ADMINISTRATIVE INDICATORS & GUIDANCE

Review Year July 2014 through June 2015

The Guidance is provided as a resource to assist agencies with understanding Key Indicators. The Guidance is not intended to be, nor should be, considered as the ultimate defining resource. It should be, as inferred by its title, a GUIDANCE designed to assist. State and Federal standards including policies and procedures are the ultimate resources for establishing the requirements for an Indicator.

A1	Administrative Issues	Guidance
A1-01	For those for whom outlier status has been approved due to the need for enhanced staff support, the Board / Provider provides the additional support as outlined in the approved request	250-11-DD requires that residential service providers must retain staff schedules that document the increased level of supervision is being provided. Using the staffing schedule submitted by the provider and approved by SCDDSN, review the documentation that certifies that the enhanced staff support was provided (100% sample for the last quarter of the year in review) and compare with actual time sheets (showing hours actually worked) to determine if the enhanced staff support was provided. Source: MOA DDSN/HHS, 250-11DD (3/31/09)
A1-02	For those for whom outlier status has been approved due to the need for 1:1 staff support, the Board / Provider provides the additional support as outlined in the approved request	At the end of each shift that 1:1 Supervision was provided the direct care staff assigned to provide the 1:1 supervision must document that the 1:1 supervision was provided. Using the staff schedule submitted by the provider and approved by SCDDSN, review the documentation that certifies that the 1:1 supervision was provided (100% sample for the last quarter of the year in review) and compare with actual time sheets (showing hours actually worked) to determine if the 1:1 staff was provided. Source: MOA DDSN/DHHS, 250-11DD (3/31/09)
A1-03	The Board / Provider has a Human Rights Committee that is composed of a minimum of 5 members and includes representation from a family member of a person receiving services, a person representing those receiving services or a self-advocate nominated by the local self-advocacy group, and a representative of the community with	Review Board / Provider Policy regarding the Human Rights Committee. Review membership of the Board / Provider's Human Rights Committee to ensure that membership consists of the required persons and that none are employees or former employees. Membership should reflect cultural, racial, and disabilities diversity. Exceptions to the minimum and composition must be approved by the Associate State Director, Policy. Note: South Carolina Code Ann. 44-26-70 (Supp. 2007) requires that each DDSN Regional Center and DSN Board establish a Human Rights Committee. Contract service providers may either use the Human Rights Committee of the local DSN Board or establish their own Committee. Contract providers must have formal documentation of this relationship. *Apply the Admin. Indicators regarding Human Rights Committee and Risk Management to all Providers

	expertise or a demonstrated interest in the care and treatment of persons (employees or former employees must not be appointed)	Source: South Carolina Code Ann. 44-26-70 (Supp. 2007) and 535-02-DD Supports CQL Basic Assurances Factor 1, Shared Values Factor 2
A1-04	The Human Rights Committee will provide review of Board / Provider practices to assure that consumer rights are protected	Review Board / Provider HRC policy to assure that its defined role and responsibilities are consistent with those set forth in DDSN policy 535-02-DD. Review Board / Provider HRC meeting minutes (100% sample) to determine if the HRC is fulfilling the role and responsibilities as set forth in its policy. Review Board/ Provider HRC meeting minutes/training records (100% sample) to determine if the HRC members have received training as described in DDSN policy 535-02-DD. Note: Effective 6/30/08 the person must be invited to attend HRC meetings when those meetings concern their care/treatment. *Apply the Admin. Indicators regarding Human Rights Committee and Risk Management to all Providers Source: 535-02-DD Supports CQL Basic Assurances Factor 1, Shared Values Factor 2
A1-05	The Board / Provider employs Case Management Staff who meet the minimum requirements to provide Medicaid Targeted Case Management and DDSN State Funded Case Management.	Determine from personnel records if the minimum requirements for employment were met. Review • All Case Managers hired during the review period, • 25% or 5 experienced Case Managers (hired prior to review period) and • All Case Manager Supervisors. Refer to SCDDSN Case Management Standards for educational and vocational requirements. Source: DDSN Case Management Standards
A1-06	The Board / Provider employs Early Intervention Staff who meet the minimum requirements for the position	Determine from personnel records if the minimum requirements for employment were met or if an exception to the requirement was granted by SCDDSN. This includes minimum education requirements and all reference and background check requirements outlined in DDSN Directive 406-04-DD. Review • All EI's hired during the review period, • 25% or 5 experienced EI's (hired prior to review period) • All EI Supervisors See Early Intervention Standards for educational, vocational and credentialing requirements. Source: EI Manual

A1-07 R	**The Board / Provider employs Waiver Case Management Staff who meet the requirements for the position.**	**Determine from personnel records if the minimum requirements were met. This includes minimum education requirements and all reference and background check requirements outlined in DDSN Directive 406-04-DD.** **Review all WCMs serving waiver participants** **Refer to SCDDSN waiver manuals for educational, vocational and credentialing requirements.**
A1-08	The Board / Provider employs Residential Staff who meet the minimum requirements for the position	Determine from personnel records if the minimum requirements for employment were met or if an exception to the requirement was granted by SCDDSN. This includes minimum education requirements and all reference and background check requirements outlined in DDSN Directive 406-04-DD. Review • 25% of Residential Staff hired during the review period, • 10% or 5 experienced Residential Staff (hired prior to review period) • All Residential Supervisors. Refer to SCDDSN Residential Habilitation Standards for educational and vocational requirements. Source: DDSN Residential Habilitation Standards
A1-09	The Board / Provider employs Day Services Staff who meet the minimum requirements for the position	Determine from personnel records if the minimum requirements for employment were met or if an exception to the requirement was granted by SCDDSN. This includes minimum education requirements and all reference and background check requirements outlined in DDSN Directive 406-04-DD. Review • 25% of Day Services Staff hired during the review period, • 10% or 5 experienced Day Services Staff (hired prior to review period) and all Day Services Supervisors Refer to SCDDSN Day Services Standards for educational and vocational requirements. Source: DDSN Day Service Standards
A1-10	The Board / Provider employs/ contracts Respite/ In-Home Support staff who meet the minimum requirements for the position	Determine from personnel records if the minimum requirements for employment were met or if an exception to the requirement was granted by SCDDSN. This includes minimum education requirements and all reference and background check requirements outlined in DDSN Directive 406-04-DD. Review • 25% of Respite/ Home Support Staff hired/ contracted during the review period, • 10% or 5 experienced Staff/ contractors (hired prior to review period).
A1-11	Case Managers who provide MTCM or SFCM receive training as required.	Review personnel files to determine if training occurred as required. Review • All Case Managers hired during the review period, • 25% or 5 experienced Case Managers (hired prior to review period) and • All Case Manager Supervisors. Refer to Case Management Standards Source: DDSN Case Management Standards , Supports CQL Shared Values Factors 8 & 10

A1-12 R	**Waiver Case Management Staff receive training as required.**	**Review personnel files to determine if training occurred as required.** **Review all WCMs serving waiver participants.** **WCMs are required to receive twenty (20) hours of training annually.** **Training must include the following topic areas:** • **Abuse and Neglect** • **Confidentiality** • **Annual Level of Care for NF and ICF/IID** • **Service Authorizations/ Terminations** • **Waiver Participant Disenrollment**
A1-13	Early Intervention staff receive training as required	Review personnel files to determine if training occurred as required. Refer to Early Intervention Standards and SCDDSN Policy 534-02-DD regarding staff training related to abuse, neglect and exploitation and SCDDSN Policy 567-01-DD regarding HIPPA Training. After the first year of employment, all Early Intervention staff must receive a minimum of 10 hours of training annually on topics related to the provision of services and must include training on Abuse and Neglect and Confidentiality. Review • All EIs hired during the review period, • 25% or 5 experienced EI's (hired prior to review period) • All EI Supervisors To ensure that they received initial and ongoing training as documented in their personnel file or records Source: Early Intervention Standards and SCDDSN Policy 534-02-DD DDSN
A1-14	Residential staff receive training as required	Review personnel files to determine if training occurred as required. Refer to Residential Habilitation Standards and SCDDSN Policy 534-02-DD regarding staff training related to abuse, neglect and exploitation and SCDDSN Policy 567-01-DD regarding HIPPA Training. After the first year of employment, all Residential staff must receive a minimum of 10 hours of training annually on topics related to the provision of services and must include training on Abuse and Neglect Confidentiality and consumer funds (DDSN Directive 200-12-DD). Review • 25% or 7 experienced residential staff (hired at least one year prior to review period) • All Residential Supervisors (hired at least one year prior to review period). To ensure that they received initial and ongoing training as documented in their personnel file or records Source: Residential Habilitation Standards and SCDDSN Policy 534-02-DD and 567-01-DD.

A1-15	Day Services staff receive training as required	Review personnel files to determine if training occurred as required. Refer to Day Services Standards and SCDDSN Policy 534-02-DD regarding staff training related to abuse, neglect and exploitation and SCDDSN Policy 567-01-DD regarding HIPPA Training. After the first year of employment, all Day Services staff must receive a minimum of 10 hours of training annually on topics related to the provision of services and must include training on Abuse and Neglect and Confidentiality. Review • 25% or 7 experienced day services staff (hired at least one year prior to review period) and • All day services supervisors (hired at least one year prior to review period). To ensure that they received initial and ongoing training as documented in their personnel file or records Source: Day Services Standards and SCDDSN Policy 534-02-DD,567-01-DD
A1-16	Respite/ Home Supports staff/ contractors receive training as required	Review personnel files to determine if training occurred as required. Refer to SCDDSN Policy 534-02-DD regarding staff training related to abuse, neglect and exploitation and SCDDSN Policy 567-01-DD regarding HIPPA Training. After the first year, there must be documentation of training, as required, related to the provision of services. There must be annual training on Abuse and Neglect and Confidentiality. In addition, First Aid training must take place every other year through a certified program. Review • 10% or 5 respite/ home supports staff/ contractors hired during the review period, • 10% or 5 experienced (hired prior to review period) To ensure that they received initial and ongoing training as documented in their personnel file or records Source: SCDDSN Policy 534-02-DD and SCDDSN Policy 567-01-DD
A1-17	Board / Provider implements a risk management and quality assurance program consistent with 100-26-DD and 100-28-DD	Board / Provider demonstrates implementation of risk management/quality assurance principles by: • designated risk manager and a risk management committee; • written policies/procedures used to collect, analyze and act on risk data; • documentation of remediation taken; • correlating risk management activities with quality assurance activities; • developing contingency plans to continue services in the event of an emergency or the inability of a service provider to deliver services. • For residential and day service providers: Review of medication errors and remediation (if not conducted through a separate committee for this purpose – documentation must be available). • For residential and day service providers: Review of any Restraints or restrictive procedures used to ensure compliance

		with applicable directives. *Apply the Admin. Indicators regarding Human Rights Committee and Risk Management to all Providers Source: 100-26-DD and 100-28-DD Supports CQL Basic Assurances Factors 6 & 10
A1-18	Board / Provider demonstrates usage of the current incident management profile data report to: • evaluate provider specific trends over time • evaluate/explain why the provider specific rate is over, under or at the statewide average • demonstrate systemic actions to prevent future incidents/ allegations	Provider must utilize provider profile data available within the prior 12 month period. In the event the provider has not had any reports of incidents, they must document the review of trend data and discuss continued actions to prevent incidents and respond where appropriate.
A1-19	Board / Provider follows SCDDSN procedures regarding preventing, reporting and responding to abuse / neglect / exploitation as outlined in 534-02-DD	• Submits timely initial reports for all ANE Allegations through the DDSN Incident Management System according to DDSN Directive 534-02-DD • Submits timely final reports for all ANE Allegations through the DDSN Incident Management System according to DDSN Directive 534-02-DD. Source: 534-02-DD Supports CQL Basic Assurances Factors 4, 6, & 10
A1-20	Board / Provider follows SCDDSN procedures regarding preventing, reporting and responding to critical incidents as outlined in 100-09-DD	• Submits timely initial reports for all Critical Incidents through the DDSN Incident Management System according to DDSN Directive 100-09-DD. • Submits timely final reports for all Critical Incidents through the DDSN Incident Management System according to DDSN Directive 100-09-DD. Source: 100-09-DD Supports CQL Basic Assurances Factors 4, 5, 6, & 10
A1-21	Board / Provider follows SCDDSN procedures regarding death or impending death as outlined in 505-02-DD	For DDSN Residential Providers: • Submits timely initial reports for all Deaths through the DDSN Incident Management System according to DDSN Directive 505-02-DD. • Submits timely final reports for all Deaths through the DDSN Incident Management System according to DDSN Directive 505-

		02-DD. Source: 505-02-DD Supports CQL Basic Assurances Factor 10 and Shared Values Factor 10
A1-22	The Board / Provider follows SCDDSN procedures regarding Medication Error/ Event Reporting, as outlined in 100-29-DD	For DDSN Residential and Day Services Providers: Determine if the Board / Provider has developed an internal database to record, track, analyze, and trend medication errors or events associated with the administration of medication errors. The method for calculating medication error rate has been defined in DDSN Directive 100-29-DD. Proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including medication technician certification), changes in procedure, securing additional technical assistance from a consulting pharmacist or other medical professional, and improving levels of supervision. If medication errors have been recorded, but not analyzed, the standard has not been met. Source: 100-29-DD Supports CQL Basic Assurances Factor 5
A1-23	Upper level management staff of the Board/Provider conduct quarterly unannounced visits to all residential settings to assure sufficient staffing and supervision are provided. SLP II should include visits to all apartments	When a residential setting does not utilize a shift model for staffing (e.g. CTH I and SLPI) visits need only to be conducted quarterly. Managers should not visit homes they supervise, but should visit homes managed by their peers. Senior management may visit any/all of the homes. Documentation of the visit must include the date and time of the visit, the names of the staff/caregivers and consumers present, notation of any concerns and actions taken in response to noted concerns. Please note: It is not necessary to visit individual SLP II apartments during 3rd shift, although 3rd shift checks to the complex/staff review are still required. *Quarterly = 4 times per year with no more than 4 months between visits. Source: Contract…Capitated Model Article III Supports CQL Basic Assurances Factor 10
A1-24	Board / Provider keep service recipients' records secure and information confidential	Determine if records are maintained in secure locations. Look for evidence that confidential information is kept confidential. Consider the following: • Are any records in public areas or in areas that are not secure including lying on desks in empty offices, etc.? • Is personal information in conspicuous locations or posted in common areas? • Is information about one person found in another person's file? (Cite only if two or more occurrences) • Are records/information provided or released without consent including by the phone?

		• Are computers and fax machines in easily accessible public areas with incoming/outgoing information left on/around the machine? • Are staff heard discussing information about clients in restrooms, hallways, etc. in a manner that clearly identifies the person about whom they are speaking? Source: 167-06-DD
A1-25	Provider agency of HASCI Division Rehabilitation Supports (RS) maintains required administrative records for the RS Program	Review agency administrative records to confirm presence of the following: • Documentation of qualifications of RS Staff, including RS Coordinator, RS Specialist and Clinical Professional providing tiered clinical supervision of the RS Program if the RS Coordinator is not a "Licensed or Master's level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)* • Documentation of Pre-Service Training of RS Specialists to include date, amount of time, those in attendance, name of trainer(s), and topic(s) covered. • Documentation of In-service Training of RS Specialists to include date, amount of time, those in attendance, name of trainer(s), and topic(s) covered • Documentation of at least monthly Staff Meetings (individual or group) conducted by the RS Coordinator with RS Specialist(s) to include date, those in attendance, person(s) discussed, forms reviewed and signed, other issues addressed, and any recommendations made by the RS Coordinator • If the RS Coordinator is not a "Licensed or Master's Level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)*, documentation of at least monthly meetings of RS Coordinator with a qualified Clinical Professional to include date, persons/staff discussed, forms reviewed and co-signed, other issues addressed, and any recommendations made by the Clinical Professional • Documentation of any individual case consultations provided by the RS Coordinator or Clinical Professional if not in a person's RS Record, to include name of consumer, date, those in attendance, issues addressed, and any recommendations made • Waiting list for Rehabilitation Supports to include name of consumers and date added to/removed from waiting list Source: Rehabilitation Supports Manual
A1-26	Board / Provider conducts all residential admissions / discharges in accordance with 502-01-DD	Review all "Community Residential Admissions/Discharge Reports" submitted to DDSN. Review relevant supporting documentation to assure all of the admissions / discharge criteria stipulated in 502-01-DD were met. Compare "Community Residential Admissions / Discharge Reports" against relevant CDSS/STS data to assure actual admissions / discharges and transfers do not occur prior to DDSN approval (District Office and Central Office) and all systems (SPM and CDSS) are updated timely. Also, verify that the home is properly licensed for the number of people intended to live there, including the new admission, on the admission date. Source: 502-01-DD

A1-27	Annually, employees are made aware of the False Claims Recovery Act, that the Federal government can impose a penalty for false claims, that abuse of the Medicaid Program can be reported and that reporters are covered by Whistleblowers' laws	Review the annual statement that all employees sign concerning fraud, abuse, neglect, and exploitation of consumers to determine if it also contains a statement that (1) the employee is aware of the False Claims Act and that the Federal Government can impose a penalty on any person who submits a false claim to the federal government that he/she knows or should know is false; (2) they are aware that they can report abuse of the Medicaid program; and, (3) they are protected by "Whistleblower Laws." Source: Contract for … Capitated Model and Source: Contract for … Non-Capitated Model
A1-28	Case Management providers must have a system that allows access to assistance 24 hours daily, 7 days a week	Test the system by making calls before/after normal business hours. Source: SCDDSN Case Management Standards
A1-29	The Residential Habilitation provider must have procedures that specify the actions to be taken to assure that <u>within 24 hours</u> following a visit to a physician, Certified Nurse Practitioner (CNP), or Physician's Assistant (PA all ordered treatments will be provided	Verify that a system is in place that specifies actions to be taken to assure that within 24 hours following a visit to a physician, CNP, or PA, all ordered treatments will be provided. Source: Residential Habilitation Standard RH 5.0 Supports CQL Basic Assurances - A3.

A2	Fiscal Issues	Guidance
A2-01	The Governing Board approves the annual budget and Comprehensive Financial Reports are presented at least quarterly to the Governing Board with a comparison to the approved budget	Review Governing Board Minutes for evidence that the Board approves the annual budget and reviews Financial Reports at least on a quarterly basis. Source: Contract for …Capitated Model and Contract for Non-Capitated Model Supports CQL Basic Assurances Factor 10
A2-02	Annual Audit Report is presented to Governing Board once a year and includes the written management letter *Board Providers Only	Review Governing Board minutes to determine if the final annual audit report and any management letter comments are presented by the external auditor or CPA to the Governing Board. Source: 275-04-DD Supports CQL Basic Assurances Factor 10
A2-03	The person's financial responsibility is made known to them by the Board / Provider *All Residential Providers	Determine that a Statement of Financial Rights exists and was completed when the consumer was admitted to the residential program. This form should be signed by the consumer or his/her parent, guardian, or responsible party.

GENERAL AGENCY INDICATORS & GUIDANCE
Review Year July 2014 through June 2015

The Guidance is provided as a resource to assist agencies with understanding Key Indicators. The Guidance is not intended to be, nor should be, considered as the ultimate defining resource. It should be, as inferred by its title, a GUIDANCE designed to assist. State and Federal standards including policies and procedures are the ultimate resources for establishing the requirements for an Indicator.

G1	Service Coordination Non-Waiver	Guidance
G1-01 R	**The Plan is developed by the Service Coordinator within 365 days**	**Not Applicable Effective 4/30/2014** **Review current Plan. A current Plan must be present. A current Plan is defined as one completed within the last 365 days. When there is a leap year, the plan date would be calculated accordingly to ensure the plan is developed and signed within 365 days.** **Except for those transferring from an ICF/ID, Plans must be entered into the Consumer Data and Support System (CDSS) using the Consumer Assessment and Planning (CAP) module unless otherwise approved by the SCDDSN Director of Service Coordination. The Plan implementation date is the date a plan is completed in the CAP module of CDSS.** **For those receiving Level 1 Service Coordination, a plan must be completed on CDSS:** • **By the 45th calendar day following the determination of eligibility for SCDDSN services** • **Within 365 days of the last plan** • **By the 45th day of being transferred from Level II Service Coordination** • **By the 45th day of being transferred from Early Intervention** • **Before Waiver Services are authorized/provided.** **Source: Support Plan Instructions and the Case Management Standards.**
G1-02	Needs in the Plan are justified by formal or informal assessment information in the record	**Not Applicable Effective 4/30/2014** Review the Service Coordination record to determine if formal or informal assessment information is available to justify the “need” noted on the Plan for which interventions are being implemented. The assessment information (formal or informal) must be current and accurate. Formal and/or informal assessments may include information provided by the person and/or his/her caregivers about the person’s current situation, medical status, school records or other formalized assessment tools.

		At the time of annual planning, the *SCDDSN Service Coordination Annual Assessment* will be used to identify needs and justify services/interventions reflected in the Support Plan. The *SCDDSN Service Coordination Annual Assessment* (SCAA) must be completed on the CAP module of CDSS unless otherwise approved by SCDDSN. Information from providers currently providing services should be considered in planning. The record should reflect attempts to secure information from all current service providers. Attempts should be made in sufficient time prior to planning so that information can be secured. If the person is enrolled in the Waiver, then formal or informal assessments and recommendations for all Waiver services will be present. Needs assessment during the course of the year *outside* of annual planning will be documented in the service notes. Source: "Guidelines on How to Complete the SCDDSN Annual Service Coordination Assessment", Support Plan Instructions, Case Management Standards, Waiver Manuals pertaining to needs assessment.
G1-03	Services/ Interventions are appropriate to meet assessed needs	**Not Applicable Effective 4/30/2014** Interventions are identified to address assessed "needs". Interventions must have a logical connection to the need. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"*. Also, reference Case Management Standards and Waiver Manuals.
G1-04	The Plan identifies appropriate funding sources for services/interventions	**Not Applicable Effective 4/30/2014** Appropriate funding sources are identified for every service/intervention. Review the person's "current resources" identified in the SCDDSN Service Coordination Annual Assessment (or the service notes when needs assessment occurs outside of planning and resources have changed from those noted on the Plan) to determine what resources the person has. Compare the person's resources to the services/interventions noted on the Plan to determine if the appropriate funding source is listed for the service/intervention to be/being provided. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment".* Also, reference Case Management Standards and Waiver Manuals.
G1-05	The Plan is amended / updated as needed	**Not Applicable Effective 4/30/2014** Review all plans and service notes in effect during the review period to determine if:

		a. updates are made when new service needs or interventions are identified, b. there have been significant changes in the person's life, c. a service is determined to not be effective, d. a need/s has/have been met, e. the person is not satisfied. When any part of the "Needs/Interventions" section (Section D) of the plan is no longer current, an amendment/update must be completed using the CAP module of CDSS. It is acceptable to have a brief service note provided the change/update is explained in detail on the "needs change" form printed from the CAP module of CDSS for the file. For new needs identified during the course of the year, needs assessment and identification of the need will be in the service notes and, if applicable, a new "needs/interventions" page will be added to the plan using the CAP module of CDSS. Plan must be current at all times. Source: Support Plan Instructions, Case Management Standards and Waiver Manuals. Supports CQL Shared Values Factor 8
G1-06	The Plan is reviewed at least every 6 months	**Not Applicable Effective 4/30/2014** 1. Review the Plan to determine if all needs and interventions were reviewed as often as needed, but at least every 6 months. 2. Ensure that needs and interventions were implemented as prescribed in the Plan. Six Month reviews are completed on the CAP module of CDSS. Monitoring/review forms on CAP include all of the necessary components of monitoring Refer to Case Management Standards and Support Plan Instructions

G1-100	Case Management Non-Waiver	Guidance Effective May 1, 2014
G1-101	The person's file contains either an Authorization Letter from SCDHHS for MTCM or approval from DDSN for State Funded Case Management dated on or prior to the first reported case management activity.	This indicator is applicable for services starting on or after May 1, 2014. For services starting prior to May 1, 2014 – Form 259 (transition form) must be present in the person's file. *A valid precertification date range on CDSS is acceptable documentation for approval of SFCM.
G1-102	The person's file contains documentation that establishes the person in a target group, if receiving MTCM.	MTCM target groups/ populations include: • Individuals with Intellectual and Related Disabilities • Individuals with Head and Spinal Cord injuries and Related Disabilities and • Includes those suspected of being in these groups.
G1-103	The person's file contains an appropriately signed Freedom of Choice for MTCM form, if receiving MTCM.	Prior to May 1, 2014, the Freedom of Choice for MTCM form may indicate "DDSN" as the chosen provider. For forms signed after May 1, 2014, the Case Management provider agency's name should be noted as the chosen provider.
G1-104	An assessment of the person's needs is completed.	• Assessment must be completed within 45 days of the date on the DHHS Authorization letter for MTCM or approval from DDSN for SFCM. • Assessment must be re-completed annually. • All required assessment areas are completed.
G1-105	A face to face contact with the person in his/her residence is made at the time of initial/ annual assessment.	• Contact should be in the person's residence • A face-to-face contact in the person's natural environment is permissible in lieu of the residence if: - the person is homeless - the person or homeowner refuses to allow access to the residence - in the case manager may be in danger due to documented criminal activity or violence in the residence or due to the isolation of the residence
G1-106	A plan addressing the person's assessed needs is completed.	• The plan must be completed within 45 days of the date on the DHHS Authorization Letter for MTCM or approval from DDSN for SFCM. • The plan must be re-completed annually.

G1-107	The plan contains all required components.	• A statement of need. • The case management action(s) to address the need. • The name of or type of provider to which the person will be referred if being referred and linked. • A projected completion date.
G1-108	The plan is signed, titled and dated by the Case Manager.	
G1-109	The plan is signed by the person or his/her representative.	If the person/ representative is unavailable to sign at the time of planning, documentation must explain their non-availability and the plan must be signed at the next face to face contact.
G1-110	The person must be provided a copy of the plan.	Documentation that a copy was provided to the person or his/her representative must be documented.
G1-111	Annually, people are provided information about abuse, neglect and exploitation and information about critical incidents	If receiving active case management, information should define abuse, neglect, exploitation and critical incidents and explain how to report.
G1-112	Contact (face-to-face, email or telephone) is made with the person, his/her family or representative or a provider who provides a service to the person at least every 60 days.	• If the person's needs dictate, contact should be made frequently than every 60 days. • The contact should determine if: services are being furnished as planned; planned services are adequate to address the identified need; the person's status has changed.
G1-113	The Case Management Assessment and Plan must be reviewed at least 180 days from the Date of the Plan.	• Review should include a review of the accuracy of assessment information and determination if the actions on the plan should continue, be revised or be discontinued. • Review should occur 180 days from the date of the plan was completed.
G1-114	The 180 Day Plan Review must be completed in consultation with the person/his/her representative. Consultation must include a face-to-face visit in the person's natural environment.	The 180 day plan review and update must be completed in consultation with the person. A face-to-face contact/ visit can occur in the person's natural environment (does not need to occur in the person's residence).

