Georgia Department of Behavioral Health & Developmental Disabilities

PROVIDER MANUAL

FOR

COMMUNITY DEVELOPMENTAL DISABILITIES PROVIDERS

FOR

THE DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

FISCAL YEAR 2017

Effective Date: July 1, 2016 (Posted: June 1, 2016)

"DBHDD publishes its expectations, requirements, and standards for Community Developmental Disability Providers via policies and the Developmental Disabilities Provider Manuals. This manual is updated quarterly throughout each fiscal year (July – June), and is posted one month prior to the effective date. Provider Manuals from previous fiscal years and quarters are archived on DBHDD's website at: http://dbhdd.georgia.gov/provider-manuals-archive".

INTRODUCTION

The FY 2017 Provider Manual for the Division of Developmental Disabilities has been designed as an addendum to your contract/agreement with DBHDD to provide you structure for supporting and serving individuals residing in the state of Georgia.

SUMMARY OF CHANGES

A table listing the changes in the **FY 2017 – 1st Quarter** Provider Manual is provided for your convenience. Please click here to be linked to the Summary of Changes Table.

DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

FY 2017 COMMUNITY DEVELOPMENTAL DISABILITIES PROVIDER MANUAL

TABLE OF CONTENTS

When accessing this manual electronically, use your mouse to left click on the part or section you would like to access and you will be quickly linked to the corresponding page. If you see a red arrow (►) please check the Summary of Changes Table for details.

PART I **Eligibility, Service Definitions and Requirements**
► Eligibility, Service Definitions and Service Guidelines for Developmental Disabilities Services

PART II **Service Standards for DD Providers**

Section 1: Community Service Standards for DD Providers

Section 2: Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD)

Section 3: Request for Conversion

PART III **Block Grant Funding Requirements**
Title XX Social Services Block Grant for DD Services

PART IV **General Policies and Procedures**
DBHDD Policy Stat- **http://gadbhdd.policystat.com**

SUMMARY OF CHANGES TABLE

UPDATED FOR JULY 1, 2016

As a courtesy for Providers, this Summary of Changes is designed to guide the review of new and revised content contained in this updated version of the Provider Manual. The responsibility for thorough review of the Provider Manual content remains with the Provider.

Item #	Topic	Location	Summary of Changes
1	IDD/Developmental Disabilities Services Definitions(NOW/COMP Waiver Services)-Support Coordination and Intensive Support Coordination	Part I-pg. 29	Deleted all content and replaced with: Information relating to Support Coordination and Intensive Support Coordination services are located in NOW/COMP Manual PART III (Chapter 2900) at www.mmis.ga.gov. In addition, policies in regards to the provision of these services are located at (https://gadbhdd.policystat.com) under the new SC/ISC Index Policy titled "Operating Principles for Support Coordination & Intensive Support Coordination" effective July 1, 2016."

ALL POLICIES ARE NOW POSTED IN DBHDD POLICYSTAT LOCATED AT

http://gadbhdd.policystat.com

Details are provided in Policy titled Access to DBHDD Policies for Community Providers, 04-100.

The DBHDD Policy Stat INDEX helps to identify policies applicable for Community Providers.

The New and Updated policies are listed below. For 90 days after the date of revision, users can see the track changes version of a policy by clicking on New and Recently Revised Policies at the bottom of Policy Stat Home Page.

Item #	Topic	Location	Summary of Changes
1	Georgia Department of Behavioral Health and Developmental Disabilities' Definition of Severe and Persistent Mental Illness, 01-121	Part III General Policies and Procedures	**NEW:** https://gadbhdd.policystat.com/policy/2339257/latest/
2	Transition Process for Individuals with Intellectual and/or Developmental Disabilities moving from State Hospitals to their Family Home or Community Residences, 04-120	Part III General Policies and Procedures	**REVISED:** https://gadbhdd.policystat.com/policy/2351737/latest/
3	DBHDD Abbreviations and Acronyms, 04-112	Part III General Policies and Procedures	**REVISED:** https://gadbhdd.policystat.com/policy/2413457/latest/
4	Internal and External Reviews and Corrective Action Plans, 13-101	Part III General Policies and Procedures	**NEW:** https://gadbhdd.policystat.com/policy/2293099/latest/
5	Family Support Services Participant Eligibility, 02-406	Part III General Policies and Procedures	**REVISED:** https://gadbhdd.policystat.com/policy/1161850/latest/
6	Family Support Services Brokered Goods and Services List and Protocols, 02-409	Part III General Policies and Procedures	**REVISED:** https://gadbhdd.policystat.com/policy/1161846/latest/
7	Region of Responsibility Determination, 02-602	Part III General Policies and Procedures	**COMING SOON.**

Part I

Eligibility, Service Definitions and Service Guidelines for Developmental Disabilities Services

Provider Manual

For

Community Developmental Disabilities Providers

Fiscal Year 2017

Georgia Department of Behavioral Health and Developmental Disabilities
July 2016

Part I

Eligibility, Service Definitions and Service Guidelines for Developmental Disabilities Services

Eligibility for Developmental Disabilities Services
To be eligible for Developmental Disabilities Home and Community-Based Waiver Program Services, individuals must meet disability and financial criteria. One of the Department of Behavioral Health and Developmental Disabilities (DBHDD) Field Office s determines disability waiver eligibility for individuals residing in that region. The Department of Family and Children Services (DFCS) determines financial and Medicaid eligibility for services which are funded through Medicaid Waiver resources. Eligibility for the Medicaid waiver programs is determined by DBHDD Field Office s in accordance with waiver policies.

To be eligible for **developmental disabilities waiver services, an individual must meet the eligibility criteria below.** The contractor will deliver services to individuals who meet the following criteria:

A. **Most in Need:** The individual demonstrates:
   1. Substantial risk of harm to self or others; or
   2. Substantial inability to demonstrate community living skills at an age appropriate level; or
   3. Substantial need for supports to augment or replace insufficient or unavailable natural resources.

AND

B. **Diagnosis**:
   1. **Intellectual Disability:** The individual has a diagnosis of an intellectual disability based on onset before the age of 18 years and assessment findings from standardized instruments recognized by professional organizations (American Psychological Association, American Association on Intellectual and Developmental Disabilities) of significantly sub-average general intellectual functioning and significantly impaired adaptive functioning defined as an intelligence quotient (IQ) of about 70 or below (approximately two standard deviations below the mean)and significantly impaired adaptive functioning (two or more standard deviations below the mean) in at least two of the following skill areas: self-care, communication, home living, self-direction, functional academic skills, social/interpersonal skills, use of community resources, work, leisure, health, and safety.

AND/OR

   2. **Related Condition:** The individual has a diagnosis of a condition found to be closely related to an intellectual disability, as determined by a professional licensed to do so, and is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, which results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability and meets the following criteria (Code of Federal Regulations, Title 42 Section 435.1010):

      a. Is manifested before the individual attains age 22;
      b. Is likely to continue indefinitely;
      c. Results in substantial limitations in adaptive functioning (two or more standard deviations below the mean) in three or more of the following areas of functioning;

         1. Self-care;
         2. Receptive and expressive language;
         3. Learning;
         4. Mobility;
         5. Self-direction; and
         6. Capacity for independent living; and

The adaptive impairments must be directly related to the developmental disability and cannot be primarily attributed to mental/emotional disorders, sensory impairments, substance abuse, personality disorder, specific learning disability, or attention deficit/hyperactivity disorder.

Eligibility for State Funded Developmental Disabilities Services
Individuals who meet the above eligibility criteria for developmental disabilities waiver services are eligible to receive state funded developmental disabilities services. Individuals who do not meet the above developmental disabilities waiver criteria may receive state funded developmental disabilities services depending upon the availability of funding, priority of need.

Please refer to the Provider Manual for DD State Funded Services located at:
https://gadbhdd.policystat.com/policy/1386258/latest/

IDD/Developmental Disabilities Services Definitions
NOW & COMP Waiver Services

Behavioral Supports Consultation NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1 Self D	Mod2	Mod3	Mod4
Behavioral Supports Consultation	H2019	UC			

Definition of Service: Individuals can choose the self-direction option with Behavioral Supports Consultation Services.

Behavioral Supports Consultation Services are professional consultation services that assist the individual with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work, or similar situations. These services consist of behavioral supports professional evaluation, training, and intervention services. Evaluation services by the Behavioral Supports professional consultant include functional assessment of behavior and other diagnostic assessment of behavior. Training and intervention services by the Behavioral Supports professional consultant comprise direct skills training of individuals as well as family education and training on Positive Behavioral Supports.

Behavioral Supports Consultation Services provide for the development of Behavior Supports plans for the acquisition or maintenance of appropriate behaviors for community living and behavioral intervention for the reduction of maladaptive behaviors. Intervention modalities described in plans must relate to the identified behavioral needs of the waiver individual, and specific criteria for remediation of the behavior must be established and specified in the plan. Behavioral Supports Consultation Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver (COMP).

Behavioral Supports Consultation services are provided by appropriately qualified individuals with expertise in behavioral supports evaluation and services for people with developmental disabilities. These services may be provided in an individual's own or family home, the Behavioral Supports Consultant's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based behavioral supports goals specified in the Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Providers of Behavioral Supports Consultation services must comply with the guidelines and requirements for the provision of behavioral supports to individuals with developmental disabilities in the DHR, MHDDAD Guidelines for Supporting Adults with Challenging Behaviors in Community Settings and Behavioral Supports Guidelines (see Guidelines in Appendix D) in the delivery of these services; providers rendering Behavioral Supports Consultation services to individuals under the age of eighteen years must comply with any guidelines and requirements in these DBHDD Guidelines that are applicable to children and adolescents with developmental disabilities.
2. Providers can provide Behavioral Supports Consultation Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Community Access Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Co Emp	Mod4
Community Access Group	T2025	HQ	UC	UA	
Community Access Individual	T2025	UB	UC	UA	

Definition of Service:
Community Access Services are designed to assist the individual in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active community participation and independent functioning *outside* the individual's home or family home. These services are interventions in the areas of social, emotional, physical, and intellectual development and may include training in the areas of daily living skills (including leisure/recreation skills); communication training; mobility training; programming to reduce inappropriate and/or maladaptive behaviors; and training in the use of common community resources.

The emphasis of training will be on assisting the individual in increasing self-help, socialization skills, skills or daily living and adaptive skills required for active community participation and independent functioning outside the individual's home or family home. These activities include accompanying individuals to the grocery store, or eating establishments; teaching an individual how to participate in appropriate social and recreational activities; and assessing other activities of community living.

The services typically occur during the day but may also take place in the evenings and weekends. Community Access services are individually planned to meet the individual's needs and preferences for active community participation. These services are provided in either community-based or facility-based settings but not in the Individual's home, family home, or any other residential setting. The intended outcome of these services is to improve the individual's access to the community through increased skills and/or less paid supports.

Community Access Group services are provided to individual individuals or to groups of individuals. Community Access Group services are provided to groups of individuals, with a staff to individual ratio of one to two or more. The staff to individual ratio for Community Access Group services cannot exceed one (1) to ten (10). Community Access Individual services are provided to an individual, with a one-to-one staff to individual ratio. Community Access Services Providers offer (or arrange when needed) any of the Community Access Services that are needed by the individuals served and specified in the individuals' Individual Service Plans.

The following Community Access Services are offered:

- Community Access Group.
- Community Access Individual.

ADDITIONAL SERVICE INFORMATION:

1. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
2. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
3. Services and planning meetings shall be scheduled to accommodate individual and family needs.
4. Provider shall collaborate with the Field Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.

5. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
6. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
7. Providers rendering facility-based Community Access and other services (e.g., Prevocational Services and adult therapy services) can provide these services in the same facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Community Guide NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community Guide Self Directed	H2015	UC			
Community Guide Co-Employer	H2015	UA			

Definition of Service: Community Guide Services are direct assistance to individuals in skills building and information in meeting participant-direction responsibilities. These services are available ***only*** for individuals who choose the participant-direction option for service delivery. The individual, with the Support Coordinator, determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide. The specific Community Guide Services for the individual are specified in the Individual Service Plan. Individuals may elect to receive Community Guide Services, and when elected, individuals choose their Community Guide.

Community Guide Services are individualized services designed to assist individuals in meeting their responsibilities in the individual-direction option for service delivery. Community Guides provide information, direct assistance, and training to individuals in support of Individual direction. The intended outcome of these services is to improve the individual's knowledge and skills for individual direction.

Community Guides assist and train individuals to build the skills required for individual direction, such as exploring and brokering available community resources, problem solving, and decision-making, being an effective employer of support workers, developing and managing the individual budget, and record keeping. Information provided by the Community Guide helps the individual's understanding of provider qualifications, record keeping, and other individual-direction responsibilities.

The scope, intensity, and frequency of Community Guide Services may change over time, based on the needs of the Individual.

ADDITIONAL SERVICE INFORMATION:

1. Community Guide Services are only for individuals who opt for participant-direction.
2. The individual determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide.
3. The specific Community Guide Services for the individual are specified in the Individual Service Plan.
4. Individuals may elect to receive Community Guide Services, and when elected, individuals choose their Community Guide.
5. The need for Community Guide Services must be related to the individual disability and tied to a specific goal in the Intake and Evaluation Team approved Individual Service Plan (ISP).

Community Residential Alternative Services COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community Residential Alternative	T2033				

Definition of Service:
Community Residential Alternative (CRA) services are targeted for Individuals who require intense levels of support. These services are a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time. CRA Services are individually planned and tailored to meet the specific needs of the Individual and to accommodate fluctuations in his or her needs for various services.

CRA services include assistance with and/or training in activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring, and other similar tasks. These services also include training and/or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, simple home repair, yard care, and other similar tasks. CRA services consist of medically related services, such as basic first aid, arranging and transporting Individuals to medical appointments, assisting with therapeutic exercises, and assisting with or supervising self-administration of medication. These services also consist of implementing behavioral support plans designed for Individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors. CRA Services include transportation to all other waiver services specified in the Individual Service Plan and as needed to facilitate the individual's participation in personal shopping, recreation and other community activities.

Individuals receive CRA services in small group settings of four or less, in host home/life sharing situations for adults 19 years and above, or foster home for Individuals under the age of 19 years through an approved foster home operating under a licensed Child Placing Agency. CRA Services may not be provided to individuals living in their own or family homes.

Community Residential Alternative Services is provided to individuals who live in one of the following settings:

1. "Host Home" (Life sharing). A home where an individual, who receives services, resides in an owner occupied home where the owner/family is funded to include the individual with the disability into their household routines and provide training and supervision. **This is an unlicensed setting for two adults (19 years or above) receiving community residential alternative services. For CRA services rendered in life sharing/host home settings to individuals under the age of 19 years, the provider agency must have a Department of Human Services, Office of Residential Child Care license from the Department of Community Health, Division of Healthcare Facility Regulations. These homes can only serve a maximum of two (2) individuals under the age of 19 years at a time and can only serve individuals receiving services through the COMP Waiver.**

2. Community Living Arrangement (CLA). Agencies providing this community residential alternative service must have a Community Living Arrangement License from the Office of Regulatory Services. **If anyone in the home receives Medicaid Waiver funding no more than four people may reside in the home, unless granted an exception by the Office of DD.**

3. Personal Care Home (PCH) Agencies providing this community residential alternative service must have a Personal Care Home Permit from the Department of Community Health, Division of Healthcare Facility Regulation. PCH permits for the provision of CRA services are no longer accepted in applications to provide CRA services. PCH agencies enrolled to provide CRA services prior to January 1, 2011 may continue to provide CRA services. No more than four (4) individuals may reside in a PCH if anyone in the

home receives Medicaid Waiver funding, unless an exception has been granted by the Division of Developmental Disabilities. New homes will not be granted this exception.

The services provided, the frequency and intensity of services are specific to the individual receiving services as detailed in his/her Individual Services Plan (ISP).

ADDITIONAL SERVICE INFORMATION:

1. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
2. The selection of living environments shall include consideration of opportunities for community inclusion of individuals receiving services, individual choice (including preference to be close to family) and distance from other homes (e.g. apartments, house) of individuals receiving services to assure that individuals with developmental disabilities are not grouped in a conspicuous manner.
3. Daily and weekly rhythms and routines shall be directly related to individual's needs, interests and preferences.
4. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
5. Provider shall collaborate with the Field Office Intake and Evaluation staff and Planning List Administration staff and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. The Contractor's direct support staff will directly participate in both the ISP and the SIS.
6. The Provider ***must*** have Field Office approval before moving individual(s) to a new address. Emergency relocation plans identified in the Individual Service Plans is acceptable as prior approval for moving to a new location in emergencies. Each individual Community Residential Alternative site must be individually enrolled.
7. Provider will adhere to Policy on Personal Spending and Protection of Funds for individuals receiving community residential alternative services. See Part IV.
8. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.

Community Living Support Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Comp	Mod4
Community Living Support Services 15 Minutes	T2025	U5	UC	UA	
Community Living Supports Daily (COMP only)	T2025	U6	UC	UA	

Definition of Service:
Individuals can choose the self-direction OR co-employer options with CLS services. Community Living Support (CLS) Services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to an Individual's continued residence in his or her own or family home. Personal care/assistance may be a component part of CLS services but may not comprise the entirety of the services. CLS services are offered to Individuals who live in their own or family home.

CLS services include training and assistance with activities of daily living (ADLs), such as bathing, dressing, toileting, and transferring, and with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management. These services include transportation to facilitate the individual's participation in grocery or personal shopping, banking, and other community activities that support continued residence of the individual in his or her own or family home. CLS services may include medically related services, such as basic first aid, arranging and transporting individuals to medically appointments, accompanying individuals on medical appointments, documenting an individual's food and/or liquid intake or output, reminding individuals to take medication, and assisting with or supervising self-administration of medication.

Personal care/assistance may be a component part of CLS services but may not be the only service provided to an Individual. The amount of personal care/assistance is specific to the individual needs of the individual, as determined by the Supports Intensity Scale, the Health Risk Screening Tool, and other person-centered assessment data. The individual amount of personal care/assistance provided the individual is specified in the individual Service Plan.

A personal assistance retainer is a component of Community Living Support Services. This retainer allows continued payment to personal caregivers under the waiver for the following: (1) up to seven (7) days from the date of each admission to a general hospital or nursing facility, including ICF/MR and skilled nursing facilities; and (2) up to thirty (30) days per year for other absences of the individual from his or her home, such as vacations and family/relative visits.

CLS services are only for individuals who live in their own or family home. The types and intensity of services provided are specific to the individual and detailed in his or her Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
2. Daily and weekly rhythms and routines shall be directly related to individual's needs, interests and preferences.
3. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
4. Provider shall collaborate with the Field Office Intake and Evaluation and Planning List Administration staff and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Provider's direct support staff will directly participate in both the ISP and the SIS.

5. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
6. **Personal Assistance Retainer Documentation:** Providers, except for providers of participant-directed services, must document the following in the record of each individual for whom a personal assistance retainer is a component of Community Living Support Services: (1) Beginning and end date of absence, (2) Reason for absence, (3) Scheduled days and units per day for Community Living Support Services as specified in the ISP.
7. **Provider agencies must have a Private Home Care Provider License from the Department of Community Health (DCH), Division of Healthcare Facility Regulations (HFR) if providing covered services as required by DCH/HFR.**

Financial Support Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Financial Support Services	T2040	UC			

Definition of Service:
Financial Support Services (FSS) are designed to perform fiscal and related finance functions for the Individual or representative who elects the participant-direction option for service delivery and supports. FSS assure that the funds to provide services and supports, outlined in the Individual Service Plan (ISP) and to be implemented through a self-directed approach are managed and distributed as intended.

Additional Service Information:

1. Financial Support Services are provided by a Fiscal Intermediary Agency (FIA) established as a legally recognized entity in the United States, qualified and registered to do business in the state of Georgia, and approved as a Medicaid provider by the Department of Community Health (DCH).
2. Financial Support Services are mandatory and integral to participant-direction through a fiscal intermediary.
3. Financial Support Services are not available to individuals who choose the Co-Employer model for self-directed services and supports.
4. Financial Support Services are provided by agencies that do not provide any other Medicaid services in Georgia.

Individual Directed Goods and Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Individual Directed Goods and Services (NOW only)	T2025	U7	UC		

Definition of Service:

Individual Directed Goods and Services are goods and services not otherwise provided through the NOW or the Medicaid State Plan, but are identified by the waiver individual/representative who opts for -direction and the Support Coordinator or interdisciplinary team. These services are available ***only*** for individuals who choose the participant-direction option for service delivery. Individual Directed Goods and Services must be clearly linked to an assessed need of the individual due to his or her disability and be documented in the individual's Individual Service Plan.

Individual Directed Goods and Services are purchased from the participant-directed budget and cover services that include improving and maintaining the individual's opportunities for full membership in the community. Goods and services purchased under this coverage may not circumvent other restrictions on NOW services, including the prohibition against claiming for the costs of room and board. Individual Directed Goods and Services must be authorized by the operating agency prior to service delivery.

