist the participant in eventual reduction or elimination of the restriction;

4. Removed upon reaching clearly-defined objectives; and

5. Reviewed by the human rights committee at least once annually if the restriction remains in place for at least twelve (12) months.

(b) In an emergency where there is imminent danger or potential harm to a participant or other individuals, the participant's SCL service provider in consultation with the case manager and participant's guardian, as appropriate, may limit or restrict the participant's rights for a maximum of one (1) week.

(c) If a participant is under the care of a psychologist, counselor, psychiatrist, or behavior support specialist, a restriction plan:

1. Shall be developed with the input of the psychologist, counselor, psychiatrist, or behavior support specialist; and

2. May be implemented for up to two (2) weeks.

(d) A proposed continuation of a restriction shall be immediately reviewed and approved by three (3) members of the local human rights committee while alternative strategies are being developed.

(e) If it is decided that a rights restriction needs to be continued and addressed in the participant's person-centered service plan, the restriction shall be submitted to the local:

1. Behavior intervention committee; and

2. Human rights committee at the next regularly scheduled meeting.

Section 8. Behavior Intervention Committee. (1) A behavior intervention committee shall include at least:

(a) One (1) self-advocate, representative, or family member;

(b) At least one (1) member from the community at large with experience in human rights is-

sues or in the field of intellectual or developmental disabilities;

(c) One (1) professional in the medical field; and

(d) At least one (1) of the following:

1. A positive behavior support specialist;
2. A licensed psychologist;
3. A certified psychologist; or
4. A licensed clinical social worker.

(2)(a) A behavior intervention committee shall meet at least quarterly to review, approve, and as necessary, make written technical recommendations for each new or revised positive behavior support plan as submitted.

(b) A behavior intervention committee meeting shall have a quorum of at least three (3) members including at least one (1):

1. Self-advocate, representative, or family member; and
2. Member from the community at large with experience in:
  - a. Human rights issues; or
  - b. The field of intellectual or developmental disabilities.

(3) A behavior intervention committee shall ensure that:

(a) Positive behavior supports are clinically sound and based on person-centered values considering what is important for the participant;

(b) Assessments and interventions utilize evidenced based and best practices for treatment of a behavioral health condition as the primary support services when supplemental behavioral interventions are needed;

(c) The use of both behavioral health treatment and positive behavioral supports shall be utilized in a collaborative manner; and

(d) A new or revised positive behavior support plan is not implemented until it is approved by:

1. The behavior intervention committee; and
2. If rights restrictions are recommended, the human rights committee.

(4) A behavior intervention committee shall:

(a) Maintain a record of each meeting; and

(b) Send a summary of each person-centered service plan reviewed to the:

1. Relevant participant; or
2. Participant's guardian and case manager.

(5) Each behavior intervention committee member shall:

(a) Complete an orientation approved by DBHDID;

(b) Sign a confidentiality agreement; and

(c) Function in accordance with the Health Insurance Portability and Accountability Act codified as 45 C.F.R. Parts 160, 162, and 164.

Section 9. Other Assurances. (1) For each participant to whom it provides services, an SCL provider shall ensure:

(a) The participant's:

1. Right to privacy, dignity, and respect; and
2. Freedom from coercion or restraint;

(b) The participant's freedom of choice as defined by the experience of independence, individual initiative, or autonomy in making life choices in all matters (small as well as large);

(c) That the participant or participant's representative chooses services, providers, and service settings including non-disability specific settings if so desired;

(d) That the participant is provided with a choice of where to live with as much independ-

ence as possible and in the most community-integrated environment; and

(e) That the service setting options are:

1. Identified and documented in the participant's person-centered service plan; and
2. Based on the participant's needs and preferences.

(2) An SCL provider shall not use an aversive technique with a participant.

(3) Any right restriction imposed by an SCL provider shall:

- (a) Be annually reviewed by a human rights committee;
- (b) Be subject to approval by a human rights committee; and
- (c) Include a plan to restore the participant's rights.