G1-115	Service notes must document all Case Management activity on behalf of the person and justify the need for Case Management	
G1-116	Services notes are appropriately documented.	Service notes include each entry: • Type of activity and type of contact • Place of contact and activity • Person with whom the contact occurred and relationship to the beneficiary • Purpose of the contact and activity • Description of the MTCM intervention delivered • Outcome(s) of the contact activity, and the next step(s) for that activity note-follow-up needed (if applicable) • Each case management activity performed and the case management component being provided • Be authorized, signed, titled and signature dated by the qualified staff person(s) who rendered the case management activity • Be filed or entered in the beneficiary's record within seven days of delivery of activity.

G2	Service Coordination Non-Waiver	Guidance
G2-01 W	Contact occurs as required: a) Face-to-face contacts occur every 6 months b) Every other month (bi-monthly), at least one contact (as defined by SC Standards) is made	**Not Applicable Effective 4/30/2014** Beginning 7/1/11, review to determine that: a) Face-to-face visits occur every 6 months and are with the person receiving services. b) At least one contact is made every other month (bi-monthly). A contact is defined as any of the following: • A face-to-face encounter for the purpose of performing a core function. • A telephone call, letter or email when a face-to-face contact is not required or is not possible for the purpose of performing a core function Source: Case Management Standards
G2-02 W	If determined eligible for DDSN services after 9/2001, an eligibility correspondence from the CAT is on file	**Not Applicable Effective 4/30/2014** Review the Service Coordination record for SCDDSN Eligibility Determination Correspondence (correspondence from the Consumer Assessment Team) regarding the person's eligibility. If prior to 9/01, information may not be available from the Consumer Assessment Team; therefore, absence of eligibility information prior to 9/01 should not be held against the provider. Source: Case Management Standards
G2-03	A valid Service Agreement is present and signed as appropriate	A valid Service Agreement (review most recently completed Service Agreement to assure that it is dated and signed.) For children and for adult's adjudicated incompetent, the current legal guardian (if applicable) must sign the form. For those 18 years and older or those with a name change, a new Service Agreement should be signed by the person. The most current Service Agreement that is signed and dated by the appropriate party must be filed in the primary case record. Score "Not Met" if there is not a Service Agreement in the primary case record and/or it is not signed and dated by the appropriate party. If a person is unable to sign but can make their "mark", the mark must be witnessed. If a person is unable to sign or make their mark on the Service Agreement, there will be an explanation on the form and supporting documentation in the file.
G2-04	Upon notification of an identified health care need, the Service Coordinator has	**Not Applicable Effective 4/30/2014** As needs are identified for health care, the person's options for health care and choice of health care providers were discussed to make sure

	provided information for, offered choice of and monitored a person's access to health care services/providers (inclusive of primary health care provider / physician) when health care needs are identified	the person has accessed health care to address needs. The record clearly reflects the person/legal guardian's (if legal guardian is applicable)decision not to have a primary physician, or if the record reflects the person has a primary physician and is satisfied with his/her physician, the record does not have to show that the Service Coordinator provided information for and offered choice of primary healthcare services/providers. All persons must have a choice of physician/specialist for healthcare needs even if the Board / Provider contracts with a physician unless there are no other physicians in the area. Medical records/reports can serve as a form of assessment provided the Service Coordinator has addressed all recommendations from those reports and by providing information (understanding of options of care and choice of providers) and monitoring access of healthcare services as a result of the recommendations. NOTE: Where there is no reasonable choice available due to the presence of only one qualifying physician within a reasonable distance, this item should be scored "Met" reflecting compliance provided that this is documented in the record. Source: Case Management Standards Supports CQL Basic Assurances Factors 5 & 9, Shared Values Factor 3
G2-05	The person/legal guardian (if applicable) will receive information on abuse and neglect annually	Check the record for documentation that information was provided to person/legal guardian. This may be found in service notes or as a form letter in the record. Information must define what abuse and neglect is and how to report. Source: Case Management Standards; CQL Basic Assurances 1, 2, 4,10

G3	Day Services *With the exception of Employment–Individual (See G4 Indicators)	A"DDSN Day Service" includes Career Preparation, Employment Services through a Mobile Work Crew or Enclave, Community Service, Day Activity, or Support Center. *Employment Services through Individual Community Employment is not included. Indicator Guidance with Observation Guidelines
G3-01	After acceptance into service but prior to the first day of attendance in a DDSN Day Service, a preliminary plan must be developed that outlines the care and supervision to be provided	Plan must include essential information to ensure appropriate services and supports are in place to assure health, safety, supervision and rights protection. Applies only to those waiver participants admitted to the Day Service within 1 year prior to review. Source: Day Services Standards
G3-02	On the first day of attendance in a DDSN Day Service, the preliminary plan must be implemented **OBSERVATION:** The interventions in the plan are implemented	Preliminary plan is to be implemented on the day of admission. When assessments are completed and training needs/priorities have been identified, the plan will be completed and will replace the preliminary plan. Applies only to those waiver participants admitted to the Day Service within 1 year prior to review. Source: Day Services Standards
G3-03	Within thirty (30) calendar days of the first day of attendance in a DDSN Day Service and annually thereafter, an assessment will be completed	At a minimum, assessments must be completed every 12 months. Source: Day Services Standards
G3-04	The assessment identifies the: (1) abilities / strengths, (2) interests / preferences and (3) needs of the consumer	The assessment identifies the (1) abilities / strengths, (2) interests / preferences and (3) needs of the consumer in the following areas: **Career Preparation** • Self-Advocacy/Self Determination • Self-Esteem • Coping Skills • Personal Responsibility • Personal Health and Hygiene • Socialization • Community Participation • Mobility and Transportation • Community Safety • Money Management • Pre-Employment • Job Search

		Employment (Mobile Work Crew/Enclave) • Self-Advocacy/Self Determination • Self-Esteem • Coping Skills • Personal Responsibility • Personal Health and Hygiene • Socialization • Community Participation • Mobility and Transportation • Community Safety • Money Management • Pre-Employment • Job Search **Community Service** • Self-Advocacy/Self Determination • Self-Esteem • Coping Skills • Personal Responsibility • Personal Health and Hygiene • Socialization • Community Participation • Mobility and Transportation • Community Safety • Money Management **Day Activity** • Self-Advocacy/Self Determination • Self-Esteem • Coping Skills • Personal Responsibility • Personal Health and Hygiene • Socialization • Community Participation • Mobility and Transportation • Community Safety • Money Management **Support Center** • non-medical care, • the supervision, • assistance and • interests / preferences of the consumer. Source: Day Services Standards
G3-05	Based on the results of the assessment, within thirty (30) calendar days of the first day of attendance and annually thereafter, a plan is developed with input from the consumer and/or his/her legal guardian	• At a minimum, the plan must be completed every 12 months. • Input from the consumer can be documented in any manner (e.g. sign-in sheet for a planning meeting, signature on plan, etc.) Source: Day Services Standards

G3-06	The plan must include: a) A description of the interventions to be provided including time limited and measurable goals/objectives when the consumer participates in **Day Activity**, **Employment Services**, **Community Services**, and/or **Career Preparation** b) or, a description of the care and assistance to be provided when the consumer participates in **Support Center**	• If more than one service has been authorized, the plan must include a Section II page for each service authorized. • If 2 units per day are received, the plan must include interventions and goals/objectives for both the 1st and the 2nd unit. • Medications taken by the consumer during day services must be listed and any assistance in medicating must be documented (self-medicate or assisted medication). All relevant medication information known to the Day Program must be documented. All specific instructions concerning individual reactions, side effects or restrictions to medicine must be documented Source: Day Services Standards
G3-07	The plan must include a description of the type and frequency of supervision to be provide	• In accordance with Department Directive 510-01-DD, services provided shall include the provision of any interventions and supervision needed by the consumer, which includes dining/eating. • The interventions to be provided must be based on assessed needs. • Supervision must encompass any time outside of the actual unit time when the consumer is present and supervision is needed. Source: Day Services Standards
G3-08	For **Support Center**, the plan must include a description of the kinds of activities in which the consumer is interested or prefers to participate	Goals and objectives are not required for **Support Center**. Note: This Indicator is N/A for all other Day Services. Source: Day Services Standards
G3-09	The interventions in the plan must support the provision of the DDSN Day Service(s) as defined in the standards	The interventions in the plan must support the provision of the DDSN Day Service(s) as defined in the standards: **Career Preparation** is aimed at preparing persons for careers through exposure to and experience with various careers and through teaching such concepts as compliance, attendance, task completion, problem solving, safety, self- determination, and self-advocacy. Services are not job-task oriented, but instead, aimed

		at a generalized result. Services are reflected in the person's service plan and are directed to habilitative rather than explicit employment objectives. Services will be provided in facilities licensed by the state. DDSN Day activities that originate from a facility licensed by the state will be provided and billed as DDSN Day. On site attendance at the licensed facility is not required to receive services that originate from the facility. **Employment Services** consist of intensive, on-going supports that enable persons for whom competitive employment at or above minimum wage is unlikely absent the provision of supports and who, because of their disabilities, need supports to perform in a regular work setting. Employment Services may include services to assist the person to locate a job or develop a job on behalf of the person. Employment services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed and include activities such as supervision and training needed to sustain paid work. Employment Services may be provided in group settings, such as mobile work crews or enclaves, or in community-based individual job placements. **Community Service** is aimed at developing one's awareness of, interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital. Services will be provided in facilities licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Community Service. On site attendance at the licensed facility is not required to receive services that originate from the facility. **Day Activity Services** are supports and services provided in therapeutic settings to enable persons to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills. Services are provided in non-residential settings that are licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Day Activity Service. On site attendance at the licensed facility is not required to receive services that originate from the facility. **Support Center Service** includes non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the person's home to people who because of their disability are unable to care for and supervise themselves. Services provided are necessary to prevent institutionalization and maintain the persons' health and safety. The care,

		supervision and assistance will be provided in accordance with a plan of care. An array of non-habilitative activities and opportunities for socialization will be offered throughout the day but not as therapeutic goals. **All Services**: Transportation will be provided from the person's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the person's habilitation site to their residence when the service start time is after 12:00 Noon. Source: Day Services Standards

G3-10	As soon as the plan is developed, it must be implemented
	
	OBSERVATION
		• The interventions in the plan are implemented as specified in the plan. This includes:
		  ○ The type and frequency of supervision
		  ○ Specific training.
		
		Source: Day Services Standards

G3-11	Data must be collected as specified in the plan and must be sufficient to support the implementation of the plan for each unit of service reported	For each unit of service provided: • Documentation must be present to show the service was provided on the day the service was reported. • Additionally, for training objectives, the data documenting the response to and/or outcome of training must be sufficient to measure the progress. Source: Day Services Standards
G3-12	At least monthly, the plan is monitored by the Program Director or his/her designee to determine its effectiveness	• The Program Director's or designee's signature on the Monthly Data Recording Sheet signifies that the training intervention(s) in the plan have been monitored. • An evaluation of progress for each training intervention must be noted. • If no progress is made over the previous month's percentage, a comment is required on the Monthly Data Recording Sheet detailing the changes to the intervention or methods, or an explanation for the lack of progress and justification for continuing with the intervention and methods unchanged Source: Day Services Standards
G3-13	The plan is amended when significant changes to the plan are necessary	Significant changes may include, but are not limited to: • Interventions are not appropriate, • Interventions are not supporting progress, and/or • The person's life situation has changed. **This indicator should be cited when an amendment was warranted but was not made due to an inaccurate determination of progress resulting from miscalculation(s) on the Monthly Data Recording Sheet.** **<u>NOTE:</u> Amendments must be made using a separate form identified as a plan amendment, indicating the date of the amendment, the name and date of birth, the reason for the amendment, and description of how the plan is being amended.** Source: Day Services Standards

G4	Employment- Individual Placement	Guidance
G4-01	A comprehensive vocational service assessment that is appropriate for the authorized service is completed within 30 calendar days of admission/enrollment in the service	• A comprehensive service assessment will be appropriate for the authorized service. • The service assessment will be completed within 30 calendar days of acceptance into the service. • Annual assessment is not required. **<u>NOTE</u>: Review for those enrolled or re-enrolled during the review period** Source: Employment Services Standards
G4-02	An individual plan of employment is developed within 30 calendar days of admission/enrollment	• If using a plan of employment other than The Individual Plan of Supported Employment (IPSE) the plan must contain all the information that is recorded on an IPSE • The record must reflect that the consumer made decisions regarding his/her services as evidenced by required signatures in the individual plan of employment as in Section 4, Terms and Conditions of the IPSE. • The individual plan of employment is not an annual plan. **<u>NOTE</u>: Review for those enrolled and re-enrolled during the review period** Source: Employment Services Standards
G4-03	The record will contain notations that show evidence of monitoring and evaluation of progress	• Documentation, monitoring and evaluating of activities is current and updated. • Documentation includes the date of the activity, the number of hours for each activity and a detailed description of the activity. Source: Employment Services Standards
G4-04	Individualized, on-the-job instruction and needed and wanted supports are being provided in a nonintrusive method	• A record of an employment training plan including interventions (training objectives) and evaluations is documented to support individualized instruction on the job • N/A for consumers who were not employed during the review period. Source: Employment Services Standards
G4-05	Long-term support plans are identified in the individual plan of employment and contact with the consumer is maintained monthly for a minimum of 6 months	• Identify needs, preferences, options and long term support plans. The employment specialist must maintain contact monthly for at least 6 months to determine the long term plan is sufficient and ensure job retention and stability. • N/A for participants who were not employed during the review period Source: Employment Services Standards
G4-06	An exit interview is conducted when a consumer no longer needs the service of the Employment Specialist	• At a determined point when the consumer becomes stabilized in his/her employment position and long term support needs have been identified or the consumer is terminated voluntarily or involuntarily from services, an exit interview must be conducted prior to termination of Employment Services/Individual Placement. Source: Employment Services Standards

	HASCI Division Rehabilitation Supports	Guidance
G5-01	RS Record contains a valid Medical Necessity Statement (MNS)	Review participant's RS record to confirm presence of a Medical Necessity Statement *(RS Form 2)* signed prior to initiation of RS during review period. For ongoing participants, there must be a MNS signed no more than 365 calendar days after previous MNS was signed. When RS were not received for 45 consecutive days, there must be a new MNS signed prior to reinstatement of RS. In all instances, the MNS must be signed by a "Licensed Practitioner of the Healing Arts" (LPHA) as defined by SCDHHS (RS Manual - Appendix A). Source: Rehabilitation Supports Manual
G5-02	RS Record documents a comprehensive assessment of needs and strengths to guide development or update of an IPOC	Review participant's RS Record to confirm presence of a Rehabilitation Supports Assessment *(RS Form 3)* completed no later than 20 business days after date the RS slot was awarded, and prior to development of initial Individual Plan of Care (IPOC) and initiation of RS during review period. For ongoing participants, there must be an RS Assessment update completed within 365 calendar days of previous one. Source: Rehabilitation Supports Manual
G5-03	RS Record contains a valid Individual Plan of Care (IPOC)	Review participant's RS Record to confirm presence of a Rehabilitation Supports Individual Plan of Care *(RS Form 4)* completed no later than 20 business days after the RS slot was awarded, within 45 calendar days of date MNS was signed, and prior to initiation of RS during review period. For ongoing participants, there must be an update of the IPOC completed within at least 365 calendar days of date of previous IPOC. If RS were not received for 45 consecutive days, the IPOC must be updated within 45 calendar days of the date a new MNS was signed. The IPOC and each subsequent amendment (*RS Form 5* attached to initial or updated *RS Form 4*) must be signed by the participant, parent or guardian if necessary, and RS Coordinator. If the RS Coordinator is not a "Licensed or Master's Level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)* the forms must be co-signed by a Clinical Professional. Source: Rehabilitation Supports Manual
G5-04	RS Record contains 90 Day Progress Reviews of the IPOC	Review participant's RS Record to confirm presence of a 90 Day Progress Review of the IPOC conducted within 90 calendar days from the signature date of the initial IPOC or annual update (regardless of amendments) and at least every 90 calendar days thereafter (regardless of amendments). Latest dates for completing 90 Day progress Reviews must be documented as part of the IPOC *(RS Form 4, Page 2)*; including date, progress of participant, effectiveness of methods/frequency, participant's continued need for RS, and comments/recommendations. Each 90 Day Progress Review must be signed by the RS Coordinator. If the RS Coordinator is not a "Licensed of Master's Level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)*, it must

		be co-signed by a Clinical Professional. Source: Rehabilitation Supports Manual
G5-05	RS Record contains a Rehabilitation Supports Summary Note for each day that RS were received	Review participant's RS Record to confirm presence of a Rehabilitation Supports Summary Note *(RS Form 7)* for each day of service documenting date and location, beginning and ending time of face-to-face contact, goal(s) and objective(s) addressed, method(s) of intervention, consumer's response and general progress, and future plan for IPOC implementation. *RS Form 7* must be signed by the RS Specialist and RS Coordinator. Signature by the participant or representative is optional. Source: Rehabilitation Supports Manual
G5-06	RS Record contains a Rehabilitation Supports Monthly Progress Summary for each month RS were received	Review participant's RS Record to confirm presence of a Rehabilitation Supports Monthly Progress Summary *(RS Form 8)* for each month of service documenting Units of Service provided, progress/status of participant, efforts of RS Specialist(s) to implement the participant's IPOC, date of staff meeting, problems/issues, recommendations of the RS Coordinator, and future action. *RS Form 8* must be signed by the RS Coordinator and RS Specialist(s). If the RS Coordinator is not a "Licensed or Master's Level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)*, it must be co-signed by a Clinical Professional. Source: Rehabilitation Supports Manual
G5-07	RS service provision billed to SCDDSN is substantiated in the RS Record	Review copies of Rehabilitation Supports Report of Service *(RS Form 6)* and Summary Invoice for Rehabilitation Supports Provided *(RS Form 6 Summary)* and verify these are consistent with documentation in the participant's RS Record *(RS Form7 and RS Form 8)* for the corresponding month and days of service. Source: Rehabilitation Supports Manual

G6	Residential Services	Guidance
G6-01	The Residential Support Plan must include: a) The type and frequency of care to be provided b) The type and frequency of supervision to be provided c) The functional skills training to be provided d) Any other supports/ interventions to be provided e) Description of how each intervention will be documented	Score "Met" if, • There is a residential support plan and • The plan is within 365 calendar days old and • The plan includes a description of care to be provided. Care: Assistance with or completion of tasks that cannot be completed by the person and about which the person is not being taught (including but not limited to medical/dental care, regulation of water temperature, fire evacuation needs, etc.) • The plan includes a description of how the person is to be supervised throughout the day. Supervision: Oversight by another provided according to SCDDSN policy 510-01-DD Supervision of People Receiving Services and must be as specific and individualized as needed to allow freedom while assuring safety and welfare. • The plan includes functional skills training to assist the person with acquiring, maintaining or improving skills related to activities of daily living, social and adaptive behavior necessary to function as independently as possible. Skills training outlined within the plan should focus on teaching the most useful skills/abilities for the person according to the person's priorities. Every consideration should be given to adaptations that could make the task easier/more quickly learned. Functional: Activities/skills/abilities that are frequently required in natural, domestic or community environments. Source: Residential Habilitation Standard 4.6 Supports CQL Basic Assurances Factor 8 and Shared Values Factor 9
G6-02	A comprehensive functional assessment: A. Is completed prior to the development of the initial plan B. Is updated as needed to insure accuracy	Score "Met" if a comprehensive functional assessment has been done addressing the following areas: Self Care: a) Bowel/bladder care b) Bathing/grooming (including ability to regulate water temperature) c) Dressing d) Eating e) Ambulation/Mobility f) Need to use, maintain prosthetic/adaptive equipment. Personal Health: a) Need for professional medical care (how often, what care) b) Ability to treat self or identify the need to seek assistance c) Ability to administer own meds/treatments (routine, time limited, etc.) d) Ability to administer over the counter meds for acute illness e) Ability to seek assistance when needed. Self Preservation: a) Respond to emergency b) Practice routine safety measures c) Avoid hazards d) Manage (use/avoid) potentially harmful household substances e) Ability to regulate water temperature

		Self Supervision: a) Need for supervision during bathing, dining, sleeping, other times during the day b) Ability to manage own behavior Rights: Human rights are those rights established by the United Nations that all people are entitled to by virtue of the fact that they are human. Ex. Life, liberty and security of person, right not to be subjected to torture, etc. Personal finances/money: People are expected to manage their own money to the extent of their ability. Community Involvement: a) Extent of involvement b) Awareness of community activities c) Frequency d) Type Social network/family relationships a) Family and Friends b) Status of relationships c) Desired contact d) Support to re-establish/maintain contact Site Assessment (FOR SLP I ONLY) using SLP I Assessment Form: a) Completed annually b) Any items assessed as "NO" have a plan to address, approved by the District Office c) Process implemented 4/01/10 AND the assessment supports skills training, care and supervision objectives identified within the person's plan. AND the assessment is current i.e. accurately reflects the skills/abilities of the person. Events that may trigger an assessment update may include, but not be limited to: completion of a training objective, failure to progress on a training objective, when the intervention yields 100% accuracy the first month, upcoming annual plan, major change in health/functioning status such as stroke, hospitalization, etc. The assessment does not have to be re-done annually. It is acceptable to review the assessment and indicate the date of review and the fact that the assessment remains current and valid. This notation must be signed or initialed by the staff that completed the review. Source: Residential Habilitation Standard RH 4.4 Supports CQL Basic Assurances Factor 8 and Shared Values Factor 8
G6-03 W	Within 30 days of admission and every 365 days thereafter, a residential plan is developed: a) that supports	Initial plan must be developed within 30 days of admission and every 365 days thereafter. The Plan must reflect the person's priorities and a balance between self-determination and health and safety.

	the person to live the way he/she wants to live b) that reflects balance between self-determination and health and safety c) that reflects the interventions to be applied	Source: Residential Habilitation Standard RH 4.5 The document," Balancing the Rights of Consumers to Choose with the Responsibility of Agencies to Protect" which is located on the extranet under Quality Assurance. Supports CQL Basic Assurances Factors 6 and 8
G6-04	The effectiveness of the residential plan is monitored and the plan is amended when: a) No progress is noted on an intervention b) new intervention, strategy, training, or support is identified; or c) The person is not satisfied with the intervention	Data should be looked at monthly to see that training has been completed as scheduled and data is collected as prescribed. Corrective action should be taken and recorded when: The plan is not implemented as written by staff; **When the intervention yields 100% accuracy the first month;** there is no correlation between recorded data and observed individual performance; the health, safety and welfare of the person is not maintained, when the person is not satisfied with the intervention, etc. Miscalculations of data, i.e. incorrect computations of percentages should be corrected during monitoring and will be cited if they affect the outcome of the training (result in no amendments to the plan when amendment should have occurred). As a general rule, if no progress has been noted for three (3) consecutive months with no reasonable justification for the lack of progress, the strategy must be amended, and if necessary, the Plan as well. Source: Residential Habilitation Standard 4.9 Supports CQL Shared Values Factors 1 and 8, Basic Assurances Factor 8
G6-05	A quarterly report of the status of the interventions in the plan must be completed	Score "Met" if a summary of progress is done at a minimum, quarterly. The provider may elect to do monthly progress notes. If monthly progress notes are done, quarterly reports are not required. Note: • Quarterly reports are to be completed and available within 10 business days of the close of the quarter. • Monitoring of all interventions not just training/ all components Source: Residential Habilitation Standard 4.7
G6-06	People receive training on rights and responsibilities	Score "Met" if there is documentation that the person has received training on rights and responsibilities at least once every three months. Training may include but not be limited to: On-going exposure to information regarding rights (ex. Agency wide focus on right of the month, rights discussions during house meetings, involvement in focus groups organized around rights, formal training objectives on rights most important to the person (ex. How to vote), etc.

		Documentation must be available to verify that the person was present during such trainings and must include the person's signature or mark. If the person has a formal training objective, the data collected will be sufficient documentation. Source: Residential Habilitation Standard RH 2.0 Supports CQL Shared Values Factors 1, 2 and Basic Assurances Factor 1
G6-07	Personal freedoms are not restricted without due process	Personal freedoms include but are not limited to: Making a phone call in private. Entertaining family/visitors in a private area. Unopened mail. Food choices Free access to the environment in which they live. Possessing a key to their bedroom and home if they so desire. Due process means human rights review of any restriction. The person must be offered the opportunity to attend the HRC meeting and have someone accompany them to assist in advocating for themselves, if they so desire. Verified by Service Notes. Source: Residential Habilitation Standard RH 2.0 535-02-DD Human Rights Committee Supports CQL Shared Values Factor 2
G6-08	People are expected to manage their own funds to the extent of their capability	People should manage their funds to the extent that they are capable. If assistance must be provided, provisions of 200-12-DD apply. The person must be actively involved in the development of their financial plan to include but not be limited to: planned purchases, weekly spending money, saving, etc. People should receive an accounting of their funds, at least quarterly (amount, what it is spent for, where it is kept, how to access it, etc.) Source: Residential Habilitation Standard RH 2.0 200-12-DD Management of Funds for Individuals Participating in Community Residential Programs Supports CQL Shared Values Factors 1,3 and Basic Assurances Factor 9
G6-09	People who receive services are trained on what constitutes abuse and how and to whom to report	Score "Met" if there is documentation that training on abuse is occurring on an on-going basis. Ongoing, is at a minimum, once every three months. Training information about abuse/neglect should be incorporated into all aspects of the training program, not just a one-time, large group training experience. Training may occur at meetings within residences, "rap sessions", self-advocates' meetings, etc. as well as in formal training objectives. Documentation <u>including the person's signature/mark</u> must be available to show that the person attended. If the person has a formal training objective, the data collected is sufficient documentation. Source: Residential Habilitation Standard RH 2.2 534-02-DD Procedures

		for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency. Supports CQL Shared Values Factor 1 and Basic Assurances Factor 4.