The Individual Directed Goods and Services must:

Decrease the need for other Medicaid services; **AND**

Not be available through another source, including the individual not having the funds to purchase the item or service; **AND**

Promote inclusion in the community; **OR**

Increase the individual's safety in the home environment.

The individual/representative must submit a request to the Support Coordinator for the goods or service to be purchased that includes the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipt that provides clear evidence of the purchase must be on file in the Individual's records to support all goods and services purchased. Authorization for these services requires Support Coordinator documentation that specifies how the Individual Directed Goods and Services meet the above-specified criteria for these services. Individuals receiving flexible support coordination are required to follow these same procedures.

ADDITIONAL SERVICE INFORMATION:

1. Individual Directed Goods and Services are provided by vendors with the applicable Georgia business license as required by the local, city or county government in which the services are provided.

Supported Employment NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 CoEmp	Mod4
Supported Employment Individual	T2019	UB	UC	UA	
Supported Employment Group	T2019	HQ	UC	UA	

Definition of Service: Individuals can choose the self-direction or co-employer options with Supported Employment Services.

Supported Employment services are ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. The scope and intensity of Supported Employment supports may change over time, based on the needs of the individual. Supported Employment services are conducted in a variety of settings, particularly work sites where individuals without disabilities are employed.

Individuals who receive Supported Employment services must require long-term, direct, or indirect job-related support in job supervision, adapting equipment, adapting behaviors, transportation assistance, peer support, and/or personal care assistance during the work day. Supported Employment services consist of activities needed to obtain and sustain paid work by individuals, including job location, job development, supervision, training, and services and supports that assist individuals in achieving self-employment through the operation of a business, including helping the individual identify potential business opportunities, assisting in the development of a business plan, identifying the supports that are necessary for the individual to operate a business, and ongoing assistance, counseling and guidance once the business has been launched. These services do not include the supervisory activities rendered as a normal part of the business setting.

The planned outcomes of these services are to increase the hours worked by each individual toward the goal of forty hours per week and to increase the wages of each individual toward the goal of increased financial independence. Supported Employment services are based on the individual individual's needs, preferences, and informed choice. These services allow for flexibility in the amount of support an individual receives over time and as needed in various work sites.

Supported Employment Group services are provided to groups of individuals, with a staff to individual ratio of one to two or more. The staff to individual ratio for Supported Employment Group services cannot exceed one (1) to ten (10). Supported Employment Individual services are provided to an individual, with a one-to-one staff to individual ratio.

ADDITIONAL SERVICE INFORMATION:

1. Supported Employment may be provided in individual or group settings. When contracts or Memorandums of Agreement require providers to report the types of settings in which Supported Employment has occurred, providers will report those settings using the following categories:

- Community Based Employment Services – Individual.
- Community Based Employment Services – Group.

2. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
3. Provider supports individuals receiving services to experience meaningful days by assuring that activities are directly related to the individual's interests and preferences as documented in the ISP.
4. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
5. Provider shall assure that individuals (and/or their families, as appropriate) have accurate and individualized information regarding the impact and value of employment and wages on benefits.
6. Service shall be aimed at increased opportunities for meaningful adult career development with focus towards paid employment.
7. Services and planning meetings shall be scheduled to accommodate individual and family needs.
8. Provider shall collaborate with the Field Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.
9. The SIS will contribute to, but not determine exclusively, the nature of the employment goals identified in the ISP as they shall always be primarily identified through person-centered planning and discovery.
10. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
11. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
12. Group Supported Employment Services: a staff to individual ratio of one to two or more, not to exceed one (1) to ten (10).
13. Individual Supported Employment Services: a one-to-one staff to individual ratio.

Prevocational NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Co Emp	Mod4
Prevocational Services	T2015				

Definition of Service:
Prevocational Services prepare an individual for paid or unpaid employment. These services are for the individual not expected to be able to join the general work force within one year as documented in the Individual Service Plan. If compensated, individuals are paid in accordance with the requirements of Part 525 of the Fair Labor Standards Act.

Prevocational Services occur in facility-based settings or at community sites outside the facility for small groups of individuals, called mobile crews, who travel from the facility to these community sites. Mobile crews receive Prevocational Services by performing tasks, such as cleaning or landscaping, at community sites other than the individual's home or family home or any residential setting.

The emphasis of Prevocational Services is directed to habilitative rather than explicit employment objectives. These services include teaching individuals concepts necessary to perform effectively in a job in the community. Activities included in these services are directed at teaching concepts such as rule compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, increased attention span, motor skills, safety, and appropriate social skills.

The intended outcome of these services is to prepare the individual for paid or unpaid employment through increased skills. Prevocational Services are individually planned to meet the Individual's needs for preparation for paid or unpaid employment. These services are provided either facility-based or at community sites other than the individual's home or family home or any other residential setting.

Prevocational Services are provided to groups of individuals at a facility or to small groups of individuals who travel to sites outside the facility, referred to as mobile crews. The staff to individual ratio for facility-based Prevocational Services cannot exceed one (1) to ten (10). The staff to individual ratio for Mobile Crew Prevocational Services cannot exceed one (1) to six (6).

ADDITIONAL SERVICE INFORMATION:

1. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
2. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
3. Provider shall assure that individuals (and/or their families, as appropriate) have accurate and individualized information regarding the impact and value of wages on benefits.
4. Service shall be aimed at increased opportunities for meaningful adult career development with focus towards paid employment.
5. Services and planning meetings shall be scheduled to accommodate individual and family needs.

6. Provider shall collaborate with the Field Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.
7. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
8. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
9. Providers rendering facility-based Prevocational Services and other services (e.g., Community Access Services and adult therapy services) can provide these services in the same facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Respite Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Respite Care Services 15 Minutes	S5150				
Respite Care Services Overnight	S5151				

Definition of Service:

Respite Services provide brief periods of support or relief for caregivers of individuals with disabilities. Respite is provided in the following situations:

When families or the usual caretakers are in need of additional support or relief;

When the individual needs relief or a break from the caretaker;

When an individual is experiencing a crisis and needs structured, short-term support;

When relief from care giving is necessitated by unavoidable circumstances, such as a family emergency.

Planned or scheduled respite, or Maintenance Respite, provides brief periods of support or relief for caregivers or Individuals. Respite Services might also be needed to respond to emergency situations. Emergency/Crises Respite is intended to be a short term service for an individual experiencing a crisis (usually behavioral) and requires a period of structured support, or when respite services are necessitated by unavoidable circumstances, such as a family emergency. Maintenance Respite and Emergency/Crises Respite may be provided In-Home (provider delivers service in the individual's home) or Out-Of-Home (The individual receives service outside of their home).

Respite Services may be provided in the individual's own or family home, or outside the individual's home in a private residence of a Respite Services provider (i.e., a home that is owned or rented by the provider or an employee of the provider) or in a licensed Personal Care Home. Respite Services include short-term services during a day or overnight services.

ADDITIONAL SERVICE INFORMATION:

1. Provider agencies that render in-home Respite Services must hold a Private Home Care license if providing services as required by DCH/HFR.
2. Provider agencies that render out-of-home Respite Services in a Personal Care Home must have a Personal Care Home license.
3. Respite Services in personal care homes can only be rendered in personal care homes in which **all** residents are adults with developmental disabilities.
4. Respite Services provided in Personal Care Homes serve no more than a total of four (4) individuals at a time.
5. Respite Services provided in the private residence of a provider serve no more than one (1) individual in the home at a time.
6. DBHDD may grant an exception of the private residence capacity limit up to two (2) individuals when serving *only* individuals under the age of 18.

Specialized Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1 Self D	Mod2	Mod3	Mod4
Specialized Medical Supplies	T2028	UC			
Specialized Medical Equipment	T2029	UC			
Vehicle Adaptation	T2039	UC			
Environmental Accessibility Adaptation	S5165	UC			

Definition of Service: Specialized Medical Supplies (SMS) Services include various supplies which enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. SMS consist of food supplements, special clothing, diapers, bed wetting protective chucks, and other supplies that are specified in the Individual Service Plan and are not available under the Medicaid State Plan. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service.

Specialized Medical Equipment (SME) Services include various devices, controls or appliances which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. SME services also include assessment or training needed to assist individuals with mobility, seating, bathing transferring, security, or other skills such as operating a wheelchair, locks, door openers, or side lyers. These services additionally consist of customizing a device to meet an individual's needs.

Vehicle Adaptation Services include various adaptations and technical assistance to individually or family owned vehicles which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. Vehicle Adaptations are limited to an individual's or his or her family's privately owned vehicle and include such things as a hydraulic lift, ramps, special seats and other interior modifications to allow for access into and out of the vehicle as well as safety while moving. The adapted or to be adapted vehicle must be the individual's primary means of transportation.

Environmental Accessibility Adaptation Services include adaptations and technical assistance to individually or family owned private residences which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These services include physical adaptations to the individual's or family's home which are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home and without which, the individual would require institutionalization. Environmental Accessibility Adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual, and are of direct medical or remedial benefit to the individual.

ADDITIONAL SERVICE INFORMATION:

1. Specialized Medical Supplies services must be documented to be the payer of last resource. The DME program prior approval process is used to determine medical necessity for medical supplies. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity. Providers for Specialized Medical Supplies should refer to the Department of Community Health, Division of Medical Assistance, Part II, Policies and Procedures for Durable Medical Equipment, Part II, Policies and Procedures for Orthotics and Prosthetics and Part III, Hearing Services for additional information about coverage of these services.

2. Specialized Medical Equipment services must be documented to be the payer of last resource. The DME program prior approval process is used to determine medical necessity for medical equipment. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.

3. Individuals may choose the self-direction option with Specialized Medical Equipment Services. Providers for Specialized Medical Equipment should refer to the Department of Community Health, Division of Medical Assistance, Part II, Policies and Procedures for Durable Medical Equipment, Part II, Policies and Procedures for Orthotics and Prosthetics and Part III, Hearing Services for additional information about coverage of these services.

4. Any item billed under Vehicle Adaptation Services must not be available under the State Medicaid plan. These services must also be documented to be the payer of last resource. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.

5. Any item billed under Environmental Accessibility Adaptation Services must not be available under the State Medicaid Plan. These services must also be documented to be the payer of last resource. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.

Natural Support Training Service NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Natural Support Training Service	T2025	UD	UC		

Definition of Service: Individuals can choose the self-direction option with Natural Support Training Services.

Natural Support Training (NST) Services provide training and education to individuals who provide ***unpaid*** support, training, companionship, or supervision to individuals. For purposes of this service, individual is defined as any individual, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship, or support to an individual served on the waiver. These services must relate to the individual individual's needs due to his or her disability and tie to a specific goal in the Individual Service Plan. All training for individuals who provide unpaid support to the individual provided through NST Services must be included in the Individual's ISP.

NST Services include individualized training of families and members of the individuals' natural support networks for the acquisition or enhancement of their ability to support the waiver individual. This training consists of instruction about treatment regimens and other services included in the ISP. NST Services comprise training on the use of equipment as specified in the ISP. There services may include updates in training required to maintain the individual safely at home. NST Services encompass the costs of registration and training fees associated with formal instruction in areas relevant to the individual's disability needs identified in the ISP. These services do not include the costs of travel, meals, and overnight lodging to attend a training event or conference.

NST Services are provided by Developmental Disability Professionals (see Provider Manual for definition). These services may be provided in an individual's own or family home, the Developmental Disability Professional's office, outpatient clinics, Supported Employment work sites, or other community settings specific to community-based Natural Support Training goals specified in the Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. NST Services must not duplicate any family education or training provided through Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services.
2. NST Services may not occur simultaneously or on the same day as Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services.

Therapy Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Adult Occupational Therapy	97003 97530 97533	 GO GO	UC UC UC		
Adult Physical Therapy	97001 97110		UC UC		
Adult Speech and Language Therapy	92523 92507 92609	GN	UC UC UC		

Definition of Service: Individual can choose self-direction option with these therapies.

Adult Occupational Therapy Services are evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the occupational therapy needs of the adult individual that result from his or her developmental disability. Adult Occupational Therapy Services include occupational therapy evaluation, individual/family education, occupational therapy activities to improve functional performance, and sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands. Adult Occupational Therapy Services are provided by a Georgia licensed occupational therapist and by order of a physician. These services may be provided in an individual's own or family home, the Occupational Therapist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Occupational Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

Adult Physical Therapy Services are evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the physical therapy needs of the adult individual that result from his or her developmental disability. Adult Physical Therapy Services include physical therapy evaluation, individual/family education, and therapeutic exercises to develop sitting and standing balance, strength and endurance, and range of motion and flexibility. Adult Physical Therapy Services also consist of muscle strengthening and endurance to facilitate transfers from wheelchairs and the use of other equipment. Adult Physical Therapy Services are provided by a Georgia licensed physical therapist and by order of a physician. These services may be provided in an individual's own or family home, the Physical Therapist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Physical Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

Adult Speech and Language Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the speech and language therapy needs of the adult individual that result from his or her developmental disability. Adult Speech and Language Therapy Services include the evaluation of speech language, voice, and language communication, auditory processing, and/or aural rehabilitation status. Adult Speech and Language Therapy Services also consist of individual/family education, speech language therapy, and therapeutic services for the use of speech-generating devices, including programming and modification. Adult Speech and Language Therapy Services are provided by a Georgia licensed speech and language pathologist and by order of a physician. These services may be provided in an individual's own or family home, the Speech and Language Pathologist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Speech and Language Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

ADDITIONAL SERVICE INFORMATION:

1. Services must be provided by a Georgia licensed individual in the specific therapy discipline.
2. Provider agencies must have available a sufficient number of employees or professionals under contract that are Georgia licensed individuals in the specific therapy discipline.

Support Coordination and Intensive Support Coordination NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Support Coordination	T2022				
Intensive Support Coordination	T2022 U1				

Information relating to Support Coordination and Intensive Support Coordination services are located in NOW/COMP Manual PART III (Chapter 2900) at www.mmis.ga.gov. In addition, policies in regards to the provision of these services are located at (https://gadbhdd.policystat.com) under the new SC/ISC Index Policy titled "Operating Principles for Support Coordination & Intensive Support Coordination" effective July 1, 2016."

Transportation Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Transportation – Trip	T2003				
Transportation – Trip – Self Directed	T 2003	UC			
Transportation – Trip – Co-Employer	T 2003	UA			
Transportation Commercial Carrier, Multi Pass	T 2004				
Transportation Commercial Carrier, Multi Pass Self Directed	T 2004	UC			

Definition of Service: Individuals may choose the participant-direction or co-employer options with Transportation Services.

Transportation Services enable waiver individuals to access non-medical services, activities, resources, and organizations typically utilized by the general population. These services are only provided as independent, stand-alone waiver services when transportation is not otherwise included as an element of another waiver service. Transportation services are not intended to replace available formal or informal transit options for individuals. Whenever possible, family, neighbors, friends or community agencies, which can provide this service, without charge, are to be utilized. The need for Transportation Services and the unavailability of other resources for transportation must be documented in the Individual Service Plan (ISP).

Transportation Services provide transportation for the individual to waiver services and other community services, activities, resources, and organizations typically utilized by the general population. These services include:

One-way or round trips provided by Georgia licensed drivers and/or DD Service Agencies; and

Transit by commercial carrier available to the community at large.

Transportation Services must not be available under the Medicaid Non-Emergency Transportation Program, State Plan, Individual with Disabilities Education Act (IDEA), or the Rehabilitation Act. These services do not include transit provided through Medicaid non-emergency transportation. Transportation Services are not available to transport an individual to school (through 12th grade). These services do not include transportation that is included as an element of another waiver service as follows:

- Community Living Support Services.
- Prevocational Services.
- Supported Employment Group Services.
- Community Access Group or Individual Services, which entail activities and settings primarily utilized by people with disabilities, such as transportation to and from a IDD Service Center or other day center.

Transportation Services are only for individuals who do not have formal or informal transit options available. The type and amount of Transportation Services provided are specific to the individual and detailed in his or her Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Individual Providers rendering Transportation Services must hold a valid Class C license as defined by the Georgia Department of Driver Services (or any allowable other state license per Department of Community Health, Division of Medical Assistance policy).

2. DD Service Provider Agency driver staff providing Transportation Services must hold the class of license appropriate to the vehicle operated as defined by the Georgia Department of Driver Services (or any allowable other state license per Department of Community Health, Division of Medical Assistance policy).

PART II

Standards for Developmental Disabilities Service Providers

Provider Manual

For

Community Developmental Disabilities Providers

Section 1: Community Service Standards for Developmental Disabilities Providers

Section 2: Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD)

Section 3: Request for Conversion

Georgia Department of Behavioral Health and Developmental Disabilities
July 2016

Part II

Section 1

Community Service Standards for Developmental Disabilities Providers

VISION: A SATISFYING, INDEPENDENT LIFE WITH DIGNITY AND RESPECT
It is the vision of the Department of Behavioral Health and Developmental Disabilities (DBHDD) that every person who participates in our services leads a satisfying, independent life with dignity and respect.

DEVELOPMENTAL DISABILITY SERVICES

DBHDD believes it is critical that services, supports, treatment and care respect the vision of the individual. Each agency or organization must incorporate this belief and practice into its service delivery to support individuals with intellectual and developmental disabilities in living a meaningful life in the community. Specifically, the provider must ensure:

- Person-centered service planning and delivery that address the balance of what is important to and for individuals.
- Capacity and capabilities, including qualified and competent providers and staff.
- Participant safeguards.
- Satisfactory participant outcomes.
- Systems of care that have the infrastructure necessary to provide coordinated services, supports, treatment and care.
- Participants rights and responsibilities.
- Participant access.

The Standards that follow are applicable to the organizations that provide Developmental Disability services to individuals that are financially supported in whole or in part by funds authorized through DBHDD, regardless of the age or disability of the individual served.

Participant self-determination includes freedom, authority and responsibility and is considered key to achieving the vision of *a satisfying, independent life with dignity and respect for everyone.*

ORGANIZATIONAL PRACTICES

A. PROGRAM STRUCTURE

1. The organization has a description of its services that includes a description of:
    a. The population served;
    b. How the organization plans to strategically address the needs and desires of those served;
    c. The services available to potential and current individuals; and
    d. A detailed expectation and outcomes for services offered.
2. The organization has internal structures that support good business practices such as:
    a. Clearly stated current policies and procedures for all aspects of the operation of the organization;
    b. Policies and corresponding procedures that direct the practice of the organization;
    c. Staff trained in organization policies and procedures;
    d. Providing services according to benchmarked practices;

e. The level and intensity of services offered is within the organization's scope of services;
f. The identified services are offered timely as required by individual need; and
g. Administrative and clinical structures are clear and promote unambiguous relationships and responsibilities to support individual care.

3. The program description identifies the minimum staff to individual served ratios for each service offered. In addition, the program description needs to address the following considerations:
   a. Staff ratios reflect the needs of individuals supported, implementation of behavioral procedures, best practice guidelines and safety considerations.
   b. Staff ratios reflect considerations such as licensure waivers and special (exceptional) rates reflecting unique individual care needs, etc.
   c. Define clearly in P&P and practice, what constitutes the staffing requirements and levels of observation procedures to meet the individual's clinical care and safety needs as outlined:
      1) Staffing requirements for: Line of sight is not 1:1 staff support but the staff has the ability to always view the individual and intervene and provide support as needed; Arm's length is not necessarily 1:1 staff support, but the staff must be within arm's length distance while the individual is engaged in an activity. Staff is in close proximity at all times to be able to support and intervene as needed and the 1:1 staff support is exclusive focus on the individual and the staff cannot provide support to another individual or be engaged in any other activity at the time the 1:1 supports are mandated; and
      2) Levels of observation include routine observations whereby staff is maintaining the general awareness of the individual's whereabouts and status by visually observing the individual at least every 30 minutes or as required; continuous/special observations involves increased levels of monitoring and documentation by maintaining a continuous awareness through visual observations at all times with at least one staff that remain in such close proximity to the individual as to be able to intervene and prevent actions that are unsafe to the individual or others.
4. Applicable statutory requirements, rules, regulations, licensing, accreditation, and contractual/agreement requirements are evident in organizational policies, procedures and practices.
   a. Appropriate licenses are obtained for residential services, if applicable;
   b. Licensure and other permits, when applicable, must be available at the agency or by the individual provider and open to view by the public;
   c. Accreditation/compliance with community standards requirements meet contractual requirements;
   d. All DD Providers must have current general liability insurance in the amount of $1 million per occurrence and $3 million aggregate; and
   e. The Provider must demonstrate full cooperation in allowing full and complete access by the Department and its agents and state and federal agencies to conduct reviews to evaluate and improve quality of service delivery, administrative performance and/or individual complaints.
5. There is a written budget which includes expenses and revenue that serves as a plan for managing resources. Utilization of fiscal resources is assessed in Quality Improvement Processes and/or by the Board of Directors.
6. The organization policy must state explicitly in writing whether or not research is conducted on individuals served by the organization.
   a. If the organization wishes to conduct research involving individuals, a research design shall be developed and must be approved by:
      i. The agency's governing authority; and
      ii. The Director of Division of Developmental Disabilities; and
      iii. The Institutional Review Board operated by the Department of Public Health (DPH) and its policies as provided in Research, Protection of Human Subjects, and Institutional Review Board (IRB), 25-101.
   b. The Research design shall include:

i. A statement of rationale;
ii. A plan to disclose benefits and risks of research to the participating individual;
iii. A commitment to obtain written consent of the individuals participating; and
iv. A plan to acquire documentation that the individual is informed that they can withdraw from the research process at any time.

c. The organization using unusual medication and investigational experimental drugs shall be considered to be doing research.
   i. Policies and procedures governing the use of unusual medications and unusual investigational and experimental drugs shall be in place;
   ii. Policies, procedures, and guidelines for research promulgated by the DCH Institutional Review Board shall be followed;
   iii. The research design shall be approved and supervised by a physician;
   iv. Information on the drugs used that shall be maintained include:
      a) Drug dosage forms;
      b) Dosage range;
      c) Storage requirements;
      d) Adverse reactions; and
      e) Usage and contraindications.
   v. Pharmacological training about the drug(s) shall be provided to nurses who administer the medications; and
   vi. Drugs utilized shall be properly labeled.

d. If research is conducted, there is evidence that involved individuals are:
   i. Fully aware of the risks and benefits of the research;
   ii. Have documented their willingness to participate through full informed consent; and
   iii. Can verbalize their choice to participate in the research. If the individual is unable to verbalize or otherwise communicate this information, there is evidence that a legal representative, guardian or guardian ad litem has received this information and consented accordingly.