Section 10. Participant-Directed Services (PDS). (1)(a)1. The services listed in subparagraph 2. of this paragraph may be participant directed and shall be provided in accordance with the:

a. Specifications and requirements established in Section 4 of this administrative regulation except for the monthly summary note requirements established in Section 4 of this administrative regulation; and

b. Training requirements specified in paragraph (b) of this subsection.

2. Participant-directed services may include:

- a. Community access services;
- b. Community guide services;
- c. Day training;
- d. Personal assistance services;
- e. Respite;
- f. Shared living; or
- g. Supported employment.

(b) An individual who provides a participant-directed service shall complete the:

1. Background and related requirements established in Section 3(3)(p), (q), (r), (v), (w), (x), (y), and (z) of this administrative regulation; and

2. Following training requirements in the timeframe established by paragraph (c) of this subsection:

a. First aid and cardiopulmonary resuscitation certification by a nationally accredited entity;

b. If providing supported employment services, the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within eight (8) months of the date of employment as an employment specialist;

c. Individualized instruction regarding the participant receiving a support;

d. The following areas of the Kentucky College of Direct Support modules:

- (i) Maltreatment of vulnerable adults and children;
- (ii) Individual rights and choices;
- (iii) Safety at home and in the community;
- (iv) Supporting healthy lives; and
- (v) Person-centered planning; and

e. Other training if required by the participant.

(c) The training required by paragraph (b) of this subsection shall be completed within six (6) months of the date of hire for a new provider of a participant-directed service.

(2) An individual providing a participant-directed service to more than three (3) participants in the same household or different households shall complete all provider training requirements as specified in Section 3 of this administrative regulation.

(3)(a) The following services may be participant directed and shall be provided in accordance with the specifications and requirements established in Section 4 of this administrative

regulation and this section:

1. Environmental accessibility adaptation services;
2. Goods and services;
3. Natural supports training;
4. Transportation services; or
5. Vehicle adaptation.

(b) A participant-directed service shall not be available to a participant who resides in a living arrangement, regardless of funding source, that is furnished to four (4) or more individuals who are unrelated to the proprietor.

(4) An immediate family member or guardian of a participant may provide a support to a participant-directed service if:

(a) Allowed to do so pursuant to Section 4 of this administrative regulation;

(b) The family member or guardian has the unique abilities necessary to meet the needs of the participant;

(c) The service is not something normally provided by the family member or guardian to the participant;

(d) Delivery of the service by the family member or guardian is cost effective;

(e) The use of the family member or guardian is age and developmentally appropriate;

(f) The use of the family member or guardian enables the participant to:

1. Learn and adapt to different people; and

2. Form new relationships;

(g) The participant learns skills to increase independence;

(h) Having the family member or guardian provide the service:

1. Truly reflects the participant's wishes and desires;

2. Increases the participant's quality of life in measurable ways;

3. Increases the participant's level of independence;

4. Increases the participant's choices; and

5. Increases the participant's access to the amount of service hours for needed support;

(i) There is no qualified provider:

1. Within thirty (30) miles from the participant's residence; or

2. Who can furnish the service at the necessary times and places; and

(j) The participant, participant's immediate family member, or guardian of the participant:

1. Completes a MAP - 532 PDS Request Form for Immediate Family Member, Guardian, or Legally Responsible Individual as Paid Service Provider; and

2. Uploads the completed MAP - 532 PDS Request Form for Immediate Family Member, Guardian, or Legally Responsible Individual as Paid Service Provider into the MWMA.

(5) A legally responsible individual may provide a service to a participant if:

(a) Allowed to do so pursuant to Section 4 of this administrative regulation;

(b) The legally responsible individual meets the requirements established for a family member or guardian in subsection (4) of this section;

(c) The service exceeds the range of activities that a legally responsible individual would ordinarily provide in a household on behalf of a person:

1. Without a disability; and

2. Of the same age;

(d) The service is necessary to:

1. Assure the health and welfare of the participant; and

2. Avoid institutionalization; and

(e) The participant or legally responsible individual:

1. Completes a MAP - 532 PDS Request Form for Immediate Family Member, Guardian, or

Legally Responsible Individual as Paid Service Provider; and

2. Uploads the completed MAP - 532 PDS Request Form for Immediate Family Member, Guardian, or Legally Responsible Individual as Paid Service Provider into the MWMA.