G6-10	People receive a health examination by a licensed Physician, Physician's Assistant, or Certified Nurse Practitioner who determines the need for and frequency of medical care and there is documentation that the recommendations are being followed	Score "Met" if:
		• the person has received an exam by a licensed physician, Physician's Assistant or Certified Nurse Practitioner
		• AND there is documentation that the plan of care is being followed
		• AND the health care received is comparable to any person of the same age, group and sex. i.e., mammogram for females 40 and above, annual pap smears, prostate checks for males over 50, etc.
		• Health conditions such as dysphasia and GERD are ruled out before behaviors such as rumination, intentional vomiting, etc. are addressed behaviorally.
		• People with specific health concerns, such as seizures, people who are prone to aspirate, etc., receive individualized care and follow-up.
		• If the person has refused medical care, documentation of this must be in the file.
		• People actively participate in the management of their healthcare to the extent capable. At a minimum:
		  ○ People should be offered choice
		  ○ Kept informed regarding appointments and purpose
		  ○ Have information regarding purpose/side effects of medications taken
		Supports CQL Shared Values Factors 1,3 and Basic Assurances Factor 5

G6-11	People receive a dental examination by a licensed dentist who determines The need for and frequency of dental care, and there is documentation that the dentist's recommendations are being carried out	Score Met if there is documentation that a dental exam has been done by a licensed dentist and there is documentation that the recommendations are being carried out. A person who is edentulous may be checked by a physician. Note: If a person has refused dental care, there must be documentation of this in the file. Source: Residential Habilitation Standard RH 5.0
G6-12	For any residential consumer with swallowing disorders or dysphagia documented on their Plan (residential or Case Management), or with a critical incident report documenting choking or aspiration, a dysphagia protocol checklist is completed and, if indicated, a referral is completed for evaluation.	Annual Swallowing Checklist is completed. Documentation is present that referral for evaluation was submitted. IF evaluation complete, recommendations are documented on plan and implemented.

G7	Health & Behavior Support Services	Guidance
G7-01 W	Behavior(s) that pose a risk to the person, others, the environment, or that interfere with his/her ability to function in the environment are addressed	If behaviors that pose a risk to the person, others or the environment or that interfere with the person's ability to function in the environment are being displayed, the behaviors must be addressed. Review the Plan, service notes, progress notes, critical incident reports and other documentation to determine if the problem behaviors occurred. Review documentation to determine if the behaviors were identified and are being addressed. Behaviors may be considered to be addressed if their occurrence is acknowledged and there is a plan for when the frequency of occurrence will warrant further intervention, steps are being taken to analyze and assess the behavior so that a strategy can be developed, informal strategies such as environmental changes, etc. are being tried, a BSP or guidelines are being implemented. Behaviors may also be considered addressed if there is evidence that an approved provider was sought (even if not found). More than one provider should be contacted before it can be determined that no provider is available. Source: 600-05-DD
G7-02	As needed by the person, but at least quarterly, psychotropic medications and the BSP are reviewed by the consulting psychiatrist, behavior consultant, and support team	[Psychotropic Drug Reviews] Review BSP, any psychiatrist and behavior consultant notes, and documentation of support team meetings to determine if psychotropic medications and the effectiveness of the BSP are reviewed at least quarterly for: A. Desired responses; B. Adverse side-effects; and C. Gradual decrease in drug dosage and ultimate discontinuance of the drug(s) unless clinical evidence/data is documented that this is contraindicated. Source: 600-05-DD
G7-03	In advance of the meeting, the Behavior Support provider is notified of the date, time and location of the Psychotropic Drug Review	When the person is being actively served by a provider of Behavior Support Services, the Behavior Support Services provider is notified of the date, time and location of the Psychotropic Drug Review. Source: Residential Habilitation Standards
G7-04	The specific behaviors/psychiatric symptoms targeted for change by the use of the Psychotropic medication are clearly noted	Source: 600-05-DD
G7-05	The Psychotropic Drug Review process	Source: 600-05-DD

	provides for gradually diminishing medication dosages and ultimately discontinuing the drug unless clinical evidence to the contrary is present	
G7-06	Consent for health care or restrictive interventions is obtained in accordance with 535-07-DD.	Review for documentation that procedures or restriction(s) were discussed with the person and surrogate, if required, before presentation to the HRC and person was informed of his/her right to refuse and appeal. Source: 535-07-DD
G7-07	When prescribed anti-psychotic medication or other medication(s) associated with Tardive Dyskinesia, monitoring is conducted	**Note** If medication prescribed at the time of admission, a baseline T.D. Score is obtained within one month Source: 603-01-DD, Supports CQL Basic Assurances Factors 2, 5, 6, & 8
G7-08	Restraints may be employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible.	Restraint procedures may only be included in a Behavior Support Plan when necessary to protect an individual or others from harm and when the procedures are the least restrictive alternatives possible to meet the needs of the person. The use of any approved restraint must also be included in the person's support plan. Restraint is defined as a procedure that involves holding an individual (i.e., manual restraint) or applying a device (i.e., mechanical restraint) that restricts the free movement of or normal access to a portion or portions of an individual's body. Note: The use of mechanical devices, such as splints or braces, bed rails to prevent injury, wheelchair harness and lap belts to support a person's proper body positioning are not considered restraint even though they may restrict movement. Such medical necessity for these devices must be documented in the person's record. Authorized emergency procedures are those defined in DDSN Directive 567-04-DD: Preventing and Responding to Disruptive Behavior and Crisis Situations. Emergency situations involving the use of psychotropic medication or mechanical restraint shall be authorized in writing by the Executive Director/Facility Director or their designee (or approved by the physician if involving transport to the emergency room) and a report of that emergency provided to the physician or psychiatrist, Executive

		Director/Facility Director (if approved by a designee) and an approved provider of behavioral supports within 24 hours. Mechanical restraint procedures should be designed and used in a manner that causes no injury and a minimum of discomfort. While in mechanical restraint, the individual will be supervised in accordance with his/her plan with documentation of their response to the restraint <u>every 30 minutes with a maximum duration not to exceed one (1) continuous hour unless an exception is granted</u>. The restrained person must be under constant, direct, visual supervision with the status of the person documented every 30 minutes. This documentation should include the physical condition of the individual (i.e., breathing, circulation) and comments documented indicating the degree to which the restraint is serving its desired effect. Source documents: 567-04-DD and 600-05-DD.

G8	HASCI Waiver	Guidance
G8-01 R	**The Support Plan is completed as required.**	**Review participant's most recent Support Plan in review period and verify it was completed within the previous 365 days. The same applies when there is a leap year.** **Except if transferring from an ICF/ID, a participant's Support Plan must be entered into the Consumer Data and Support System (CDSS) using the Consumer Assessment and Planning (CAP) module unless otherwise approved by SCDDSN. Completion and implementation date of the Support Plan is the date it is fully entered in CDSS.** **A Support Plan must be completed:** • **Before HASCI Waiver Services are authorized** • **Within 365 days of the previous plan** **Source: Support Plan Instructions, HASCI Waiver Manual**
G8-02	Needs identified in the Support Plan are justified by formal or informal assessment information in the record	Review the participant's record and service notes to verify there is formal or informal assessment information to justify each need in the Support Plan for which interventions were implemented, including for all HASCI Waiver services. During annual planning, the SCDDSN Service Coordination Annual Assessment (SCAA) identifies needs and justifies services/interventions in the Support Plan. The SCAA must be completed and entered on the CAP module of CDSS unless otherwise approved by SCDDSN. Needs assessment during the course of the year outside of annual planning must be documented in service notes. Formal and/or informal assessments may include information provided by the participant and/or caregivers about current situation, medical status, school records, formal assessment tools, and reports from past and/or current service providers. Source: "Guidelines on How to Complete the SCDDSN Annual Service Coordination Assessment", Support Plan Instructions, HASCI Waiver Manual
G8-03 R	**Waiver services correctly documented in Support Plan**	**Review participant's Support Plan and revisions in review period to verify correct documentation of each Waiver service, including:** • **name of service as listed in HASCI Waiver Manual** • **amount (units), frequency (weekly, monthly, annually, or one-time) and duration (length of authorization)** • **valid provider type as designated in HASCI Waiver document** **Source: HASCI Waiver Manual**

G8-04	Services/ Interventions identified in Support Plan to meet assessed needs	Review participant's Support Plan in review period to verify presence of documentation that services and/or interventions were identified to appropriately address all assessed needs. Services/interventions must have a logical connection to the need. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"* HASCI Waiver Manual
G8-05	Appropriate funding sources are identified in the Support Plan	Review participant's Support Plan and Service Notes in review period to verify presence of documentation that appropriate funding sources were identified for every service/intervention. Review "current resources" identified in the person's SCAA (or Service Notes if needs assessment occurred outside of annual planning and resources changed) to determine what resources the person has. Compare the person's resources to the services/interventions noted on the Support Plan to verify an appropriate funding source is listed for each service/intervention. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"*, HASCI Waiver Manual
G8-06	The Plan is provided to the participant/ representative.	A copy of the completed annual plan is provided to the participant/ representative.
G8-07 R	**The Support Plan is amended or updated as required**	**When service changes are identified as needed in the participant's waiver record but the CM fails to update the plan, the CM services will be identified for recoupment by the reviewer.** **Review participant's Support Plan, Service Notes, and record in review period to verify presence of documentation that changes were made when any of the following occurred:** **a. new service needs or interventions were identified** **b. there were significant changes in the person's life** **c. a service was determined to not be effective** **d. a need was met (service/interventions no longer needed** **e. the person or legal guardian was not satisfied** **The Support Plan must be current at all times. If any part of Section D ("Needs/Interventions") of the Support Plan is no longer current, an amendment/update must be completed using the CAP module of CDSS. A brief Service Note is acceptable so long as the change is explained in detail on the "Needs Change" form printed from the CAP module and included in the record.** **For new needs that occur outside of annual planning, identification and assessment of the need must be addressed in Service Notes**

		and, if applicable, a new "Needs/Interventions" page must be added to the Support Plan using the CAP module. **Source: Support Plan Instructions, HASCI Waiver Manual.**
G8-08 W	Service Coordination contacts and face- to - face visits are made as required,	***DDSN will provide notification when this key indicator is no longer applicable***. Review participant's record and Service Notes in review period to verify presence of documentation that: a. at least one contact was made bi-monthly (every other month) b. at least one face-to-face visit occurred every six (6) months A contact is a telephone call, letter, or email for the purpose of performing a core service coordination function when a face-to-face visit is not required. A face-to-face visit is a meeting with the person receiving services for the purpose of performing a core service coordination function. Source: Case Management Standards
G8-09	The Support Plan is reviewed at least every 6 months	***DDSN will provide notification when this key indicator is no longer applicable.*** Review participant's Support Plan and Service Notes in review period to verify presence of documentation that: a. needs and interventions were reviewed as often as needed, but at least every six (6) months b. needs and interventions were implemented as indicated in the Support Plan. Six Month reviews are completed on the CAP module of CDSS. Monitoring/review forms on CAP include all of the necessary components of monitoring Source: Case Management Standards, Support Plan Instructions
G8-10	A valid Service Agreement is present and correctly signed	Review participant's primary case record to verify presence of a current and valid SCDDSN Service Agreement (initial or updated); review most recent Service Agreement to verify it is current, correctly dated and signed by the appropriate party. The Service Agreement form must be signed by: • a parent or a legal guardian if the participant is under age18 years • a legal guardian if the participant is age 18 years or older and has been adjudicated incompetent • the participant if he or she is age 18 years or older and has not been adjudicated incompetent; A new Service Agreement must be updated and signed if the participant's name was legally changed, there was a change in legal guardianship, or the participant turned 18 years old.

		If the participant was a competent adult but physically unable to sign, he or she can make a “mark” on the Service Agreement form, which must be witnessed. If the participant can neither sign nor make a “mark”, both the Service Agreement form and a Service Note must indicate why the participant’s signature or “mark” was not obtained. Source: Service Coordination Standards
G8-11	Abuse and Neglect information is provided annually	Review participant’s record and Service Notes to verify presence of documentation that information concerning abuse and neglect was provided to the participant and/or legal guardian at least annually. Information provided must explain what abuse and neglect is and how it must be reported to authorities. Source: Waiver Case Management Policy; CQL Basic Assurances
G8-12	Acknowledgement of Choice and Appeal Rights form completed prior to Waiver enrollment and annually	Review participant’s record to verify Acknowledgement of Choice and Appeal Rights (HASCI Form 19) is present for review period. Verify it was signed by participant or Legal Guardian prior to HASCI Waiver initial enrollment or re-enrollment in review period or within 365 days of previous. If participant was a competent adult, but physically unable to sign, both the form (initial or annual update) and a Service Note should indicate why participant’s signature was not obtained. Source: HASCI Waiver Manual
G8-13	Acknowledgement of Rights & Responsibilities form completed prior to Waiver enrollment	For participants who have enrolled within the year, prior to review period, review participant records to verify Acknowledgement of Rights and Responsibilities (HASCI Form 20) is present. Verify it was signed by participant or Legal Guardian prior to HASCI Waiver initial enrollment or re-enrollment. If participant was a competent adult at time of HASCI Waiver initial enrollment or re-enrollment, but physically unable to sign, both the form and a Service Note should indicate why participant’s signature was not obtained. *Not required annually* Source: HASCI Waiver Manual
G8-14	Freedom of Choice documented prior to Waiver enrollment	For participant initially enrolled or re-enrolled in HASCI Waiver in review period, review participant’s record to verify Freedom of Choice form (HASCI Form 2) was properly completed prior to enrollment, indicated choice of Waiver services in the community, and signed by the participant

		or Legal Guardian. If participant was age 18 years or older, not adjudicated incompetent, but physically unable to sign, both the form and a Service Note should indicate why signed choice was not obtained. If participant not adjudicated incompetent became 18 years old in review period and after HASCI Waiver enrollment, verify either a new Freedom of Choice form was completed and signed by participant or original form was re-dated and signed by participant. This must have been done within 30 days after participant's 18th birthday. If participant was a competent adult, but physically unable to sign, both the form and a Service Note should indicate why signed choice was not obtained. Source: HASCI Waiver Manual
G8-15	Level of Care (LOC) initial certification properly completed within 30 days prior to or on date of Waiver enrollment	For participant initially enrolled or re-enrolled in HASCI Waiver in review period, review NF Level of Care or ICF-ID Level of Care initial determination to verify it was completed by the appropriate entity within 30 days prior to or on the date of enrollment. SCDHHS Community Long Term Care (CLTC) must complete NF Level of Care initial certification for HASCI Waiver enrollment or re-enrollment; LOC initial certification date is the date on the CLTC transmittal form (HASCI Form 7). SCDDSN Consumer Assessment Team must complete ICF-ID Level of Care initial certification for HASCI Waiver enrollment or reenrollment; LOC initial certification date is the "effective date" on the ICF-ID Certification Letter Source: HASCI Waiver Manual
G8-16 R	**Level of Care (LOC) re-certification properly completed within 365 days after previous certification**	**For on-going HASCI Waiver participant, review most recent and previous NF or ICF-ID Level of Care determinations to verify that re-certification occurred within 365 days. Verify all sections of the LOC certification form were completed and signed by the appropriate entity.** **HASCI Case Management staff complete NF Level of Care re-certification. The date the Level of Care re-evaluation staffing was completed is the effective date.** **The SCDDSN Consumer Assessment Team completes ICF-ID Level of Care re-certification for participants who have SCDDSN eligibility that is "Time-Limited", "At Risk" or "High Risk". HASCI Service Coordination staff complete ICF-ID Level of Care re-certification for all other participants. The date the Level of Care re-evaluation staffing was completed is the effective date.** **Source: HASCI Waiver Manual**

G8-17 R	**Current Level of Care (LOC) determination supported by appropriate information and assessment**	**Review participant's most recent LOC determination in review period and verify it is consistent with corresponding SCDHHS Form 1718 for NF Level of Care or with assessments/information cited for ICF-ID Level of Care.** **Source: HASCI Waiver Manual**
G8-18	Risks associated with refusing a Waiver service identified	Review participant's Support Plan and revisions, Service Notes, and other documentation to determine if a HASCI Waiver service was refused in review period. If a service was refused, verify that risks and other options were specifically discussed with participant or Legal Guardian Source: HASCI Waiver Manual
G8-19 W	Choice of provider offered for each new Waiver service	Review participant's Support Plan and revisions, Service Notes, and other documentation to verify that choice of provider was offered to participant or Legal Guardian for each new HASCI Waiver service authorized in review period Source: HASCI Waiver Manual
G8-20	Waiver services provided consistent with service definitions	Review definition in HASCI Waiver document for each service the participant received in review period. Review participant's Support Plan and revisions, Service Notes, and other documentation to verify each HASCI Waiver service was provided consistent with its definition. Source: HASCI Waiver Manual
G8-21 R	**Authorization forms are completed for services, as required, prior to service provision**	**Review the person's Plan to ensure that Authorization forms for services received are present and note a "start date" for services that is the same or after the date of the Service Coordinator's signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS-enrolled or contracted provider) and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. *Authorization forms are required for all HASCI Waiver services except Prescribed Drugs*** **Source: HASCI Waiver Manual**
G8-22 W	Index provided and followed for Waiver documentation in participant record	Review participant's record to verify HASCI Waiver information and documents follow the HASCI Waiver Documentation Index designated in HASCI Waiver Manual or a SC provider agency index with same content. So long as required documentation can be located, order of documents will not be subject to citation. Source: HASCI Waiver Manual

G8-23 R	**Medicaid Waiver Nursing Services authorized consistent with Physician' s Order and SCDDSN Centralized Review of Nursing Services**	**Review participant's record and Service Notes to verify that current Authorization of Medicaid Waiver Nursing Services (HASCI Form 12-D) is supported by a Physician's Order for Nursing Services (HASCI Form 15) and correctly reflects amount and type of nursing approved by the most recent SCDDSN Centralized Review of Nursing Services.** **Source: HASCI Waiver Manual**
G8-24	Minimum of one Waiver service received during 30 days in a calendar month	***DDSN will provide notification when this key indicator is no longer applicable.*** Review participant's record, Support Plan and revisions, Service Notes, and HASCI Waiver Budget reports in review period to verify at least one HASCI Waiver service was received during 30 consecutive days within a calendar month. Verify participant was terminated from the Waiver if at least one service was not received during 30 consecutive days within each month in review period. Source: HASCI Waiver Manual
G8-25 W	Needs of participant outside scope of Waiver services identified and addressed	Review participant's Support Plan and revisions, Service Notes, and other documentation to verify Waiver Case Manager identified and addressed to extent possible all service needs, regardless of funding source or lack of funding Source: HASCI Waiver Manual
G8-26	Waiver Tracking System (WTS) consistent with Support Plan and authorized services	Review participant's Support Plan and revisions, Service Authorizations, and HASCI Waiver Budget reports and verify that correct services and units are posted in WTS Source: HASCI Waiver Manual
G8-27 R	**Written notification made for denial, reduction, suspension, or termination of a Waiver service and information for reconsideration and appeal provided**	**When participant records that indicate the CM failed to submit correct waiver service denials, terminations, reductions or suspensions, the CM billable activities will be subject to recoupment. Waiver services allowed to pay due to the CM's error are subject to recoupment.** **Review participant's Support Plan and revisions, Service Notes, and other documentation to determine if any HASCI Waiver service was denied, reduced, temporarily suspended, or terminated in review period.** **If any of these actions occurred, verify the participant or Legal Guardian was given written notification specifying the reason and was provided information concerning SCDDSN Reconsideration and SCDHHS Appeal.** **Verify the appropriate form was used for written notification:** • **Notice of Denial of Service (HASCI Form 11C)** • **Notice of Reduction of Service (HASCI Form 11A)** • **Notice of Suspension of Service (HASCI Form 11B)** • **Notice of Termination of Service (HASCI Form 11)**

		Source: HASCI Waiver Manual
G8-28 R	**Waiver termination properly completed**	**When participant records that indicate the CM failed to complete termination forms properly, CM service activities are subject to recoupment. Waiver services allowed to pay due to the CM error are subject to recoupment.** **Review participant's Service Notes and other documentation to determine if participant was terminated from HASCI Waiver in review period. If this action occurred, verify Service Coordinator sent a Waiver Termination Form (HASCI Form 8) to SCDDSN Head and Spinal Cord Injury Division within 2 working days after determining that termination was required.** **Except for termination due to death, verify participant or Legal Guardian was given written notification of Waiver termination specifying reason and was provided information concerning SCDDSN Reconsideration and SCDHHS Appeal** **Source: HASCI Waiver Manual**
G8-29	Provision of Board-Billed Waiver services properly documented and billed	Review participant's Support Plan and revisions and Service Authorizations to determine if HASCI Waiver services authorized as Board-Billed services were received in review period. If yes, review Service Notes and other documentation to verify a qualified vendor or provider as indicated in HASCI Waiver Manual was used for each Board-Billed service. Verify presence of documentation that service was provided as authorized. Verify presence of documentation to support all billing for the service. Source: HASCI Waiver Manual
G8-30	Unavailability of Waiver service provider documented and actively addressed	Review participant's Support Plan and Service Notes in review period to verify unavailability of a provider for a HASCI Waiver service was documented and the Waiver Case Manager actively attempted to locate a provider. Source: HASCI Waiver Manual
G8-31	Copies of Daily Logs for Self-Directed Attendant Care received and service monitored	For participant receiving HASCI Waiver Self-Directed Attendant Care (UAP Option), review Service Notes and other documentation to verify Waiver Case Manager obtained copies of Attendant Care Daily Logs for each Attendant at least monthly in review period, reviewed them, and addressed any service provision issue. Source: HASCI Waiver Manual

G8-100	HASCI Waiver Case Management Activities	Guidance DDSN will provide notification of an effective date.
G8-101 R	For newly enrolled waiver participants, the first non-face-to-face contact is completed within 30 days of waiver enrollment.	Upon implementation of WCM, for new enrollees, the waiver case manager's first non-face-to-face contact must be completed within 30 days of waiver enrollment and documented within 7 days, per policy. The WCM billing for this activity is recoupable if not documented within 7 days. Please refer to the WCM policy for additional guidance and exact text. For participants enrolled in the waiver since implementation of Waiver Case Management or within the past 12 months, whichever is sooner, determine if non-face to face contact occurred within the first 30 days.
G8-102 R	For newly enrolled waiver participants, the first quarterly face-to-face visit is completed within 90 days of waiver enrollment.	Upon implementation of WCM, for new enrollees, the waiver case manager's first face-to-face contact must be completed within the first 90 days and documented within 7 days, per policy. The WCM billing for this activity is recoupable if not documented within 7 days. Please refer to the WCM policy for additional guidance and exact text. For participants enrolled in the waiver for 90 days or more, determine if a face to face visit occurred within 90 days of enrollment.
G8-103 R	Each month, except during the months when required quarterly face-to face visits are completed, a non-face to face contact is made with the participant or his/her representative.	Upon implementation of WCM, WCM services billed but not documented per policy during the review period may be subject to recoupment. It is expected that during each month of the plan year there will be either a non-face-to face contact or a face-to-face visit with the waiver participant/family member. A non- face-to face contact with the participant/family must be completed by the WCM in each calendar month when a quarterly visit is not required. The purpose of the non-face-to-face contacts/activities is to establish meaningful communication with the participant/family in order to review and monitor Plan and current services and to monitor the participant's health and welfare, and changes in the residence and/or family status. The monthly non-face-to-face contact is intended to be made by telephone to the participant/family for the majority of waiver participants. The purpose is for meaningful discussion on behalf of the waiver participant in order to monitor the plan, services, and the participant's health and welfare.