7. Organizations that provide developmental disabilities services must participate in the Georgia Developmental Disabilities Provider information website. The address is www.georgiacollaborative.com .
8. **Children eighteen and younger may not be served** with adults in residential programs. Situations representing exceptions to this standard must have written documentation from the DBHDD Field Office such as:
   a. Exceptions must demonstrate that it would be disruptive to the living configuration and relationships to disturb the 'family' make-up of those living together.
   b. Emancipated minors and juveniles who are age 17 years may be served with adults when their life circumstances demonstrate they are more appropriately served in an adult environment.

B. OVERSIGHT OF CONTRACTED/SUBCONTRACTED PROVIDERS/PROFESSIONALS BY THE ORGANIZATION

1. The organization is responsible for the Contracted/Subcontracted Provider/Professional compliance with:
   a. Contract/Agreement requirements, documented and maintained for review;
   b. Standards of practice and specified requirements in the Provider manual for the Department of BHDD, including *Community Standards for All Providers;*
   c. Licensure requirements (Provider shall hold the Community Living Arrangement License {or Personal Care Home Permit for providers approved prior to April 2011}by Healthcare Facility Regulations {HFR} for Community Residential Alternative services for all residential sites housing individuals with Developmental Disabilities as required by HFR).
   d. Accreditation or Community Service Standards Quality Review requirements
   e. Quality improvement and risk reduction activities; and

f. Subcontracting of Community Residential Alternative Service is Limited (Restricted) to Host Home Providers.

2. There is documented evidence of active oversight of the Contracted/Subcontracted Provider/Professional capacity and compliance to provide quality care to include monitoring of:
   a. Financial oversight and management of individual funds;
   b. Staff competency and training;
   c. Mechanisms that assure care is provided according to the plan of care for each individual served; and
   d. The requirement for a Host Home Study when contracting with a Host Home provider, to provide updating and meeting home study requirements for new members to include general health examination, screening for communicable disease, criminal records check/clearance, character references and training compliance.
   3. All nursing services delivered by subcontracted provider(s) with a Private Home Care (PHC) license or Community Living Arrangements (CLA) license must at a minimum meet the requirements for subcontracting nursing services outlined in the DCH NOW/COMP Waiver Manual Chapter 3400 and Rules and Regulations for PHC Nursing Services Chapter 111-8-65. **Note:** All nursing services provided under a CLA license require site-specific nursing enrollment.
4. A report shall be made quarterly to the agency's Board of Directors regarding:
   a. Services provided by Contracted/Subcontracted Provider/Professional ; and
   b. Quality of performance of the Contracted/Subcontracted Provider/Professional.
5. A report shall be made to the DBHDD Field Office prior to the end of the first quarter and third quarter of the fiscal year that includes:
   a. Name and contact information of all contracted providers;
   b. The specific services provided by each contracted provider;
   c. The number and location of individual supported by each contracted provider; and
   d. Annualized amount paid to each contracted provider.

C. QUALITY IMPROVEMENT AND RISK MANAGEMENT

1. There is a well-defined quality improvement plan for assessing and improving organizational quality. The QI plan addresses:
   a. Processes for how issues are identified;
   b. What solutions are implemented;
   c. Any new or additional issues are identified and managed on an ongoing basis;
   d. The internal structures minimize risks for individuals and staff;
   e. The processes used for assessing and improving organizational quality are identified; and
   f. The quality improvement plan is reviewed and updated at a minimum annually and this review is documented.
2. Areas of risk to persons served and to the organization are identified and monitored based on services, supports, treatment or care offered including, but not limited to:
   a. Incidents and accidents:
      i. There is evidence that incidents are reported to the DBHDD Office of Incident Management and Investigation as required by DBHDD Policy, Reporting and Investigating Deaths and Critical Incidents in Community Service, 04-106.
   b. Healthcare Standard & Welfare;
   c. Complaints & Grievances;
      i. The organization's policy and process for complaints and grievances should include the external process as defined in Complaints and Grievances Regarding Community Services, 19-101

d. Individual Rights Violations;
    i. There is documented evidence that any restrictive interventions utilized must be reviewed by the organization's Rights Sub-Committee;
e. Practices that limit freedom of choice or movement;
f. Medication Management;
g. Infection Control;
h. Positive Behavior Support Plan tracking and monitoring to include restrictive interventions to include review for efficacy of plan and needed adjustments, recommendations and modifications are made in a timely manner;
i. Breaches of Confidentiality; and
j. Protection of Health and Human Rights of persons with developmental disabilities.

3. Indicators of performance are in place for assessing and improving organizational quality. The organization is able to demonstrate:
    a. The indicators of performance established for each issue:
        i. The method of routine data collection and reporting;
        ii. The method of routine measurement;
        iii. The method of routine evaluation; and
        iv. Target goals/expectations for each indicator;
    b. Outcome Measurements determined and reviewed for each indicator on a quarterly basis;
    c. The inclusion of cultural diversity competency practices is evident by:
        i. Staff articulating an understanding of the social, cultural, religious and other needs and differences unique to the individual;
        ii. Staff honoring these differences and preferences (such as worship or dietary preferences in supporting the individuals daily; and
        iii. The inclusion of cultural competency in Quality Improvement Processes.
    d. Distribution of Quality Improvement findings on a quarterly basis to:
        i. Individuals served or their representatives as indicated in the plan;
        ii. Organizational staff;
        iii. The governing body; and
        iv. Other stakeholders as determined by the governing body.
4. At least four individual records or the records of five percent (5%) of the total number of individuals served (whichever number is greater) are reviewed each quarter and the reviews are kept for a period of at least two years. Records of individuals who are "at risk" are included. Reviews include these determinations:
    a. That the record is organized; complete, accurate and timely;
    b. Whether services are based on assessment and need;
    c. That individuals have choices;
    d. Documentation of service delivery including individuals' responses to services and progress toward ISP goals;
    e. Documentation of health service delivery;
    f. Medication management and delivery, including the use of PRN and over the counter PRN medications; and their effectiveness;
    g. That approaches implemented for individuals with challenging behaviors are addressed as specified in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings.* When a behavioral support plan is necessary, providers of developmental disabilities services develop these plans in accordance with the *Best Practice Standards for Behavioral Support Service* (www.dbhdd.georgia.gov); and
5. Appropriate utilization of human resources is assessed, including but not limited to:
    a. Competency;
    b. Qualifications;

c. Numbers and type of staff, for example, a behavior specialist, required based on the services, supports, treatment and care needs of persons served; and
d. Staff to individual ratios.

6. The organization has an advisory board made up of citizens, local business providers, individuals and family members. The Board:
   a. Meets at least semi-annually;
   b. Reviews items such as but not limited to:
      i. Policies;
      ii. Risk management reports; and
      iii. Assess budget and utilization of fiscal resources.
   c. Provides objective guidance to the organization.

D. MEDICATION AND HEALTHCARE MANAGEMENT (CRITICAL)

1. A current copy of the physician(s) order or current prescription dated and signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:
   a. Regular, on-going medications;
   b. Controlled substances;
   c. PRN (as needed) Over-the-counter (OTC) medications;
   d. PRN medications (does not include standing orders for psychotropic medications for symptom management of behavior); or
   e. Discontinuance order.
2. Anti-psychotic medications must be prescribed by a psychiatrist or psychiatric nurse practitioner unless the medication is prescribed for epilepsy or dementia and there is documentation that include:
   a. Informed consent for the medication is obtained and a signed copy is maintained in the clinical record. It is the responsibility of the physician/designee to complete the informed consent;
   b. The treating psychiatrist or psychiatric nurse personally examines the individual to determine whether this person has the capacity to understand to consent for herself or himself;
   c. If the individual does not have the capacity to consent for herself or himself, an appropriate substitute decision maker is identified based on the Order of Priority outlined in Georgia Medical Consent Law;
   d. The risks/benefits is explained in language the individual can understand;
   e. Medication education provided by the organization's staff should be documented in the clinical record; and
   f. Education regarding the risks and benefits of the medication is documented.
3. The organization must have written policies, procedures, and practices specific to the type of services provided for all aspects of medication management including, but not limited to:
   a. Prescribing:
      i. The physician's order or current prescription is defined as a prescription signed by one authorized to prescribe in Georgia; and
      ii. Electronic prescriptions (E-scripts and Sure scripts), if practiced
   b. Authenticating orders: Describes the required time frame for obtaining the actual or faxed physician's signature for telephone or verbal orders accepted by a licensed nurse.
   c. Ordering and Procuring medication and refills: Procuring initial prescription medication and over-the-counter drugs within twenty-four hours of prescription receipt, and refills before twenty-four hours of the exhaustion of current drug supply.
   d. Medication Labeling: Describes that all medications must have a label affixed by a licensed professional with the authority to do so. This includes sample medications.

e. Storing: Includes prescribed medications, floor stock drugs, refrigerated drugs, and controlled substances.
f. Security: Requires safe storage of medication as required by law including single and double locks, shift counting of the medications, individual dose sign-out recording, documented planned destruction, and refrigeration and daily temperature logs. All controlled substances are double locked and there is documented accountability of controlled substances at all stages of possession.
g. Dispensing: Describes the process allowed for pharmacists and/or physicians only. Includes the verification of the individual's medications from other agencies and provides a documentation log with the pharmacists or physician's signature and date when the drug was verified. Only physicians or pharmacists may re-package or dispense medications:
    i. This includes the re-packaging of medications into containers such as "day minders" and medications that are sent with the individual when the individual is away from his residence.
    ii. Note that an individual capable of independent self-administration of medication may be coached in setting up their personal "day minder".
h. Supervision of individual self-administration: Includes all steps in the process from verifying the physician's medication order to documentation and observation of the individual for the medication's effects, each time, and supervision of individual self-administration occurs. Makes clear that staff members may not administer medications unless licensed to do so, and the methods staff members may use to supervise or assist, such as via hand-over-hand technique, when an individual self-administers his/her medications. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication.
i. Administration of medications: Administration of medications may be done only by those who are <u>licensed</u> in this state to do so.
j. Recording: Includes the guidelines for documentation of all aspects of medication management. This includes adding and discontinuing medication, charting scheduled and as needed medications, observations regarding the effects of drugs, refused and missing doses, making corrections, and a legend for recording. The legend includes initials, signature and title of staff member.
k. Disposal of discontinued or out-of-date medication: Includes via an environmentally friendly method of disposal by pharmacy.
l. Education to the individual and family (as approved by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record.
m. All PRN or "as needed" medications will be accessible for each individual as per his/her prescriber(s) order(s) and as defined in the individual's ISP. Additionally, the organization must have written protocols and documented practice that ensures safe and timely accessibility that includes, at a minimum, how medication will be stored, secured or refrigerated when transported to different programs and home visits.
n. Timeliness of medication administration/supervision: Organizations must adopt medication administration/supervision P&P based on accepted standards of practice that meet the individual safety needs, the nature of the prescribed medication and its specific clinical use. P&P must address protocols for obtaining/educating organizational staff in the specific individualized medication information from the individual's primary physician, a prescribing practitioner or pharmacy for the importance of timeliness of medication administration/supervision of medications.

4. Organizational policy, procedures and documented practices stipulate that:
    a. If "health maintenance activities" are elected by an individual/guardian to be provided by Proxy Caregivers, the Licensed DD provider agencies, including co-employer agencies must abide by the

Rules & Regulations for Proxy Caregivers used in licensed Healthcare facilities Chapter 111-80-100. The licensed agency must:

i. Have a written informed consent in the individual's record that designate the selected proxy caregiver to receive training to provide the health care activities outlined in the physician's written order working under a nurse protocol agreement or job description;
ii. Demonstrate knowledge and skills to perform the health maintenance activities in the written plan;
iii. Health maintenance activities to be implemented by the proxy caregiver are clearly defined in the written care plan and provided to the proxy caregiver; and
iv. The organization's policy, procedures, and documented practices clearly define what health maintenance activities can or cannot be provided by the proxy caregiver and that delivery of such activities are specified for each individual. (Refer to Rules & Regulations for Proxy Caregivers Chapter 111-80-100 for complete details of practice including Section 1 of the Community Service Standards).

b. There are safeguards utilized for medications known to have substantial risk or undesirable effects, to include:
   i. Obtaining and maintaining copies of appropriate lab testing and assessment tools that accompany the use of the medications prescribed from the individual's physician for the individual's clinical record, or at a minimum, documenting in the clinical record the requests for the copies of these tests and assessments, and follow-up appointments with the individual's physician for any further actions needed;
   ii. For individual in residential services, there is documentation of a review of polypharmacy usage in order to ensure that intra-class and inter-class polypharmacy use for psychiatric reasons are justifiable, if applicable, using the following monitoring criteria:
      a) Intra-class Polypharmacy monitoring reports includes individuals who are on more than one psychotropic medication in the <u>same</u> single class of medications (2 or more antipsychotics, antidepressants, mood stabilizers). E.g., The use of 2 anti-depressants to treat depression.
      b) Inter-class Polypharmacy monitoring reports includes individuals who are on 3 or more <u>different</u> classes of medications (antipsychotics, antidepressants, mood stabilizers). E.g., The use of an antipsychotic, an antidepressant and mood stabilizer to treat someone with Schizoaffective Disorder.
c. There are protocols for the handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.
d. The organization defines requirements for timely notification to the prescribing professional regarding:
   i. Medication errors;
   ii. Medication problems;
   iii. Drug reactions;
   iv. Refusal of medication by the individual; and
   v. Failure to administer/supervise on time medications.
e. There are practices for regular and ongoing physician review of prescribed medications including, but not limited to:
   i. Appropriateness of the medication;
   ii. Documented need for continued use of the medication;
   iii. Monitoring the presence of side effects. (Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS) testing.);
   iv. Monitoring of therapeutic blood levels, if required by the medication such as Blood Glucose testing, Dilantin blood levels and Depakote blood levels;

v. Ordering specific monitoring and treatment protocols for Diabetic, hypertensive, seizure disorder, and cardiac individuals, especially related to medications prescribed and required vital sign parameters for administration;
vi. Maintain individualized medication protocols for specific individuals -receiving health maintenance activities;
vii. Monitoring of other associated laboratory studies.

f. For organizations that secure their medications from retail pharmacies, there is a biennial assessment of agency practice of management of medications at all sites housing medications. An independent licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
   i. A written report of findings, including corrections required;
   ii. A photocopy of the pharmacist's license or a photocopy of the license of the Registered Nurse; and
   iii. A statement of attestation from the independent licensed pharmacist or licensed Registered Nurse that all issues have been corrected.

g. The organization needs to have policy which describes the process for developing individualized healthcare protocols, monitoring, reporting and, if applicable, preventative healthcare maintenance, to include but not limited to the following healthcare needs:
   i. Bowel Elimination (Constipation and Diarrhea);
   ii. Hypertension;
   iii. Weight;
   iv. Skin Care;
   v. Seizures;
   vi. Fluid Intake (Hydration);
   vii. Aspirations;
   viii. Falls;
   ix. Diabetes; and
   x. Protocols for medication schedule for critical and non-critical timings.

5. The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right:
   a. Right person: Check the name on the order and the individual and include the use of at least two identifiers.
   b. Right medication: Check the medication label against the order.
   c. Right time: Check the frequency and time to be given of the ordered medication and double check that the ordered dose is given at the correct time. Confirm when last dose was given.
   d. Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record document to ensure all are the same.
   e. Right route: Check the order and appropriateness of route ordered and confirm that the individual can take or receive the medication by the ordered route.
   f. Right position: The correct anatomical position for the medication method or route to ensure its proper effect, instillation and retention. If needed, individual should be assisted to assume the correct position.
   g. Right Documentation: Document the administration/supervision after the ordered medication is given on the MAR; and
   h. Right to Refuse Medication: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
6. A Medication Administration Record is in place for each calendar month that an individual takes or receives medication(s):

a. Documentation of routine, ongoing medications occur in one discreet portion of the MAR and include but may not be limited to:
   i. Documentation by calendar month that is sequential according to the days of the month;
   ii. A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication:
      a) Name of the medication;
      b) Dose as ordered;
      c) Route as ordered;
      d) Time of day as ordered; and
      e) Special instructions accompanying the order, if any, such as but not limited to:
         1. Must be taken with meals;
         2. Must be taken with fruit juice;
         3. May not be taken with milk or milk products.
   iii. If the individual is to take or receive the medication more than one time during one calendar day:
      a) Each time of day must have a corresponding line that permits as many entries as there are days in the month;
   iv. All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;
   v. When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing discontinuation; followed by a mark through of all lines representing days and times that were discontinued.

b. Documentation of medications that are taken or received on a periodic basis, including over the counter medications, occur in a separate discreet portion of the MAR and include but may not be limited to:
   i. Documentation by calendar month that is sequential according to the days of the month;
   ii. A listing of each medication taken or received on a periodic basis during that month including a full replication of information in the physician's order for each medication:
      a) Name of medication;
      b) Dose as ordered;
      c) Route as ordered;
      d) Purpose of the medication; and
      e) Frequency that the medication may be taken.
   iii. The date and time the medication is taken or received is documented for each use.
   iv. When 'PRN' or 'as needed' medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.

c. Each MAR shall include the legend that clarifies:
   i. The identity of the authorized staff's initials using full signature and title;
   ii. The reasons that a medication may not be given, is held or otherwise note received by the individual, such as but not limited to:

"H"	=	Hospital
"R"	=	Refused
"NPO"	=	Nothing by mouth
"HM"	=	Home Visit
"DS"	=	Day Service

E. ADEQUATE AND COMPETENT STAFF (CRITICAL)

1. Unless otherwise specified by DBHDD Policy or within the contract/agreement with the Department, one or more professionals in the field must be attached to the organization as employees of the organization or

as consultants on contract. The professional(s) attached to the organization have experience in the field of expertise best suited to address the needs of the individual(s) served. (Refer to Professional Designation Section G).

2. When medical and/or psychiatric services involving medication are provided, the organization receives direction for that service from a professional with experience in the field, such as medical director, physician consultant, or psychiatrist.
3. DDP services must be rendered by a qualified individual DDP employed by or under contract with the agency. At least one agency employee or professional under contract with the agency must be a DDP (Refer to Professional Designation Section G for a list of professionals who qualify to be a DDP).
4. The DDP personnel file must include the following:
    a. A signed DDP job functions that meet the DDP requirements for oversight and professional consultation;
    b. A specified schedule for each site and sufficient contract hours (not a PRN staff) to meet the individual's needs of the assigned caseload must be maintained on site;
    c. There is documentation of attestation by the DDP that the scheduled or contracted hours do not conflict with his/her work with another provider agency;
    d. A copy of diploma, license or certification to verify qualifications for performing DDP job functions is maintained; and
    e. Annual evaluation of adequacy of the DDP deliverable relative to the agency functions and needs as part of QI activities.

DDP documentation requirements must include the following:

    a. Agencies will identify for the DDP's ongoing review any participant receiving clinical services(nursing, therapy(s),behavioral services) and any participant with changes in functional, medical, behavioral or social status;
    b. There is documentation to verify all necessary face-to-face participant's visits, other contact or communication with or on behalf of the participants in the participant's record;
    c. Documentation will contain the purpose of the visit or contact, assessment or evaluation, training, plan for intervention, and any changes in service delivery such as change in staff recommendations;
    d. DDP documentation must meet documentations requirements of date, location of service delivery, signature (title), beginning and ending time when the service was provided.