(6) An individual serving as a representative for a participant shall not be eligible to provide a 1915(c) home and community based waiver service to the participant.

(7) A participant-directed reimbursement service shall be provided by a financial management agency with whom the department contracts that shall:

(a) Only pay for a service identified and prior authorized in a participant's person-centered service plan;

(b) Ensure compliance with all Internal Revenue Service regulations, United States Department of Labor regulations, and Kentucky Department of Workers' Claims administrative regulations regarding workers' compensation;

(c) Process employer-related payroll and deposit and withhold necessary mandatory employer withholdings;

(d) Receive, disburse, and track public funds based on a participant's approved person-centered service plan; and

(e) Provide:

1. A participant and the participant's case manager with payroll reports monthly; and

2. Additional payroll information to a participant's case manager on a per request basis.

(8)(a) A participant may voluntarily disenroll from a participant-directed service at any time.

(b) If a participant elects to disenroll from a participant-directed service, the participant's case manager shall assist the participant and the participant's guardian to locate a traditional 1915(c) home and community based waiver service provider of the participant's choice to provide the service.

(c) 1. Except as provided in subparagraph 2 of this paragraph, a participant-directed service shall not be terminated until a traditional service provider is ready to provide the service.

2. If a participant does not wish to continue receiving the service, the service shall be terminated.

(9)(a) A participant's case manager shall develop a corrective action plan in conjunction with the participant, the participant's guardian, and any other person-centered team member if:

1. The participant does not comply with the participant's person-centered service plan;

2. The participant, a family member of the participant, an employee of the participant, the participant's guardian, or a legal representative of the participant threatens, intimidates, or consistently refuses services from an SCL provider;

3. Imminent threat of harm to the participant's health, safety, or welfare exists; or

4. The participant, a family member of the participant, an employee of the participant, the participant's guardian, or a legal representative of the participant interferes with or denies the provision of case management.

(b) The participant's case manager shall monitor the progress of the corrective action plan and resulting outcomes to resolve the issue described in paragraph (a) of this subsection that necessitated a corrective action plan.

(c) If the issue referenced in paragraph (a) of this subsection is not resolved, the participant's case manager, in conjunction with the participant's person-centered team members, shall assist the participant to locate a traditional 1915(c) home and community based waiver service provider of the participant's choice to provide the service.

(d) A participant-directed service shall not be terminated until a traditional service provider is ready to provide the service.

(10) Documentation of a participant-directed service shall include:

(a) A timesheet;

- (b) A note documenting each contact, which shall include:
  1. A full description of each service provided to support an outcome or outcomes in the participant's person-centered service plan;
  2. The date of the service;
  3. The location of the service;
  4. The beginning and ending time of the service;
  5. The signature and title of the person providing the service; and
  6. The date the entry was made in the record; and
- (c) Any applicable form for each service in accordance with Section 4 of this administrative regulation.

Section 11. Incident Reporting Process. (1) The following shall be the two (2) classes of incidents:

- (a) An incident; or
  - (b) A critical incident.
- (2) An incident shall be any occurrence that impacts the health, safety, welfare, or lifestyle choice of a participant and includes:
- (a) A minor injury;
  - (b) A medication error without a serious outcome; or
  - (c) A behavior or situation that is not a critical incident.
- (3) A critical incident shall be an alleged, suspected, or actual occurrence of an incident that:
- (a) Can reasonably be expected to result in harm to a participant; and
  - (b) Shall include:
    1. Abuse, neglect, or exploitation;
    2. A serious medication error;
    3. Death;
    4. A homicidal or suicidal ideation;
    5. A missing person; or
    6. Other action or event that the provider determines may result in harm to the participant.
- (4)(a) If an incident occurs, the:
1. Individual who discovered or witnessed the incident shall document the details of the incident and report it to designated agency staff for entry into the MWMA; and
  2. Incident shall be immediately assessed for potential abuse, neglect, or exploitation.
- (b) If an assessment of an incident indicates that the potential for abuse, neglect, or exploitation exists:
1. The individual who discovered or witnessed the incident shall immediately act to ensure the health, safety, or welfare of the at-risk participant;
  2. The incident shall immediately be considered a critical incident;
  3. The critical incident procedures established in subsection (5) of this section shall be followed; and
  4. The SCL provider shall report the incident to the participant's case manager and participant's guardian, if the participant has a guardian, within twenty-four (24) hours of discovery of the incident.
- (5)(a) If a critical incident occurs, the individual who witnessed the critical incident or discovered the critical incident shall immediately act to ensure the health, safety, and welfare of the at-risk participant.
- (b) If the critical incident:
1. Requires reporting of abuse, neglect, or exploitation, the critical incident shall be immedi-

ately reported via the MWMA; or

2. Does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA by a designated agency staff person within eight (8) hours of discovery.

(c) The SCL provider shall:

1. Conduct an immediate investigation and involve the participant's case manager in the investigation; and

2. Prepare a report of the investigation, which shall be recorded in the MWMA and shall include:

a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident;

b. Details of the critical incident; and

c. Relevant participant information including:

(i) Diagnostic impressions and medical diagnoses based on the current version of American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders<sup>TM</sup>;

(ii) A listing of recent medical concerns;

(iii) An analysis of causal factors; and

(iv) Recommendations for preventing future occurrences.

(6)(a) Following a death of a participant receiving services from an SCL provider, the SCL provider shall enter mortality data documentation into the MWMA within fourteen (14) days of the death.

(b) Mortality data documentation shall include:

1. The participant's person-centered service plan at the time of death;

2. Any current assessment forms regarding the participant;

3. The participant's medication administration records from all service sites for the past three (3) months along with a copy of each prescription, if applicable;

4. Progress notes regarding the participant from all service elements for the past thirty (30) days, including case management notes;

5. The results of the participant's most recent physical exam;

6. All incident reports, if any exist, regarding the participant for the past six (6) months;

7. Any medication error log related to the participant for the past six (6) months;

8. The most recent psychological evaluation of the participant;

9. A full life history of the participant including any update from the last version of the life history;

10. Names and contact information for all staff members who provided direct care to the participant during the last thirty (30) days of the participant's life;

11. Emergency medical services notes regarding the participant if available;

12. The police report if available;

13. A copy of:

a. The participant's advance directive, medical order for scope of treatment, living will, or health care directive if applicable;

b. Any functional assessment of behavior or positive behavior support plan regarding the participant that has been in place over any part of the past twelve (12) months; and

c. The cardiopulmonary resuscitation and first aid card for any SCL provider's staff member who was present at the time of the incident that resulted in the participant's death;

14. A record of all medical appointments or emergency room visits by the participant within the past twelve (12) months; and

15. A record of any crisis training for any staff member present at the time of the incident that resulted in the participant's death.



(7) An SCL provider shall document all medication error details on a medication error log retained on file at the SCL provider site.

Section 12. SCL Waiting List. (1)(a) In order to be placed on the SCL waiting list, an individual or individual's representative shall:

1. Apply for 1915(c) home and community based waiver services via the MWMA; and
2. Complete a MAP - 115 Application Intake - Participant Authorization and upload it into the MWMA.

(b) The following information shall be included in the information entered by the individual into the MWMA:

1. A signature from a physician or an SCL developmental disability professional verifying diagnostic impressions and medical diagnoses;
2. A current and valid intellectual or development disability diagnosis, including supporting documentation to validate the diagnosis and age of onset; and
3. List of diagnoses.

(c) Supporting documentation to validate a diagnosis and age of onset shall include:

1. A psychological or psycho-educational report of the assessment results of at least an individual test of intelligence resulting in an intelligence quotient (IQ) score; and
2. The results of an assessment of adaptive behavior abilities that has been signed by the licensed psychologist, licensed psychological associate, certified psychologist with autonomous functioning, or certified school psychologist who prepared the report.