G8-104 R	**Non-face to face contact is appropriately documented in services notes.**	**Upon implementation of WCM, the WCM should not bill for notes that were not documented appropriately. Recoupment is intended to be directed to the incorrect entries.** **The entire contact/visit must be documented in the service notes including:** • **Are the current services meeting the participant's needs?** • **What changes in the residence or family status warrant revisions to current services/plan? List the changes.** • **Does the participant/family know how to report abuse, neglect, and exploitation (ANE)? If so, is there anything to report this month?** • **Based on statements made by the participant/family, are increases/decreases or changes needed to the services? List the changes.** • **Are service terminations needed?** • **What follow-up activities or contact with providers is needed based on this monitoring?** • **List the date and the individual(s) who participated in the contact.** • **List the number of minutes used for the contact; and** • **WCM signature and title** **Entries to the participant record must be documented on the date of the contact/visit. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the actual contact/visit. All entries of the contact/visit must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.**
G8-105 R	**A minimum of four (4) quarterly face-to face visits are made with the participant/family each plan year.**	**Upon WCM implementation WCM, WCM policy requires a minimum of 4 quarterly face to face visits each year. The visits must be documented per policy within 7 days to be billable. This indicator relates to these 4 visits, not other WCM activities. Each visit is subject to recoupment based on policy and documentation requirements.** **At least four quarterly face to face visits are required each plan year. Two (2) of the required four (4) quarterly face-to-face visits must be in the participant's residence. The other two (2) may be at other locations.** **The purpose of the non-face-to-face contacts/activities and the face-to-face quarterly visits is to establish meaningful communication with the participant/family in order to review and monitor the Plan and current services. It is also important to monitor the participant's health and welfare, and changes in the residence and/or family status which could impact the participant's needs.** **The face-to-face quarterly visits cannot be conducted in consecutive months.**

G8-106 R	**Two of the four (4) quarterly face-to face visits with the participant/family are conducted in the participant's residence and are conducted every other quarter of the plan year.**	**Upon WCM implementation, WCM policy requires the participant to receive 2 of the 4 quarterly WCM face to face visits in their home during the review period. The visits must be documented per policy. Each visit is subject to recoupment based on policy and documentation requirements.** **The face-to-face quarterly visits cannot be conducted in consecutive months.** **The purpose of visits to the residence is to ensure the health and welfare of the participant in the home environment, assess the safety of the surroundings and to monitor for changes in the family status or dynamics, all of which might require changes to the plan.** **When only two quarterly face-to-face visits in the residence are completed during a plan year, those two visits cannot be in consecutive quarters of the year.** **During each visit to the residence the WCM is expected to make professional observations which could impact the health and welfare of waiver participants.**
G8-107 R	**Quarterly face to face visits are appropriately documented.**	**Upon WCM implementation, quarterly face to face visits must meet documentation standards and be completed within 7 days; if either requirement is not met the service may be subject to recoupment.** **The following must be documented in the service notes:** • **Did the family report changes in the residence or family status?** • **Does the participant/family know how to report ANE? If so, is there anything to report during this contact/visit?** • **Did the family report any changes in the participant's health status? If so, list the changes.** • **Based on professional observations or statements made by the participant/family, are increases/decreases or changes needed to the services? List the changes.** • **Are service terminations needed?** • **Have providers been delivering services as authorized? If not, explain.** • **Does the participant/family wish to make any changes with current providers/services on the plan? If so, describe the changes.** • **List the date and individuals present for the visit.** • **List the number of minutes used for the quarterly visit with the participant/family; and** • **WCM signature and title.** **Entries to the participant record must be documented on the date of the contact/visit. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the**

		actual contact/visit. All entries of the contact/visit must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.
G8-108	Participants received two (2) waiver services every thirty (30) days.	Upon implementation of WCM, participants received waiver services every 30 days.
G8-109	**When contacts (other than the required monthly contacts and required quarterly face to face contacts) are made or activities are conducted, the contact/activity is appropriately documented.**	**Upon implementation of WCM, when contacts/activities are conducted, they must be documented appropriately within 7 days, per policy.** **Refer to policy**
G8-110	Contacts (other than the required monthly contact and required quarterly face to face contact) are recorded as NON-REPORTABLE on CDSS if the required monthly contact and/or quarterly face-to-face visit has not been completed during the month/quarter with the participant/family member, or if the required monthly contact/quarterly visit is not documented in the participant's record within seven (7) calendar days of completion.	Other contacts are allowed if they are specifically designed to monitor the participant's progress or status regarding needs identified on the plan. The following contacts are allowable if the required monthly contact or quarterly face-to-face visit is completed during the month/quarter with the participant/family member, and the entire contact/visit is documented in the participant's record within seven (7) calendar days of completion: Telephone contact with Providers; Email communication with the professional community; School Visits; ADHC and other on-site day service visits with professional staff; These other allowable activities are not intended to supplant or replace the required monthly non-face-to-face contact or quarterly face-to-face visits with waiver participants and their family members. Reporting these other types of allowable contacts as "reportable" without completing the required monthly non-face-to-face contacts or quarterly visits with the participant/family, and the necessary required documentation may result in recoupment.
G8-111 R	**Service notes intended to document Waiver Case Management**	**Recoupment is intended to be directed to the incorrect entries.** **All entries to the participant record must be completed by the WCM who actually conducted the contact/activity.**

	activities are sufficient in content to support Medicaid billing.	**Documentation and service note entries specific to an individual must be maintained in a waiver participant record in chronological order. Documentation or references to other participants should not be incorrectly filed or noted in the waiver record.** **Service notes are expected to be entered into the record in a timely manner. This is defined as the day of, or within seven (7) calendar days of the activity, call, contact, visit or event.** **Entries to the participant record must be documented on the date of the contact/visit/activity. The designation "*Late entry*" must be added to any entry in the participant record if it is made after the day of the actual contact/visit/activity. All entries of the contact/visit/activity must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.** **All entries in the record should offer such detail and clarity that a different WCM or supervisor could review the waiver record and serve the participant with minimal difficulty.** **The following activities are allowed / reportable:** • **Conduct timely LOC reevaluations per Medicaid policy** • **Conduct annual participant assessments (within every 365 days)** • **Re-establish FOC document as needed according to policy** • **Develop annual service plans (within every 365 days) ensuring frequency, duration, amount and provider type for waiver services** • **Include identified State Plan or other needs on service plan** • **Provide linkage, and referral of waiver participants to federal, state, local or community programs and/or Medicaid benefits** • **Monitor access to and receipt of waiver services; address and correct problems identified in waiver service provision** • **Review service plans quarterly and amend with needed**

		changes • **Provide copy of completed annual service plan to participant/legal representative** • **Conduct ongoing monitoring of the service plan with the participant/family during monthly non-face-to-face contacts, or quarterly face-to-face visits. At least every other quarterly contact must be made in the residence** • **Conduct all necessary follow up activities as a result of the contacts/visits with participant/family** • **Perform ongoing monitoring of the participant's health and welfare** • **Monitor participant's emergency/evacuation plan** • **Respond to urgent, emergent or unplanned circumstances for participant.** • **Document participant record according to professional protocols and policy** • **Provide information about participant/representative-directed care services, including benefits and risks** • **Assess and document the absence of cognitive deficits in the participant or representative that would preclude the use of participant/representative care if selected** • **Provide participant/representative information about hiring, management and termination of workers, as well as, the role of the Financial Management System** • **If voluntary or involuntary termination of attendant care, in-home supports, or EIBI line therapy, provide a list of qualified providers to assist with replacement** • **Offer and document choice of qualified providers, as needed and upon request** • **Offer and document choice of qualified waiver case management providers at least annually and upon request** • **Inform waiver participant/ representative about and monitor individual cost cap for CS and PDD waivers** • **Provide Reconsideration/Appeal rights when appropriate and according to policy** • **Participate in witness preparation, testify, and/or provide records and evidence on behalf of SCDHHS/SCDDSN for**

		Medicaid Waiver Appeals and Hearings as required, acting as an agent of the State • **Assist with service delivery problems/service provider resolution or other problems as requested** • **Review and submit appropriate caregiver logs for payment; contact provider if logs are inappropriate to resolve outstanding issues** • **Suspend waiver/state plan services when participants enter inpatient facilities (hospital, nursing facility or ICF/ID)** • **According to circumstances, properly suspend, deny, terminate or reduce waiver/state plan services with "Notice"** • **Complete waiver termination information timely** • **Determine other participant resources such as third party liability (TPL) or Medicare and provide information to providers** • **Inform new waiver enrollees that the waiver program is not a source of 24 hour care, excluding Residential Habilitation** • **Maintain written or electronically retrievable records for a minimum of five (5) years unless under appeal or other guidance from SCDHHS** • **On an annual basis provide participant/representative written information about what constitutes abuse and how to report. This must be documented in the participant record** • **Provide participant/representative of their rights annually and document this in the participant record** • **Assess for Children's Personal Care (CPCA)/State Plan Nursing/Incontinence Supplies/Respite/EIBI services using approved assessment documents** • **Follow policy for approval of CPCA hours/State Plan Nursing hours/respite hours/incontinence supplies/EIBI services** • **Comply with out-of-state policy for waiver participants making short-term visits out of South Carolina** • **At the time of enrollment waiver case managers must provide information about available waiver services** • **WCM must understand the limitations subject to DDSN or Medicaid Policy for HASCI participants who use attendant care services directed by a representative** • **Waiver case managers will report critical incidents according**

		to approved policy. • **On an annual basis, waiver case managers must review and obtain the participant/representatives signature on the Rights and Responsibility Statement** • **Waiver case managers must review caseloads with supervisors as required for Quality Assurance/Team Staffing or discharge planning purposes** **The following activities may be reportable if provided to a participant who is preparing for discharge from a facility to the waiver. These activities can be conducted for 120 days prior to the actual date of waiver enrollment:** • **Using approved form, document Freedom of Choice (FOC) between institution and home and community-based services.** • **Initiate level of care (LOC) determinations** • **Conduct an initial participant assessment** • **Establish updates to LOC through State-approved process if LOC expires** • **Complete waiver enrollment information timely** • **Verify that waiver applicant is not enrolled in another waiver, state plan or managed care program prior to submitting enrollment request, or coordinating program transition as needed** **Waiver case management does not allow the direct delivery of waiver, state plan or any other services. The following activities are <u>NON-reportable /allowable activities.</u> This list is not all-inclusive and is simply intended as a guide.** • **Activities provided by anyone other than the individual who meets the qualifications to be a waiver case manager, even if they are working under the supervision of a case manager.** • **Unsuccessful telephone attempts to contact the waiver participant/family and provider.** • **Review of the waiver case management record.** • **Participating in social or recreational activities at the invitation of the waiver participant/family.** • **Rendering WCM to individuals in institutional placement except during the last 120 days of the institutional stay prior to waiver enrollment for the purpose of transitional and/or discharge planning.** • **Rendering WCM services to waiver participants while**

		incarcerated, in jail, prison or other detention/evaluation centers. • **Time spent documenting waiver contacts/activities.** • **Completing administrative duties such as copying, filing, or mailing reports.** • **Rendering activities on behalf of the participant/family related to judicial matters, court/legal proceedings.** • **Rendering services/activities on behalf of the family after the death of a waiver participant.** • **Providing training/the provision or personal care, daily living skills, job skills, or social skills.** • **Training or provision of housekeeping, laundry, cooking or household chores.** • **Providing individual group or family therapy.** • **Providing child care or adult elder care for the participant/family.** • **Providing transportation/escort services.** • **Obtaining food at food bank, grocery store.** • **Delivering supplies, prescriptions, clothing/laundry, Christmas trees or gifts.** • **Accompanying participant/family to medical visits.** • **Setting up medications such as a pill box.** • **Paid or unpaid time off.** • **Services provided by more than one case manager to the same participant at the same time.** • **Staff meetings, trainings, travel-time, and supervision.** • **Contacts with administrative or secretarial staff within the agency.** • **Scheduling case manager's appointments.** • **Claim submission and collection activities.** • **Calls or emails to the information technology helpdesk.** • **Reading mail or newspaper to the participant/family.** • **Financial tasks such as paying bills, applying/submitting for loan applications, and/or taking the participant/family member to the bank.** • **Going to the library or running errands on behalf of the participant/family.** • **Taking participant/family member to get driver's license/moped license/voter ID.** • **Preparing documentation, filing appeals or testifying at appeals on behalf of participant/family member or any other entity.** • **Home decorating or house or apartment hunting for the participant/family.** • **Taking participant/family member to beauty salon or barber shop.** • **Yard/garden work for the participant/family.** • **Taking the participant/family member vehicles, electronics or appliances for repairs; and** • **Traveling to and from appointments on behalf of the participant/family.**

G9	ID/RD Waiver Activities	Guidance
G9-01 R	**The Plan is developed as required.**	**Review current Plan. A current Plan must be present. A current Plan is defined as one completed within the last 365 days. When there is a leap year, the plan date would be calculated accordingly to ensure the plan is developed and signed within 365 days.** **Except for those transferring from an ICF/ID, Plans must be entered into the Consumer Data and Support System (CDSS) using the Consumer Assessment and Planning (CAP) module unless otherwise approved by SCDDSN. The Plan implementation date is the date a plan is completed in the CAP module of CDSS.** **Plan must be developed before waiver services are authorized.** **Source: Support Plan Instructions**
G9-02 R	**The plan includes ID/RD Waiver service(s) name, frequency of the service(s), amount of service(s), duration of service(s) and valid provider type for service(s)**	**For each waiver service received by the participant, the plan must document the need for the service; the correct waiver service name, the amount, frequency, duration and the provider type [refer to the ID/RD Waiver Document for provider types (Chapter 2 of ID/RD Waiver Manual)].** **The amount of a service that is authorized in units should be specified in units, not in hours or days. The frequency of a service must be expressed in a manner that is consistent with how the service is authorized (e.g. "per month" or "monthly" for Respite, "per week" or "weekly" for Personal Care).** **Note: Regarding "duration" check only that a duration is specified.** **Source: ID/RD Waiver Manual**
G9-03 W	Service needs outside the scope of Waiver services are identified in Plans and addressed	Review the Plan, service notes, and other documentation in the record to ensure that the Waiver Case Manager has identified and addressed all service needs regardless of the funding source. Source: ID/RD Waiver Manual
G9-04	Needs in the Plan are justified by formal or informal assessment information in the record	Review the record to determine if formal or informal assessment information is available to justify the "need" noted on the Plan for which interventions are being implemented. The assessment information (formal or informal) must be current and accurate. Formal and/or informal assessments may include information provided by the person and/or his/her caregivers about the person's current situation, medical status, school records or other formalized assessment tools. At the time of annual planning, the *SCDDSN Service Coordination Annual Assessment* will be used to identify needs and justify services/interventions reflected in the Support Plan. The *SCDDSN Service Coordination Annual Assessment* (SCAA) must be completed on the CAP module of CDSS unless otherwise approved by SCDDSN.

		Information from providers currently providing services should be considered in planning. The record should reflect attempts to secure information from all current service providers. Attempts should be made in sufficient time prior to planning so that information can be secured. If the person is enrolled in the Waiver, then formal or informal assessments and recommendations for all Waiver services will be present. Needs assessment during the course of the year *outside* of annual planning will be documented in the service notes. Source: "Guidelines on How to Complete the SCDDSN Annual Service Coordination Assessment", Support Plan Instructions, Waiver Manual pertaining to needs assessment.
G9-05	Assessment(s) justify the need for all ID/RD Waiver services included on the plan	Review the Plan, DDSN Service Coordination Annual Assessment, service assessments (e.g. Respite Assessment, PC/Attendant Care Assessment, etc.) and service notes to ensure that all ID/RD Waiver services included on the Plan are supported by assessed need. Source: ID/RD Waiver Manual
G9-06	Services/ Interventions are appropriate to meet assessed needs	Interventions are identified to address assessed "needs". Interventions must have a logical connection to the need.
G9-07	The Plan identifies appropriate funding sources for services/interventions	Appropriate funding sources are identified for every service/intervention. Review the person's "current resources" identified in the SCDDSN Service Coordination Annual Assessment (or the service notes when needs assessment occurs outside of planning and resources have changed from those noted on the Plan) to determine what resources the person has. Compare the person's resources to the services/interventions noted on the Plan to determine if the appropriate funding source is listed for the service/intervention to be/being provided. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"* for defined resources Waiver Manual.
G9-08	The Plan is provided to the participant/ representative.	A copy of the completed annual plan is provided to the participant/ representative.
G9-09 R	**The Plan is amended / updated as needed**	**When service changes are identified as needed in the participant's waiver record but the CM fails to update the plan, the CM services will be identified for recoupment by the reviewer.** **Review all plans and service notes in effect during the review period to determine if:** **a. updates are made when new service needs or interventions are identified,** **b. there have been significant changes in the person's life,** **c. a service is determined to not be effective,** **d. a need/s has/have been met,** **e. the person is not satisfied.**

		When any part of the "Needs/Interventions" section (Section D) of the plan is no longer current, an amendment/update must be completed using the CAP module of CDSS. It is acceptable to have a brief service note provided the change/update is explained in detail on the "needs change" form printed from the CAP module of CDSS for the file. For new needs identified during the course of the year, needs assessment and identification of the need will be in the service notes and, if applicable, a new "needs/interventions" page will be added to the plan using the CAP module of CDSS. Plan must be current at all times. **Source: Support Plan Instructions and Waiver Manual.** **Supports CQL Shared Values Factor 8**
G9-10 W	Contact occurs as required: a) Face-to-face contacts occur every 6 months b) Every other month (bi-monthly), at least one contact (as defined by SC Standards) is made	***DDSN will provide notification when this key indicator is no longer applicable***. Beginning 7/1/11, review to determine that: a) Face-to-face visits occur every 6 months and are with the person receiving services. b) At least one contact is made every other month (bi-monthly). A contact is defined as any of the following: • A face-to-face encounter for the purpose of performing a core function. • A telephone call, letter or email when a face-to-face contact is not required or is not possible for the purpose of performing a core function Source: Case Management Standards
G9-11	The Plan is reviewed at least every 6 months	***DDSN will provide notification when this key indicator is no longer applicable.*** 1. Review the Plan to determine if all needs and interventions were reviewed as often as needed, but at least every 6 months. 2. Ensure that needs and interventions were implemented as prescribed in the Plan. Six Month reviews are completed on the CAP module of CDSS. Monitoring/review forms on CAP include all of the necessary components of monitoring Refer to Case Management Standards and Support Plan Instructions
G9-12	A valid Service Agreement is present and signed as appropriate	A valid Service Agreement (review most recently completed Service Agreement to assure that it is dated and signed.) For children and for adult's adjudicated incompetent, the current legal guardian (if applicable) must sign the form. For those 18 years and older or those with a name change, a new Service Agreement should be signed by the person. The most current Service Agreement that is signed and dated by the appropriate party must be filed in the primary case record. Score "Not

		Met" if there is not a Service Agreement in the primary case record and/or it is not signed and dated by the appropriate party. If a person is unable to sign but can make their "mark", the mark must be witnessed. If a person is unable to sign or make their mark on the Service Agreement, there will be an explanation on the form and supporting documentation in the file.
G9-13	The person/legal guardian (if applicable) will receive information on abuse and neglect annually	Check the record for documentation that information was provided to person/legal guardian. This may be found in service notes or as a form letter in the record. Information must define what abuse and neglect is and how to report.
G9-14 R	**At the time of annual planning, all children enrolled in the ID/RD receiving CPCA services must have a newly completed physician's order (Physician's Information Form – MSP Form 1), assessment (CPCA Assessment – MSP Form 2), and authorization (MSP – Form 3)**	**See MSP forms/attachments in the miscellaneous Chapters of the ID/RD Waiver Manuals.**
G9-15	If a child is assessed to need over 10 hours of Children's PCA services per week, DDSN prior authorization is obtained	Review file for an email correspondence giving approval of requested units of CPCA services. If service units were not approved prior to initiation of the service, or prior to the completion of the annual plan, there must be a correspondence present allowing flexibility with approval.
G9-16	If a child receives CPCA services, the Service Needs Requirement and, unless otherwise specified, a Functional deficit exists (check only for those receiving 10 hours or less of CPCA services)	Refer to CPCA services section of the Waiver Manual (Miscellaneous chapter), page one, for guidance to determine if the child meets the "Special Needs Requirement" and has one of the four allowable "Functional Deficits". Look for The Physician's Information Form – it will be present and indicate if a doctor agrees CPCA services is needed to meet the Special Needs Requirement (section II. Of the form). Look for the CPCA Assessment – it gives information to determine if at least one functional deficit is present.

G9-17 W	Documentation is present verifying that a choice of provider was offered to the participant/ family for each new ID/RD Waiver service	Review the service notes and the participant's Plan to determine if the participant was given a choice of provider of service each time a new service was authorized. Source: ID/RD Waiver Manual
G9-18	The Freedom of Choice Form is Present	Review the record of those enrolled or re-enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). For forms completed during the review period, if the waiver participant is over age 18 and not adjudicated incompetent but is physically unable to sign the form, the form and the service notes should indicate why signed choice was not obtained. If the participant has reached the age of majority since waiver enrollment during the review period and has not been adjudicated incompetent, the waiver participant must either date and sign a new Freedom of Choice form or sign and date the original Freedom of Choice form documenting choice of waiver services in the community over institutionalization. This should be completed within 90 days of their 18th birthday. NOTE: Look at only those enrolled, re-enrolled or who turned 18 during the review period. Source: ID/RD Waiver Manual
G9-19	The Initial Level of Care is present.	Review the initial LOC determination to verify it was completed within 30 days prior to or on the date of Waiver enrollment.
G9-20 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care determination and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/IID evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Waiver Case Managers for all consumers except for those participants whose eligibility determination is "Time-Limited", or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Note: Look only at timeframes and who completed it.**

		Source: ID/RD Waiver Manual
G9-21 R	**The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination**	**Review the most current LOC determination and compare it to information in the assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment.** **Note: Look only at lines on LOC assessments** **Source: ID/RD Waiver Manual**
G9-22 R	**The Current Level of Care is completed appropriately**	**Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete with appropriate responses.** **Note: Ensure that all areas are complete or checked.** **Source: ID/RD Waiver Manual**
G9-23	Acknowledgment of Rights and Responsibilities (ID / RD Form 2) is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by participant or legal guardian, if applicable) on the current and previous forms to ensure they have been completed annually (within 12 months of the previous form). Source: ID/RD Waiver Manual
G9-24	ID/RD Waiver services are provided in accordance with the service definitions found in the Waiver document	Review Service definitions in the ID/RD Waiver document (Chapter 2 of the ID/RD Manual) for each service that the participant is receiving. Review the participant's Plan, service notes and relevant service assessments to ensure that services are being provided according to the definitions. Source: ID/RD Waiver Manual
G9-25 R	**If Nursing Services are provided, an order from the physician is present and is consistent with the authorization form (ID/RD Form A-12)**	**Review record to ensure that a physician's order is available and is consistent with the type of Nursing Services authorized for the participant (RN or LPN).** **Note: Do not look at Nursing Services for children (State Plan Service).** **Source: ID/RD Waiver Manual**
G9-26	ID/RD Waiver services are received at least every 30 calendar days	***DDSN will provide notification when this key indicator is no longer applicable.*** Review service notes and Plan to ensure that the participant has received or is receiving at least one ID/RD Waiver service every 30 calendar days during the review period. A service must be received at least every 30 calendar days. If at least one service was not received every 30 calendar days, the participant should have been disenrolled from the Waiver. Note: Children's PCA and Private Duty Nursing do not count, as they are State Plan Medicaid Services.

		Source: ID/RD Waiver Manual
G9-27 R	**Authorization forms are properly completed for services as required, prior to service provision**	**Review the participant's plan, and ensure that authorization forms for services received are present and note a "start date" for services that is the same or after the date of the Waiver Case Manager's signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS-enrolled or contracted provider) and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. Authorization forms are required for all services except Prescribed Drugs, Adult Vision Services, Adult Dental Services, and an Audiological Evaluation.** **Source: ID/RD Waiver Manual**
G9-28	Authorized waiver services are suspended when the waiver participant is hospitalized, temporarily placed in an NF or ICF/IID	
G9-29 R	**Waiver termination properly completed**	**When participant records indicate that the CM failed to complete termination forms properly, CM service activities are subject to recoupment. Waiver services allowed to pay due to the CM error are subject to recoupment.** **Review participant's Service Notes and other documentation to determine if participant was terminated from the Waiver in the review period. If this action occurred, verify Service Coordinator sent a Waiver Termination Form 2 working days after determining that termination was required.** **Except for termination due to death, verify participant or Legal Guardian was given written notification of Waiver termination specifying reason and was provided information concerning SCDDSN Reconsideration and SCDHHS Appeal.**
G9-30 R	**The Participant/Legal Guardian (if applicable) was notified in writing regarding any denial, termination, reduction, or suspension of ID/RD Waiver services with accompanying reconsideration/appe**	**When participant records that indicate the CM failed to submit correct waiver service denials, terminations, reductions or suspensions, the CM billable activities will be subject to recoupment. Waiver services allowed to pay due to the CM's error are subject to recoupment.** **Review service notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the participant/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and**

	als information	**provided with the appropriate reconsideration/appeals process.** **Note: If the participant/legal guardian (if applicable) requested to terminate, suspend, or reduce the service, this Indicator is N/A** **Source: ID/RD Waiver Manual**
G9-31	Information including the benefits and risks of participant/ representative directed care is provided to the participant/ representative prior to the authorization of Adult Attendant Care.	
G9-32	Before authorization of Adult Attendant Care Services, the absence of cognitive deficits in the participant/ representative that would preclude the use of participant/ representative directed care is assessed and documented.	
G9-33	Before authorization of Adult Attendant Care Services, the participant/ representative is provided information about hiring management and termination of workers as well as the role of the Financial Management System is provided to the participant/ representative.	