5. Organizational policy and practice demonstrates that appropriate professional staff shall conduct the following services, supports, care and treatment, including but not limited to:
    a. Overseeing the services, supports, care and treatment provided to individuals;
    b. Supervising the formulation of the individual service plan or individual recovery plan;
    c. Conducting diagnostic, behavioral, functional and educational assessments;
    d. Designing and writing behavior support plans;
    e. Implementing assessment, care and treatment activities as defined in professional practice acts; and
    f. Supervising high intensity services such as screening or evaluation, assessment, and residential behavior support services.
6. Providers must ensure an adequate staffing pattern to provide access to services in accordance with service guidelines and professional designations. Refer to Service Guidelines in this Provider Manual for specific staffing requirements.
7. The type and number of professional staff and all other staff attached to the organization are:
    a. Properly trained, licensed or credentialed in the professional field as required;
    b. Present in numbers to provide adequate supervision to staff;
    c. Present in numbers to provide services, supports, care and treatment to individuals as required;
    d. In 24 hour or residential care settings, at least one staff trained in Basic Cardiac Life Support (BCLS) and first aid is on duty at all times on each shift;

e. DD providers using Proxy Caregivers must receive training that includes knowledge and skills to perform any identified specialized health maintenance activity. Additional information regarding Proxy Caregivers can be found in Section V of this document;
f. Experienced and competent to provide services, supports, care and treatment and/or supervision as required; and
f. Behavior Support Consultant and provider of Behavior Support Services have documentations of proficiency trainings in behavioral support courses completed within six (6) months of enrollment as a provider of services.

8. The organization must have procedures and practices for verifying licenses, credentials, experience and competence of staff:
    a. There is documentation of implementation of these procedures for all staff attached to the organization; and
    b. Licenses and credentials are current as required by the field.
9. Federal law, state law, professional practice acts and in-field certification requirements are followed regarding:
    a. Professional or non-professional licenses and qualifications are required to provide the services offered. If it is determined that a service requiring licensure or certification by State Law is being provided by an unlicensed staff, it is the responsibility of the organization to comply with DBHDD Policy regarding Professional Licensing or Certification Requirements and the Reporting of Practice Act Violations, 04-101.
    b. Laws governing hours of work such as but not limited to the Fair Labor Standards Act.
10. Job descriptions are in place for all personnel that include:
    a. Qualifications for the job;
    b. Duties and responsibilities;
    c. Competencies required;
    d. Expectations regarding quality and quantity of work; and
    e. Documentation that the individual staff has reviewed, understands, and is working under a job description specific to the work performed within the organization.
11. Processes for managing personnel information and records which should include but not be limited to:
    a. Criminal records checks in accordance with Criminal History Records Checks for Contractors, 04-104 (including process for reporting CRC status change);
    b. Driver's license checks; and
    c. Annual TB testing (for all staff providing direct support).

a. Provisions for and documentation of:
    i. Timely orientation of personnel;
    ii. Periodic assessment and development of training needs;
        a) Development of activities responding to those needs; and
    iii. Annual work performance evaluations.

b. Provisions for sanctioning and removal of staff when:
    i. Staff are determined to have deficits in required competencies;
    ii. Staff is accused of abuse, neglect or exploitation.

c. Administration of personnel policies without discrimination.

12. All staff, direct support volunteers, and direct support consultants shall be trained and show evidence of competence in the following:
    a. Orientation requirements are specified for all staff and are provided **prior to direct contact with individuals** and are as follows:
        i. The purpose, scope of services, supports, care and treatment offered including related policies and procedures;
        ii. HIPAA and Confidentiality of individual information, both written and spoken;
        iii. Rights and Responsibilities of individuals;

iv. Requirements for recognizing and mandatory reporting suspected abuse, neglect or exploitation of any individual:
    a) To the DBHDD;
    b) Within the organization;
    c) To appropriate licensing agencies (Healthcare Facility Regulation) and for in home services (Adult Protective Services); and
    d) To law enforcement agencies.

b. Within the first sixty (60) days from date of hire, all staff having direct contact with individuals shall receive training in the following which shall include, but not be limited to:
    i. Person centered values, principles and approaches;
    ii. A Holistic approach for providing care, supports and services for the individual;
    iii. Medical, physical, behavioral and social needs and characteristics of the individuals served;
    iv. Human Rights and Responsibilities (*);
    v. Promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders;
    vi. The utilization of:
        a) Communication Skills (*);
        b) Behavioral Support and Crisis Intervention techniques to de-escalate challenging and unsafe behaviors (*);
        c) Nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization) (*); and
        d) The Georgia Crisis Response System (GCRS) to access crisis services.
    vii. Ethics, and Cultural Diversity Policies;
    viii. Fire safety (*);
    ix. Emergency and disaster plans and procedures (*);
    x. Techniques of Standard Precautions, including:
        a) Preventative measures to minimize risk of HIV;
        b) Current information as published by the Centers for Disease Control (CDC); and
        c) Approaches to individual education.
    xi. First aid and safety;
    xii. BCLS including both written and hands on competency training is required;
    xiii. Specific individual medications and their side effects (*);
    xiv. Suicide Prevention Skills Training (such as AIM, QPRP); and
    xv. Ethics and Corporate Compliance training is evident.
    xvi. Training to work with individuals who have co-occuring /are dually diagnosed, as appropriate.

c. A minimum of 16 hours of training must be completed annually to include the trainings noted by an asterisk (*) in 11.b. (iv, vi, viii, ix).

13. The organization details in policy by job classification:
    a. Training that must be refreshed annually;
    b. Additional training required for professional level staff; and
    c. Additional training/recertification (if applicable) required for all other staff.
14. Regular review and evaluation of the performance of all staff is documented at a minimum annually by Managers who are clinically, administratively and experientially qualified to conduct evaluations on the staff's Knowledge, Skills & Abilities (KS &A) to deliver person-centered services.
15. It is evident that the organization demonstrates administration of personnel policies without discrimination.

OUTCOMES FOR PERSONS SERVED

A. INDIVIDUAL RIGHTS, RESPONSIBILITIES, PROTECTIONS (CRITICAL)

1. There is evidence of the individual or legal guardian's signature on notification that all individuals are informed about their rights and responsibilities:
    a. At the onset of services, supports, care and treatment;
    b. At least annually during care;
    c. Through written information that is well prepared in a language/format understandable by the individual; and
    d. How confidentiality will be addressed including but not limited to who they wish to be informed about their services, supports, care and treatment.
2. The organization has policies and promotes practices that:
    a. Do not discriminate;
    b. Promote receiving equitable supports from the organization;
    c. Provide services, supports, care and treatment in the least restrictive environment possible;
    d. Emphasize the use of teaching functional communication, functional adaptive skills to increase independence, and using least restrictive interventions that are likely to be effective;
    e. Incorporate Clients Rights and the Human Rights Council policy found at www.dbhdd.ga.gov, as applicable to the organization; and
    f. Delineates the rights and responsibilities of persons served.
3. In policy and practice, the organization makes it clear that under no circumstances will the following occur:
    a. Threats of harm or mistreatment (overt or implied);
    b. Corporal punishment;
    c. Fear-eliciting procedures;
    d. Abuse or neglect of any kind;
    e. Withholding basic nutrition or nutritional care; or
    f. Withholding of any basic necessity such as clothing, shelter, rest or sleep.
4. Federal and state law and rules are evident in policy and practice including, but not limited to:
    a. For **all community based programs**, practices promulgated by DBHDD or the Rules or Regulations for Clients Rights, Chapter 290-4-9 are incorporated into the care of individuals served. Issues addressed include but are not limited to:
        i. Care in the least restrictive environment;
        ii. Humane treatment or habilitation that affords protection from harm, exploitation or coercion; and
        iii. Unless adjudicated incompetent by a court of law, be considered legally competent for any purpose without due process of law, including to maintain:
            a) Civil;
            b) Political;
            c) Personal; and
            d) Property rights.
    b. For **all DD Crisis programs service adults, children or youth**, practices promulgated by DBHDD, the Rules and Regulations for Clients Rights, Chapter 290-4-9 and Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD) are incorporated into the treatment of adults, children and youth served in the crisis programs.
5. There are no barriers in accessing the services, supports, care and treatment offered by the organization, including but not limited to:
    a. Geographic;
    b. Architectural;
    c. Communication;
        i. Language access is provided to individuals with limited English proficiency or who are sensory impaired;

ii. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed.

d. Attitudinal;
e. Procedural; and
f. Organizational scheduling and availability.

6. There is evidence of organizational person-centered planning and service delivery that demonstrates:
   a. Sensitivity to individual differences (including disabilities) and preferences;
   b. Practices and activities that reduce stigma; and
   c. Interactions that is respectful, positive and supportive.
7. The organization must have written policies and procedures regarding the visitation rights of individuals, including a requirement that any reasonable restrictions must be based on the seriousness of the individual's mental or physical condition as ordered in writing by the attending physician. Such orders shall state the type and extent of the restriction. The order shall be reviewed for changes as needed and renewed at least annually. Additional orders shall follow the same procedure. The organization must meet the following requirements:
   a. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of his or her visitation rights, including any clinical restriction of such rights, when he or she is informed of his or her other rights under this section;
   b. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of the right, subject to his or her consent, to receive visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. However, the parent, guardian or custodian of a minor may restrict his or her visitation rights;
   c. Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identify, sexual orientation or disability;
   d. Ensure that all visitors enjoy full and equal visitation privileges consistent with the preferences of the individual;
   e. Not restrict visitation by an individual's attorney or personal physician on the basis of the individual's physical or mental condition;
   f. Visitors/guardians are also expected to adhere to any reasonable restrictions as ordered in writing by the attending physician in the area of diet; and
   g. If visitation facilitates/results in problematic behaviors, reasonable restrictions may be ordered and incorporated into the Safety Plan.
8. Access to Appropriate services, supports, care and treatment is available regardless of :
   e. Age;
   f. Race, National Origin, Ethnicity;
   g. Gender;
   h. Religion;
   i. Social Status;
   j. Physical Disability;
   k. Mental Disability;
   l. Gender Identity; and
   m. Sexual Orientation

B. BEHAVIORAL SUPPORT PRACTICES (CRITICAL)

1. In policies, procedures and practices, the organization outlines and defines the adaptive, supportive, medical protection devices and the restrictive interventions that are implemented or prohibited by the organization and licensure requirements. These devices include but are not limited to:

a. Use of adaptive supportive devices or medical protective devises (devises which restrain movement but are applied for the protection of accidental injury, required for medical treatment or for corrective/supportive needs):
    i. May be used in any service, support, care and treatment environment;
    ii. Use is defined by a physician's order (order not to exceed six calendar months);
    iii. Written order to include rationale and instructions for the use of the device;
    iv. Authorized in the individual service plan (ISP);
    v. Are used for medical and/or protection against injury and not for treatment of challenging behaviors(s); and
    v. Renewal order of device requires documentation to justify continued use for a period not to exceed six calendar months.
b. Time out (also known as withdrawal to a quiet area):
    i. Under no circumstance is egress physically or manually restricted;
    ii. Time out periods must be brief, not to exceed 15 minutes;
    iii. Procedure for time out utilization is incorporated in the behavior support plan; and
    iv. The justification for use and implementation details for time out utilization is documented.
c. Manual Hold/Restraint(also known as Personal Restraints): The application of physical force, without the use of any device, for the purpose of restricting the free movement of a person's body:
    i. May be used in all community settings except residential settings licensed as Personal Care Homes;
    ii. Circumstances of use must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
    iii. Brief handholding (less than 10 seconds) support for the purpose of providing safe crossing, safety or stabilization does not constitute a personal hold;
    iv. If permitted, Manual/Personal Restraint (ten seconds or more), shall not exceed five (5) minutes and use of personal restraint is documented;
    v. Use of manual/personal restraints must be outlined as an approved intervention in his/her safety plan; and
    vi. If manual/personal restraints are implemented more than three (3) times in a six (6) month period, there must be corresponding procedures to teach the individual skills that will decrease/eliminate the use of personal restraints.
d. Mechanical Restraint (also known as Physical Restraints): A device attached or adjacent to the individual's body that one cannot easily remove and that restricts freedom of movement or normal access to one's body or body parts. Mechanical/Physical restraints are prohibited in community settings.
e. Seclusion: The involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving, regardless of the purpose of the confinement. The practice of "restrictive time-out" (RTO) is seclusion and may not be utilized except in compliance with the requirement related to seclusion. The phrase "prevented from leaving" includes not only the use of a locked door, but also the use of physical control or verbal threats to prevent the individual from leaving. Seclusion is not permitted in developmental disabilities services.
f. **Chemical restraint may never be used under any circumstance.** Chemical restraint is defined as a medication or drug that is:
    i. Not a standard treatment for the individual's medical or psychiatric condition;
    ii. Used to control behavior; and
    iii. Used to restrict the individual's freedom of movement.

    Examples of chemical restraint are the following:
    i. The use of over the counter medications such as Benadryl for the purpose of decreasing an individual's activity level during regular waking hours;

ii. The use of an antipsychotic medication for a person who is not psychotic but simply 'pacing' or agitated.

g. PRN anti-psychotic medications for behavior control are not permitted. See; Appendix 1 for list of medications.

2. The approach to developing a positive behavior support plan (including a safety plan) and treatment for individuals demonstrating challenging behaviors should be consistent with the definitions and protocols in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings* and *Best Practice Standards for Behavioral Support Services* found in the provider manual. Behavior Support activities outlined in the PBSP is guided by an overall emphasis on not only decreasing target behaviors but also concurrently increasing skills in appropriate areas. The primary emphasis of the plan should be on pro-active skill building and prevention of challenging behaviors. Refer to service description for Behavior Supports Services in NOW/COMP Waiver requirements.
3. The PBSP and Safety Plan for challenging behaviors should be a collaborative effort among each provider providing services for the individual to include Host Home and Community Access Services Providers. The providers must work to develop and implement one plan that includes any modification and/or interventions specific to the setting but provide a holistic strategy for all settings requiring Behavior Support Services for implementation for each service site and the modification must be addressed and approved prior to finalizing the plan. The final approved PBSP is incorporated by reference into the ISP. A copy of the individual's PBSP must be available at all service sites for implementation. The provider is responsible for training and coaching in the setting where the target behaviors occur.
4. a) A positive behavior support plan should be developed and implemented for individuals with developmental disabilities who receive psychotropic medications for symptom management of challenging behavior that continues to pose a significant risk to the individual, others, or the environment (e.g., self-injury, physical aggression, property destruction) and is not specifically related to mental illness or epilepsy requiring treatment with psychotropic medications. The positive behavior support plan must minimally include:
    1) An operationally defined behavior(s) for which the drug is intended to affect;
    2) Measuring target behaviors which shall constitute the basis on which medication adjustments will be made; and
    3) A focus on teaching replacement behaviors in an effort to replace the use of medication with behavioral programming.

    b) A positive behavior support plan is not required for individuals receiving psychotropic medication to treat mental illness (e.g., schizophrenia, bi-polar disorder) or epilepsy when the record documents that the medication addresses the symptoms of the mental illness or epilepsy.
5. When positive behavior support plan is used to reduce challenging behaviors there must evidence that the following issues have been addressed. The plan is:
    a. Individualized (Person Centered Planning);
    b. Based on a functional assessment;
    c. One that has addressed potential medical causes;
    d. Developed and overseen by a qualified professional (Refer to the Outcomes for Persons Served Section G for Professional Designations Categories of Psychologist, Behavior Specialists and Board Certified Behavior Analyst);
    e. PBSP utilizes non-punitive, non-restrictive procedures & interventions;
    f. Inclusive of methods outlined to teach alternative appropriate behaviors that will achieve the same results as the challenging behavior(s);
    g. Inclusive of rationale for the following:
        i. Use of identified approaches;
        ii. The time of their use;
        iii. An assessment of the impact on personal choice of the individual;
        iv. The targeted behavior; and

v. How the targeted behavior will be recognized for success.

h. Implemented by trained and competent staff as documented by individual who developed the PBSP/Safety Plan and trained the staff.

i. Has monitoring plans for review, analyzing trends, and summarizing the effectiveness of the plan and termination criteria. In addition, PBSP are routinely monitored to ensure provider compliance with prescribed data collection & interventions;

j. Consent provided by the individual and his or her legal guardian;

k. Discussed with the individual and family/natural supports (as permitted by the individual);

l. Developed in accordance with *Best Practice Standards for Behavioral Support Services for Providers of Developmental Disabilities Services* (www.dbhdd.ga.gov); and

m. All behavioral services to include Behavior Support Consultation and Behavior Support Services adhere to the service description outlined in Chapter 1600 and Chapter 3300 of Waiver program.

6. Providers must document the following in the record of each participant receiving Behavioral Support Consultation Services and Behavior Support Services:
   a. Specific activity, training, or assistance provided;
   b. Date and the beginning and ending time when the service was provided;
   c. Location where the service was delivered;
   d. Verification of service delivery, including first and last name and title (if applicable) of the person providing services;
   e. Progress towards goals outlined in ISP; and
   f. Description of outcome specific to each target behavior intervention to include but not limited to behavioral changes, acquisition of new replacement skills, ability to increase community integration and other positive life outcomes.
7. Intrusive or restrictive procedures must be clearly justified through documentation of less restrictive procedures ineffectiveness and/or the need for more intrusive procedures due to the safety or health risks presented by the targeted behaviors. These procedures are authorized, incorporated into the PBSP and/Safety Plan, approved by ISP interdisciplinary team, reviewed by organization's Rights Committee and supervised by qualified professional(s) and may not be in conflict with Federal or State Laws, Rules and Regulations, Clients Rights or Department standards to include but not limited to the document *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings* and the *Best Practice Standards for Behavioral Support* when developing a positive behavior support/safety plan.
8. When Enhanced Service Delivery and/or Exceptional Rate is approved for specialized behavioral supports, training and skilled service delivery, the following must be addressed in the BSP/safety plan that includes:
   a. Person-Centered Behavior Supports Planning (PCBS);
   b. Programmatic guidelines for staff that addresses the individual's preferences and values;
   c. Collaborative teamwork by all service delivery providers to assist the behavioral professional conducting the functional behavioral assessment across settings (such as residential, day service, supported employment);
   d. Development of interventions that will be most effective in each setting or situation;
   e. Lifestyle and competency improvements based on the individual's strengths, skills, abilities, personal preferences and choices;
   f. Safety checks, staff monitoring and ratio are clearly outlined and defined (such as 1:1 support, 2:1 support, line of sight, and arm's length, 1:1 inclusive line of sight);
   g. ER Crisis Plan to support the exceptional behavioral or medical needs And
   h. There is documented evidence of a clinical assessment and validation of behavior support needs. The clinical assessment is based on HRST & SIS eligibility criteria. E.g., HRST score of 4 on Item Q for 1:1 staffing; SIS score of 7 or higher for behavior support.
9. Providers must have processes in place to implement crisis intervention as needed. The staff must be trained to respond to a crisis situation that occurs at the service site and have an agency's crisis plan, that at a minimum addresses:

a. Approved interventions to be utilized by staff;
b. Availability of additional resources to assist in diffusing the crisis;
c. If the acute crisis presents a substantial risk of imminent harm to self and others, that community based crisis services to include the Georgia Crisis Response System(GCRS) serves as an alternative to emergency room care, calling 911, institutional placement, and/or law enforcement involvement (including incarceration) is implemented;
d. Protocols to access community-based crisis services to include the Georgia Crisis Response System must be included in agency's policy and procedures with staff trained to implement this protocol; and
e. Notification process by Direct Support Staff that includes informing the designated on-call management staff and /or Director.

10. All organizations must have the capacity to address individual's behavioral needs. If the cause of the challenging behavior cannot be determined or satisfactorily addressed by the provider, there should be evidence of consultation with an outside professional who is licensed or qualified through education, supervised training and experience to address the behavior needs of the Individual. Those authoring such plans should minimally meet professional criteria as a Psychologist, Behavioral Specialist or a Board Certified Behavior Analyst (Refer to Professional Designations, Section G. for professional qualifications).
11. If the need for behavior supports is identified, the individual or guardian is given a choice to select the qualified person to develop the PBSP and /or Safety plan.

C. I. RESPECTFUL SERVICE ENVIRONMENT (CRITICAL) {to include Host Homes and Day Service Sites}:

1. Services, supports, care or treatment approaches support the individual in:
   a. Living in the most integrated community setting appropriate to the individual's requirement, preferences and level of independence;
   b. Exercising meaningful choices about living environments, providers of services received, the types of supports, and the manner by which services are provided;
   c. Obtaining quality services in a manner as consistent as possible with community living preferences and priorities; and
   d. Inclusion and active community integration is supported and evident in documentation.
2. Services are provided in an appropriate environment that is respectful and ensures the privacy of individuals supported or served. (For Host Homes and Community Access Services Sites refer to DBHDD policy Process for Enrolling, Matching, and Monitoring Host Home/Life-Sharing Sites for DBHDD Developmental Disabilities Community Service Providers, 02-704 and Physical Environment NOW/COMP Chapter 1700 for Community Access Services). The environment is:
   a. Clean;
   b. Age appropriate;
   c. Accessible (individuals who need assistance with ambulation shall be provided bedrooms that have access to a ground level exit to the outside or have access to exits with easily negotiable ramps or accessible lifts. The home shall provide at least two (2) exits, remote from each other that are accessible to the individuals served);
   d. Individual's rooms are personalized;
   e. Adequately lighted, ventilated, and temperature controlled;
   f. There is sufficient space, equipment and privacy to accommodate;
   g. An area/room for visitation; and
   h. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported.
   i. The Americans with Disabilities Act of 1990 requiring facilities to be readily accessible to and usable by people with disabilities is addressed, if applicable. Refer to 2010 Standard ADA Compliance for accessible design.