(d) The IQ test referenced in paragraph (c)1. of this subsection shall:

1. Have been conducted before the age of eighteen (18) years for a diagnosis of intellectual disability or before the age of twenty-two (22) years for a diagnosis of a developmental disability; or

2. If a record of an IQ score prior to the age of eighteen (18) years for an applicant with an intellectual disability or prior to the age of twenty-two (22) years for an applicant with a developmental disability cannot be obtained, the following shall qualify as supporting documentation to validate a diagnosis and age of onset:

- a. Individual education program documentation that contains an IQ score and a report or description of adaptive behavior skills;

- b. The results of a psychological assessment submitted during the course of guardianship proceedings; or

- c. The results of a current psychological assessment that shall:

- (i) Include evidence of onset prior to the age of eighteen (18) years for an intellectual disability or the age of twenty-two (22) years for a developmental disability obtained through a comprehensive developmental history; and

- (ii) Provide documentation ruling out factors or conditions that may contribute to diminished cognitive and adaptive functioning, including severe mental illness, chronic substance abuse, or medical conditions.

(2) DBHDID shall review an individual's application information to determine if the information is complete and valid.

(3)(a) An individual's order of placement on the SCL waiting list shall be determined by:

1. The chronological date of receipt of complete application information regarding the individual being entered into the MWMA; and

2. Category of need of the individual as established in paragraphs (b) through (d) of this subsection.

(b) An individual's category of need shall be the emergency category if an immediate service is needed as determined by any of the following if all other service options have been ex-

plored and exhausted:

1. Abuse, neglect, or exploitation of the individual as substantiated by DCBS;
2. The death of the individual's primary caregiver and lack of an alternative primary caregiver;
3. The lack of appropriate placement for the individual due to:
  - a. Loss of housing;
  - b. Loss of funding; or
  - c. Imminent discharge from a temporary placement;
4. Jeopardy to the health and safety of the individual due to the primary caregiver's physical or mental health status; or
5. Imminent or current institutionalization.

(c) An individual's category of need shall be the urgent category if an SCL service is needed within one (1) year; and

1. There is a threatened loss of the individual's existing funding source for supports within the year due to the individual's age or eligibility;
2. The individual is residing in a temporary or inappropriate placement but the individual's health and safety is assured;
3. The individual's primary caregiver has a diminished capacity due to physical or mental status and no alternative primary caregiver exists; or
4. The individual exhibits an intermittent behavior or action that requires hospitalization or police intervention.

(d) An individual's category of need shall be classified as future planning if an SCL service is needed in more than one (1) year; and

1. The individual is currently receiving a service through another funding source that meets the individual's needs;
  2. The individual is not currently receiving a service and does not currently need the service;
- or
3. The individual is in the custody of DCBS.

(4) A written notification of original placement on the SCL waiting list and any change due to a reconsideration shall be mailed to an individual or the individual's guardian and case management provider if identified.

(5) In determining chronological status, the original date of an individual's complete application information being entered into the MWMA shall:

- (a) Be maintained; and
  - (b) Not change if an individual is moved from one (1) category of need to another.
- (6) Maintenance of the SCL waiting list shall occur as established in this subsection.

(a) The department shall, at a minimum, annually update the waiting list information about an individual during the birth month of that individual.

(b) The individual or individual's guardian and case management provider, if identified, shall be contacted in writing to verify the accuracy of the information on the SCL waiting list and the individual's or individual's guardian's continued desire to pursue placement in the SCL program.

(c) If a discrepancy in diagnostic information is noted at the time of the annual update, the department may request a current diagnosis of intellectual or developmental disability signed by a physician or SCL IDP, including documentation supporting the diagnosis.

(d) The information referenced in paragraph (c) of this subsection shall be received by the department within thirty (30) days from the date of the written request in order to be considered timely.