G9-100	ID/RD Waiver Case Management Activities	Guidance DDSN will provide notification of an effective date.
G9-101 R	For newly enrolled waiver participants, the first non-face-to-face contact is completed within 30 days of waiver enrollment.	Upon implementation of WCM, for new enrollees, the waiver case manager's first non-face-to-face contact must be completed within 30 days of waiver enrollment and documented within 7 days, per policy. The WCM billing for this activity is recoupable if not documented within 7 days. Please refer to the WCM policy for additional guidance and exact text. For participants enrolled in the waiver since implementation of Waiver Case Management or within the past 12 months, whichever is sooner, determine if non-face to face contact occurred within the first 30 days.
G9-102 R	For newly enrolled waiver participants, the first quarterly face-to-face visit is completed within 90 days of waiver enrollment.	Upon implementation of WCM, for new enrollees, the waiver case manager's first face-to-face contact must be completed within the first 90 days and documented within 7 days, per policy. The WCM billing for this activity is recoupable if not documented within 7 days. Please refer to the WCM policy for additional guidance and exact text. For participants enrolled in the waiver for 90 days or more, determine if a face to face visit occurred within 90 days of enrollment.
G9-103 R	Each month, except during the months when required quarterly face-to face visits are completed, a non-face to face contact is made with the participant or his/her representative.	Upon implementation of WCM, WCM services billed but not documented per policy during the review period may be subject to recoupment. It is expected that during each month of the plan year there will be either a non-face-to face contact or a face-to-face visit with the waiver participant/family member. A non- face-to face contact with the participant/family must be completed by the WCM in each calendar month when a quarterly visit is not required. The purpose of the non-face-to-face contacts/activities is to establish meaningful communication with the participant/family in order to review and monitor Plan and current services and to monitor the participant's health and welfare, and changes in the residence and/or family status. The monthly non-face-to-face contact is intended to be made by telephone to the participant/family for the majority of waiver participants. The purpose is for meaningful discussion on behalf of the waiver participant in order to monitor the plan, services, and the participant's health and welfare.
G9-104 R	Non-face to face contact is	Upon implementation of WCM, the WCM should not bill for notes that were not documented appropriately. Recoupment is intended

	appropriately documented in services notes.	**to be directed to the incorrect entries.** **The entire contact/visit must be documented in the service notes including:** • **Are the current services meeting the participant's needs?** • **What changes in the residence or family status warrant revisions to current services/plan? List the changes.** • **Does the participant/family know how to report abuse, neglect, and exploitation (ANE)? If so, is there anything to report this month?** • **Based on statements made by the participant/family, are increases/decreases or changes needed to the services? List the changes.** • **Are service terminations needed?** • **What follow-up activities or contact with providers is needed based on this monitoring?** • **List the date and the individual(s) who participated in the contact.** • **List the number of minutes used for the contact; and** • **WCM signature and title** **Entries to the participant record must be documented on the date of the contact/visit. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the actual contact/visit. All entries of the contact/visit must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.**
G9-105 R	**A minimum of four (4) quarterly face-to face visits are made with the participant/family each plan year.**	**Upon WCM implementation WCM, WCM policy requires a minimum of 4 quarterly face to face visits each year. The visits must be documented per policy within 7 days to be billable. This indicator relates to these 4 visits, not other WCM activities. Each visit is subject to recoupment based on policy and documentation requirements.** **At least four quarterly face to face visits are required each plan year. Two (2) of the required four (4) quarterly face-to-face visits must be in the participant's residence. The other two (2) may be at other locations.** **The purpose of the non-face-to-face contacts/activities and the face-to-face quarterly visits is to establish meaningful communication with the participant/family in order to review and monitor the Plan and current services. It is also important to monitor the participant's health and welfare, and changes in the residence and/or family status which could impact the participant's needs.** **The face-to-face quarterly visits cannot be conducted in consecutive months.**

G9-106 R	**Two of the four (4) quarterly face-to face visits with the participant/family are conducted in the participant's residence and are conducted every other quarter of the plan year.**	**Upon WCM implementation, WCM policy requires the participant to receive 2 of the 4 quarterly WCM face to face visits in their home during the review period. The visits must be documented per policy. Each visit is subject to recoupment based on policy and documentation requirements.** **The face-to-face quarterly visits cannot be conducted in consecutive months.** **The purpose of visits to the residence is to ensure the health and welfare of the participant in the home environment, assess the safety of the surroundings and to monitor for changes in the family status or dynamics, all of which might require changes to the plan.** **When only two quarterly face-to-face visits in the residence are completed during a plan year, those two visits cannot be in consecutive quarters of the year.** **During each visit to the residence the WCM is expected to make professional observations which could impact the health and welfare of waiver participants.**
G9-107 R	**Quarterly face to face visits are appropriately documented.**	**Upon WCM implementation, quarterly face to face visits must meet documentation standards and be completed within 7 days; if either requirement is not met the service may be subject to recoupment.** **The following must be documented in the service notes:** • **Did the family report changes in the residence or family status?** • **Does the participant/family know how to report ANE? If so, is there anything to report during this contact/visit?** • **Did the family report any changes in the participant's health status? If so, list the changes.** • **Based on professional observations or statements made by the participant/family, are increases/decreases or changes needed to the services? List the changes.** • **Are service terminations needed?** • **Have providers been delivering services as authorized? If not, explain.** • **Does the participant/family wish to make any changes with current providers/services on the plan? If so, describe the changes.** • **List the date and individuals present for the visit.** • **List the number of minutes used for the quarterly visit with the participant/family; and** • **WCM signature and title.** **Entries to the participant record must be documented on the date of the contact/visit. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the**

		actual contact/visit. All entries of the contact/visit must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.
G9-108	Participants received two (2) waiver services every thirty (30) days.	Upon implementation of WCM and waiver renewal, participants received 2 waiver services every 30 days.
G9-109 R	**When contacts (other than the required monthly contacts and required quarterly face to face contacts) are made or activities are conducted, the contact/activity is appropriately documented.**	**Upon implementation of WCM, when contacts/activities are conducted, they must be documented appropriately within 7 days, per policy.** **Refer to policy**
G9-110	Contacts (other than the required monthly contact and required quarterly face to face contact) are recorded as NON-REPORTABLE on CDSS if the required monthly contact and/or quarterly face-to-face visit has not been completed during the month/quarter with the participant/family member, or if the required monthly contact/quarterly visit is not documented in the participant's record within seven (7) calendar days of completion.	Other contacts are allowed if they are specifically designed to monitor the participant's progress or status regarding needs identified on the plan. The following contacts are allowable if the required monthly contact or quarterly face-to-face visit is completed during the month/quarter with the participant/family member, and the entire contact/visit is documented in the participant's record within seven (7) calendar days of completion: Telephone contact with Providers; Email communication with the professional community; School Visits; ADHC and other on-site day service visits with professional staff; These other allowable activities are not intended to supplant or replace the required monthly non-face-to-face contact or quarterly face-to-face visits with waiver participants and their family members. Reporting these other types of allowable contacts as "reportable" without completing the required monthly non-face-to-face contacts or quarterly visits with the participant/family, and the necessary required documentation may result in recoupment.
G9-111 R	**Service notes intended to document Waiver Case Management activities are sufficient in content to support Medicaid**	**Recoupment is intended to be directed to the incorrect entries.** **All entries to the participant record must be completed by the WCM who actually conducted the contact/activity.** **Documentation and service note entries specific to an individual must be maintained in a waiver participant record in chronological**

	billing.	**order. Documentation or references to other participants should not be incorrectly filed or noted in the waiver record.** **Service notes are expected to be entered into the record in a timely manner. This is defined as the day of, or within seven (7) calendar days of the activity, call, contact, visit or event.** **Entries to the participant record must be documented on the date of the contact/visit/activity. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the actual contact/visit/activity. All entries of the contact/visit/activity must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.** **All entries in the record should offer such detail and clarity that a different WCM or supervisor could review the waiver record and serve the participant with minimal difficulty.** **The following activities are allowed / reportable:** • **Conduct timely LOC reevaluations per Medicaid policy** • **Conduct annual participant assessments (within every 365 days)** • **Re-establish FOC document as needed according to policy** • **Develop annual service plans (within every 365 days) ensuring frequency, duration, amount and provider type for waiver services** • **Include identified State Plan or other needs on service plan** • **Provide linkage, and referral of waiver participants to federal, state, local or community programs and/or Medicaid benefits** • **Monitor access to and receipt of waiver services; address and correct problems identified in waiver service provision** • **Review service plans quarterly and amend with needed changes** • **Provide copy of completed annual service plan to participant/legal representative** • **Conduct ongoing monitoring of the service plan with the**

		participant/family during monthly non-face-to-face contacts, or quarterly face-to-face visits. At least every other quarterly contact must be made in the residence • **Conduct all necessary follow up activities as a result of the contacts/visits with participant/family** • **Perform ongoing monitoring of the participant's health and welfare** • **Monitor participant's emergency/evacuation plan** • **Respond to urgent, emergent or unplanned circumstances for participant.** • **Document participant record according to professional protocols and policy** • **Provide information about participant/representative-directed care services, including benefits and risks** • **Assess and document the absence of cognitive deficits in the participant or representative that would preclude the use of participant/representative care if selected** • **Provide participant/representative information about hiring, management and termination of workers, as well as, the role of the Financial Management System** • **If voluntary or involuntary termination of attendant care, in-home supports, or EIBI line therapy, provide a list of qualified providers to assist with replacement** • **Offer and document choice of qualified providers, as needed and upon request** • **Offer and document choice of qualified waiver case management providers at least annually and upon request** • **Inform waiver participant/ representative about and monitor individual cost cap for CS and PDD waivers** • **Provide Reconsideration/Appeal rights when appropriate and according to policy** • **Participate in witness preparation, testify, and/or provide records and evidence on behalf of SCDHHS/SCDDSN for Medicaid Waiver Appeals and Hearings as required, acting as an agent of the State** • **Assist with service delivery problems/service provider resolution or other problems as requested**

		• **Review and submit appropriate caregiver logs for payment; contact provider if logs are inappropriate to resolve outstanding issues** • **Suspend waiver/state plan services when participants enter inpatient facilities (hospital, nursing facility or ICF/ID)** • **According to circumstances, properly suspend, deny, terminate or reduce waiver/state plan services with "Notice"** • **Complete waiver termination information timely** • **Determine other participant resources such as third party liability (TPL) or Medicare and provide information to providers** • **Inform new waiver enrollees that the waiver program is not a source of 24 hour care, excluding Residential Habilitation** • **Maintain written or electronically retrievable records for a minimum of five (5) years unless under appeal or other guidance from SCDHHS** • **On an annual basis provide participant/representative written information about what constitutes abuse and how to report. This must be documented in the participant record** • **Provide participant/representative of their rights annually and document this in the participant record** • **Assess for Children's Personal Care (CPCA)/State Plan Nursing/Incontinence Supplies/Respite/EIBI services using approved assessment documents** • **Follow policy for approval of CPCA hours/State Plan Nursing hours/respite hours/incontinence supplies/EIBI services** • **Comply with out-of-state policy for waiver participants making short-term visits out of South Carolina** • **At the time of enrollment waiver case managers must provide information about available waiver services** • **WCM must understand the limitations subject to DDSN or Medicaid Policy for HASCI participants who use attendant care services directed by a representative** • **Waiver case managers will report critical incidents according to approved policy.** • **On an annual basis, waiver case managers must review and obtain the participant/representatives signature on the Rights and Responsibility Statement**

		• **Waiver case managers must review caseloads with supervisors as required for Quality Assurance/Team Staffing or discharge planning purposes** **The following activities may be reportable if provided to a participant who is preparing for discharge from a facility to the waiver. These activities can be conducted for 120 days prior to the actual date of waiver enrollment:** • **Using approved form, document Freedom of Choice (FOC) between institution and home and community-based services.** • **Initiate level of care (LOC) determinations** • **Conduct an initial participant assessment** • **Establish updates to LOC through State-approved process if LOC expires** • **Complete waiver enrollment information timely** • **Verify that waiver applicant is not enrolled in another waiver, state plan or managed care program prior to submitting enrollment request, or coordinating program transition as needed** **Waiver case management does not allow the direct delivery of waiver, state plan or any other services. The following activities are <u>NON-reportable /allowable activities.</u> This list is not all-inclusive and is simply intended as a guide.** • **Activities provided by anyone other than the individual who meets the qualifications to be a waiver case manager, even if they are working under the supervision of a case manager.** • **Unsuccessful telephone attempts to contact the waiver participant/family and provider.** • **Review of the waiver case management record.** • **Participating in social or recreational activities at the invitation of the waiver participant/family.** • **Rendering WCM to individuals in institutional placement except during the last 120 days of the institutional stay prior to waiver enrollment for the purpose of transitional and/or discharge planning.** • **Rendering WCM services to waiver participants while incarcerated, in jail, prison or other detention/evaluation centers.** • **Time spent documenting waiver contacts/activities.** • **Completing administrative duties such as copying, filing, or**

		mailing reports. • **Rendering activities on behalf of the participant/family related to judicial matters, court/legal proceedings.** • **Rendering services/activities on behalf of the family after the death of a waiver participant.** • **Providing training/the provision or personal care, daily living skills, job skills, or social skills.** • **Training or provision of housekeeping, laundry, cooking or household chores.** • **Providing individual group or family therapy.** • **Providing child care or adult elder care for the participant/family.** • **Providing transportation/escort services.** • **Obtaining food at food bank, grocery store.** • **Delivering supplies, prescriptions, clothing/laundry, Christmas trees or gifts.** • **Accompanying participant/family to medical visits.** • **Setting up medications such as a pill box.** • **Paid or unpaid time off.** • **Services provided by more than one case manager to the same participant at the same time.** • **Staff meetings, trainings, travel-time, and supervision.** • **Contacts with administrative or secretarial staff within the agency.** • **Scheduling case manager's appointments.** • **Claim submission and collection activities.** • **Calls or emails to the information technology helpdesk.** • **Reading mail or newspaper to the participant/family.** • **Financial tasks such as paying bills, applying/submitting for loan applications, and/or taking the participant/family member to the bank.** • **Going to the library or running errands on behalf of the participant/family.** • **Taking participant/family member to get driver's license/moped license/voter ID.** • **Preparing documentation, filing appeals or testifying at appeals on behalf of participant/family member or any other entity.** • **Home decorating or house or apartment hunting for the participant/family.** • **Taking participant/family member to beauty salon or barber shop.** • **Yard/garden work for the participant/family.** • **Taking the participant/family member vehicles, electronics or appliances for repairs; and** • **Traveling to and from appointments on behalf of the participant/family.**

G10	PDD Program	Guidance
G10-01 R	**PDD Waiver participants must meet all eligibility criteria**	**Review the record to determine if the child meets the criteria for services through the PDD Program:** • **Be ages 3 through 10 years.** • **Diagnosed with a PDD by age eight years. The diagnosis must be made by a qualified, licensed or certified diagnostician. Children who are currently eligible for DDSN under the Autism Division must meet these criteria.** • **Meet Medicaid financial criteria or provide documentation of financial ineligibility for Medicaid.** • **Meets ICF/ID Level of Care medical criteria (as determined by the DDSN Consumer Assessment Team for this program).** **Source: PDD Waiver Manual**
G10-02	The Freedom of Choice Form is present for PDD Waiver recipients	Review the record to ensure that the Freedom of Choice form is present in the record. The form must be "checked" to indicate choice of Waiver services in the community over institutionalization and signed by the child's parent/legal guardian.
G10-03	The Initial Level of Care is present	Review the initial LOC determination to determine if it was completed prior to or on the date of Waiver enrollment.
G10-04 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination and is completed by the Consumer Assessment Team**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/ID evaluations are requested from SCDDSN's Consumer Assessment Team. The Case Manager must submit a packet of information to the team to determine LOC. Reevaluations are completed by the Consumer Assessment Team. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2003 the effective date would be 7/3/03 with an expiration date of 7/2/04.**
G10-05 W	Documentation is present verifying that a choice of providers was offered to the child's parents/legal guardians for each PDD service	Review the contact notes, the child's Plan and other file documents to determine if the parents/legal guardians were given a choice of provider of service before the service (i.e. Case Management and EIBI) was authorized.
G10-06	The Acknowledgment of Rights and Responsibilities is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates on the current and previous forms to ensure they have been completed annually.
G10-07	PDD services are provided in accordance with the service definitions	Review Service definitions in the PDD Manual for each service that the child is receiving. Review the child's Plan, contact notes and relevant service authorizations to ensure that services are being provided according to the definitions. Note: Correct terminology is required (example: "EIBI" not ABA)
G10-08	For PDD Waiver recipients, PDD Waiver	Review services notes and the Plan to ensure that the person has received or is receiving at least one Waiver service every 30 days during

	services are received at least every 30 days	the review period. A service must be received at least every 30 days. If at least one service was not received every 30 days, the person should have been disenrolled from the Waiver.
G10-09 R	**Authorization forms are completed for services, as required, prior to service provision**	**Review the child's budget and Plan to ensure that Authorization for Services forms are present and compare the Date Authorization Issued to the Enrollment Date and Authorization Effective Date.**
G10-10	The Person/Legal Guardian was notified in writing regarding any denial or termination of PDD services with accompanying appeals information	Review contact notes to determine if during the review period any Waiver services were reduced, suspended, terminated or denied. If this is noted, then review the contact notes to determine if the parent/legal guardian was notified in writing and provided with the appropriate appeals process.
G10-11	The Plan clearly includes and justifies the need for all PDD Waiver services received	Review the Plan, service authorizations to ensure that all PDD Waiver services are included and supported by assessed need in the child's Plan. Services should be identified and provided according to PDD Waiver service definitions. • Each need is to be addressed separately. • The term "EIBI" should be used to introduce the service (e.g. EIBI Assessment, EIBI Plan Implementation, etc.)
G10-12 R	**The Plan is amended/ updated as needed**	**When service changes are identified as needed in the participant's waiver record but the CM fails to update the plan, the CM services will be identified for recoupment by the reviewer.** **Review all plans and service notes in effect during the review period to determine if:** **a. updates are made when new service needs or interventions are identified,** **b. there have been significant changes in the person's life,** **c. a service is determined to not be effective,** **d. a need/s has/have been met,** **e. the person is not satisfied.** **When any part of the "Needs/Interventions" section (Section D) of the plan is no longer current, an amendment/update must be completed using the CAP module of CDSS. It is acceptable to have a brief service note provided the change/update is explained in detail on the "needs change" form printed from the CAP module of CDSS for the file. For new needs identified during the course of the year, needs assessment and identification of the need will be in the service notes and, if applicable, a new "needs/interventions" page will be added to the plan using the CAP module of CDSS. Plan must be current at all times.** **Source: Support Plan Instructions, and Waiver Manuals.** **Supports CQL Shared Values Factor 8**
G10-13	The record must reflect that the child's	Review the Case Management record to ensure the child's parent/legal guardian was afforded the opportunity to participate in planning. This

	parent/legal guardian was offered the opportunity to participate in planning	should be demonstrated in the record by inviting the child's parent/legal guardian to meet to discuss plans, by scheduling the meeting (If a meeting is chosen) at a time and location that facilitated participation, by soliciting input prior to the actual meeting if attendance is not possible, or by allowing participation in the meeting by phone or other means. The requirement is that the opportunity be afforded, not that participation occur.
G10-14	The parent/legal guardian was provided a copy of the Plan	Review the service notes to verify that the child's parent/legal guardian was provided a copy of the Plan.
G10-15 R	**Case Managers who serve children in the PDD Program must meet the minimum requirements for the position**	**Determine from personnel records if the minimum requirements for employment were met.** **Refer to Conditions of Participation in Chapter 8 of the PDD Manual, items 1-5.**
G10-16 R	**Records include documentation of verification that Case Managers are free from tuberculosis**	**Review TB results of each Case Manager from personnel sample. Check documentation for the following:** • **Must have a PPD Tuberculin skin test no more than ninety (90) days prior to employment, unless a previously positive reaction can be documented. Must have a PPD Tuberculin skin test no more than ninety (90) days prior to employment, unless a previously positive reaction can be documented.** • **In lieu of a PPD tuberculin test no more than 90 days prior to employment, a new employee may provide certification of a negative tuberculin skin test within the 12 months preceding the date of employment and certification from a licensed physician or local health department TB staff that s/he is free of the disease.** • **Employees with negative tuberculin skin tests shall have an annual tuberculin skin test.** • **New employees who have a history of tuberculosis disease and have had adequate treatment shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared non-contagious.** **Refer to Conditions of Participation in Chapter 8 of the PDD Manual, items #6.**
G10-17	Case Managers will provide at least 1 monthly contact with the EIBI service providers and/or family to determine progress/lack of progress on established goals and/or person satisfaction with EIBI	Review contact notes in the records to determine if the parents and/or provider has been contacted monthly. Review the Monthly Progress Report and Therapy Documentation Sheet received from the provider to determine progress or the lack of progress. Review contact notes to determine if Case Manager received complaints from families about provider services and, if the Case Manager discussed the concerns with the provider.

	providers	
G10-18	Case Managers will contact the child's family quarterly	Review contact notes and other documentation to determine: • If the family received quarterly contact from the Case Manager • If the entire Support Plan was reviewed and discussed • If the most recent EIBI service provider Quarterly Treatment/Progress Plan Report was reviewed and discussed.
G10-19 W	Case Managers will have at least one face-to-face contact visit with the child and their family annually	Review service notes in the Case Management record to determine if the child served has received face-to-face-contact by the Case Manager at least once per Plan year during each 365-day period.
G10-20 R	**Case Managers will ensure the Plan is developed, reviewed and approved every 365 days or more often if needed**	**Review current Plan in the child's record. A current Plan must be present and signed by the Case Manager. A current Plan is defined as one completed within the last 365 days. A Plan must be completed:** • **Within 365 days of the last plan** • **Before PDD Services are authorized or provided**
G10-21 R	**Case Managers are responsible for preparing and submitting all documents needed for timely determination of the ICF/ID LOC by the Consumer Assessment Team. The most current Level of Care Determination is dated within 365 days of the last Level of Care determination**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/ID evaluations are requested from SCDDSN's Consumer Assessment Team. The Case Manager must submit a packet of information to the team to determine LOC. Reevaluations are completed by the Consumer Assessment Team. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2003 the effective date would be 7/3/03 with an expiration date of 7/2/04.**
G10-22	Case Managers must document all activities in the child's record	Contact notes must include the following: name and title of contact person, type of contact, location of contact, purpose of contact, intervention or services provided, the outcome, needed follow-up, and the date and signature of the Case Manager.
G10-23	Case Managers must document the date on which the child's referral was first received and the date all actions taken thereafter	Review contact notes to determine if the family's initial choice of a Case Management provider was documented. Review the records for the Choice of Provider form and ensure it was signed and dated by the child's parents/legal guardians. Review the notes to ensure all subsequent entries are dated.
G10-24	Case record documentation must reflect that the child's parents were given	Review the contact notes and the person's Plan to determine if the parent/legal guardian was given information on all EIBI qualified providers in the State of South Carolina and given guidance on which providers are in close proximity to the parent/legal guardian's community.

	information on all EIBI qualified providers in the State and given guidance on which providers are in close proximity to the parent/legal guardian's community	
G10-25	Case Managers must utilize required forms, completed properly, and they must include the required signatures	Review the PDD Manual including the index of forms. Compare this to the actual documents found in the person's file to determine proper usage. Review all documents for signatures and dates as required.
G10-26	Case Manager's must assure, and records must reflect that each child's parent has been provided with information about how to file a complaint	Review records to ensure that parents are provided information on the Reconsideration/Appeals Process at least annually and at any relevant action such as termination or denial of services.
G10-27	Case Managers are required to attend at least one in-service training annually related to autism and the provision of case management to individuals enrolled in the PDD Waiver. The training must be facilitated by the Autism Division.	Review documentation in the personnel file to ensure annual training occurred as required.
G10-28 W	Case Management records are maintained and include required information	Review the Case Management record to determine if records include the following: • A current Single/Support Plan (After 7/1/07 the Support Plan will be used) • Current IEP (for school age children) It is only required to • Obtain a new/current IEP during annual Service Coordination plan development. • Service Notes (when reviewing service notes, check to make sure that service notes are typed or handwritten in black or dark blue ink, legible, in chronological order, entries dated and signed with the date, Case Manager's name and title or initials (a signature/initial sheet must be maintained at the Case Management provider's office), if abbreviations or symbols are used, there is a list of any abbreviations or symbols maintained at the Case Management provider's office, persons referenced are identified by their relationship to the person receiving services either at least once on each page or on a separate list located in each record, proper error correction procedures are followed if errors have occurred and no correction fluid or erasable ink was used)

G10-29 R	**Written notification made for denial, reduction, suspension, or termination of a Waiver service and information for reconsideration and appeal provided**	**When participant records that indicate the CM failed to submit correct waiver service denials, terminations, reductions or suspensions, the CM billable activities will be subject to recoupment. Waiver services allowed to pay due to the CM's error are subject to recoupment.** **Review participant's Support Plan and revisions, Service Notes, and other documentation to determine if any Waiver services were denied, reduced, temporarily suspended, or terminated in the review period.** **If any of these actions occurred, verify the participant or Legal Guardian was given written notification specifying the reason and was provided information concerning the reconsideration/appeals process.** **Note: If the participant/legal guardian (if applicable) requested to terminate, suspend, or reduce the services, this indicator is N/A**
G10-30 R	**Waiver termination properly completed**	**When participant records that indicate the CM failed to complete termination forms properly, CM activities are subject to recoupment. Waiver services allowed to pay due to the CM error are subject to recoupment.** **Review participant's Service Notes and other documentation to determine if participant was terminated from the Waiver in the review period. If this action occurred, verify Service Coordinator sent a Waiver Termination Form 2 working days after determining that termination was required.** **Except for termination due to death, verify participant or Legal Guardian was given written notification of Waiver termination specifying reason and was provided information concerning SCDDSN Reconsideration and SCDHHS Appeal.**

G10-100	PDD Waiver Case Management Activities	Guidance DDSN will provide notification of an effective date.
G10-101 R	For newly enrolled waiver participants, the first non-face-to-face contact is completed within 30 days of waiver enrollment.	Upon implementation of WCM, for new enrollees, the waiver case manager's first non-face-to-face contact must be completed within 30 days of waiver enrollment and documented within 7 days, per policy. The WCM billing for this activity is recoupable if not documented within 7 days. Please refer to the WCM policy for additional guidance and exact text. For participants enrolled in the waiver since implementation of Waiver Case Management or within the past 12 months, whichever is sooner, determine if non-face to face contact occurred within the first 30 days.
G10-102 R	For newly enrolled waiver participants, the first quarterly face-to-face visit is completed within 90 days of waiver enrollment.	Upon implementation of WCM, for new enrollees, the waiver case manager's first face-to-face contact must be completed within the first 90 days and documented within 7 days, per policy. The WCM billing for this activity is recoupable if not documented within 7 days. Please refer to the WCM policy for additional guidance and exact text. For participants enrolled in the waiver for 90 days or more, determine if a face to face visit occurred within 90 days of enrollment.
G10-103 R	Each month, except during the months when required quarterly face-to face visits are completed, a non-face to face contact is made with the participant or his/her representative.	Upon implementation of WCM, WCM services billed but not documented per policy during the review period may be subject to recoupment. It is expected that during each month of the plan year there will be either a non-face-to face contact or a face-to-face visit with the waiver participant/family member. A non- face-to face contact with the participant/family must be completed by the WCM in each calendar month when a quarterly visit is not required. The purpose of the non-face-to-face contacts/activities is to establish meaningful communication with the participant/family in order to review and monitor Plan and current services and to monitor the participant's health and welfare, and changes in the residence and/or family status. The monthly non-face-to-face contact is intended to be made by telephone to the participant/family for the majority of waiver participants. The purpose is for meaningful discussion on behalf of the waiver participant in order to monitor the plan, services, and the participant's health and welfare.