3. The environment is safe:
    a. All local and state ordinances are addressed:
        i. Copies of inspection reports are available;
        ii. Licenses or certificates are current and available as required by the site or the service;
        iii. An automatic extinguishing system (sprinkler) shall be installed per city/county requirements for residential settings excluding host homes not governed by other federal, state and county rules and regulations, if applicable; and
        iv. Approved smoke alarm shall be installed in all sleeping rooms, hallways and in all normally occupied areas on all levels of the residences per safety code. Smoke alarms especially in the bedrooms shall be tested monthly and practice documented. The facility shall be inspected annually to meet fire safety code and copies of inspection maintained.
    b. Installation of Fire alarm system and inspection of equipment meets safety code.
    c. Fire drills are conducted for individuals and staff:
        i. Once a month at alternative times; including;
        ii. Twice a year during sleeping hours if residential services;
        iii. All fire drills shall be documented with staffing involved;
        iv. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit.
4. Food guidelines are in place for safe food consumption and storage of food in refrigerator, freezer and cupboards to maintain temperature, expiration dates on food items to include open items and the prevention of foodborne illnesses. When food service is utilized, required certifications related to health, safety and sanitation are available. A three day supply of non-perishable emergency food and water is available for all individuals supported in residences. A residence shall arrange for and serve special diets as prescribed.
5. Policies, plans and procedures are in place that addresses Emergency Evacuation, Relocation, Preparedness and Disaster Response. Supplies needed for emergency evacuation are maintained in a readily accessible manner, including individuals' information, family contact information and current copies of physician's orders for all individual's medications.
    a. Plans include detailed information regarding evacuating, transporting and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:
        i. Medical emergencies;
        ii. Missing persons;
            a) Georgia's Mattie's Call Act provides for an alert system when an individual with developmental disabilities, dementia, or other cognitive impairment is missing. Law requires residences licensed as Personal Care Homes to notify law enforcement within 30 minutes of discovering a missing individual.
        iii. Natural and man-made disasters;
        iv. Power failures;
        v. Continuity of medical care as required;
        vi. Notifications to families or designees; and
        vii. Continuity of Operation Planning (COOP) to include identifying locations and providing a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided. COOP must also include plans for sheltering in place (for more information go to: http://www.georgiadisaster.info/PersonsWithDisabilities/disasterpreparedness.html.
    b. Emergency preparedness notice and plans are:
        i. Reviewed annually;
        ii. Tested at least quarterly for emergencies that occur locally on a less frequent basis such as, but not limited to flood, tornado or hurricane; and
        iii. Drilled with more frequency if there is a greater potential for the emergency.

6. Residential living support service options:
    a. Are integrated and established within residential neighborhoods;
    b. Are single family dwellings;
    c. Have space for informal gatherings;
    d. Have personal space and privacy for persons supported; and
    e. **Are understood to be the "home" of the person supported or served.**
7. Video/Camera monitoring **<u>may not be used</u>** in the following instances:
    a. In an individual's personal residence as it is an invasion of privacy and is strictly prohibited; and
    b. In lieu of staff presence.
8. There are policies, procedures, and practices for transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place:
    a. Policies and procedures apply to all vehicles used, including:
        i. Those owned or leased by the organization;
        ii. Those owned or lease by subcontractors; and
        iii. Use of personal vehicles of staff.
    b. Policies and procedures include, but are not limited to:
        i. Authenticating licenses of drivers;
        ii. Proof of insurance;
        iii. Routine maintenance;
        iv. Requirements for evidence of driver training;
        v. Safe transport of persons served;
        vi. Requirements for maintaining an attendance log of persons while in vehicles;
        vii. Safe use of lift;
        viii. Availability of first aid kits;
        ix. Fire suppression equipment; and
        x. Emergency preparedness.
9. Locks on exterior doors in **ALL** community settings (including, but not limited to, Personal Care Homes, Host Home/Life-Sharing sites, and Day Services sites) must comply with the following provisions:
    a. **ALL** locks used on any exterior door must be capable of being unlocked from the inside by the individuals receiving services in that setting, without the need for obtaining assistance from provider staff or any other person.
    b. Neither the lock nor any mechanism or control for operating the lock may be placed in a location that is inaccessible to or concealed from any individual receiving services in the setting.
    c. No exterior door may be fitted with any lock that requires a key, key card, badge, combination, or passcode to unlock it from the inside.

C II. Infection Control Practices are Evident in Service Settings:

1. The organization, at a minimum, has a basic Infection Control Plan which is reviewed bi-annually for effectiveness and revision, if needed. The Plan addresses:
    a. Standard Precautions;
    b. Hand Washing Guidelines;
    c. Proper storage of Personal Hygiene items; and
    d. Specific common illnesses/infectious diseases likely to be emergent in the particular service setting.
2. The organization has policies, procedures and practices for controlling and preventing infections in the service setting. There is evidence of:
    a. Guidelines for environmental cleaning and sanitizing;
    b. Guidelines for safe food handling and storage;
    c. Guidelines for laundry; and
    d. Guidelines for food preparation.

3. Procedures for the prevention of infestation by insects, bed bugs, rodents or pests shall be maintained and conducted continually to protect the health of individuals served.
4. No vicious/dangerous animals shall be kept. Any pets living in the service setting must be healthy and not pose a health risk to the individual supported. All pets must meet the local, state, and federal requirements to include the following:
    a. All animals that require rabies vaccinations annually must have current documentation of the rabies inoculation;
    b. Exotic animals must be obtained from federally approved sources; and
    c. Parrots and Psittacine family birds must be USDA inspected and banded.

D. A HOLISTIC PERSON-CENTERED APPROACH TO CARE, SUPPORT AND SERVICES

I. Assessments:

1. Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The purpose of the assessment is to determine the individual's hopes, dreams or vision for their life and to determine how best to assist the individual in reaching those hopes, dreams or vision, including determining appropriate staff to deliver these services. Assessments should include, but are not limited to, the following:
    a. The individual's:
        i. Hopes and dreams, or personal life goals;
        ii. Perception of the issue(s) of concern;
        iii. Strengths;
        iv. Needs;
        v. Abilities; and
        vi. Preferences.
    b. Medical history;
    c. A current health status report or examination in cases where:
        i. Medications or other ongoing health interventions are required;
        ii. Chronic or confounding health factors are present;
        iii. Medication prescribed as part of DBHDD services has research indicating necessary surveillance of the emergence of diabetes, hypertension, and/or cardiovascular disease;
        iv. Allergies or adverse reactions to medications have occurred; or
        v. Withdrawal from a substance is an issue.
    d. Appropriate diagnostic tools such as impairment indices, psychological testing, or laboratory tests;
    e. Social history;
    f. Family history;
    g. School records (for school age individuals);
    h. Collateral history from family or persons significant to the individual, if available:
        i. NOTE: When collateral history is taken, information about the individual **may not be shared** with the person giving the collateral history unless the individual has given specific written consent; and
    i. Review of legal concerns including:
        i. Advance directives;
        ii. Legal competence;
        iii. Legal involvement of the courts; and
        iv. Legal status as adjudicated by a court.
2. Additional assessments should be performed or obtained by the provider if required to fully inform the services, supports, care and treatment provided. These may include but are not limited to:
    a. Assessment of trauma or abuse;
    b. Suicide risk assessment;

c. Functional assessment;
d. Cognitive assessment;
e. Behavioral assessments;
f. Spiritual assessment;
g. Assessment of independent living skills;
h. Cultural assessment;
i. Recreational assessment;
j. Educational assessment;
k. Vocational assessment;
l. Nutritional assessment; and
m. Nursing assessment (Note: Required for nursing services to identify healthcare risks).

3. Policies, procedures and practice describe processes or referral of the individual based on ongoing assessment of individual need:
   a. Internally to different programs or staff; or
   b. Externally to services, supports, care and treatment not available within the organization, including but not limited to:
      i. Health care for:
         a) Routine assessment such as annual physical examinations;
         b) Chronic medical issues;
         c) Ongoing psychiatric issues;
         d) Acute and emergent needs:
            1. Medical.
            2. Psychiatric.
      ii. Diagnostic testing such as psychological testing or labs; and
      iii. Dental services.

II. Individual Service Plan (ISP)

1. An individualized service plan is developed by a Support Coordinator, a State Services Coordinator or a Planning List Administrator with input from the individual/representative, service providers and others, as applicable.
   a. Be driven by the individual and focused on outcomes the individual desires to achieve;
   b. Fully explained to the individual using language/communication he or she can understand and agreed to by individual;
   c. Provided with necessary information in order to identify social, education and other needs that is important "To" the individual to make informed choice of service options and services provider.
   d. Identify and prioritize the needs of the individual and include a page for signatures of the individual or guardian or other members to indicate who participated in the planning of services. Subsequent addendums must also document individual/guardian's signature; and
   e. Others assisting in the development of the individualized service plan are persons who:
      i. Are significant in the life of the individual;
      ii. Have a historical perspective of the desires of the individual;
      iii. The individual gives consent to have input from family and friends, if desired and if permission is **not** given by the individual, this is documented in the record/ISP; and
      iv. Will deliver the specific services, supports, care and treatment identified in the plan:
         a) For individuals with coexisting, complex and confounding needs, cross disciplinary approaches to planning should be used;
         b) Planning should be facilitated by professional(s) qualified to plan or provide services to persons with this level of complexity; and
         c) Representatives of other agencies outside of DBHDD or providers affecting the daily life of the individual should be present and participating.

f. A page for signature, title and date by participants (including the individual and professionals) that is attached to the plan, to indicate all participants presence and involvement in the plan that provides services, supports, care and treatment to the individual. The participants signature on the ISP signifies the acceptance of the ISP. If participant declines or is unable to sign the ISP, it is documented in the participant's record. A signature mark by the participant is not acceptable if the participant does not have the capacity to accept or comprehend the content of the ISP document. A substitude decision maker is then needed.
g. The ISP must list the services to be provided, the frequency of the services, and the name of provider to deliver the services. No service will be reimbursed which is not listed on the Individual Service Plan approved by the Regional DBHDD Intake and Evaluation Team.

2. Statement of goals or objectives of the individual are:
   a. Each goal/objective is specific to the services provided:
      i. **S**pecific to the desired outcomes;
      ii. **M**easurable for progress;
      iii. **A**chievable skills;
      iv. **R**elevant to service provision;
      v. **R**ealistic to service provision; and
      vi. **T**ime-limited with specified target dates.
   b. The frequency or intensity that the specific service, support, care and treatment will be given or provided;
   c. Identification of staff responsible to deliver or provide the specific service, support, care and treatment;
   d. Clear authorization of the plan:
      i. Refer to definitions of service included in this Provider Manual to determine who must authorize the plan:
         a) Part I, Section II: *DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines.*
      ii. A physician must authorize the plan when it includes medical care and treatment or as required by Georgia Department of Community Health Division of Medical Assistance, Pc art II Policies and Procedures for Comprehensive Support Waiver Program (COMP) and New Option Waiver Program (NOW). *Protocol for Physician Signature is in waiver manual*.
      iii. When more than one physician is involved in individual care, there is evidence that an RN or MD has reviewed all in-field information to assure there are no contradictions or inadvertent contraindications within the care and treatment orders or plan.
3. Documents to be incorporated by reference into an individual service plan include, but are not limited to:
   a. Medical updates as indicated by physician orders or notes (diagnosis are indicated to ensure treatment of medical conditions such as obesity and diabetes);
   b. Addenda as required when a portion of the plan requires reassessment;
   c. A personal crisis plan which directs in advance the individual's desires/wishes/plans/ objectives in the event of a crisis;
   d. A behavior support plan and/or a safety plan for individuals demonstrating challenging behaviors; and
   e. A PBSP and safety plan for individuals who received psychotropic meds for symptom management.
4. Wellness of individuals is facilitated through:
   a. Advocacy;
   b. Individual care practices;
   c. Education;
   d. Sensitivity to issues affecting wellness including, but not limited to:
      i. Gender;
      ii. Culture; and
      iii. Age.

e. Incorporation of wellness goals within the individual plan.
f. The intent of the development of the ISP is a process that focuses on the individual's hopes, dreams and visions of a "life well-lived." Information included within this individualized plan should be presented as a single plan that addresses residential and all other paid supports that the individual receives. The Support networks should work closely together to identify issues of risk and needed supports to address those risks while never losing sight that the individual is at the center of the planning process and included in all discussions. If the individual receives residential services, the residential provider has the primary responsibility in conjunction with the support coordinator or state services coordinator to assure a holistic (i.e. integrated) support plan for all services identified as a need for the individual.

5. There is evidence that the person's data from tracking sheets and learning logs have been reviewed, analyzed for trends, and summarized to determine the progress toward goals **at least quarterly**.
6. Individualized plans or portions of the plan must be reassessed as indicated by the following:
   a. Changing needs, circumstances and responses of the individual, including but not limited to:
      i. Any life change;
      ii. Change in provider;
      iii. Change of address;
      iv. Change in frequency of service; and
      v. Change in medical, behavioral, cognitive or physical status.
   b. As requested by the individual;
   c. As required by re-authorization;
   d. At least annually; and
   e. When goals are not being met.
   f. ISP Annual Review Amendments: Each ISP must be reviewed and/or edited annually or more often as needed to reflect all life changes, progress or lack of progress to identify changes in outcome, review changes in medical/psychological or social services and to identify new problems or goals.

III. Documentation

1. The individual record is a legal document, information in the record should be:
   a. Organized;
   b. Complete;
   c. Current;
   d. Meaningful;
   e. Succinct; and
   f. Essential to:
      i. Provide adequate and accurate services, supports, care and treatment;
      ii. Tell an accurate story of services, supports, care and treatment rendered and the individual's response;
      iii. Protect the individual; their rights; and
      iv. Comply with legal regulation.
   g. Dated, timed, and authenticated with the authors identified by name, credential and by title:
      i. Notes entered retroactively into the record after an event or a shift must be identified as a "late entry";
      ii. Documentation is to be done each shift or service contact by staff providing the service;
      iii. If notes are voice recorded and typed or a computer is used to write notes that are printed, each entry must be dated and the physical documentation must be signed and dated by the staff writing the note. Notes should then be placed in the individual's record; and
      iv. If handwritten notes are transcribed electronically at a later date, the former should be kept to demonstrate that documentation occurred on the day billed.
   h. Written in black or blue ink;
   i. Red ink may be used to denote allergies or special precautions;

j. Corrected as legally prescribed by:
    i. Drawing a single line through the error;
    ii. Labeling the change with the word "error";
    iii. Inserting the corrected information; and
    iv. Initialing and dating the correction.

2. At a minimum, the individual's information shall include:
    a. The name of the individual, precautions, allergies (or no known allergies – NKA) and "volume #x of #y" on the front of the record;
        i. Note that the individual's name, allergies and precautions must be flagged on the medication administration record.
    b. Individual's identification and emergency contract information;
    c. Financial information;
    d. Rights, consent and legal information including but not limited to:
        i. Consent for service (written agreement);
        ii. Release of information documentation;
        iii. Any psychiatric or other advanced directive;
        iv. Legal documentation establishing guardianship;
        v. Evidence that individual rights are reviewed at least one time a year; and
        vi. Evidence that individual responsibilities are reviewed at least one time a year.
    e. Pertinent medical information;
    f. Screening information and assessments, including but not limited to:
        i. Functional, psychological and diagnostic assessments.
    g. Individual service plan, including:
        i. Identified outcomes or goals (in measurable terms);
        ii. Interventions or activities occurring to achieve the goals;
        iii. The individual's response to the interventions or activities (progress notes, tracking sheets, learning logs or data);
        iv. A projected plan to modify or decrease the intensity of services, supports, care and treatment as goals are achieved; and
        v. Discharge planning is begun at the time of admission that includes specific objectives to be met prior to decreasing the intensity of service or discharge.
    h. Discharge summary information provided to the individual and new service provider, if applicable, at the time of discharge includes:
        i. Strengths, needs, preferences and abilities of the individual;
        ii. Services, supports, care and treatment provided;
        iii. Achievements;
        iv. Necessary plans for referral; and
        v. A dictated or hand-written summary of the course of services, supports, care and treatment incorporating the discharge summary information provided to the individual and new service provider, if applicable, must be placed in the record within 30 days of discharge.
    i. The organization must have policy, procedures and practices for Discharge/Transfer/ immediate transfer due to medical or behavioral needs of individuals in all cases. Agency employees, subcontractors and their employees and volunteers who abandon an individual are subject to administrative review by the contracting Field Office (s) representing DBHDD to evaluate increasing new admission capacity further or continuing the relationship with the provider agency.
    j. All relocation/discharge of individuals within or outside the agency must have prior approval from the contracting Field Office representing DBHDD. A copy of the approval must be maintained in the individual record.
    k. Progress notes or Learning Logs (for DD individuals) describing progress toward goals, including:
        i. Implementation of interventions specified in the plan;

ii. The individual's response to the intervention or activity based on data; and
iii. Date, location and the beginning and ending time when the service was provided.

l. Event notes documenting:
   i. Issues, situations or events occurring in the life of the individual;
   ii. The individual's response to the issues, situations or events;
   iii. Relationships and interactions with family and friends, if applicable;
   iv. Missed appointments including:
      a) Findings of follow-up; and
      b) Strategies to avoid future missed appointments.
m. Records or reports from previous or other current providers; and
n. Correspondence.

3. A provider must ensure that DBHDD, DCH, Healthcare Facility Regulation (as applicable) and Support Coordination are provided updated, accurate information which includes but is not limited to the following:
   a. Correct address of the agency/business location.
   b. Correct street address of the service location, if different from above.
   c. Current phone number(s).
   d. Name of contact person() Comprehensive Supports Waiver Program VI-19.
   e. Data on subcontractors providing direct member care.
   f. Enrolled providers are required to furnish written notice to the DBHDD Provider Enrollment Unit, DCH, the Support Coordination agency, and individual supported within 10 calendar days change in provider data. Changes requiring written notice include, but are not limited to the following:
      - Address of the provider agency administrative business office.
      - Address of the service location.
      - Payee changes.
      - Change in permit/license issued by Healthcare Facility Regulation Section.
      - If the contact person for the administrative or service location changes, the provider must notify the DBHDD applicable region within 30 calendar days of the change.
4. The provider must maintain on file a copy of all approved waiver requests and/or exceptional rate approval documents and have such waiver(s) and/or rate documents available for review by the State. The original letter may be maintained at the provider office location but a copy of the exceptional rate request/waiver of standards request and all supporting documentation relevant to service delivery must be maintained in the individual record at the service delivery site(s). The provider must notify the Regional Coordinator or designee when there is any change to services and/or exceptional rate for which the waiver and/or exceptional rate was requested. For waivers of standards for services that are audited/monitored by DBHDD or Department of Community Health contracted entities, the provider must produce a copy of the waiver letter at the time of the audit in order for the DBHDD reviewer, External Review Organization or other contracted entity to appropriately incorporate the approved waiver into the audit/monitoring activity.

   Waiver Requests for More than One Year. All approved waivers and/or exceptional rate approvals expire at the end of one year following their approval or as indicated on the approval letter. If the petitioner believes there are special circumstances justifying an extension beyond one year, they may apply again prior to the expiration date, completing another **Request for Waiver of Standards Form and/or Exceptional Rate Request Template** with updated documentation.

5. The individual's response to the services, supports, care and treatment is a consistent theme in documentation.
   a. Frequency and style of documentation are appropriate to the frequency and intensity of services, supports, care and treatment; and

b. Documentation includes record of contacts with persons involved in other aspects of the individual's care, including but not limited to internal or external referrals.

6. Community integration and inclusion into the larger natural community is supported and evident. Terms "Integration and Inclusion" mean:
   a. Use of community resources that are available to other citizens;
   b. Providing the opportunity to actively participate in community activities and types of employment as citizens without disabilities;
   c. The organization has community partnerships for capacity building and advocacy of activities to achieve this goal of integration;
   d. The organization must provide supports and inclusion activities that show respect for the individual's dignity, personal preference and cultural differences; and
   e. There is documentation of individualized preferences, person-centered integration, informed choice, autonomy and inclusion in the community;
   f. Building of community relationships (natural/paid/unpaid); and
   g. Supporting individual's choice as measured by the amount of control an individual has over his/her life.
   h. Supervised Apartment Living Arrangements such as scattered and cluster arrangements must meet all standards for integrated settings and comply with all state and local zoning regulations (such as setting attributes & choice). (Refer to DBHDD Policy Community Integration in Residential Service Options and Supervised Apartment Living Arrangements for Individuals with DD, 02-601 for details.)
7. There is a process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts.