(7) A reassignment of an individual's category of need shall be completed based on updated

information and the validation process.

(8) An individual or individual's guardian may submit a written request for consideration of movement from one (1) category of need to another if there is a change in status of the individual.

(9)(a) The criteria for removal from the SCL waiting list shall be:

1. After a documented attempt, the department is unable to locate the individual or the individual's guardian;

2. The individual is deceased;

3. A review of documentation reveals that the individual does not have an intellectual or a developmental disability diagnosis;

4. A notification of potential SCL funding is made and the individual or the individual's guardian:

a. Declines the potential funding; and

b. Does not request to be maintained on the SCL waiting list; or

5. Notification of potential SCL funding is made and the individual or the individual's guardian does not complete the enrollment process with DBHDID nor notify DBHDID of the need for an extension within sixty (60) days of the potential funding notice date.

(b)1. A notification of need for an extension for good cause shall consist of a statement signed by the individual or the individual's guardian explaining the reason for the delay in accessing services, steps being taken to access services, and expected date to begin utilizing services.

2. Upon receipt of documentation, the department shall grant, in writing, one (1) sixty (60) day extension.

(10) If a notification of potential SCL funding is made and an individual or the individual's guardian declines the potential funding but requests to be maintained on the SCL waiting list, the:

(a) Individual shall be placed in the appropriate category on the SCL waiting list; and

(b) Chronological date shall remain the same.

(11) If an individual is removed from the SCL waiting list, DBHDID shall mail written notification to the:

(a) Individual or the individual's guardian; and

(b) Individual's case management provider.

(12) The removal of an individual from the SCL waiting list shall not prevent the submission of a new application at a later date.

(13) An individual shall be allocated potential funding based upon:

(a) Category of need;

(b) Chronological date of placement on the SCL waiting list; and

(c) Region of origin in accordance with KRS 205.6317(3) and (4).

(14) To be allocated potential funding, an individual residing in an institution shall meet the following criteria in addition to the criteria established in this section:

(a) The individual's treatment professionals shall determine that an SCL placement is appropriate for the individual; and

(b) The SCL placement is not opposed by the individual or the individual's guardian.

Section 13. Use of Electronic Signatures. The creation, transmission, storage, or other use of electronic signatures and documents shall comply with:

(1) The requirements established in KRS 369.101 to 369.120; and

(2) All applicable state and federal statutes and regulations.

Section 14. Employee Policies and Requirements Apply to Subcontractors. Any policy or requirement established in this administrative regulation regarding an employee shall apply to a subcontractor.

Section 15. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid beneficiary based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department decision regarding Medicaid eligibility of an individual based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:560.

(3) An appeal of a department decision regarding a provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

(4) The department shall not grant an appeal regarding a category of need determination made pursuant to Section 12 of this administrative regulation.

Section 16. Participant Rather than Provider Driven. Funding for the SCL waiver program shall be associated with and generated through SCL waiver program participants rather than SCL waiver service providers.

Section 17. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 18. Incorporation by Reference. (1) The following material is incorporated by reference:

- (a) "MAP - 115 Application Intake – Participant Authorization", May 2015;
- (b) "MAP - 116 Service Plan – Participant Authorization", May 2015;
- (c) "MAP - 350 Long Term Care Facilities and Home and Community Based Program Certification Form", June 2015;
- (d) The "Supported Employment Long-Term Support Plan", December 2011;
- (e) "Person Centered Employment Plan", March 2012;
- (f) "MAP - 531 Conflict-Free Case Management Exemption", October 2015; and
- (g) "MAP - 532 PDS Request Form for Immediate Family Member, Guardian, or Legally Responsible Individual as Paid Service Provider", December 2013.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:

(a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at the department's Web site at <http://www.chfs.ky.gov/dms/incorporated.htm>. (39 Ky.R. 690; 1239; 1431; eff. 2-1-2013; TAm eff. 9-10-2014; TAm eff. 11-4-2014; 42 Ky.R. 1031, 1871, 2759; eff. 6-3-2016; TAm eff. 5-3-2017.)