G10-104 R	**Non-face to face contact is appropriately documented in services notes.**	**Upon implementation of WCM, the WCM should not bill for notes that were not documented appropriately. Recoupment is intended to be directed to the incorrect entries.** **The entire contact/visit must be documented in the service notes including:** • **Are the current services meeting the participant's needs?** • **What changes in the residence or family status warrant revisions to current services/plan? List the changes.** • **Does the participant/family know how to report abuse, neglect, and exploitation (ANE)? If so, is there anything to report this month?** • **Based on statements made by the participant/family, are increases/decreases or changes needed to the services? List the changes.** • **Are service terminations needed?** • **What follow-up activities or contact with providers is needed based on this monitoring?** • **List the date and the individual(s) who participated in the contact.** • **List the number of minutes used for the contact; and** • **WCM signature and title** **Entries to the participant record must be documented on the date of the contact/visit. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the actual contact/visit. All entries of the contact/visit must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.**
G10-105 R	**A minimum of four (4) quarterly face-to face visits are made with the participant/family each plan year.**	**Upon WCM implementation WCM, WCM policy requires a minimum of 4 quarterly face to face visits each year. The visits must be documented per policy within 7 days to be billable. This indicator relates to these 4 visits, not other WCM activities. Each visit is subject to recoupment based on policy and documentation requirements.** **At least four quarterly face to face visits are required each plan year. Two (2) of the required four (4) quarterly face-to-face visits must be in the participant's residence. The other two (2) may be at other locations.** **The purpose of the non-face-to-face contacts/activities and the face-to-face quarterly visits is to establish meaningful communication with the participant/family in order to review and monitor the Plan and current services. It is also important to monitor the participant's health and welfare, and changes in the residence and/or family status which could impact the participant's needs.** **The face-to-face quarterly visits cannot be conducted in consecutive**

		months.
G10-106 R	**Two of the four (4) quarterly face-to face visits with the participant/family are conducted in the participant's residence and are conducted every other quarter of the plan year.**	**Upon WCM implementation, WCM policy requires the participant to receive 2 of the 4 quarterly WCM face to face visits in their home during the review period. The visits must be documented per policy. Each visit is subject to recoupment based on policy and documentation requirements.** **The face-to-face quarterly visits cannot be conducted in consecutive months.** **The purpose of visits to the residence is to ensure the health and welfare of the participant in the home environment, assess the safety of the surroundings and to monitor for changes in the family status or dynamics, all of which might require changes to the plan.** **When only two quarterly face-to-face visits in the residence are completed during a plan year, those two visits cannot be in consecutive quarters of the year.** **During each visit to the residence the WCM is expected to make professional observations which could impact the health and welfare of waiver participants.**
G10-107 R	**Quarterly face to face visits are appropriately documented.**	**Upon WCM implementation, quarterly face to face visits must meet documentation standards and be completed within 7 days; if either requirement is not met the service may be subject to recoupment.** **The following must be documented in the service notes:** • **Did the family report changes in the residence or family status?** • **Does the participant/family know how to report ANE? If so, is there anything to report during this contact/visit?** • **Did the family report any changes in the participant's health status? If so, list the changes.** • **Based on professional observations or statements made by the participant/family, are increases/decreases or changes needed to the services? List the changes.** • **Are service terminations needed?** • **Have providers been delivering services as authorized? If not, explain.** • **Does the participant/family wish to make any changes with current providers/services on the plan? If so, describe the changes.** • **List the date and individuals present for the visit.** • **List the number of minutes used for the quarterly visit with the participant/family; and** • **WCM signature and title.**

		Entries to the participant record must be documented on the date of the contact/visit. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the actual contact/visit. All entries of the contact/visit must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.
G10-108	Participants received two (2) waiver services every thirty (30) days.	Upon implementation of WCM and waiver renewal, participants received 2 waiver services every 30 days.
G10-109 R	**When contacts (other than the required monthly contacts and required quarterly face to face contacts) are made or activities are conducted, the contact/activity is appropriately documented.**	**Upon implementation of WCM, when contacts/activities are conducted, they must be documented appropriately within 7 days, per policy.** **Refer to policy**
G10-110	Contacts (other than the required monthly contact and required quarterly face to face contact) are recorded as NON-REPORTABLE on CDSS if the required monthly contact and/or quarterly face-to-face visit has not been completed during the month/quarter with the participant/family member, or if the required monthly contact/quarterly visit is not documented in the participant's record within seven (7) calendar days of completion.	Other contacts are allowed if they are specifically designed to monitor the participant's progress or status regarding needs identified on the plan. The following contacts are allowable if the required monthly contact or quarterly face-to-face visit is completed during the month/quarter with the participant/family member, and the entire contact/visit is documented in the participant's record within seven (7) calendar days of completion: Telephone contact with Providers; Email communication with the professional community; School Visits; ADHC and other on-site day service visits with professional staff; These other allowable activities are not intended to supplant or replace the required monthly non-face-to-face contact or quarterly face-to-face visits with waiver participants and their family members. Reporting these other types of allowable contacts as "reportable" without completing the required monthly non-face-to-face contacts or quarterly visits with the participant/family, and the necessary required

		documentation may result in recoupment.
G10-111 R	**Service notes intended to document Waiver Case Management activities are sufficient in content to support Medicaid billing.**	**Recoupment is intended to be directed to the incorrect entries.** **All entries to the participant record must be completed by the WCM who actually conducted the contact/activity.** **Documentation and service note entries specific to an individual must be maintained in a waiver participant record in chronological order. Documentation or references to other participants should not be incorrectly filed or noted in the waiver record.** **Service notes are expected to be entered into the record in a timely manner. This is defined as the day of, or within seven (7) calendar days of the activity, call, contact, visit or event.** **Entries to the participant record must be documented on the date of the contact/visit/activity. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the actual contact/visit/activity. All entries of the contact/visit/activity must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.** **All entries in the record should offer such detail and clarity that a different WCM or supervisor could review the waiver record and serve the participant with minimal difficulty.** **The following activities are allowed / reportable:** • **Conduct timely LOC reevaluations per Medicaid policy** • **Conduct annual participant assessments (within every 365 days)** • **Re-establish FOC document as needed according to policy** • **Develop annual service plans (within every 365 days) ensuring frequency, duration, amount and provider type for waiver services** • **Include identified State Plan or other needs on service plan** • **Provide linkage, and referral of waiver participants to federal, state, local or community programs and/or Medicaid benefits** • **Monitor access to and receipt of waiver services; address and correct problems identified in waiver service provision** • **Review service plans quarterly and amend with needed**

		changes • **Provide copy of completed annual service plan to participant/legal representative** • **Conduct ongoing monitoring of the service plan with the participant/family during monthly non-face-to-face contacts, or quarterly face-to-face visits. At least every other quarterly contact must be made in the residence** • **Conduct all necessary follow up activities as a result of the contacts/visits with participant/family** • **Perform ongoing monitoring of the participant's health and welfare** • **Monitor participant's emergency/evacuation plan** • **Respond to urgent, emergent or unplanned circumstances for participant.** • **Document participant record according to professional protocols and policy** • **Provide information about participant/representative-directed care services, including benefits and risks** • **Assess and document the absence of cognitive deficits in the participant or representative that would preclude the use of participant/representative care if selected** • **Provide participant/representative information about hiring, management and termination of workers, as well as, the role of the Financial Management System** • **If voluntary or involuntary termination of attendant care, in-home supports, or EIBI line therapy, provide a list of qualified providers to assist with replacement** • **Offer and document choice of qualified providers, as needed and upon request** • **Offer and document choice of qualified waiver case management providers at least annually and upon request** • **Inform waiver participant/ representative about and monitor individual cost cap for CS and PDD waivers** • **Provide Reconsideration/Appeal rights when appropriate and according to policy** • **Participate in witness preparation, testify, and/or provide records and evidence on behalf of SCDHHS/SCDDSN for**

		Medicaid Waiver Appeals and Hearings as required, acting as an agent of the State • **Assist with service delivery problems/service provider resolution or other problems as requested** • **Review and submit appropriate caregiver logs for payment; contact provider if logs are inappropriate to resolve outstanding issues** • **Suspend waiver/state plan services when participants enter inpatient facilities (hospital, nursing facility or ICF/ID)** • **According to circumstances, properly suspend, deny, terminate or reduce waiver/state plan services with "Notice"** • **Complete waiver termination information timely** • **Determine other participant resources such as third party liability (TPL) or Medicare and provide information to providers** • **Inform new waiver enrollees that the waiver program is not a source of 24 hour care, excluding Residential Habilitation** • **Maintain written or electronically retrievable records for a minimum of five (5) years unless under appeal or other guidance from SCDHHS** • **On an annual basis provide participant/representative written information about what constitutes abuse and how to report. This must be documented in the participant record** • **Provide participant/representative of their rights annually and document this in the participant record** • **Assess for Children's Personal Care (CPCA)/State Plan Nursing/Incontinence Supplies/Respite/EIBI services using approved assessment documents** • **Follow policy for approval of CPCA hours/State Plan Nursing hours/respite hours/incontinence supplies/EIBI services** • **Comply with out-of-state policy for waiver participants making short-term visits out of South Carolina** • **At the time of enrollment waiver case managers must provide information about available waiver services** • **WCM must understand the limitations subject to DDSN or Medicaid Policy for HASCI participants who use attendant care services directed by a representative** • **Waiver case managers will report critical incidents according**

		to approved policy. • **On an annual basis, waiver case managers must review and obtain the participant/representatives signature on the Rights and Responsibility Statement** • **Waiver case managers must review caseloads with supervisors as required for Quality Assurance/Team Staffing or discharge planning purposes** **The following activities may be reportable if provided to a participant who is preparing for discharge from a facility to the waiver. These activities can be conducted for 120 days prior to the actual date of waiver enrollment:** • **Using approved form, document Freedom of Choice (FOC) between institution and home and community-based services.** • **Initiate level of care (LOC) determinations** • **Conduct an initial participant assessment** • **Establish updates to LOC through State-approved process if LOC expires** • **Complete waiver enrollment information timely** • **Verify that waiver applicant is not enrolled in another waiver, state plan or managed care program prior to submitting enrollment request, or coordinating program transition as needed** **Waiver case management does not allow the direct delivery of waiver, state plan or any other services. The following activities are <u>NON-reportable /allowable activities.</u> This list is not all-inclusive and is simply intended as a guide.** • **Activities provided by anyone other than the individual who meets the qualifications to be a waiver case manager, even if they are working under the supervision of a case manager.** • **Unsuccessful telephone attempts to contact the waiver participant/family and provider.** • **Review of the waiver case management record.** • **Participating in social or recreational activities at the invitation of the waiver participant/family.** • **Rendering WCM to individuals in institutional placement except during the last 120 days of the institutional stay prior to waiver enrollment for the purpose of transitional and/or**

		discharge planning. • **Rendering WCM services to waiver participants while incarcerated, in jail, prison or other detention/evaluation centers.** • **Time spent documenting waiver contacts/activities.** • **Completing administrative duties such as copying, filing, or mailing reports.** • **Rendering activities on behalf of the participant/family related to judicial matters, court/legal proceedings.** • **Rendering services/activities on behalf of the family after the death of a waiver participant.** • **Providing training/the provision or personal care, daily living skills, job skills, or social skills.** • **Training or provision of housekeeping, laundry, cooking or household chores.** • **Providing individual group or family therapy.** • **Providing child care or adult elder care for the participant/family.** • **Providing transportation/escort services.** • **Obtaining food at food bank, grocery store.** • **Delivering supplies, prescriptions, clothing/laundry, Christmas trees or gifts.** • **Accompanying participant/family to medical visits.** • **Setting up medications such as a pill box.** • **Paid or unpaid time off.** • **Services provided by more than one case manager to the same participant at the same time.** • **Staff meetings, trainings, travel-time, and supervision.** • **Contacts with administrative or secretarial staff within the agency.** • **Scheduling case manager's appointments.** • **Claim submission and collection activities.** • **Calls or emails to the information technology helpdesk.** • **Reading mail or newspaper to the participant/family.** • **Financial tasks such as paying bills, applying/submitting for loan applications, and/or taking the participant/family member to the bank.** • **Going to the library or running errands on behalf of the participant/family.** • **Taking participant/family member to get driver's license/moped license/voter ID.** • **Preparing documentation, filing appeals or testifying at appeals on behalf of participant/family member or any other entity.** • **Home decorating or house or apartment hunting for the participant/family.** • **Taking participant/family member to beauty salon or barber shop.** • **Yard/garden work for the participant/family.** • **Taking the participant/family member vehicles, electronics or appliances for repairs; and** • **Traveling to and from appointments on behalf of the participant/family.**

G-11	Community Supports Waiver Activities	Guidance
G11-01 R	**The Plan is developed as required**	**Review current Plan. A current Plan must be present. A current Plan is defined as one completed within the last 365 days. When there is a leap year, the plan date would be calculated accordingly to ensure the plan is developed and signed within 365 days.** **Except for those transferring from an ICF/ID, Plans must be entered into the Consumer Data and Support System (CDSS) using the Consumer Assessment and Planning (CAP) module unless otherwise approved by SCDDSN. The Plan implementation date is the date a plan is completed in the CAP module of CDSS.** **The plan must be developed before waiver services are authorized.**
G11-02 R	**The Plan includes COMMUNITY SUPPORTS Waiver service/s name, frequency of service/s, amount of service/s, duration of service/s, and valid provider type for service/s**	**For each waiver service received by the person, the plan must document the need for the service, the correct waiver service name, the amount, frequency, duration and the provider type (refer to the COMMUNITY SUPPORTS Waiver Document for provider types/Chapter 2, CSW Manual)** **The amount of a service that is authorized in units should be specified in units, not in hours or days. The frequency of a service must be expressed in a manner that is consistent with how the service is authorized (e.g. "per month" or "monthly" for Respite, "per week" or "weekly" for Personal Care).** **Note: Regarding "duration" check only that a duration is specified.** **Source: COMMUNITY SUPPORTS Waiver Manual**
G11-03	Service needs outside the scope of Waiver services are identified in Plans and addressed	Review the Plan, service notes, and other documentation in the record to ensure that the Waiver Case Manager has identified and addressed all service needs regardless of the funding source. Source: COMMUNITY SUPPORTS Waiver Manual
G11-04	Needs in the Plan are justified by formal or informal assessment information in the record	Review the record to determine if formal or informal assessment information is available to justify the "need" noted on the Plan for which interventions are being implemented. The assessment information (formal or informal) must be current and accurate. Formal and/or informal assessments may include information provided by the person and/or his/her caregivers about the person's current situation, medical status, school records or other formalized assessment tools. At the time of annual planning, the *SCDDSN Service Coordination Annual Assessment* will be used to identify needs and justify services/interventions reflected in the Support Plan. The *SCDDSN Service Coordination Annual Assessment* (SCAA) must be completed on the CAP module of CDSS unless otherwise approved by SCDDSN. Information from providers currently providing services should be

		considered in planning. The record should reflect attempts to secure information from all current service providers. Attempts should be made in sufficient time prior to planning so that information can be secured. If the person is enrolled in the Waiver, then formal or informal assessments and recommendations for all Waiver services will be present. Needs assessment during the course of the year *outside* of annual planning will be documented in the service notes. Source: "Guidelines on How to Complete the SCDDSN Annual Service Coordination Assessment", Support Plan Instructions, Community Supports Waiver Manual pertaining to needs assessment.
G11-05	Assessment(s) justify the need for all COMMUNITY SUPPORTS Waiver services included on the plan	Review the Plan, DDSN Service Coordination Annual Assessment, and service notes to ensure that all COMMUNITY SUPPORTS Waiver services included on the Plan are supported by assessed need. Source: COMMUNITY SUPPORTS Waiver Manual
G11-06	Services/ Interventions are appropriate to meet assessed needs	Interventions are identified to address assessed "needs". Interventions must have a logical connection to the need. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"* for defined resources and the Service Coordination Standards glossaries. Also, reference Community Supports Waiver Manual.
G11-07	The Plan identifies appropriate funding sources for services/interventions	Appropriate funding sources are identified for every service/intervention. Review the person's "current resources" identified in the SCDDSN Service Coordination Annual Assessment (or the service notes when needs assessment occurs outside of planning and resources have changed from those noted on the Plan) to determine what resources the person has. Compare the person's resources to the services/interventions noted on the Plan to determine if the appropriate funding source is listed for the service/intervention to be/being provided. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"* for defined resources Community Supports Waiver Manual.
G11-08	The Plan is provided to the participant/ representative.	A copy of the completed annual plan is provided to the participant/ representative.
G11-09 R	**The Plan is amended / updated as needed**	**When service changes are identified as needed in the participant's waiver record but the CM fails to update the plan, the CM services will be identified for recoupment by the reviewer.** **Review all plans and service notes in effect during the review period to determine if:** **a. updates are made when new service needs or interventions**

		are identified, **b. there have been significant changes in the person's life,** **c. a service is determined to not be effective,** **d. a need/s has/have been met,** **e. the person is not satisfied.** **When any part of the "Needs/Interventions" section (Section D) of the plan is no longer current, an amendment/update must be completed using the CAP module of CDSS. It is acceptable to have a brief service note provided the change/update is explained in detail on the "needs change" form printed from the CAP module of CDSS for the file. For new needs identified during the course of the year, needs assessment and identification of the need will be in the service notes and, if applicable, a new "needs/interventions" page will be added to the plan using the CAP module of CDSS. Plan must be current at all times.** **Source: Support Plan Instructions, and Community Supports Waiver Manual.** **Supports CQL Shared Values Factor 8**
G11-10 W	Contact occurs as required: a) Face-to-face contacts occur every 6 months b) Every other month (bi-monthly), at least one contact (as defined by SC Standards) is made	***DDSN will provide notification when this key indicator is no longer applicable***. Beginning 7/1/11, review to determine that: a) Face-to-face visits occur every 6 months and are with the person receiving services. b) At least one contact is made every other month (bi-monthly). A contact is defined as any of the following: • A face-to-face encounter for the purpose of performing a core function. • A telephone call, letter or email when a face-to-face contact is not required or is not possible for the purpose of performing a core function Source: Service Coordination Standards
G11-11	The Plan is reviewed at least every 6 months	***DDSN will provide notification when this key indicator is no longer applicable.*** 1. Review the Plan to determine if all needs and interventions were reviewed as often as needed, but at least every 6 months. 2. Ensure that needs and interventions were implemented as prescribed in the Plan. Six Month reviews are completed on the CAP module of CDSS. Monitoring/review forms on CAP include all of the necessary components of monitoring Refer to Service Coordination Standards and Support Plan Instructions
G11-12	A valid Service Agreement is present	A valid Service Agreement (review most recently completed Service Agreement to assure that it is dated and signed.) For children and for

	and signed as appropriate	adult's adjudicated incompetent, the current legal guardian (if applicable) must sign the form. For those 18 years and older or those with a name change, a new Service Agreement should be signed by the person. The most current Service Agreement that is signed and dated by the appropriate party must be filed in the primary case record. Score "Not Met" if there is not a Service Agreement in the primary case record and/or it is not signed and dated by the appropriate party. If a person is unable to sign but can make their "mark", the mark must be witnessed. If a person is unable to sign or make their mark on the Service Agreement, there will be an explanation on the form and supporting documentation in the file.
G11-13	The person/legal guardian (if applicable) will receive information on abuse and neglect annually	Check the record for documentation that information was provided to person/legal guardian. This may be found in service notes or as a form letter in the record. Information must define what abuse and neglect is and how to report. Source: CQL Basic Assurances 1, 2, 4,10
G11-14 R	**At the time of annual planning, all children enrolled in the CS Waiver receiving CPCA services must have a newly completed physician's order (Physician's Information Form – MSP Form 1), assessment (CPCA Assessment – MSP Form 2), and authorization (MSP – Form 3)**	**See MSP forms/attachments in the miscellaneous Chapters of the CS Waiver Manual.**
G11-15	If a child is assessed to need over 10 hours of Children's PCA services per week, DDSN prior authorization is obtained	Review file for an email correspondence giving approval of requested units of CPCA services. If service units were not approved prior to initiation of the service, or prior to the completion of the annual plan, there must be a correspondence present allowing flexibility with approval.
G11-16	If a child receives CPCA services, the Service Needs Requirement and, unless otherwise	Refer to CPCA services section of the Waiver Manual (Miscellaneous chapter), page one, for guidance to determine if the child meets the "Special Needs Requirement" and has one of the four allowable "Functional Deficits". Look for The Physician's Information Form – it will be present and

	specified, a Functional deficit exists (check only for those receiving 10 hours or less of CPCA services)	indicate if a doctor agrees CPCA services is needed to meet the Special Needs Requirement (section II. Of the form). Look for the CPCA Assessment – it gives information to determine if at least one functional deficit is present.
G11-17	Documentation is present verifying that a choice of provider was offered to the person/ family for each new COMMUNITY SUPPORTS Waiver service	Review the service notes and the person's Plan to determine if the person was given a choice of provider of service each time a new service need was identified/ authorized. Source: COMMUNITY SUPPORTS Waiver Manual
G11-18	The Freedom of Choice Form is Present	Review the record of those enrolled or re-enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). For forms completed during the review period, if the waiver participant is over age 18 and not adjudicated incompetent but is physically unable to sign the form, the form and the service notes should indicate why signed choice was not obtained. If the person has reached the age of majority since waiver enrollment during the review period and has not been adjudicated incompetent, the waiver participant must either date and sign a new Freedom of Choice form or sign and date the original Freedom of Choice form documenting choice of waiver services in the community over institutionalization. This should be completed within 90 days of their 18th birthday. Note: Look at only those enrolled, re-enrolled or who turned 18 during the review period. Source: COMMUNITY SUPPORTS Waiver Manual
G11-19	The Initial Level of Care is present.	Review the initial LOC determination to verify it was completed within 30 days prior to or on the date of Waiver enrollment.
G11-20 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care determination and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/IID evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Waiver Case Managers for all consumers except for those persons whose eligibility determination is "Time-Limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care**

		re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09. **Note: Look only at timeframes and who completed it.** **Source: COMMUNITY SUPPORTS Waiver Manual**
G11-21 R	**The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination**	**Review the most current LOC determination and compare it to information in the assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment.** **Note: Look only at lines on the LOC Assessment** **Source: COMMUNITY SUPPORTS Waiver Manual**
G11-22 R	**The Current Level of Care is completed appropriately**	**Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete.** **Note: Ensure that all areas are complete with appropriate responses.** **Source: COMMUNITY SUPPORTS Waiver Manual**
G11-23	Acknowledgment of Rights and Responsibilities (CSW Form 2) is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by person or legal guardian, if applicable) on the current and previous forms to ensure they have been completed annually (within 12 months of the previous form). Source: COMMUNITY SUPPORTS Waiver Manual
G11-24	COMMUNITY SUPPORTS Waiver services are provided in accordance with the service definitions	Review Service definitions in the COMMUNITY SUPPORTS Waiver document for each service that the person is receiving. Review the person's Plan, service notes and relevant service assessments to ensure that services are being provided according to the definitions. Source: COMMUNITY SUPPORTS Waiver Manual
G11-25	COMMUNITY SUPPORTS Waiver services are received at least every 30 calendar days	***DDSN will provide notification when this key indicator is no longer applicable.*** Review service notes and Plan to ensure that the person has received or is receiving at least one COMMUNITY SUPPORTS Waiver service every 30 calendar days during the review period. A service must be received at least every 30 calendar days. If at least one service was not received every 30 calendar days, the person should have been disenrolled from the Waiver. Note: Children's PCA is state plan Medicaid Source: COMMUNITY SUPPORTS Waiver Manual
G11-26 R	**Authorization forms are completed for services as required, prior to service provision**	**Review the person's Plan to ensure that Authorization forms for services received are present and note a "start date" for services that is the same or after the date of the Waiver Case Manager's signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS enrolled or contracted provider)**

		and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. **Source: COMMUNITY SUPPORTS Waiver Manual**
G11-27	Authorized waiver services are suspended when the waiver participant is hospitalized, temporarily placed in an NF or ICF/IID.	
G11-28 R	**Waiver termination properly completed**	**When participant records that indicate the CM failed to complete termination forms properly, CM service activities are subject to the recoupment. Waiver services allowed to pay due to the CM error are subject to recoupment.** **Review participant's Service Notes and other documentation to determine if participant was terminated from the Waiver in the review period. If this action occurred, verify Service Coordinator sent a Waiver Termination Form 2 working days after determining that termination was required.** **Except for termination due to death, verify participant or Legal Guardian was given written notification of Waiver termination specifying reason and was provided information concerning SCDDSN Reconsideration and SCDHHS Appeal.**
G11-29 R	**The Person/Legal Guardian (if applicable) was notified in writing regarding any denial, termination, reduction, or suspension of COMMUNITY SUPPORTS Waiver services with accompanying reconsideration/appeals information**	**When participant records that indicate the CM failed to submit correct waiver service denials, terminations, reductions or suspensions, the CM billable activities will be subject to recoupment. Waiver services allowed to pay due to the CM's error are subject to recoupment.** **Review service notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the person/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate reconsideration/appeals process.** **Note: If the person/legal guardian (if applicable) requests to terminate, suspend, or reduce the service, this Indicator is N/A.** **Source: COMMUNITY SUPPORTS Waiver Manual**

G11-30	Information including the benefits and risks of participant/ representative directed care is provided to the participant/ representative prior to authorization of In-Home Support	
G11-31	Before authorization of In-Home Support, the absence of cognitive deficits in the participant/ representative directed care is assessed and documented.	
G11-32	Before authorization of In-Home Support, the participant/ representative is provided information about hiring management and termination of workers as well as the role of the Financial Management System is provided to the participant/ representative.	

G11-100	Community Supports Waiver Case Management Activities	Guidance DDSN will provide notification of an effective date.
G11-101 R	For newly enrolled waiver participants, the first non-face-to-face contact is completed within 30 days of waiver enrollment.	Upon implementation of WCM, for new enrollees, the waiver case manager's first non-face-to-face contact must be completed within 30 days of waiver enrollment and documented within 7 days, per policy. The WCM billing for this activity is recoupable if not documented within 7 days. Please refer to the WCM policy for additional guidance and exact text. For participants enrolled in the waiver since implementation of Waiver Case Management or within the past 12 months, whichever is sooner, determine if non-face to face contact occurred within the first 30 days.
G11-102 R	For newly enrolled waiver participants, the first quarterly face-to-face visit is completed within 90 days of waiver enrollment.	Upon implementation of WCM, for new enrollees, the waiver case manager's first face-to-face contact must be completed within the first 90 days and documented within 7 days, per policy. The WCM billing for this activity is recoupable if not documented within 7 days. Please refer to the WCM policy for additional guidance and exact text. For participants enrolled in the waiver for 90 days or more, determine if a face to face visit occurred within 90 days of enrollment.
G11-103 R	Each month, except during the months when required quarterly face-to face visits are completed, a non-face to face contact is made with the participant or his/her representative.	Upon implementation of WCM, WCM services billed but not documented per policy during the review period may be subject to recoupment. It is expected that during each month of the plan year there will be either a non-face-to face contact or a face-to-face visit with the waiver participant/family member. A non- face-to face contact with the participant/family must be completed by the WCM in each calendar month when a quarterly visit is not required. The purpose of the non-face-to-face contacts/activities is to establish meaningful communication with the participant/family in order to review and monitor Plan and current services and to monitor the participant's health and welfare, and changes in the residence and/or family status. The monthly non-face-to-face contact is intended to be made by telephone to the participant/family for the majority of waiver participants. The purpose is for meaningful discussion on behalf of the waiver participant in order to monitor the plan, services, and the participant's health and welfare.