IV. Information Management SYSTEM THAT PROTECTS INDIVIDUAL INFORMATION AND IS SECURE, ORGANIZED AND CONFIDENTIAL:

1. The organization has clear policies, procedures and practices that support secure, organized and confidential management of information, to include electronic individual records, if applicable.
2. All individuals determine how their right to confidentiality will be addressed including but not limited to who they wish to be informed about their services, supports and treatment. Maintenance and transfer of both written and spoken information is addressed:
   a. Personal individual information;
   b. Billing information; and
   c. All service related information.
3. The organization has a Confidentiality and HIPAA Privacy Policy that clearly addresses state and federal confidentiality laws and regulations, including but not limited to federal regulations on "Confidentiality of Alcohol and Drug Abuse Patient Records" at 42 C.F.R. Part 2 (as applicable) and state laws at O.C.G.A. §§ 37-3-166 (MH), 37-4-125 (DD) and 37-7-166 (AD) as applicable. The organization has a Notice of Privacy Practices that gives the individual adequate notice of the organization's policies and practices regarding use and disclosure of their Protected Health Information (PHI). The notice should contain mandatory elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II). In addition, the organization should address:
   a. HIPAA Privacy and Security Rules, as outlined at 45 CFR Parts 160 and 164 are specifically reviewed with staff and individuals;
   b. Appointment of the Privacy Officer;
   c. Training to be provided to all staff;
   d. Posting of the Notice of Privacy Practices in a prominent place; and
   e. Maintenance of the individual's signed acknowledgement of receipt of Privacy Notice in their record;
   f. Provision of the rights of individuals regarding their PHI as defined in federal and state laws and in HIPAA, including but not limited to:
      i. Right to access to one's own record.

ii. Right to request an amendment.
iii. Right to request communications by alternative means.
iv. Right to request restriction of access by others.

g. Identification of its Business Associates, and obtaining Business Associate agreements with Business Associates, in compliance with HIPAA requirements.

h. Identification of violations of confidentiality or HIPAA and follow up to include compliance with all requirements of HIPAA at 45 C.F.R. sections 164.400 through 164.414:
   i. Reporting of violations to the Privacy Officer.
   ii. Risk assessment of the violation as required by HIPAA provisions.
   iii. Determination of whether the violation constitutes a "breach" as defined by HIPAA.
   iv. Notifications of breaches to the individual(s) affected, to the Secretary of Health and Human Services, and if necessary to the media, in compliance with HIPAA requirements.

i. Corrective Actions for sanctions of employee(s) as necessary, mitigation of harm to any individual and preventing risks to PHI.

4. A record of all disclosures of Protected Health Information (PHI) should be kept in the medical record, so that the organization can provide an accounting of disclosures to the individual for 6 years from the current date. The record must include:
   a. Date of disclosure;
   b. Name of entity or person who received the Protected Health Information;
   c. A brief description of the Protected Health Information disclosed;
   d. A copy of any written request for disclosure; and
   e. Written authorization from the individual or legal guardian to disclose PHI, where applicable.
5. Authorization for release of information is obtained when Protected Health Information of an individual is to be released or shared between organizations or with others outside the organization. All applicable DBHDD policies and procedures and HIPAA Privacy Rules (45 CFR parts 160 and 164) related to disclosure and authorization of Protected Health Information are followed. Information contained in each release of information must include:
   a. Specific information to be released or obtained;
   b. The purpose for the authorization for release of information;
   c. To whom the information may be released or given;
   d. The time period that the release authorization remains in effect (reasonable based on the topic of information, may not exceed a year); and
   e. A statement that authorization may be revoked at any time by the individual, to the extent that the organization has not already acted upon the authorization.
6. Exceptions to use of an authorization for release of information are clear in policy:
   a. Disclosure may be made if required or permitted by law;
   b. Disclosure is authorized as a valid exception to the law;
   c. A valid court order or subpoena are required for mental health or developmental disabilities records;
   d. A valid court order and subpoena are required for alcohol or drug abuse records;
   e. When required to share individual information with the DBHDD or any provider of treatment or services for the individual under contract or LOA with the DBHDD; or
   f. In the case of an emergency treatment situation as determined by the individual's physician, the chief clinical officer can release Protected Health Information to the treating physician or psychologist.
7. The organization has written operational procedures, consistent with legal requirements governing the retention, maintenance and purging of records.
   a. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of their creation or the date when last in effect (whichever is later);
   b. Protocols for all records to be returned to or disposed of as directed by the contracting regions after specified retention period or termination of contract/agreement; and

c. Compliance with HIPAA Security Rule provisions to the degree mandated by or appropriate under the Security Rule to protect the security, integrity and availability of records.

8. The organization has written policy, protocols and documented practice of how information in the record is transferred when an individual is relocated or discharged from service to include but not be limited to:
   a. A complete certified copy of the record to the Department or the provider who will assume service provision, that includes individual's Protected Health Information, billing information, service related information such as current medical orders, medications, behavior plans as deemed necessary for the purposes of the individual's continuity of care and treatment;
   b. Unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts; and
   c. The time frames by which transfer of documents and personal belongings will be completed.
9. Assessments, ISPs, and documentation required by Medicaid are to be retained in the individual's records for six years.

E. MANAGEMENT OF INDIVIDUAL'S PERSONAL FUNDS

1. The organization must have written policies, procedures and practices for the management/supervision and safeguarding of funds, possessions, and valuables, of individuals served by the organization. All policies and procedures must be in compliance with DBHDD policy, guidelines of the Social Security Administration associated with the management and protection of the funds of individuals served, and any other federal and state laws or regulations.

   The Management of Funds Policy and Procedures must provide for the following:
   a. A procedure to inventory an individual's possessions (to include but not limited to clothing, furnishings, electronics, life insurance, burial funds & other benefit policies, etc.) and valuables at admission and updated as needed but at a minimum annually.
   b. Individuals have the right to manage their own funds. However, the residential provider organization is responsible for the management/supervision of any individual valuables or funds regardless of the payee status of the provider.
   c. The individual's ability to manage their funds is documented in their Individual Service Plan. Upon admission, each individual's capacity for money management is assessed and documented in Attachment A – Money Management Tool.
   d. When an individual is unable to manage funds, and have no other person in their life to assist, there must be **documented** effort to secure an independent party to manage those valuables and/or funds. The effort to secure an independent party will be documented in the ISP **annually**.
   e. Special care to assure that the funds are not mismanaged or exploited. Procedures define the checks and balances to ensure agency accountability and the ability to demonstrate evidence of working towards the goal of participative management of the funds of the individuals served. Checks and balances to be included in the Policy and Procedures:
      i. Funds may not be pooled or co-mingled in any organizational account or other combined accounts, or with other individual's funds. Collective accounts, as defined, require the permission of the Social Security Administration. The collective account, with a sub-account for each beneficiary, must show that the funds belong to the beneficiaries and not the payee. Documentation in current record keeping clearly indicates the amount of each beneficiary's share and proper procedures must be followed, that clearly shows the individual's amount for deposits, withdrawals, and interest earned for each beneficiary.
      ii. A procedure or set of procedures to assure that at least two people, other than those having authorization to **receive** and **disburse** funds on behalf of any individual, independently **reconcile the bank** and/or account records of any individual served by the organization on a monthly basis.

iii. When providers are selected and become the payee of individuals' checks, they must maintain records of each individual's personal funds and all other records pertaining to personal needs accounts (including bank statements and bank books). Documentation of personal spending is accounted for on the Division of DD approved Personal Spending Account Record (Attachment B), or a payee created document that contains all of the same elements as Attachment B. Only the current month's Personal Spending Account Record must be kept at the individual's place of residence, for immediate inspection, as applicable. All previous month's Personal Spending Account Records may be kept off site at the agency business office, but is to be available to the person served, his or her family, the Support Coordinators, the Field Office, and any other legally authorized representative for inspection and copying upon request, or within one to two business days of request.

f. Day to Day Living Expenses:
   i. The representative payee of individuals served determines and document the current needs of day to day living and use his/her payments to meet those needs (e.g., Day to Day living expenses including housing and utility bills that is equitably distributed among all individuals supported in the home based on specific residence cost or average cost of similar homes in a geographic area; current mortgage or rental payment food where preferences and dietary needs are honored; medical/dental if not covered by Medicare, Medicaid and/or private insurance to the extent that SSI benefits and Social Security are available and Personal items and clothing specified in Social Security Guidelines). At a minimum (regardless of day-to-day expenses) each individual in DD residential services is to receive monies for personal needs and allowances as determined by the Department, Social Security Office or Medicaid.

g. Keep written records of at least two years of all payments from the Social Security Administration (SSA), bank statements, and cancelled checks, receipts or cancelled checks for rent, utilities, and major purchases.

h. A strict prohibition, punishable by termination, for any employee, agency or representative of the organization to be listed or designated, either directly or indirectly, as a beneficiary, payee or other member of any funds of the individual, including but not limited to, any insurance, burial or trust benefits.

i. Monitoring and reporting on the use of personal funds are incorporated into the organization's QI program. Individual financial records are subject to audits by the Social Security Office and DBHDD.

j. Copies of each-day-to-day living expense agreement are maintained in the individual's record. Day to Day living expenses agreement must be signed by the CRA provider agency (and Host Home Provider or sub-contractor provided, if applicable) at admission and thereafter annually and submitted to the Division of DD or when there is a change of provider and/or Host Home provider serving the individual.

2. A procedure in accordance with the guidelines listed below to ensure the timely deposit and account of all individual funds (e.g., trust, work-related income, Social Security, disability, benefits, gifts, etc.) in an account in the individual name of each individual receiving any such funds:

   a. Funds not needed for ordinary use by the individual on a daily basis shall be deposited in an account insured by agencies of or corporations charted by the state or federal government. The account will be in a form which clearly indicates that the organization has only a fiduciary interest in the funds.

   b. Funds received from an individual or on his/her behalf may be deposited in an interest bearing account; provided, however, that any interest earned on such account shall accrue to the individual.

   c. To the extent that certain funds are properly due to the organization for services, goods, or donations, said funds must first be deposited to the individual's account and then subsequently disbursed in accordance with these requirements and the written policies of the organization.

   d. A requirement that individual funds may only be disbursed upon request or authorization of the individual and/or his/her family, if appropriate, and in the case where the organization serves as the

designee to receive and disburse funds on behalf of the individual, members or organizational representatives is needed.

3. Providers are encouraged to utilize persons outside the organization to serve as "representative payee" such as, but not limited to:
   a. Family;
   b. Other person of significance to the individual; and
   c. Other persons in the community not associated with the agency.
4. If individual's funds are not personally managed by the individual, a mechanism is in place for the review of funds by the individual and his or her representative:
   a. At least once a quarter;
   b. To include a review of the bank statement of funds received including date of deposit, fund source), funds spent (date and source with receipt) and balance of funds available;
   c. Documentation of individual review shall be maintained; and
   d. Review and update of other financial assets such as annuity accounts, personal belongings and burial funds.

F. FAITH OR DENOMINATIONALLY BASED ORGANIZATIONS WHO RECEIVE FEDERAL OR STATE MONIES ADDRESS ISSUES SPECIFIC TO BEING A FAITH OR DENOMINATIONALLY BASED ORGANIZATION IN THEIR POLICIES AND PRACTICE

1. Individuals or recipients of services are informed about the following issues relative to faith or denominationally based organizations:
   a. Its religious character;
   b. The individual's freedom not to engage in religious activities;
   c. Their right to receive services from an alternative provider;
      i. The organization shall, within a reasonable time after the date of such objection, refer the individual to an alternative provider.
2. If the organization provides employment that is associated with religious criteria, the individual must be informed.
3. In no case may federal or state funds be used to support any inherently religious activities, such as but not limited to:
   a. Inherently religious activities;
   b. Religious instruction; or
   c. Proselytizing.
4. Organizations may use space in their facilities to provide services, supports, care and treatment without removing religious art, icons, scriptures or other symbols.
5. In all cases, rules found at 42 CFR Parts 54, 54a and 45 CFR Parts 96, 260 and 1050 *Charitable Choice Provisions and Regulations: Final Rules* shall apply.

G. PROFESSIONAL DESIGNATIONS. When the requirement for a degree in a course of study is referenced, the degree must be from an accredited college or university.

<u>Developmental Disability Professional (DDP):</u>

All DDP services rendered by a provider agency must be provided by an individual qualified to be a DDP. The DDP may be employed by or be under professional contract with the provider agency. Refer to the Professional Designations Section G in the DBHDD Provider Manual for Community DD Providers Part II Section I of the Community Service Standards for a list of Professionals who qualify to be a DDP.

At least one agency employee or professional under contract with the agency must:

- Be a Developmental Disability Professional (DDP), and
- Have responsibility for overseeing the delivery of waiver and/state services to participants with the focus on overall quality of service delivery by the provider agency.

The same individual may serve as the agency Director and DDP, provided the staff member meets the professional qualifications of each position. The duties of each role must be delivered and documented separately. Documentation related to particular activities will be delineated by the use of either professional designation following the staff member's signature.

The Developmental Disability Professional (DDP) Job Functions:

Each Developmental Disability Professional (DDP) has a specified schedule with sufficient hours to meet the oversight role required by the level of need for individual(s) supported which includes but is not limited to:

1. Overseeing the services and supports provided to participant for general guidance to the provider agency in areas of compliance and quality improvement;
2. Assuring that the supports provided are within the scope of the agency's service enrollment and experience to assure effective delivery;
3. Assuring that the services address the participant's needs and adhere to the application of person-centered values, choice and participant's rights;
4. Providing, arranging or overseeing curricula used in staff training and directed to service delivery in the context of the individual's goals and objectives;
5. Recommend other needed services/supports or changes to the delivery model using a continuous quality improvement approach;
6. Providing consultation to the provider agency in ISP implementation strategies that are specific, measurable, achievable, relevant, realistic and time limited in order to meet the needs and personal goals of the participant;
7. Assess areas of risks either individually or overall risks to persons supported through agency practice, policy or lack of policy or procedures/protocols. Providing risk mitigation strategies to the provider agency;
8. Reviewing that functional assessments are in place to support formulation of the participant's plan for delivery of all waiver services that include:
   a. The Health Risk Screening Tool;
   b. The Supports Intensity Scale;
   c. Functional Behavioral Evaluation;
   d. Others (E.g., Nursing, OT, PT etc.) as needed or required.
9. Oversee high intensity services if applicable that address health and safety risks for the participant's that includes:
   a. The implementation and effectiveness of Behavior Support Plans;
   b. The implementation and effectiveness of the Participant's Crisis Plan; and
   c. Identifying ongoing supports as needed (medical and /or behavioral) in collaboration with agency personnel, staff of other agencies providing supports to the participants mutually served or other members of the healthcare team.

Developmental Disability Professional (DDP) Requirements:

The provision of DDP oversight and service provision must be documented in the Participant's record when DDP services are needed for an individual participant.

The DDP personnel file must include the following documents:

1) A signed DDP job description or contract that meet the DDP requirements for oversight and professional consultation;
2) A specified schedule for each site and sufficient contract hours (not a **PRN** staff) to meet the agency's need for general oversight and quality improvement activities as well as consultation and/or evaluation of individual participants as needed;
3) There is documentation of attestation by the DDP that the scheduled or contracted hours do not conflict with his/her work with another provider agency;
4) A copy of diploma, license or certification to verify qualifications for performing DDP job functions is maintained in the personnel file; and
5) Annual evaluation of adequacy of the DDP deliverables relative to the agency functions and needs as part of QI activities.

Note: A DDP is not scheduled to work only on a PRN (pro re nata) basis.

Documentation Requirements for DDP:

Agencies will identify for the DDP's ongoing review any participant receiving clinical services (nursing, therapy(s), behavioral services) and any participant with changes in functional, medical, behavioral or social status.

There is documentation to verify all necessary face-to-face participant's visits, other contact or communication with or on behalf of the participants in the participant's record. Documentation will contain the purpose of the visit or contact, for assessment or evaluation, training, plan for intervention, and any changes in service delivery.

DDP documentation must meet documentations requirements of date, location of service delivery, signature (title), beginning and ending time when the service was provided.

Required Training for Developmental Disabilities Professionals:

In addition to the initial orientation requirements for new employees listed in the Waiver manuals Chapter 600, Section 606, other required trainings for DDPs' in their first year of employment include:

1. Individual Service Planning (Person-Centered);
2. Support Intensity Scale overview;
3. Health Risk Screening Tool on line training overview;
4. The provider agency must also show participation and document the participation of each DDP employed or under contract, a **minimum of eight (8) hours per year** of DBHDD sponsored or other training in the area of developmental disabilities in the DDP employee's file or require and maintain the documentation of participation in such training on an annual basis from any DDP independent contractors.

Developmental Disability Professional (DDP) Competency:

The provider will be responsible for monitoring and ensuring the DDP meets his/her above assigned responsibilities utilizing the below performance indicators.

Performance indicators of the responsibilities listed are as follows:

1. Consulted with, supervised, trained and/or provided guidance to direct support staff regarding implementation of service to comply with person-centered values and techniques. Documentation of consultation may be maintained in the form of training agenda, staff meetings, etc. This documentation shall include the signature, title/credentials, timed (beginning and end time of delivery of training or in-service support) and date. Copy maintained by the provider agency;

2. Assist and provide feedback to the provider in reviewing the quality of the services delivered;

3. Provide technical assistance to the provider agency in corrective action requirements and participate in response regardless of the origin of the Corrective Action Plan requirement;

4. Participate in the agency's Quality Improvement Plan and Risk Management Reviews based on qualifications and training background; provide medical and behavioral recommendations and guidance as needed.

The following Professionals qualify to be a Developmental Disability Professional:

i. **Advanced Practice Nurse:** A registered professional nurse licensed in the State of Georgia, who meets those educational, practice, certification requirements, OR any combination of such requirements, as specified by the Georgia Board of nursing AND includes certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists in psychiatric/mental health, AND others recognized by the board AND who have one year experience in treating persons with intellectual/developmental disabilities in a medical setting or a community based setting for delivery of nursing services.

ii. **Behavior Specialist:** A behavior specialist who has completed a Master's degree in psychology, school psychology, counseling, vocational rehabilitation or a related field which included one course in psychometric testing and two courses in any combination of the following: behavior analysis or modification, therapeutic intervention, counseling, or psychosocial assessment, AND one year of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual disabilities OR developmental disabilities OR completion of a Bachelor's degree in psychology, counseling, OR a related field which included one course in psychometric testing AND two courses in any combination of the following: behavior analysis or modification, counseling, learning theory or psychology of adjustment AND two years of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual/developmental disabilities.

iii. **Board Certified Behavior Analysis (BCBA):** A **BCBA** who has completed a Master's degree, with 225 hours of approved graduate coursework, AND 1500 hours of experience in the field with 5% of those hours being supervised by a BCBA, AND has received a passing score on the Behavior Analysis Certification Board Exam, AND maintains a prescribed number of continuing education units annually,

AND has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.

iv. **Behavior Consultant:** A person with a Master's Degree in psychology, special education, counseling, social work or a related field OR licensure/certification as a Psychologist, LPC, LCSW, Psychiatrist OR BCBA (certified through the Behavior Analyst Certification Board) AND five (5) years of experience providing positive behavioral supports (functional assessment; plan development, training, and implementation) to people with intellectual and/or developmental disabilities.

v. **Educator:** An educator with a degree in education from an accredited program that includes a concentration in Special Education in college coursework OR teaching certificate in Special Education, AND one year of classroom experience in teaching individuals with intellectual/developmental disabilities.

vi. **Human Services Professional:** A human services professional with a bachelor's degree in social work OR a bachelor's degree in human services field other than social work (including the study of human behavior, human development or basic human care needs) AND with specialized training OR one year of experience in providing human services to individuals with intellectual/developmental disabilities.

vii. **Master's or Doctoral Degree Holders:** A person with a Master's or Doctoral degree in one of the behavioral OR social sciences AND with specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.

viii. **Physical or Occupational Therapist:** A physical or occupational therapist licensed in the State of Georgia, who has specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year of experience in treating individuals with intellectual/developmental disabilities.

ix. **Physician:** A physician licensed in the State of Georgia to practice medicine or osteopathy AND with specialized training in developmental disabilities OR one year of experience in treating individuals with intellectual/developmental disabilities.

x. **Physician's Assistant:** A skilled person qualified by academic and practical training to provide patients' services not necessarily within the physical presence but under the personal direction or supervision of a physician, AND who has one year experience in treating individuals with intellectual/developmental disabilities.

xi. **Psychologist:** A holder of a Doctoral degree from an accredited university or college, AND who is licensed in the State of Georgia AND who has specialized training in developmental disabilities OR one year of experience in evaluating or providing psychological services to individuals with intellectual/developmental disabilities.

xii. **Registered Nurse (Associate Degree or Diploma):** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing, AND who has three years of experience, two of which are in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.

xiii. **Registered Nurse (Bachelor's Degree):** A registered nurse who is authorized by license to practice nursing as a registered professional nurse AND who holds a Bachelor's degree in nursing with one year experience in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.

xiv. **Speech Pathologist or Audiologist:** A speech pathologist or audiologist licensed in the State of Georgia, who has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship OR one year of experience in treating individuals with intellectual/developmental disabilities.

xv. **Therapeutic Recreation Specialist:** A therapeutic recreation specialist who graduated from an accredited program AND who has specialized training in developmental disabilities as evidence by college coursework OR practicum/internship experience OR one year experience in providing therapeutic recreational services to individuals with intellectual/developmental disabilities.