G11-104 R	**Non-face to face contact is appropriately documented in services notes.**	**Upon implementation of WCM, the WCM should not bill for notes that were not documented appropriately. Recoupment is intended to be directed to the incorrect entries.** **The entire contact/visit must be documented in the service notes including:** • **Are the current services meeting the participant's needs?** • **What changes in the residence or family status warrant revisions to current services/plan? List the changes.** • **Does the participant/family know how to report abuse, neglect, and exploitation (ANE)? If so, is there anything to report this month?** • **Based on statements made by the participant/family, are increases/decreases or changes needed to the services? List the changes.** • **Are service terminations needed?** • **What follow-up activities or contact with providers is needed based on this monitoring?** • **List the date and the individual(s) who participated in the contact.** • **List the number of minutes used for the contact; and** • **WCM signature and title** **Entries to the participant record must be documented on the date of the contact/visit. The designation "*Late entry*" must be added to any entry in the participant record if it is made after the day of the actual contact/visit. All entries of the contact/visit must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.**
G11-105 R	**A minimum of four (4) quarterly face-to face visits are made with the participant/family each plan year.**	**Upon WCM implementation WCM, WCM policy requires a minimum of 4 quarterly face to face visits each year. The visits must be documented per policy within 7 days to be billable. This indicator relates to these 4 visits, not other WCM activities. Each visit is subject to recoupment based on policy and documentation requirements.** **At least four quarterly face to face visits are required each plan year. Two (2) of the required four (4) quarterly face-to-face visits must be in the participant's residence. The other two (2) may be at other locations.** **The purpose of the non-face-to-face contacts/activities and the face-to-face quarterly visits is to establish meaningful communication with the participant/family in order to review and monitor the Plan and current services. It is also important to monitor the participant's health and welfare, and changes in the residence**

		and/or family status which could impact the participant's needs. **The face-to-face quarterly visits cannot be conducted in consecutive months.**
G11-106 R	**Two of the four (4) quarterly face-to face visits with the participant/family are conducted in the participant's residence and are conducted every other quarter of the plan year.**	**Upon WCM implementation, WCM policy requires the participant to receive 2 of the 4 quarterly WCM face to face visits in their home during the review period. The visits must be documented per policy. Each visit is subject to recoupment based on policy and documentation requirements.** **The face-to-face quarterly visits cannot be conducted in consecutive months.** **The purpose of visits to the residence is to ensure the health and welfare of the participant in the home environment, assess the safety of the surroundings and to monitor for changes in the family status or dynamics, all of which might require changes to the plan.** **When only two quarterly face-to-face visits in the residence are completed during a plan year, those two visits cannot be in consecutive quarters of the year.** **During each visit to the residence the WCM is expected to make professional observations which could impact the health and welfare of waiver participants.**
G11-107 R	**Quarterly face to face visits are appropriately documented.**	**Upon WCM implementation, quarterly face to face visits must meet documentation standards and be completed within 7 days; if either requirement is not met the service may be subject to recoupment.** **The following must be documented in the service notes:** • **Did the family report changes in the residence or family status?** • **Does the participant/family know how to report ANE? If so, is there anything to report during this contact/visit?** • **Did the family report any changes in the participant's health status? If so, list the changes.** • **Based on professional observations or statements made by the participant/family, are increases/decreases or changes needed to the services? List the changes.** • **Are service terminations needed?** • **Have providers been delivering services as authorized? If not, explain.** • **Does the participant/family wish to make any changes with current providers/services on the plan? If so, describe the changes.** • **List the date and individuals present for the visit.** • **List the number of minutes used for the quarterly visit with**

		the participant/family; and • **WCM signature and title.** **Entries to the participant record must be documented on the date of the contact/visit. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the actual contact/visit. All entries of the contact/visit must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.**
G11-108	Participants received two (2) waiver services every thirty (30) days.	Upon implementation of WCM, participants received 2 waiver services every 30 days.
G11-109 R	**When contacts (other than the required monthly contacts and required quarterly face to face contacts) are made or activities are conducted, the contact/activity is appropriately documented.**	**Upon implementation of WCM, when contacts/activities are conducted, they must be documented appropriately within 7 days, per policy.** **Refer to policy**
G11-110	Contacts (other than the required monthly contact and required quarterly face to face contact) are recorded as NON-REPORTABLE on CDSS if the required monthly contact and/or quarterly face-to-face visit has not been completed during the month/quarter with the participant/family member, or if the required monthly contact/quarterly visit is not documented in the participant's record within seven (7) calendar days of completion.	Other contacts are allowed if they are specifically designed to monitor the participant's progress or status regarding needs identified on the plan. The following contacts are allowable if the required monthly contact or quarterly face-to-face visit is completed during the month/quarter with the participant/family member, and the entire contact/visit is documented in the participant's record within seven (7) calendar days of completion: Telephone contact with Providers; Email communication with the professional community; School Visits; ADHC and other on-site day service visits with professional staff; These other allowable activities are not intended to supplant or replace the required monthly non-face-to-face contact or quarterly face-to-face visits with waiver participants and their family members. Reporting these other types of allowable contacts as "reportable" without completing the required monthly non-face-to-face contacts or quarterly

		visits with the participant/family, and the necessary required documentation may result in recoupment.
G11-111 R	**Service notes intended to document Waiver Case Management activities are sufficient in content to support Medicaid billing.**	**Recoupment is intended to be directed to the incorrect entries.** **All entries to the participant record must be completed by the WCM who actually conducted the contact/activity.** **Documentation and service note entries specific to an individual must be maintained in a waiver participant record in chronological order. Documentation or references to other participants should not be incorrectly filed or noted in the waiver record.** **Service notes are expected to be entered into the record in a timely manner. This is defined as the day of, or within seven (7) calendar days of the activity, call, contact, visit or event.** **Entries to the participant record must be documented on the date of the contact/visit/activity. The designation "*Late entry*" <u>must</u> be added to any entry in the participant record if it is made <u>after</u> the day of the actual contact/visit/activity. All entries of the contact/visit/activity must be added to the participant record. Any entry made after seven (7) calendar days of the contact/visit is subject to recoupment.** **All entries in the record should offer such detail and clarity that a different WCM or supervisor could review the waiver record and serve the participant with minimal difficulty.** **The following activities are allowed / reportable:** • **Conduct timely LOC reevaluations per Medicaid policy** • **Conduct annual participant assessments (within every 365 days)** • **Re-establish FOC document as needed according to policy** • **Develop annual service plans (within every 365 days) ensuring frequency, duration, amount and provider type for waiver services** • **Include identified State Plan or other needs on service plan** • **Provide linkage, and referral of waiver participants to federal, state, local or community programs and/or Medicaid benefits** • **Monitor access to and receipt of waiver services; address and correct problems identified in waiver service provision** • **Review service plans quarterly and amend with needed**

		changes • **Provide copy of completed annual service plan to participant/legal representative** • **Conduct ongoing monitoring of the service plan with the participant/family during monthly non-face-to-face contacts, or quarterly face-to-face visits. At least every other quarterly contact must be made in the residence** • **Conduct all necessary follow up activities as a result of the contacts/visits with participant/family** • **Perform ongoing monitoring of the participant's health and welfare** • **Monitor participant's emergency/evacuation plan** • **Respond to urgent, emergent or unplanned circumstances for participant.** • **Document participant record according to professional protocols and policy** • **Provide information about participant/representative-directed care services, including benefits and risks** • **Assess and document the absence of cognitive deficits in the participant or representative that would preclude the use of participant/representative care if selected** • **Provide participant/representative information about hiring, management and termination of workers, as well as, the role of the Financial Management System** • **If voluntary or involuntary termination of attendant care, in-home supports, or EIBI line therapy, provide a list of qualified providers to assist with replacement** • **Offer and document choice of qualified providers, as needed and upon request** • **Offer and document choice of qualified waiver case management providers at least annually and upon request** • **Inform waiver participant/ representative about and monitor individual cost cap for CS and PDD waivers** • **Provide Reconsideration/Appeal rights when appropriate and according to policy** • **Participate in witness preparation, testify, and/or provide records and evidence on behalf of SCDHHS/SCDDSN for**

		Medicaid Waiver Appeals and Hearings as required, acting as an agent of the State • **Assist with service delivery problems/service provider resolution or other problems as requested** • **Review and submit appropriate caregiver logs for payment; contact provider if logs are inappropriate to resolve outstanding issues** • **Suspend waiver/state plan services when participants enter inpatient facilities (hospital, nursing facility or ICF/ID)** • **According to circumstances, properly suspend, deny, terminate or reduce waiver/state plan services with "Notice"** • **Complete waiver termination information timely** • **Determine other participant resources such as third party liability (TPL) or Medicare and provide information to providers** • **Inform new waiver enrollees that the waiver program is not a source of 24 hour care, excluding Residential Habilitation** • **Maintain written or electronically retrievable records for a minimum of five (5) years unless under appeal or other guidance from SCDHHS** • **On an annual basis provide participant/representative written information about what constitutes abuse and how to report. This must be documented in the participant record** • **Provide participant/representative of their rights annually and document this in the participant record** • **Assess for Children's Personal Care (CPCA)/State Plan Nursing/Incontinence Supplies/Respite/EIBI services using approved assessment documents** • **Follow policy for approval of CPCA hours/State Plan Nursing hours/respite hours/incontinence supplies/EIBI services** • **Comply with out-of-state policy for waiver participants making short-term visits out of South Carolina** • **At the time of enrollment waiver case managers must provide information about available waiver services** • **WCM must understand the limitations subject to DDSN or Medicaid Policy for HASCI participants who use attendant care services directed by a representative** • **Waiver case managers will report critical incidents according**

		to approved policy. • **On an annual basis, waiver case managers must review and obtain the participant/representatives signature on the Rights and Responsibility Statement** • **Waiver case managers must review caseloads with supervisors as required for Quality Assurance/Team Staffing or discharge planning purposes** **The following activities may be reportable if provided to a participant who is preparing for discharge from a facility to the waiver. These activities can be conducted for 120 days prior to the actual date of waiver enrollment:** • **Using approved form, document Freedom of Choice (FOC) between institution and home and community-based services.** • **Initiate level of care (LOC) determinations** • **Conduct an initial participant assessment** • **Establish updates to LOC through State-approved process if LOC expires** • **Complete waiver enrollment information timely** • **Verify that waiver applicant is not enrolled in another waiver, state plan or managed care program prior to submitting enrollment request, or coordinating program transition as needed** **Waiver case management does not allow the direct delivery of waiver, state plan or any other services. The following activities are <u>NON-reportable /allowable activities.</u> This list is not all-inclusive and is simply intended as a guide.** • **Activities provided by anyone other than the individual who meets the qualifications to be a waiver case manager, even if they are working under the supervision of a case manager.** • **Unsuccessful telephone attempts to contact the waiver participant/family and provider.** • **Review of the waiver case management record.** • **Participating in social or recreational activities at the invitation of the waiver participant/family.** • **Rendering WCM to individuals in institutional placement except during the last 120 days of the institutional stay prior to waiver enrollment for the purpose of transitional and/or**

		discharge planning. • **Rendering WCM services to waiver participants while incarcerated, in jail, prison or other detention/evaluation centers.** • **Time spent documenting waiver contacts/activities.** • **Completing administrative duties such as copying, filing, or mailing reports.** • **Rendering activities on behalf of the participant/family related to judicial matters, court/legal proceedings.** • **Rendering services/activities on behalf of the family after the death of a waiver participant.** • **Providing training/the provision or personal care, daily living skills, job skills, or social skills.** • **Training or provision of housekeeping, laundry, cooking or household chores.** • **Providing individual group or family therapy.** • **Providing child care or adult elder care for the participant/family.** • **Providing transportation/escort services.** • **Obtaining food at food bank, grocery store.** • **Delivering supplies, prescriptions, clothing/laundry, Christmas trees or gifts.** • **Accompanying participant/family to medical visits.** • **Setting up medications such as a pill box.** • **Paid or unpaid time off.** • **Services provided by more than one case manager to the same participant at the same time.** • **Staff meetings, trainings, travel-time, and supervision.** • **Contacts with administrative or secretarial staff within the agency.** • **Scheduling case manager's appointments.** • **Claim submission and collection activities.** • **Calls or emails to the information technology helpdesk.** • **Reading mail or newspaper to the participant/family.** • **Financial tasks such as paying bills, applying/submitting for loan applications, and/or taking the participant/family member to the bank.** • **Going to the library or running errands on behalf of the participant/family.** • **Taking participant/family member to get driver's license/moped license/voter ID.** • **Preparing documentation, filing appeals or testifying at appeals on behalf of participant/family member or any other entity.** • **Home decorating or house or apartment hunting for the participant/family.** • **Taking participant/family member to beauty salon or barber shop.** • **Yard/garden work for the participant/family.** • **Taking the participant/family member vehicles, electronics or appliances for repairs; and** • **Traveling to and from appointments on behalf of the participant/family.**

G12	EIBI Providers Only	Guidance
G12-01 R	All individuals who serve as the EIBI Consultant must meet requirements	Review personnel files for documentation, credentials and written evidence to support and demonstrate that employees meet the minimum requirements for the position in which they serve. All individuals who serve as the EIBI Consultant must meet the following requirements: • A master's degree in behavior analysis, education, psychology, special education; or related field; and • Current certification by the Behavior Analyst Certification Board as a Board Certified Behavior Analyst (BCBA); and • At least one year of experience as an independent practitioner; or • A bachelor's degree in behavior analysis, education, psychology, special education; or related field and • Current certification by the Behavior Analyst Certification Board as a Board Certified Associate Behavior Analyst (BCABA); and • At least two years of experience as an independent practitioner, or • A bachelor's degree in behavior analysis, education, psychology, special education; or related field and • At least three years of experience as an independent practitioner.
G12-02 R	All individuals who serve as Lead Therapists must meet requirements	Review personnel files for documentation, credentials and written evidence to support and demonstrate that employees meet the minimum requirements for the position in which they serve. All individuals who serve as Lead Therapist must meet the following requirements unless an exception has been granted by DDSN: • A bachelor's degree in behavior analysis, education, psychology, or special education; and • Has at least 500 hours of supervised line therapy or supervised experience in implementing behaviorally based therapy models consistent with best practices and research on effectiveness, for children with Pervasive Developmental Disorder to include autism and Asperger's disorder. If an exception has been granted, there must be written evidence from DDSN.
G12-03 R	All individuals who serve as Line Therapists must meet requirements	Review personnel files for documentation, credentials and written evidence to support and demonstrate that employees meet the minimum requirements for the position in which they serve. All individuals who serve as Level 1 Line Therapists must meet the following requirements: • Be at least 18 years old and a high school graduate;

		All individuals who serve as Level II Line Therapists must meet the following requirements: • **Have an Associate Degree, or two years post-secondary education, or two years of EIBI Line Therapy work experience.** **Line Therapists at all levels must have documentation of meeting the following initial requirements prior to providing a service:** **a. Criminal Record Checks and Reference Checks of Direct Caregivers (refer to DDSN policy 404-04-DD)** **b. Current First Aid Certification (must be renewed at least every three years)** **c. Current CPR Certification (must be renewed annually)** **d. At least 12 hours of training to include topic areas per Chapter 10 of the PDD Manual, page 3** **e. Have documentation of receiving the required annual in-service training of at least 12 hours in the implementation of applied behavior analysis, autism or PDD specific training.** **f. Provide a copy of current, valid driver's license (If no driver's license, submit a copy of an Official State ID Card)** **g. PDD Tuberculin Test**
G12-04	There must be documentation those entities that are on the qualified provider list for EIBI services completed the initial approval process	All EIBI providers should have the following documentation on file for the initial approval process: • Contract with DHHS to provide waiver services • Contract with DDSN to provide State Funded services • The EIBI Certification Letter
G12-05	Approved Consultants of EIBI services must submit required data to the child's Case Manager and the Autism Division within the timeframes specified	Review the child's records to determine the date services began and look for data reports that correspond to that date: • EIBI Monthly Progress Report and EIBI Therapy Documentation Sheet: must be submitted monthly and demonstrate/document that drills are conducted as scheduled • EIBI Quarterly Treatment/Progress Plan Report: must be submitted quarterly and contain cumulative graphs of target areas demonstrating progress or areas of concern
G12-06	Approved Consultants of EIBI services must submit required assessments to the child's Case Manager and the Autism Division within the timeframes specified	Review the child's records to determine the date services began and look for assessments that correspond to that date: • Assessment of Basic Language and Learning Skills (ABLLS): must be submitted semi-annually per the initial assessment date • Peabody Picture Vocabulary Test (PPVT) and Vineland: must be submitted annually per the initial assessment date

G12-07	Assessment Authorization: When an EIBI Provider accepts a case, the Provider must complete the Assessment within 30 days of the Assessment Authorization Effective Date	Completion means the Assessment report is written and disseminated to all necessary parties.
G12-08	Program Development and Training Authorization: Within 30 days of the Program Development and Training Authorization Effective Date, the Provider is expected to complete the Program Development and Training component (i.e. develop an individualized plan, identify a Lead Therapist for the child, and hire and train sufficient number of Line Therapists to provide established EIBI hours).	Within 30 days of the Program Development and Training Authorization Effective Date, the Provider is expected to complete the Program Development and Training component (i.e. develop an individualized plan, identify a Lead Therapist for the child, and hire and train sufficient number of Line Therapists to provide established EIBI hours). Although the Plan Implementation, Lead Therapy, and Line Therapy are authorized, they should not be provided until Program Development has been completed and Training is conducted for the family members and EIBI therapists.

RESIDENTIAL OBSERVATION

July 2014 through June 2015

This tool is to be used by the Quality Assurance Reviewer to gather information to determine whether or not a provider is meeting requirements in the areas listed below. Information may be gathered from interactions with staff and people who receive services, by observations, and/or record review. If observation/discovery shows that the provider is meeting the requirement, a score of "Met" will be recorded. If it is determined that the provider is not meeting the requirement, a score of "Not Met" will be recorded.

	Area	Suggested sources for evidence	Comments	Met	Not Met
1	Health status and personal care needs are known and people are provided the type and degree of CARE necessary to address those needs appropriately	Via interview of staff, people, review records, observation) determine whether or not the following is occurring: • Medical conditions /health risks are known and needs are adequately addressed as outlined in the support plan. • Prescribed medications are known. • Potential side effects are known and the actions to take if side effects are noted. • Risks are identified and addressed appropriately (elopement, self-injurious behavior, seizure activity, etc.) • Food provided meets the dietary requirements (restrictions, special preparations) • People receive routine health care and dental exams. • People are referred to specialists for evaluations of seizures, GERD, orthopedic problems, etc. • There are no issues with accessing quality care. • A system is in place to address acute illness promptly and ensure appropriate follow up and staffs are knowledgeable about that system. Interview people to determine if they: • are supported to choose their healthcare providers • make their own appointments if they are capable • are informed about the medications they are taking and why and possible side effects. • People are supported to be clean and well groomed.		☐	☐

	Area	Suggested sources for evidence	Comments	Met	Not Met
2	People are provided the degree and type of SUPERVISION necessary to keep them safe but not unnecessarily restricted	Through conversation with staff and observation, determine if: • Staff knows the person's capability for managing their own behavior. • Person has a plan of supervision. • Staff can describe the plan. • Plan is carried out appropriately. For example, if staff tells you that the person must be visually checked on the hour, observe to see whether or not that occurs and that it is documented as the plan specifies. • Supervision plans are individualized. • People are not receiving more supervision than they require. • Restrictive plans of supervision are reviewed and approved by HRC		☐	☐
3	People receive assistance with acquisition, retention, or improvement in skills necessary to live in the community, consistent with assessed needs, interests/personal goals	Ask the person to tell you what they are learning and how their goals were chosen. Is training meaningful to them? Is it related to their personal goals? Are they learning new skills? Has training resulted in them becoming more independent? What changes, if any have been made in their training? Are equipment/materials available to staff to implement plan? If applicable, this includes the individual's formal behavior support plan. Determine the staff's knowledge of the content of the plan including the targeted behaviors, interventions and replacement behaviors. Ask staff how they were trained on the behavior support plan. Are behavioral incidents being documented according to the behavior support plant? How effective is the behavior plan? How often does the behavior support person monitor the plan?		☐	☐
4	People are SAFE	Observe to see if any unsafe conditions are apparent. Are emergency numbers posted/readily available? Are fire drills conducted with individualized supports if needed i.e. flashing lights for people who cannot hear the alarm, etc.? Are people trained on emergency procedures? Ask how they would react if a		☐	☐

		fire, tornado, etc. happened. Ask staff what their responsibilities are in responding to emergency situations. Are staff familiar with safety equipment and how to operate it? Have modifications been made to facilitate safety based on person's needs i.e. grab bars, ramps, etc. Ask people if they feel safe in the home.			
5	People are treated with DIGNITY AND RESPECT	Are people listened to and responded to promptly. Is there interaction between staff and the people who receive services? Are people addressed in their preferred way? Are people extended the same courtesies that anyone would expect? Are personal needs attended to in private? Do people feel they are listened to? Do supports provided emphasize people's capabilities rather than their disabilities or differences? Are people provided meaningful activities and training opportunities? Are people supported to dress, style their hair, the way they prefer?		☐	☐
6	People are supported to learn about their RIGHTS and exercise the rights that are important to them	Ask staff if they are trained to respect people's individual rights. How is knowledge of rights assessed and how rights training is done? Ask people if they know what their rights are and if anyone has ever talked with them about rights. Ask people how their money is handled and whether or not they are satisfied with the process. Do they know how much money they earn or where their funds come from? Do they know where it is kept and how to access it? Are people able to access personal possessions? Do they have a key to their room and the house if they so desire? Observe to see if people move freely throughout the home. If there are house rules, were the people involved in the development of them?		☐	☐

		Are there locks on cabinets, pantries, etc.? Do people have access to money/belongings and a place to secure them? Are people encouraged to advocate for themselves? Are people supported to have choices (bedtimes, mealtimes, activities, etc.)? Do people have opportunity for privacy? Spend time alone if they so desire. Open their own mail? Is information about the person kept confidential? If rights are restricted, is Due Process afforded? Do people attend Human Rights Committee meetings and actively participate in decisions that affect them?			
7	Staff know and implement the procedures for ABUSE and people are supported to know what abuse is and how and to whom to report it	Do staff know what constitutes abuse and how to report? Does training include prevention? Are people who receive services trained on abuse? Ask if people know what abuse is. What would they do if they were abused? Would they know how to report? To whom would they report? Ask staff what happens when abuse occurs? Does the person who is abused receive appropriate follow-up (medical care, counseling, information about the resolution)?		☐	☐
8	Does the provider have a process to determine whether or not people are SATISFIED with services?	Ask staff how they know whether or not the people they work with are satisfied with the services they provide them. What concerns have been expressed? Ask staff and people served to explain the process for expressing a complaint. Ask people if they have had a complaint and what they did about it. Was it resolved in a timely manner and to their satisfaction? Determine if the supports provided are meeting the expectations of the people served.		☐	☐
9	STAFF can describe their roles/ responsibilities in supporting people	What do staff view as their most important responsibility? Do they view themselves as care givers or support providers? Are staff trained to recognize each person		☐	☐

		as an individual and to promote dignity and respect? Do they support people in achieving personal goals? Do they offer choice in services/supports? Do they understand confidentiality policies and protect consumer information? Ask staff to describe the training are they provided to assist them in performing their roles. Do they feel they are adequately prepared? Determine the staffs' understanding of what to do in the following situations: Medication assistance Health emergencies involving people Infection control Proper positioning Transportation safety			

EARLY INTERVENTION INDICATORS & GUIDANCE
Review Year July 2014 through June 2015

The Guidance is provided as a resource to assist agencies with understanding Key Indicators. The Guidance is not intended to be, nor should be, considered as the ultimate resource. It should be, as inferred by its title, a GUIDANCE designed to assist. State and Federal standards including policies and procedures are the ultimate resources for establishing the requirements for an Indicator.

E1	BabyNet Only	Guidance
E1-01	Written Prior Notice was given to the family prior to six-month update and annual IFSP	Review Service Notes, Family Training Summary Sheet, or a copy of the Written Prior Notice to ensure that the family was given their 7 days Written Prior Notice. The family may choose to have the meeting sooner than 7 days. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factors 1 & 2, Shared Values Factors 1, 2, & 3
E1-02	Written Prior Notice was given to the family prior to a change review of the IFSP	Review Service Notes, Family Training Summary Sheet, or a copy of the Written Prior Notice to ensure that the family was given their 7 days Written Prior Notice. The family may choose to have the meeting sooner than 7 days and this choice will be documented in the service notes or on the summary of service sheets. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factors 1 & 2, Shared Values Factors 1, 2, & 3
E1-03	The Parent/ Caregiver was provided a copy of the Plan	Review service notes to verify that the parent/ caregiver was provided a copy of the Plan. Source: BabyNet Manual, DDSN EI Manual, EI Services Provider Manual
E1-04 R	**Individualized Family Service Plan (IFSP) is completed annually**	**If not met, document review period dates and date range out of compliance.*** **IFSP must be current within one year, not to exceed 180 days from the last 6 month review, if applicable. The last page must be signed by the family and the EI.** **Source: IDEA, BabyNet Manual**
E1-05	IFSP six-month review was completed within 180 days of the IFSP	Ensure the IFSP six-month review was completed within 180 days of the IFSP. Source: IDEA, BabyNet Manual
E1-06	Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary Form (COSF), if applicable, at exit at age three	During the process of a child closing to BabyNet, review the service notes and Child Outcome Summary Form to ensure that the process was completed and documented. Note: If the child received six months or less of services, the ECO exit will not be required. No exit required if provider did not complete entry. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 8

E1-07	IFSP includes current information relating to vision, hearing, and all areas of development to include health	Review relevant sections of the IFSP to ensure information is current and includes health and developmental information. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factor 5
E1-08	All BabyNet services are listed on the Summary of Services/Planned Services section of the IFSP, to include amount, frequency, duration, a start date and an end date	For IFSP's completed prior to March 1, 2014-Review the Summary of Services page of the IFSP to ensure that all BabyNet services being received are listed (Section 13).Note: Must have an end date from plan to plan. For IFSP's completed after March 1, 2014-Review the Planned Services section of the IFSP, to ensure that all BabyNet services being received are listed. Source: BabyNet Manual
E1-09	If the child's IFSP indicates the need for more than 4 hours per month of family training, the service notes indicate that information has been sent to the Office of Children's Services for review	Review frequency of Family Training as identified on the IFSP. If the frequency noted on the plan is more than 4 hours per month of Family Training there should be documentation indicating that the file was sent to the Office of Children's Services for review within 15 days of the plan or as identified as a need and this choice will be documented in the service notes or on the summary of service sheets. Source: DDSN EI Manual
E1-10	Were all needs that are documented on the child's IFSP provided within 30 days of identification unless there was a child/parent driven reason why the service wasn't provided	Review the IFSP and Service Notes to determine if services began within 30 days of identification, if there was a provider available. If no provider available or the child is placed on a provider waiting list, EI should make monthly attempts to locate a provider. If monthly follow up is documented in services notes, do not cite. Delays in service provision at the request of the family should not be considered. Delays due to the inability to locate a family or their lack of attendance at scheduled appointments should not be considered. **This change is effective July 1, 2014.** Source: BabyNet Manual
E1-11	Transition to other services or settings is coordinated	Review IFSP, Family Training summary sheets and/or Service Notes to ensure that the Early Interventionist completed, or is the process of, any task(s) they were assigned to follow-up on during transitions such as hospital to home, BabyNet to school, home to childcare, have been

		identified and received follow up. Source: DDSN EI Manual, EI Services Provider Manual, BabyNet Manual
E1-12	The Transition referral is sent to the LEA by the time the child turned 2.6 years old	For IFSP's completed prior to March 1, 2014-If the child is 2.6 years or older review Services Notes, transition page of the IFSP, and a copy of the transition referral to ensure the referral was sent by the time the child was 2.6 years old. For IFSP's completed after March 1, 2014-If the child is 2.6 years or older review Service notes, transition referral form and/or front page of the IFSP to ensure that the transition referral was sent by the time the child was 2.6 years old. Source: EI Services Provider Manual, BabyNet Manual
E1-13	Transition Conference was held no later than 90 days prior to the child's third birthday	For IFSP's completed prior to March 1, 2014-Review Service Notes, IFSP, and/or transition page of IFSP to ensure the transition conference was held 90 days prior to the child's third birthday. The parent /caregiver can choose not to have a conference. For IFSP's completed after March 1, 2014-Review Service Notes, the front page of the IFSP to ensure the transition conference was held 90 days prior to the child's third birthday. The parent/caregiver can choose not to have a conference. Source: EI Services Provider Manual, BabyNet Manual
E1-14	Outcomes are based on identified needs and the team's concerns relating to the child's development	Compare relevant IFSP sections to the outcome pages to determine if the Plan indicates who should do what and where it will take place. There should only be one outcome per page. Source: EI Services Provider Manual, BabyNet Manual Supports CQL Basic Assurances Factor 8, Shared Values Factors 6, 8, 9
E1-15	Outcomes are/have been addressed by the Early Interventionist	For IFSP's completed prior to March 1, 2014-Review Service Notes and Family Training summary sheets to determine if all outcomes have been or are being addressed by the EI. All developmental outcomes should be addressed within 3 months of that outcome identification as a need. If the outcome (s) are not being addressed, review documentation for supporting information noting why they haven't been addressed. For IFSP's completed after March 1, 2014- Determine if all outcomes have been or are being addressed by the EI. See Family training box in Planned Services section for outcome numbers assigned to the EI for follow up. Source: EI Services Provider Manual, BabyNet Manual Supports CQL Shared Values Factor 8
E1-16	Assessments are completed every 6 months or as often as changes warrant	For IFSP's completed prior to March 1, 2014-Review assessment dates on chosen assessment tool(s) and IFSP to ensure they are completed <u>every 6 months or as changes warrant</u> (i.e., significant improvement or regression).

		For IFSP's completed after March 1, 2014-Review assessment dates on chosen assessment tool(s) and 5 Area Assessment or Specialty Assessment sections on the IFSP to ensure they are completed every 6 months or as changes warrant (i.e., significant improvement or regression). Source: EI Services Provider Manual, BabyNet Manual Supports CQL Shared Values Factor 8
E1-17	Family Training is provided according to the frequency determined by the team and as documented on the IFSP Summary of Services/Planned Services section of the IFSP.	For IFSP's completed before March 1, 2014-The IFSP should outline the frequency of Family Training. Review the Family Training summary sheets, IFSP Summary of Services section, to ensure that FT is provided at the frequency and duration outlined. If the frequency and duration outlined is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule. For IFSP's completed after March 1, 2014-The IFSP Planned Services section should outline the frequency of Family Training. Review the Family Training summary sheets, IFSP Planned Services section to ensure that the FT is provided at the frequency and duration outlined. If the frequency and duration is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule. Source: EI Services Provider Manual, BabyNet Manual
E1-18	Family Training summary sheets include goals and objectives for each visit as well as follow-up objectives for the next visit	Family Training summary sheets should indicate the scheduled time and date of the next visit and what the caregiver will work on with the child until the next training visit. Review Family training summary sheets to ensure that they include goals and objectives for each visit and what the caregiver will work on until the next training visit with an error rate of no more than 2 mistakes during the review period. Source: DDSN EI Manual
E1-19 W	Entries for Family training visits include how parent /caregiver(s) participated in visit	Review Family Training summary sheets and Service Notes to ensure that the parent/caregiver participated in training sessions. To only state that the parent/caregiver was present and encouraged the child is NOT sufficient. The summary of visit should include how the parent/caregiver actively participated in the visit. Review Family training summary sheets to ensure that they include this information. Source: DDSN EI Manual, EI Services Provider Manual
E1-20	Family Training activities should vary. Activities planned must be based on identified outcomes on the IFSP	Review the Family Training summary sheets to ensure that the activities vary in order to meet the outcomes for the child. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factors 3, 8, & 9
E1-21	Family Training activities correspond to	Review the outcomes on the IFSP to ensure that the family training activities documented on the summary of visit sheets correspond to at

	outcomes on the outcome section on the IFSP	least one outcome on the plan. Source: DDSN EI Manual, EI Services Provider Manual
E1-22	Time spent/reported preparing for a Family Training visit corresponds with the activity planned	Review Service Notes and Family Training Summary Sheets to determine if the time reported for preparing for a Family Training visit corresponds to the activities completed during the visit. For example, an EI should not report 15 minutes of "prep time" for a visit if when the EI got to the home they worked on singing songs or putting puzzles together. Source: DDSN EI Manual
E1-23	If the Early Interventionist is unable to provide Family Training for an extended period of time (more than a month) was the family offered a choice of an alternate Early Interventionist	Review the Service Justification Form, service notes, and/or Family Training Summary Sheets to ensure the family was offered an alternate Early Interventionist to provide Family Training. Source: IDEA, BabyNet Manual, DDSN EI Manual
E1-24	Service Notes document why and how the Early Interventionist participated in meetings / appointments on the child's behalf	Review Service Notes to ensure why and how the Early Interventionist participated in the meeting/appointment. The Early Interventionist must justify why they are reporting the time that they are at the meeting/appointment. For example, it would not be appropriate for an EI to attend a Developmental Pediatrician's appointment and then report time for attending the entire appointment. It is appropriate to report time for when the EI was actively participating in the visit. Source: DDSN EI Manual
E1-25	If applicable, documentation in service notes indicates that the case was closed	Review service notes of a closed file to determine if it was documented that the case was being closed.
E1-26	Is the Medical Necessity form present in the child's file	Review file to ensure that the Medical Necessity form is present and signed. **This change is effective July 1, 2014.** EI Source: EI Services Provider Manual
E1-27 Not included in score	Did the child receive more than 3 hours of FT/Service Coordination in any calendar month? (except for the months in which an <u>initial plan</u>, <u>annual plan</u>, or <u>transition conference</u> were held)	During the review period, except for the months in which an <u>initial plan</u>, <u>annual plan</u>, <u>Curriculum Based Assessment (CBA)</u> or <u>transition conference</u> were held, did the child receive more than 3 hours of Family Training/Service Coordination in any calendar month? If so, document the month(s) and total amount of time for the month. For example: April 2011, 2:23; June 2011, 3:35. Note: For Informational purposes only. Does not affect the score.

E2	BabyNet / DDSN	Guidance: Review all Plans (IFSP/FSP) in effect for the period in review
E2-01	Service Agreement signed and present in file once a need for a DDSN service has been identified	Review DDSN Service Agreement in file. Source: DDSN EI Manual
E2-02	Transition to other services or settings is coordinated	Review IFSP/FSP Family Training Summary Sheets and/or Service Notes to ensure that the Early Interventionist completed, or is the process of completing, any task(s) they were assigned to follow-up on during transitions. Examples of these transitions could include hospital to home, BabyNet to school, home to childcare, etc. Source: IDEA, DDSN EI Manual, EI Services Provider Manual, BabyNet Manual
E2-03	Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary Form (COSF), if applicable, at exit at age three	During the process of a child closing to BabyNet, review the service notes and Child Outcome Summary Form to ensure that the process was completed and documented. Note: If the child received six months or less of services, the ECO exit will not be required. Source: IDEA, BabyNet Manual
E2-04 R	**Individualized Family Service Plan (IFSP/FSP) is completed annually**	**IFSP/FSP must be current within one year not to exceed 180 days from the last 6 month review; if applicable the last page must be signed by the family and the EI.** **Source: IDEA, EI Services Provider Manual, BabyNet Manual**
E2-05	The Parent/ Caregiver was provided a copy of the Plan	Review service notes to verify that the parent/ caregiver was provided a copy of the Plan. Source: BabyNet Manual, DDSN EI Manual, EI Services Provider Manual
E2-06	IFSP/FSP six-month review was completed within 180 days of the IFSP/FSP	Ensure the IFSP/FSP six-month review was completed within 180 days of the IFSP/FSP. Source: IDEA, BabyNet Manual
E2-07	Written Prior Notice was given to the family prior to the six-month review of the IFSP and the annual IFSP	Review service notes, Family Training Summary Sheets, or a copy of the Written Prior Notice to ensure that the family was given at least 7 days. The family may choose to have the meeting sooner than 7 days and this choice will be documented in the service notes or on the summary of service sheets. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factors 1 & 2, Shared Values Factors 1, 2 & 3
E2-08	Written Prior Notice was given to the family	Review Service Notes, Family Training Summary Sheet, or a copy of the Written Prior Notice to ensure that the family was given their 7 days written

	prior to a change review of the IFSP	prior notice. The family may choose to have the meeting sooner than 7 days and this choice will be documented in the service notes or on the summary of service sheets. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factors 1 & 2, Shared Values Factors 1, 2, & 3
E2-09	The Choice of Early Intervention Provider is offered annually	Review services notes, Family Training Summary Sheets, and the Acknowledgment of SC/EI choice form to ensure the family has been given a choice of providers and the choice is documented. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3
E2-10	IFSP/FSP includes current information relating to vision, hearing, medical, therapy, and all areas of development to include health	Review relevant sections of the IFSP/FSP to ensure information is current and includes health and developmental information. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factor 5
E2-11	Outcomes are based on identified needs and the team's concerns relating to the child's development	Compare relevant IFSP/FSP sections to the outcome pages to determine if the IFSP/FSP indicates who should do what and where it will take place. There should only be one goal per page. Source: BabyNet Manual, EI Services Provider Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 6, 8, & 9
E2-12	Outcomes are/have been addressed by the Early Interventionist	For IFSP's completed prior to March 1, 2014-Review Service Notes and Family Training summary sheets to determine if all outcomes have been or are being addressed by the EI. All developmental outcomes should be addressed within 3 months of identification as a need. If the outcomes(s) are not being addressed, review documentation for supporting information noting why they haven't been addressed. For IFSP's completed after March 1, 2014-Determine if all outcomes have been or are being addressed by the EI. See Family Training box in Planned Services section for outcome numbers assigned to the EI for follow up. Source: EI Services Provider Manual, BabyNet Manual Supports CQL Shared Values Factor 8
E2-13	The transition referral is sent to the LEA by the time the child turns 2.6 years old	For IFSP's completed prior to March 1, 2014-If the child is 2.6 years old or older, review service notes, transition page of the IFSP/FSP and a copy of the transition referral to ensure the referral was sent by the time the child was 2.6 years old. For IFSP's completed after March 1, 2014-If the child is 2.6 years or older review service notes, transition referral form and/or front page of the IFSP

		to ensure that the transition referral was sent by the time the child was 2.6 years old. Source: IDEA, BabyNet Manual
E2-14	Transition conference was held no later than 90 days prior to the child's third birthday	For IFSP's completed prior to March 1, 2014-Review services notes, Family Training Summary Sheets, transition page of the IFSP/FSP or transition conference form to ensure the transition conference was held 90 days prior to the child's third birthday. The parent/caregiver can chose to not have a conference. For IFSP's completed after March 1, 2014-Review service notes, the front page of the IFSP to ensure the transition conference was held 90 days prior to the child's third birthday. The parent/caregiver can choose not to have a conference. Source: IDEA, BabyNet Manual, EI Services Provider Manual
E2-15	FSP "Other Services" section reflects the amount, frequency & duration of services being received. This section should reflect non BabyNet services (Waiver, Family Support Funds, Respite, ABC, etc.)	Review FSP in effect during period in review to ensure the amount, frequency & duration of current services is included. Source: IDEA, BabyNet Manual
E2-16	All BabyNet services are listed on the Summary of Services Planned Services section of the IFSP to include amount, frequency, duration, a start date and an end date	For IFSP's completed prior to March 1, 2014-Review the Summary of Service page of the IFSP to ensure that all BabyNet services being received are listed. For IFSP's completed after March 1, 2014-Review the Planned Services section of the IFSP to ensure that all BabyNet services being received are listed. Source: BabyNet Manual
E2-17	If the child's IFSP/FSP indicates the need for more than 4 hours per month of Family Training, the service notes indicate that information has been sent to the Office of Children's Services for review	Review frequency of Family Training as identified on the IFSP/FSP. If the frequency noted on the IFSP/FSP is more than 4 hours per month of Family Training there should be documentation indicating that the file was sent to the Office of Children's Services for review. Source: DDSN EI Manual

E2-18	Were all needs that are documented on the child's IFSP provided within 30 days of identification unless there was a child/parent driven reason why the service wasn't provided	Review the IFSP and Service Notes to determine if services began within 30 days of identification, if there was a provider available. If no provider available or the child is placed on a provider waiting list EI should make monthly attempts to locate a provider. If monthly follow up is documented in services notes, do not cite delays in service provision at the request of the family should not be considered. Delays due to the inability to locate a family or their lack of attendance at scheduled appointments should not be considered. **This change is effective July 1, 2014.** Source: BabyNet Manual
E2-19	Assessments are completed every 6 months or as often as changes warrant	For IFSP's completed prior to March 1, 2014-Review assessment dates on chosen assessment tool(s) and IFSP to ensure they are completed every 6 months or as changes warrant (i.e., significant improvement or regression). For IFSP's completed after March 1, 2014-Review assessment dates on chosen assessment tool(s) and 5 Area Assessment or Specialty Assessment sections on the IFSP to ensure they are completed every 6 months or as changes warrant. (i.e. significant improvement or regression) Source: BabyNet Manual, EI Services Provider Manual Supports CQL Shared Values Factor 8
E2-20 W	Family Training is provided according to the frequency determined by the team and as documented in the Summary of Services/Planned Services section of the IFSP/FSP	For IFSP's completed prior to March 1, 2014-The IFSP/FSP should outline the frequency and duration of Family Training. Review the Family Training summary sheets, IFSP/FSP Summary of Services section to ensure that Family Training is provided at the frequency and duration outlined. If the frequency and duration outlined is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule. For IFSP's completed after March 1, 2014-The IFSP Planned Services section should outline the frequency of Family Training. Review the Family Training Summary Sheets, IFSP Planned Services section to ensure that the FT is provided at the frequency and duration outlined. If the frequency and duration is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule. Source: BabyNet Manual, EI Services Provider Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3, 8, & 9

E2-21	Family Training summary sheets include goals and objectives for each visit as well as follow-up objectives for the next visit	Family Training summary sheets should indicate the scheduled time and date of the next visit and what the caregiver will work on with the child until the next training visit. Review Family Training summary sheets to ensure that they include goals and objectives for each visit as well as objectives for the next visit with an error rate of no more than 2 mistakes during the review period. Source: DDSN EI Manual
E2-22 W	Entries for Family Training visits include how parent/ caregiver(s) participated in visit	Review Family Training summary sheets and Service Notes to ensure that parent/caregiver participated in training sessions. To only state that the parent/caregiver was present <u>and encouraged the child</u> is NOT sufficient. The summary of visit should include how the parent/caregiver actively participated in the visit. Review Family Training summary sheets to ensure that they include this information. Source: DDSN EI Manual
E2-23	Family Training activities should vary. Activities planned must be based on identified outcomes on the IFSP	Review the Family Training summary sheets to ensure that the activities vary in order to meet the outcomes for the child. Source: DDSN EI Manual
E2-24	Family Training activities correspond to outcomes on the IFSP/FSP outcomes pages	Review outcomes on the IFSP/FSP outcome pages to ensure that the family training activities documented on the summary of visit sheets correspond to at least one outcome on the plan. Source: DDSN EI Manual
E2-25	Time spent/reported preparing for a Family Training visit corresponds with the activity in the IFSP/FSP	Review Service Notes and data sheets to determine if the time reported for preparing for a Family Training visit corresponds to the activities completed during the visit. For example, an EI should not report 15 minutes of "prep time" for a visit if when the EI got to the home they worked on singing songs or putting puzzles together. Source: DDSN EI Manual
E2-26	If the Early Interventionist is unable to provide Family Training for an extended period of time (more than a month) was the family offered a choice of an alternate Early Interventionist	Review the Service Justification Form, service notes, and/or Family Training Summary Sheets to ensure the family was offered an alternate Early Interventionist to provide Family Training. Source: IDEA, BabyNet Manual, DDSN EI Manual

E2-27	Service notes document why and how the Early Interventionist participated in meetings/appointments on the child's behalf	Review Service Notes to ensure why and how the Early Interventionist participated in the meeting/appointment. The Early Interventionist must justify why they are reporting the time that they are at the meeting/appointment. For example, it would not be appropriate for an EI to attend a Developmental Pediatrician's appointment and then report time for attending the entire appointment. Source: DDSN EI Manual
E2-28	If applicable, documentation in service notes indicates that the case was closed	Review service notes of a closed file to determine if it was documented that the case was being closed.
E2-29	Medical Necessity form was completed prior to any services being reported	Review file to ensure that the Medical Necessity form is present in the file and was obtained prior to services being reported. **This change is effective July 1, 2014** EI Source: EI Services Provider Manual
E2-30 Not included in score	Did the child receive more than 3 hours of FT/Service Coordination in any calendar month? (except for the months in which an initial plan, annual plan, or transition conference were held)	During the review period, except for the months in which an initial plan, annual plan, Curriculum Based Assessment (CBA) or transition conference were held, did the child receive more than 3 hours of Family Training/Service Coordination in any calendar month? If so, document the month(s) and total amount of time for the month. For example: April 2011, 2:23; June 2011, 3:35. Note: For Informational purposes only. Does not affect the score.

E3	DDSN Only	Guidance
E3-01	Service Agreement signed and present in file	Review DDSN Service Agreement in file. Source: DDSN EI Manual Review DDSN Service Agreement in file.
E3-02	There is a Service Justification form in the file for any child 5 years of age or older being served in Early Intervention	Review the service notes and the service justification form to ensure that approval has been granted by the Office of Children's Services for the child to remain in Early Intervention. Source: DDSN EI Manual
E3-03	Transition to other services or settings is coordinated	Review FSP, Family Training Summary Sheets and/or Service Notes to ensure that the Early Interventionist completed, or is the process of completing, any task(s) they were assigned to follow-up on during transitions. Examples of these transitions could include hospital to home, BabyNet to school, home to childcare, etc. Source: DDSN EI Manual, EI Services Provider Manual
E3-04	For children who are seeking DDSN eligibility, and family training is identified as a need, the Early Interventionist has 45 days from the eligibility date to complete the FSP	Review Service Notes and FSP for documentation of the completed Plan. Source: DDSN EI Manual
E3-05 R	**Family Service Plan (FSP) is completed annually**	**FSP must be current within one year. The last page must be signed by the family and the EI.** **Source: DDSN EI Manual, EI Services Provider Manual**
E3-06	The Parent/ Caregiver was provided a copy of the Plan	Review service notes to verify that the parent/ caregiver was provided a copy of the Plan. Source: BabyNet Manual, DDSN EI Manual, EI Services Provider Manual
E3-07	FSP six-month review was completed within 180 days of the FSP	Ensure the FSP six-month review was completed within 180 days of the FSP. Source: DDSN EI Manual
E3-08	The Choice of Early Intervention Provider is offered annually	Review service notes, Family Training Summary Sheets, and the Acknowledgment of SC/EI Choice Form to ensure the family has been given a choice of providers and the choice is documented. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3, 6, & 9
E3-09	When file is transferred from another SC/Family	Applies only to files transferred to new providers.

	Training provider a new FSP is completed or the current plan is updated within 14 days	Source: DDSN EI Manual
E3-10	FSP includes current information relating to vision, hearing, medical, therapy, and all areas of development to include health	Review relevant sections of the FSP to ensure information is current and includes health and developmental information. Source: DDSN EI Manual
E3-11	Outcomes are based on identified needs and the team's concerns relating to the child's development	Compare relevant FSP sections to the outcome pages to determine if the Plan indicates who should do what and where it will take place. There should only be one outcome per page. Source: DDSN EI Manual, EI Services Provider Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 6, 8, & 9
E3-12	Outcomes are/have been addressed by the Early Interventionist	Review Service Notes and Family Training summary sheets to determine if all outcomes have been or are being addressed by the EI. All developmental outcomes should be addressed within 3 months of that identification as a need. If the outcome(s) are not being addressed, review documentation for supporting information noting why they haven't been addressed. Source: DDSN EI Manual, EI Services Provider Manual
E3-13	FSP “Other Services” reflects current services	The FSP “Other Services” worksheet must be in all EI files and must reflect current services (Waiver, Center based child care, OT, ST, PT, FT amount, frequency, and duration, Family Support Funds, Respite, ABC, etc). Changes in service delivery must be documented on the FSP. Source: DDSN EI Manual
E3-14	If the child's FSP indicates the need for more than 4 hours per month of Family Training, the service notes indicate that information has been sent to the Office of Children’s Services for approval	Review frequency of Family Training as identified on the FSP. If the frequency noted on the plan is more than 4 hours per month of Family Training there should be documentation indicating that the file was sent to the Office of Children's Services for approval. Source: DDSN EI Manual
E3-15	Assessments are completed every 6	Review assessment dates on chosen assessment tool(s) and FSP to ensure they are completed every 6 months or as changes warrant (i.e..,

	months, or as often as changes warrant	significant improvement or regression). Source: DDSN EI Manual, EI Services Provider Manual Supports CQL Shared Values Factor 8
E3-16 W	Family Training is provided according to the frequency determined by the team and as documented in the Other Services section of the FSP	The FSP should outline the frequency and duration of Family Training. Review the , Family Training summary sheets and/or FSP "Other Services" section to ensure that Family Training is provided at the frequency and duration outlined. If the frequency and duration outlined is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule. Source: DDSN EI Manual, EI Services Provider Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3, 8, & 9
E3-17	Family Training summary sheets include goals and objectives for each visit as well as follow-up objectives for the next visit	Family Training summary sheets should indicate the scheduled time and date of the next visit and what the caregiver will work on with the child until the next training visit. Review Family Training summary sheets to ensure that they include goals and objectives for each visit as well as objectives for the next visit with an error rate of no more than 2 mistakes during the review period. Source: DDSN EI Manual
E3-18 W	Entries for Family Training visits include how parent/ caregiver(s) participated in visit	Review Family Training summary sheets and Service Notes to ensure that parent/caregiver participated in training sessions. To only state that the parent/caregiver was present <u>and encouraged the child</u> is NOT sufficient. The summary of visit should include how the parent/caregiver actively participated in the visit. Review Family Training summary sheets to ensure that they include this information. Source: DDSN EI Manual
E3-19	Family Training activities should vary. Activities planned must be based on identified outcomes on the IFSP	Review the Family Training summary sheets to ensure that the activities vary in order to meet the outcomes for the child. Source: DDSN EI Manual
E3-20	Family Training activities correspond to outcome on the FSP outcome pages	Review outcome and Family Training Summary Sheets. Compare outcomes with Family Training activities Source: DDSN EI Manual. EI Services Provider Manual
E3-21	Time spent/reported preparing for a Family Training visit corresponds with the activity planned	Review Service Notes and Family Training Summary Sheets to determine if the time reported for preparing for a Family Training visit corresponds to the activities completed during the visit. For example, an EI should not report 15 minutes of "prep time" for a visit if when the EI got to the home they worked on singing songs or putting puzzles together. Source: DDSN EI Manual
E3-22	If less than 2 hours	Review the FSP Other services section to determine the frequency of

	per month of Family Training is identified on the FSP there is an approved Service Justification Form in the file	Family Training. If the need for Family Training is less than 2 hours per month there must be a service justification form present and signed by the Supervisor. Source: DDSN EI Manual
E3-23	If the Early Interventionist is unable to provide Family Training for an extended period of time (more than a month) was the family offered a choice of an alternate Early Interventionist	Review the Service Justification Form, service notes, and/or Family Training Summary Sheets to ensure the family was offered an alternate Early Interventionist to provide Family Training. Source: DDSN EI Manual
E3-24	Service notes document why and how the Early Interventionist participated in meetings/ appointments on the child's behalf	Review Service Notes to ensure why and how the Early Interventionist participated in the meeting/appointment. The Early Interventionist must justify why they are reporting the time that they are at the meeting/appointment. For example, it would not be appropriate for an EI to attend a Developmental Pediatrician's appointment and then report time for attending the entire appointment. Source: DDSN EI Manual
E3-25	If applicable, documentation in service notes indicates that the case was closed	Review service notes of a closed file to determine if it was documented that the case was being closed.
E3-26	Medical Necessity form was completed prior to any services being reported	Review the file to ensure that the Medical Necessity form is present in the file and was obtained prior to services being reported **This change is effective July 1, 2014** EI Source: EI Services Provider Manual
E3-27 Not included in score	Did the child receive more than 3 hours of FT/Service Coordination in any calendar month? (except for the months in which an <u>initial plan</u>, <u>annual plan</u>, or <u>transition conference</u> were held)	During the review period, except for the months in which an <u>initial plan</u>, <u>annual plan</u>, <u>Curriculum Based Assessment (CBA),</u> or <u>transition conference</u> were held, did the child receive more than 3 hours of Family Training/Service Coordination in any calendar month? If so, document the month(s) and total amount of time for the month. For example: April 2011, 2:23; June 2011, 3:35. Note: For Informational purposes only. Does not affect the score.