H. WAIVERS TO STANDARDS

The organization may not exempt itself from any of these standards or any portion of the provider manual. All requests for waivers of these standards must be done in accordance with DBHDD Policy Requests for Waivers of Standards for DBHDD Services, 04-107.

I. For DD providers utilizing Proxy Caregivers and Health Maintenance Activities:

Licensed provider agencies, including co-employer agencies, must abide by the Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities, Chapter 111-8-100 (Go to www. dch.georgia.gov/hfr-laws-regulations). The policies and procedures specified below are applicable to all providers:

Health Maintenance Activities Definition: Health maintenance activities, which are limited to those activities that, but for a disability, a person could reasonably be expected to do for himself or herself. Such activities are typically taught by a registered professional nurse, but may be taught by an attending physician, advanced practice registered nurse, physician assistant, or directly to a person and are part of ongoing care. Health maintenance activities are those activities that do not include complex care such as administration of intravenous medications, central line maintenance (i.e., daily management of a central line, which is intravenous tubing inserted for continuous access to a central vein for administering fluids and medicine and for obtaining diagnostic information), and complex would care; do not require complex observations or critical decisions; can be safely performed and have reasonably precise, unchanging directions; and have outcomes or results that are reasonably predictable. Any activity that requires nursing judgment is not a health maintenance activity. Health maintenance activities are specified for an individual participant in written orders of the attending physician, advanced practice registered nurse, or physician assistant.

1. **Written Plan of Care Requirements:** Health maintenance activities are as defined in the written plan of care that implements the written orders of the attending physician, advanced practice registered nurse, or physician assistant and specifies the frequency of training and evaluation requirements for the proxy caregiver, including additional training when changes in the written plan of care necessitate added duties for which such proxy caregiver had not previously been trained. The written plan of care is established by a registered professional nurse, or by an attending physician, advanced practice registered nurse, or physician assistant. This written plan of care for health maintenance activities must be maintained in the individual's record and available for the proxy caregiver.

2. **Written Informed Consent:** A participant or individual legally authorized to act on behalf of the individual must complete a written informed consent designating a proxy caregiver and delegating

responsibility to such proxy caregiver to receive training and to provide health maintenance activities to the individual pursuant to the written orders of an attending physician, an advanced practice registered nurse or physician assistant working under a nurse protocol agreement or job description.

3. **Requirements for Individuals Providing Health Maintenance Activities:** Individuals who provide health maintenance activities in accordance with the above conditions must meet the following:

    a. Be selected by the individual or a person legally authorized to act on behalf of the individual to serve as the individual's proxy caregiver.

    b. Receive training by an attending physician, advanced practice registered nurse, physician assistant, or registered nurse that teaches the proxy caregiver the necessary knowledge and skills to perform the health maintenance activities documented in the individual's written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the individual.

    c. Demonstrate to the training (i.e., attending physician, advanced practice registered nurse, physician assistant, or registered nurse) the necessary knowledge and skills to perform the health maintenance activities documented in the individual's written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the individual.

4. **Non-Covered Health Maintenance Activities:** Health maintenance activities that meet any of the following are non-covered:

    a. Complex care such as administration of intravenous medications, central line maintenance and complex wound care.

    b. Provided by an individual without written informed consent designating that individual as a proxy caregiver and delegating responsibility to such proxy caregiver to receive training.

    c. Provided without the written orders of an attending physician, advanced practice registered nurse, or physician assistant working under a nurse protocol agreement or job description, respectively, pursuant to Georgia Code Section 43-34-25 or 43-34-23.

    d. Provided without written plan of care as defined above. Provided by individuals who do not meet the requirements specified above.

Appendix I:

Antipsychotic Medications	
Generic	**Trade**
Aripiprazole	Abilify
Chlorpromazine	Thorazine
Chlorprothixene	Taractan
Clozapine	Clozaril

Fluphenazine	Permitil, Prolixin*
Haloperidol	Haldol*
Loxapine	Serentil
Mesoridazine	Lidone, Moban
Molindone	Zyprexa
Olanzapine	Invega*
Palinperidone	Trilafon
Perphenazine	Orap
Pimozide (for Tourette's)	Seroquel
Quetiapine	Risperdal*
Risperidone	Mellaril
Thioridazine	Navane
Thiothixene	Stelazine
Trifluoperazine	Vesprin
Trifluopromazine	Geodon
Ziprasidone	
Mood Stabilizer Medications	
Generic	**Trade**
Lithium Carbonate	Eskalith or Lithonate
Divalproex Sodium	Depakote
Tiagabine	Bagatril
Levetiracetam	Keppra
Lamotrigine	Lamitcal
Gabapentin	Neurontin
Carbamazepine	Tegretol
Oxcarbazepine	Trileptal
Topiramate	Topomax
Zonisamide	Zonegran
Verapamil	Calan
Clonidine	Catapres
Propranolol	Inderal
Mexiletine	Mexitil
Guanfacine	Tenex

***Also has a sustained release injectable form**

PART II

Section 2

Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD)

Provider Manual

For

Community Developmental Disabilities Providers

Fiscal Year 2017

Georgia Department of Behavioral Health and Developmental Disabilities

July 2016

Part II

Section 2

Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD)

TABLE OF CONTENTS

General Requirements	Section A
Intake Requirements	Section B
DD Mobile Crisis Team Requirements	Section C
Intensive Crisis Support System Requirements	Section D
Intensive In-Home Support Requirements	Section E
Intensive Out-of-Home Support Requirements for Crisis Support Homes	Section F
Intensive Out-of -Home Support Requirements for Temporary & Immediate Support Homes	Section G
Quality Assurance and Standard Compliance Requirements	Section H
Staffing Requirements	Section I
Definitions	Section J

DESCRIPTION
The goal of this system is to provide time-limited home and community based crisis services that support individuals with developmental disabilities in the community, and provide alternatives to institutional placement, emergency room care, and/or law enforcement involvement (including incarceration). These community based crisis services and homes are provided on a time-limited basis to ameliorate the presenting crisis. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others.
The Georgia Crisis Response System includes intake, dispatch, referral, and crisis services components. An essential part of this system is the assessment of the individual situation to determine the appropriate response to the crisis. Entry into the system takes place through the Single Point of Entry (SPOE) system. Intake personnel determine if an individual meets the requirements for entry into the system and initiate the appropriate dispatch or referral option. If a Developmental Disability (DD) Mobile Crisis Team is dispatched to the crisis location, this team assesses the need for a referral or crisis services. Crisis services occur through intensive on-site or off-site supports. These crisis supports are provided on a time-limited to ameliorate the crisis.

A. GENERAL REQUIREMENTS
In addition to the Georgia Crisis Response System Standards, Developmental Disabilities (DD) crisis service providers must comply with the **Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services.*** The following standards are applicable to DBHDD or organizations that provide crisis response services to individuals, family members, care-givers, and/or DD waiver service provider agencies that activate the Georgia Crisis Response System.

1. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. The preference is not to transfer an individual to an out-of-home setting, but to provide additional supports in the home.

2. Crisis Response System staff are to coordinate with provider agencies of individuals currently receiving services, who access the Crisis Response System, on a case by case basis to assess and recommend needed changes in services.

3. Training records are to be maintained, which document that all Crisis Response System staff have participated in training and passed an examination demonstrating their competence in all crisis protocols and relevant applicable trainings as listed below:
    a. Single Point of Entry (SPOE) staff:
        i. Mobile crisis dispatch criteria.
        ii. Telephonic crisis intervention.
    b. Mobile team members and intensive support staff:
        i. Assessing the crisis.
        ii. Onsite operations.
        iii. Referral decision criteria.
        iv. Required crisis intervention curriculum:
            1. Crisis Prevention Institute (CPI) *www.crisisprevention.com*
            2. Handle with Care Behavior Management System, Inc. *www.handlewithcare.com*
            3. Mindset *www.mindsetconsulting.net*
            4. Safe Crisis Management *www.jkmtraining.com*
            5. Human Empowerment Leadership Principles (HELP) *www.capscanhelp.com*
            6. Professional Crisis Management (PCM) *www.pcma.com*
            7. Safety- Care (QBS, Inc) *www.qbscompanies.com*
        v. Cardiopulmonary Resuscitation (CPR).
        vi. First aid.
        vii. Documentation standards and expectations.

4. Clinical intervention decisions are made to ensure the least restrictive interventions and placements likely to be successful are utilized as evidenced by assessments that justify the need for any restrictive interventions and/or placements (including intensive in-home supports or intensive out-of-home supports).

5. Plans intended to modify behavior over time (not including crisis plans) are not developed unless appropriate behavioral assessments are completed, and the personnel who develop the plans are able to provide follow-up activities.

6. Discharge Planning should begin at intake and continue throughout utilization of the Crisis Response System. The discharge planning process should include collaboration with all applicable parties, family members/care-givers, providers, Support Coordination Agency, Planning List Administrator, Regional Intake and Evaluation (I & E) Teams. The social work staff in the Crisis Response System must coordinate this process with the oversight of the LCSW assigned to the Mobile Crisis Team.

7. Transportation must be provided by DD Mobile Crisis Teams, in-home support, and/or out-of-home support staff for an individual, who needs to be transported to the crisis homes, emergency facilities, and/or back to their place of residence once discharged from this Crisis Response System level of care.

8. The Georgia Crisis Response System serves children and adults with developmental disabilities aged 5 years and above who meet eligibility criteria as defined in Section B.

B. Intake Requirements

The Georgia Crisis Response System is designed for individuals with developmental disabilities in need of Behavioral Health and Developmental Disabilities (BHDD) crisis services. A person with developmental disabilities in need of BHDD crisis services is an individual who:

- Has documented evidence of a diagnosis of an intellectual disability prior to age 18 years or other closely related developmental disability prior to age 22 years, for individuals currently on the planning list or in DD services; screening indicative of a developmental disability for other individuals; AND
- Presents a substantial risk of imminent harm to self or others; AND
- Is in need of immediate care, evaluation, stabilization or treatment due to the substantial risk; AND
- Is someone for whom there currently exists no available, appropriate community supports to meet the needs of the person.

The following are requirements for the Single Point of Entry (SPOE) and Crisis Providers' Interaction with SPOE:

1. The dispatch operator for the SPOE should attempt to ameliorate the crisis situation through telephonic crisis intervention.
    a. When successful in resolving the crisis:
        i. For individuals without a waiver, state funds or planning list services, within 24 hours the SPOE is to make a referral to the Regional I&E Team for review.
        ii. For individuals with a waiver, state funds or planning list services, within 24 hours the SPOE is to notify the Field Office and DD service provider, if applicable. If the call originates from a DD service provider, the SPOE is to engage that provider during the resolution of the crisis.
    b. When unsuccessful in resolving the crisis and face-to-face intervention is needed, the SPOE must provide documentation to support the need for the dispatch of the DD Mobile Crisis Team. The SPOE is to contact immediately the Field Office, the support coordination agency, and the DD service provider if applicable.

2. When the DD Mobile Crisis Team is dispatched, the SPOE must provide the team pertinent clinical information including but not limited to:
    a. Demographics.
    b. Crisis location.
    c. Crisis description.
    d. Current medical status.
    e. Status in Case Management Information System (CIS) (if applicable):
        i. Support coordination contact information.
        ii. Planning List Administrator (PLA) contact information.
        iii. Summary of progress notes for the last 30 days.
        iv. New Options Waiver (NOW)/Comprehensive (COMP) waiver status.
        v. Current behavioral interventions.

All information provided to the DD Mobile Crisis Team by SPOE must be sufficient to allow the team to ensure that appropriate staff members are dispatched to the crisis.

3. All DD Mobile Crisis Teams must follow the direction of SPOE concerning dispatch. If SPOE through its assessment process has determined that the individual meets the requirements for crisis supports, and DD Mobile Crisis Team is dispatched, the MCT must follow the directions of SPOE.
4. Once the SPOE (Behavioral Health Line) contacts the appropriate crisis provider within a specific region, and it is determined that the crisis provider is unable to immediately dispatch a Mobile Crisis Team, all resources available to that provider must be utilized to remedy the crisis situation within the required 1.5 hours; including the use of in-home crisis supports team.

    a. If that crisis provider is not able to appropriately address the crisis in 1.5 hours, they are to inform the SPOE at the time of the initial contact and include the reason for not being able to meet the 1.5 hour response requirement. Upon receipt of this information, the SPOE must contact the nearest crisis provider for dispatch.

    b. Crisis Provider must supply SPOE its estimated time of arrival at the time of the initial contact with SPOE.

5. When a Crisis provider is dispatched across Regional lines:

    a. The newly dispatched crisis provider may be located within the same region or across regional lines. If the mobile crisis response is provided by an out-of-area team, **and** either in-home or out-of-home supports are required after the initial crisis has been supported, the individual is to be transitioned to the in-area crisis provider for ongoing supports.

    b. When an individual experiences a crisis outside their region of residence, the SPOE must dispatch the Mobile Crisis Team for the region where the crisis is occurring.

    c. The Mobile Crisis Team for that region is to assess the situation to determine if additional in-home or out-of-home supports are required, subsequent to the initial stabilization.

    d. If additional in-home or out- of- home supports are required, subsequent to the initial stabilization, the initial Mobile Crisis Team is to work in conjunction with the crisis provider within the region of residence, to insure that the individual receives the supports in their home region.

6. The DD Mobile Crisis Team is to request of the Field Office immediate access to the Consumer Information System (CIS) for the individual in crisis. The Field Office is to respond, by providing CIS information for all individuals in crisis and who are listed in the CIS.

C. DD Mobile Crisis Team Requirements

1. A minimum of three team members, including one Licensed Clinical Social Worker (LCSW), a behavior specialist, and a direct support staff will respond to each dispatch of the DD Mobile Crisis Team. Other possible team members may include a registered nurse, an additional social worker (MSW), safety officer, or additional direct support staff. In addition, a physician will be available for consultation if needed.

2. All licensed or certified team members are required to comply with the DBHDD Policy, Professional Licensing and Certification Requirements and the Reporting of Practice Act Violations, 04-101, maintaining valid/current license or certification.

3. The LCSW on the DD Mobile Crisis Team is to provide at a minimum, oversight to the operation of the team and is responsible for ensuring that the appropriate team members are dispatched or are available for consultation based on the clinical data provided by the SPOE.

4. The DD Mobile Crisis Team is required to:
    a. Dispatch whenever SPOE directs them to do so.

b. Respond and arrive on site within 1 ½ hours of the SPOE dispatch.
c. Address the crisis situation to mitigate any risk to health and safety of the individual and/or others.
d. Rule out any medical causes, through consultation with available medical professionals, which might be contributing to the crisis prior to recommending any intensive crisis supports involving behavioral interventions.
e. Notify SPOE either through email or phone of the team's arrival time at crisis location.

5. The DD Mobile Crisis Team members are responsible for completing comprehensive assessment(s) of the current crisis situation. This assessment process must include interviews with the individual, care providers and/or family members, observation of the current environment, and review of behavior and individual support plans. The LCSW on the team is responsible for ensuring that the assessment is thorough, complete, and uploaded into CIS within 24 hours of discharge from the GCRS-DD.

6. Reasonable and relatively simple environmental modifications that do not require continuing programmatic efforts are considered before intensive crisis supports and/or a behavior plan is recommended or implemented.

7. When the DD Mobile Crisis Team makes a disposition, the LCSW communicates all recommendations within 24 hours to all applicable parties (Families/Caregivers, Support Coordination Agencies, Provider Agencies, and/or Field Office I & E Teams).

8. When the DD Mobile Crisis Team completes services , the LCSW or a designated social worker (MSW) on the team completes a written discharge plan that must:
   a. Minimally include:
      i. Summary of precipitating events.
      ii. Clinical interventions.
      iii. Response to clinical interventions.
      iv. Recommendations for continued interventions.
      v. Referral for additional supports (if applicable).

   b. Be documented and uploaded to CIS within a 24-hour period after discharge from the GCRS-DD.

9. Crisis Response System providers must develop and maintain DD Mobile Crisis Team protocols for On-Site Operations. The protocols must include detailed description of its processes that include at a minimum:
   a. On-Site Stabilization, including intensive in-home supports and professional consultation.
   b. Referral and/or transport to intensive out-of-home crisis supports.
   c. Referral to hospital emergency department.

D. Intensive Case Management

1. Intensive Case Management is a time-limited service that connects the individual in crisis to the necessary services and supports to ameliorate the crisis situation, coordinates with stakeholders to assure the development of a discharge plan from crisis support services, and ensures follow up on recommended supports/services.

2. Intensive case management services are provided by the crisis provider with the assistance of designated support coordinators or planning list administrators (if applicable), for assessment/evaluation for additional needs and supports, with follow-up to ensure implementation of recommended supports/services.
3. Intensive case management services are provided throughout the continuum of the crisis response system (on-site, in-home, and out-of- home) and should be terminated after the applicable discharge plan follow-up has been completed.

E. Intensive Crisis Support Services Requirements

Intensive Crisis Supports are specialized services that provide time-limited care and intervention to an individual due to his or her need for support and protection of other(s) living with him or her. These supports provide specific intervention and case management strategies directed towards enabling the recipient to remain in the community. The outcome of these services should enhance the current family member's or provider's ability to meet the needs of the recipient.

1. With the oversight of the LCSW, the DD Mobile Crisis Team determines and documents the existing level of crisis that requires the initiation of Intensive Crisis Supports.

a. The criteria to receive Intensive In-Home Supports include:
    i. The DD Mobile Crisis Team is not able to mitigate the crisis in a reasonable amount of time **OR**
    ii. The crisis was resolved but environmental variables and/or the individual's lack of adaptive behavioral responses make another crisis imminent **AND**
    iii. The caregiver or DD service provider is not capable of providing necessary intervention and protection for the individual or others living with the individual **AND**
    iv. The Intensive Crisis Supports will enable the individual to avoid institutional placement (such as a placement in a behavioral health hospital, nursing home, jail or correctional facility).
b. The criteria to receive Intensive Out-Of-Home Supports include:
    i. All of the intensive in-home supports criteria **AND**
    ii. The safety of others living in the home with the individual or others living in the community cannot be maintained through the use of Intensive In-Home Supports with written justification based on clinical observation and/or assessment **OR**
    iii. Extensive physical environmental modifications are needed as a result of the crisis and the individual cannot safely reside in the home with Intensive In-Home Supports while modifications are completed.

2. When behavioral interventions are necessary, Crisis Response personnel follow applicable *Best Practice Standards for Behavioral Support Services* and the **Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services.*** For adults, *The Guidelines for Supporting Adults with Challenging Behavior in Community Settings* provides additional information to consider when conducting behavioral assessments (The standards and guidelines are found at *www.dbhdd.ga.gov* Provider Information: Provider Toolkit).

3. The Crisis Response System provider must maintain and develop protocols that describe processes for the provision of both In-Home and Out-of-Home Intensive Crisis Supports. The description must include the following processes at a minimum:
    a. Accessing Intensive Crisis Supports;
    b. Types of Intensive Crisis Supports it plans to provide;
    c. Procedures for utilizing Intensive Crisis Supports both in and out of the individual's home.

4. When the individual meets the following criteria, he/she must be discharged from Intensive Crisis Support Services and the Crisis Response System service provider will complete a written discharge plan indicating at a minimum that:
    a. The crisis has been resolved, and a plan has been developed that prevents future crises or allows current caregivers or staff to maintain safety should future crises arise **AND**
    b. Family and/or provider have been trained and can implement all components of the plan **AND**
    c. The individual has met the discharge criteria and the plan of discharge was developed with and reviewed with family, care-giver, and/or DD service provider **OR**
    d. The individual exhibits medical conditions requiring more intensive medical care that cannot be provided through Intensive Crisis Supports.

F. Intensive In-Home Support Requirements

1. Intensive In-Home Support services include, but are not limited to the following:
    a. Implementation of behavioral intervention strategies provided under the recommendations of the DD Mobile Crisis Team, safety plans, or behavioral support plans already established for the individual; provision of one-to-one support, as necessary, to address the crisis; modeling of interventions with family and/or provider staff; assistance with simple environmental adaptations as necessary to maintain safety; and when necessary accompanying the individual to appointments related to the crisis response.
    b. The provision of a staffing pattern up to 24 hours per day, 7 days per week, with the intensity of the Intensive In-Home Support services decreasing over 7 calendar days.
    c. Maintenance of stakeholder's involvement in the response to the crisis, in order to restore the individual to pre-crisis supports and/or provider services.
    d. Assurance of appropriate training to support crisis stabilization and the return of the individual to pre-crisis services and supports, to include:

i. Demonstration of interventions to the family/caregiver and/or existing DD service provider (if applicable) **AND**
ii. Implementation of these interventions by the family/caregiver and/or existing DD service provider (if applicable).

2. Documentation of Intensive In-Home Support services is to:
    a. Occur on a daily basis;
    b. Include a description of the behavioral interventions utilized;
    c. Indicate the training process and identity of the trained caregiver or staff that will support the individual upon termination of crisis supports.

3. As a time-limited response, Intensive In-Home Supports are not to exceed 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical. However, clinical follow-up by the behavior specialist or social worker is allowed for up to 14 days when the need is justified and documented appropriately.
    a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the crisis service provider, and the support coordinator or planning list administrator if applicable.
    b. Extensions beyond the 7calendar days are to be approved by the Regional Operations Director for Developmental Disabilities (ROD) for the applicable region. Extensions are only approved when discharge criteria noted in Section D 4a-4d have not been met as evident by observations, with assessment of outcomes related to clinical interventions documented on a daily basis.
    Note: As soon as the need is indicated by the GCRSS-DD staff, the ROD engages and reviews all necessary information for an individual's whose circumstances determine the need for an exception.

G. INTENSIVE OUT-OF-HOME SUPPORT REQUIREMENTS FOR CRISIS SUPPORT HOMES

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports, on a time-limited basis. Intensive Out-of-Home Supports are to be provided by Crisis Support Homes, which are to serve no more than four adult individuals simultaneously. Individuals under the age of 18 years must not be served in a Crisis Support Home. There is currently no required licensure of Crisis Support Homes. However, each Crisis Support Home must receive Standards Compliance Review by DBHDD prior to operation.

G-1. CRISIS SUPPORT HOME PROTOCOL FOR OPERATIONS

Crisis System Response service providers must develop and maintain protocols for the Crisis Support Homes that include but are not be limited to:

- Criteria for determining when and if a referral to a Crisis Support Home is necessary.
- Staffing plan to include the minimum staffing of a registered nurse, a licensed professional nurse, day, evening and night staff, a behavior specialist, and a psychologist.
- Transportation plan to and from home(s).
- The availability of a licensed clinical social worker to assist crisis support home staff with case management and discharge planning services, to ensure that appropriate referrals and/or coordination of services are part of the transition back to the home environment.

In addition the protocols must meet the following:

1. As a time-limited response, Intensive Out-of-Home Supports are not to exceed a 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical.
    a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the crisis service provider and the support coordinator or planning list administrator if applicable.
    b. Extensions beyond 7 calendar days are to be approved by the Developmental Disabilities Regional Operations Director (ROD) for the applicable region. The following criteria must be met for consideration for an extension of the individual's length of stay:
        i. Discharge criteria noted in Section D 4a-4d have not been met as evidenced by observations, with assessment of outcomes related to clinical interventions documented on a daily basis **AND**
        ii. Environmental conditions (due to safety concerns) within the home preclude immediate discharge, **AND/OR**
        iii. Extraordinary circumstances regarding the caregiver/provider that negate their ability to provide care for the individual upon discharge as determined by the DD ROD.

2. The development of a discharge plan is to be person-centered, beginning at intake and noting:
    a. An evaluation of additional supports and services by the support coordinator for individuals with waiver services.
    b. An evaluation of additional supports and services by the planning list administrator for individuals on the planning list.
    c. Referral for intake and evaluation by the region I & E Team, to determine eligibility and most in need of services, for individuals not in waiver services.
    d. Intensive Out-of -Home support staff have trained the personnel in post-crisis services placement and/or family members regarding any interventions utilized in the out-of-home crisis placement that will be needed upon transition back home.

3. Upon discharge from the Crisis Support Homes, the individuals may:
    a. Return to his/her family home or provider placement;
    b. Experience a permanent change in provider location. For individuals in waiver services, a permanent change in provider location will require an assessment evaluation as a result of an approved Individual Service Plan (ISP) addendum based upon the long term interests of the individual and in accordance with DBHDD policies.

4. Out-of-Home Support services and discharge planning case management are to be documented daily by appropriate personnel.

5. Records of pre-service and annual training of Crisis Support Home staff, including names of persons trained, the training source, content, dates, length of training, and copies of certificates received and persons attending must be kept and be readily available.

G-2. CRISIS SUPPORT HOME MINIMUM FLOOR PLAN REQUIREMENTS

1. A residence must be constructed, arranged, and maintained so as to provide adequately for the health, safety, access, and well-being of the individual.

2. A Crisis Support Home must provide for common living space and private sleeping areas.
    a. The living and sleeping areas for an individual must be within the same building.
    b. Windows used for ventilation to the outside and exterior doors used for ventilation must be screened and in good repair.
    c. Supportive devices must be installed as necessary to enable the individual to achieve a greater degree of mobility and safety from falling.

3. All Crisis Support Homes must provide an area that affords privacy for the individual and visitors. There must be common spaces, such as living and dining rooms, for use by the individual without restriction.

4. Common areas of the residence must be large enough to accommodate the individual without crowding. The areas must be comfortably furnished.

5. Upon request, the residence must provide a means of locked storage for the valuables or personal belongings of the individual.

6. The residence must provide laundering facilities on the premises for individual's personal laundry.

7. The following minimum standards for bedrooms must be met:
    a. Bedrooms must have sufficient space to accommodate without crowding the individual, the individual's belongings, and the minimum furniture of a bed and dresser;
    b. The individual's bedroom must have at least one window and a closet. The windows may be textured to provide privacy without the use of curtains or blinds;
    c. Bedrooms for individuals must be separated from halls, corridors, and other rooms by floor to ceiling walls. Hallways must not be used for sleeping;
    d. The floor plan must be such that no person other than the occupant of that bedroom must pass through a bedroom in order to reach another room;

e. The bedroom occupied by the individual must have doors that can be closed. For bedrooms that have locks on doors, both the occupant and staff must be provided with keys to ensure easy entry. Double-cylinder locks (locks requiring a key on both sides) may not be used on the bedroom of an individual. Doors shall not be locked from within and shall be capable of swinging outward;
f. A room must not be used as a bedroom where more than one half of the room height is below ground level. Bedrooms which are partially below ground level should have adequate natural light and ventilation and be provided with two useful means of egress; and
g. When an individual is discharged, the room and its contents must be adequately cleaned.
h. Light switches and electrical outlets shall be secured with non-tamper type screws;
i. Beds and other heavy furniture capable of use to barricade a door shall be secured to the floor or wall.

8. The following minimum standards apply to bathroom facilities:
   a. At least one functional toilet, lavatory, and bathing or showering facility must be provided for every four individuals residing in a Crisis Support Home;
   b. At least one fully handicap accessible bathroom must be available;
   c. Grab bars and non-skid surfacing or strips must be installed in all showers and bath areas;
   d. Bathrooms and toilet facilities must have a window that can be opened or must have forced ventilation;
   e. Toilets, bathtubs, and showers must provide for individual privacy;
   f. Shower fixtures in bathrooms must be flush-mounted in the wall; and

   g. All plumbing and bathroom fixtures must be maintained in good working order at all times and must present a clean and sanitary appearance.

9. All stairways and ramps must have sturdy handrails, securely fastened not less than 30 inches nor more than 34 inches above the center of the tread. Exterior stairways, decks, and porches must have handrails on the open sides unless the surface of the deck or porch is so close to ground level that it does not pose a significant risk of injury to the individual to fall from the deck or porch.

10. Floor coverings must be intact, safely secured, and free of any hazard that may cause tripping.

11. All areas including hallways and stairs must be lighted sufficiently.

12. The following exterior conditions must be maintained:
    a. Entrances and exits, sidewalks, and escape routes must be maintained free of any obstructions that would impede leaving the residence quickly in the case of fire or other emergency. All such entrances and exits, sidewalks, and escape routes must be kept free of any hazards such as ice, snow, or debris;
    b. The yard area, if applicable, must be kept free of all hazards, nuisances, refuse, and litter; **AND**
    c. The residence must have its house number displayed so as to be easily visible from the street.

G-3. CRISIS SUPPORT HOME FURNISHINGS AND FIXTURES

1. Furnishings of the individual in the living room, bedroom, and dining room, including furnishings provided by the individual, must be maintained in good condition, intact, and functional.

2. Furnishings and housekeeping standards must be such that a residence presents a clean and orderly appearance. The Crisis Support Home must provide the following bedroom furnishings based on safety:
   a. An adequate closet or wardrobe;
   b. Lighting fixtures sufficient for reading and other activities;
   c. A bureau, dresser, or the equivalent;
   d. Mirrors shall not be common glass. A polycarbonate mirror, fully secured and flat mounted to the wall is required. Polished metal mirror shall not be permitted;
   e. A standard, non-portable bed measuring at least 36 inches wide and 72 inches long with comfortable springs and a clean mattress. The mattress must be not less than 5 inches thick or 4 inches of a synthetic construction. The use of beds with springs, cranks, rails or wheels including hospital beds, rollaway beds, cots, bunk beds, stacked, hide a beds and day beds is prohibited;
   f. The furnishings shall be of durable materials not capable of breakage into pieces that could be used as weapons and must not present a hanging risk;

3. The Crisis Support Home must provide to each individual clean towels and washcloths at least twice weekly and more often if soiled.

4. The Crisis Support Home must provide bedding for each individual including two sheets, a pillow, a pillow case, and a minimum of one blanket and bedspread. The Crisis Support Home must maintain a linen supply for not less than twice the bed capacity.

G-4. CRISIS SUPPORT HOME PHYSICAL PLANT, HEALTH, AND SAFETY STANDARDS

1. Each Crisis Support Home must provide a safe and healthy environment for its individuals, and where subject to fire and safety standards promulgated by Office of the Safety Fire Commissioner, such Crisis Support Home must be in compliance with those standards.

2. Each Crisis Support Home must comply and remain in compliance with any and all state and local ordinances for fire safety in residences of that size and function. In the absence of or in addition to any such local ordinances, the following requirements must be met:
    a. Wall-mounted electric outlets and lamps or light fixtures must be maintained in a safe and operational condition;
    b. Cooking appliances must be suitably installed in accordance with approved safety practices;
    c. Space heaters must not be used;
    d. Fire screens and protective devices must be used with fireplaces, stoves, heaters, and air-conditioning units;
    e. Sufficient AC powered smoke detectors, with battery backup, must be in place and, when activated, must initiate an alarm that is audible in the sleeping rooms. Strobe alarms must be used when required by the needs of individuals (e.g. for hearing impaired persons). NOTE: Strobe alarms should have the ability to be disarmed for individuals who have epilepsy/seizure disorders that are exacerbated by strobe lighting.
    f. If natural gas or heating oil is used to heat the residence, or if a wood-burning fireplace is in the residence, the residence must be protected with carbon monoxide detectors;
    g. Each residence must have at least one charged, 5 lb. multipurpose ABC fire extinguisher on each occupied floor and in the basement that must be readily accessible. These extinguishers must be checked annually by a fire safety technician and monthly by the staff of the Crisis Support Home to ensure they are charged and in operable condition; and Sufficient AC powered smoke detectors with battery backup must be in place and, when activated, must initiate an alarm that is audible in the sleeping rooms;
    h. Exterior doors must be equipped with locks that do not require keys to open the door from the inside.
    i. An automatic extinguishing system (sprinkler) shall be install per city/county requirement for residential settings not governed by other federal, state and county rules and regulations, if applicable; and
    j. An approved smoke alarm shall be installed in all sleeping rooms, hallways and in all normally occupied areas on all levels of the residences per safety code. Smoke alarms especially in the bedrooms shall be tested monthly and practice documented. The facility shall be inspected annually to meet fire safety code and copies of inspection maintained.
3. Water and sewage systems must meet applicable federal, state, and local standards and regulations.

4. Floors, walls, and ceilings must be kept clean and in good repair.

5. Kitchen and bathroom areas must be cleaned with disinfectant and maintained to ensure cleanliness and sanitation.

6. The storage and disposal of biomedical wastes and hazardous wastes must comply with applicable federal and state rules and standards.

7. The storage and disposal of garbage, trash, and waste must be accomplished in a manner that will not permit the transmission of disease, create a nuisance, or provide a breeding place for insects or rodents. Waste must be removed from the kitchen as necessary and from the premises at least weekly.

8. No animals must be kept at the residence.

9. Poisons, caustics, and other dangerous materials must be stored in clearly labeled and appropriate containers, safeguarded in an area away from medication storage areas and from food preparation and storage areas and secured as required by the capacity of the individuals.

10. The Crisis Support Home must be equipped and maintained so as to provide a sufficient amount of hot water for the use of the individuals. Heated water provided for use by individuals must not exceed 120 degrees Fahrenheit at the hot water fixture, unless a cooler temperature is required by the needs of the individual. A water temperature monitor or a scald valve must be installed where necessary to ensure the safety of the individuals.

11. There must be clearly accessible route(s) for emergencies throughout the residence.

12. The temperature throughout the residence must be maintained by a central heating system or its equivalent at ranges that are consistent with individual's health needs. No individual must be in any area of the residence that falls below 65 degrees or that exceeds 82 degrees Fahrenheit.

13. There must be a supply of first-aid materials available with a minimum of the following: bandages, antiseptic, gauze, tape, thermometer, and gloves.

G-5. CRISIS SUPPORT HOME SERVICES

1. Each Crisis Support Home must provide room, meals, and crisis services that are commensurate with the needs of the individuals. Services must be provided by appropriately qualified staff members.

2. Personal hygiene assistance must be given to those individuals who are unable to keep themselves neat and clean.

3. The Crisis Support Home administrator or his or her designee must teach each individual the techniques of "Standard Precautions," as appropriate to the individual's ability, or must support each individual in the performance of the techniques of "Standard Precautions," including washing his or her hands thoroughly after toileting, sneezing, or any other activity during which the individual's hands may become contaminated.

4. The routine of the residence must be such that an individual may spend the majority of his or her non-sleeping hours out of the bedroom if he or she so chooses.

5. The Crisis Support Home administrator or his or her designee must be available to any person within the Crisis Support Home, including each individual served.

G-6. CRISIS SUPPORT HOME RECORD MANAGEMENT

All records must be kept in accordance with requirements of the Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services*.

G-7. CRISIS SUPPORT HOME DOCUMENTATION OF SERVICES

Providers must document the following in the record of each individual based on the plan to support the individual as determined by the assessment team. The following must be on file for each individual:

1. Dates (beginning and ending) of service.
2. Completed intake/evaluation documents (Medical and/or Behavioral Assessment).
3. Determined model of support.
4. Discharge plan.

Additionally documentation of Intensive Out-Of-Home Support services is to:

5. Occur on a daily basis;
6. Include a description of the behavioral interventions utilized;
7. Indicate the training process and identity of the trained caregiver or staff that will support the individual upon termination of crisis supports.

G-8. CRISIS SUPPORT HOME INDIVIDUAL FILES AND INFORMATION

All individual files and information must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

G-9. INDIVIDUAL RIGHTS IN A CRISIS SUPPORT HOME
All services delivered should be in accordance with Client's Rights Chapter 290- 4-9 and DBHDD Policy Human Rights Council for Developmental Disabilities, 02-1101.

G-10. ABUSE IN A CRISIS SUPPORT HOME
It is expressly prohibited to Mistreat, Abuse, Neglect, Exploit, and Seclude or Restrain any person(s) service in a Crisis Support Home. These include but are not limited to:

1. Physical Abuse- includes but is not limited to such actions as striking, pulling, pushing, twisting body parts, or inflicting any physical injury to an individual by any means. Physical abuse includes directing one individual to physically abuse another individual.

2. Sexual Abuse- includes but is not limited to sexual assault, rape, fondling, sexual exploitation or any sexual interaction.

3. Mental Abuse- includes but is not limited to any action, which creates mental anguish for the individual. These actions include but are not limited to discriminatory remarks, belittlement, derogatory name-calling, teasing, and unreasonable exclusion from conversation or activities and verbal abuse.

4. Neglect- includes but is not limited to the denial of meals, medication, habilitation and other necessities.

5. Exploitation- includes but is not limited to any illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

6. Seclusion, is defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

7. Physical restraints (i.e., mechanical restraints) - are not used as punishment, for staff convenience, or through a behavioral support plan or behavioral management intervention for purposes of restricting a participant's movement. Those devices which restrain movement, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints.

Refer to the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Standards for all Providers for additional details.

G-11. REPORTING AND INVESTIGATION OF DEATHS AND CRITICAL INCIDENTS IN A CRISIS SUPPORT HOME
Death and/or critical incidents of individuals in service must be reported to the Department of Behavioral Health and Developmental Disabilities according to the policy found in the Department of Behavioral Health and Developmental Disabilities current Provider Manual. This policy can be located at the website**:** http://dbhdd.georgia.gov/portal/site/DBHDD (click on *Provider Information*, and the *Provider Tool Kit* for the current Provider *Manual*, *Policy:* Reporting and Investigation of Individual Deaths and Critical Incidents for Community, 04-106).

G-12. NUTRITION SERVICES IN A CRISIS SUPPORT HOME

1. A minimum of three regularly scheduled, well-balanced meals must be available seven days a week. Meals must be served in the early morning, at midday, and the evening, with the last meal taking place no earlier than 5:00 P.M. Meals must meet the general requirements for nutrition found in the recommended Daily Diet Allowances, Food and Nutrition Board, National Academy of Sciences or a diet established by a registered dietitian. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least one nutritious snack must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu.

2. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.

3. Food received or used in a Crisis Support Home must be clean, wholesome, free from spoilage, adulteration, and mislabeling, and safe for human consumption.

4. A Crisis Support Home must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment. In such case, a copy of required certification related-health, safety, sanitation is available.

5. A Crisis Support Home must maintain a three-day supply of non-perishable foods and water for emergency needs for all individuals receiving services in the Crisis Support Home and staff assigned.

6. A Crisis Support Home must arrange for and serve special diets as prescribed.

7. The Crisis Support Home shows evidence of individual choice and participation in the planning of meals, as appropriate.

G-13. MEDICATION MANAGEMENT IN A CRISIS SUPPORT HOME
All medication must be kept and administered in accordance with requirements of the Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services.*

G-14. STANDARDS COMPLIANCE REVIEW OF A CRISIS SUPPORT HOME
Each DD Crisis Support Home delivering out-of-home intensive supports must receive Community Service Standards Quality Review by the Provider Performance Unit prior to operation. Each DD Crisis Support Home is subject to periodic review by Division and Regional staff and the Standards Compliance Unit.

Outcomes of those reviews may include but not be limited to a corrective action being required of provider or a moratorium on use of home for out-of-home intensive supports.

G-15, Emergency Evacuation Plan for Crisis Support Home in case of Natural Disaster
In the case of a natural disaster (i.e. tornado, flood, hurricane, etc.) that requires emergency evacuation of the DD Crisis Home, individuals currently receiving in the home will be transported by the Crisis Provider to the nearest and safest DD Crisis Home. This home does not have to be located within the same Region of the original home.

H. Intensive Out-of-Home Support Requirements for Temporary and Immediate Support Homes
The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports on a time-limited basis. Individuals between ages 10-17 years needing this level of care must be served in a Temporary and Immediate Support (TIS) Home. The TIS Home provider must be a Licensed Child Placing Agency. The TIS Home provider must comply with the Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services.* TIS Home supports will be available twenty-four hours a day, seven days a week. It is critical that children and youth remain in their family home environment and thus extraordinary circumstances must exist in order to place children and youth in this level of support.

H-1. TIS HOME PROTOCOL FOR OPERATION
TIS providers must develop and maintain protocols that include but are not be limited to:

- Criteria for determining when and if a referral to a TIS Home is necessary.
- Staffing plan to include the minimum staffing of an RN, behavior specialist, TIS coordinator, TIS staff, and a psychiatrist.
- Transportation plan to and from home(s).

In addition, the protocols must meet the following:

1. As a time-limited response, Intensive Out-of-Home Supports are not to exceed 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical.
    a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the support coordinator or planning list administrator.
    b. Extensions beyond 7 calendar days are to be approved by the Developmental Disabilities Regional Operations Director for the applicable region. The following criteria must be met for consideration for an extension of the individual's length of stay:
        i. Discharge criteria noted in Section D 4a-4d have not been met as evidenced by observations, with assessment of outcomes related to clinical interventions documented on a daily basis **AND**
        ii. Environmental conditions (due to safety concerns) within the home preclude immediate discharge, **AND/OR**
        iii. Extraordinary circumstances regarding the care-giver/provider that negate their ability to provide care for the individual upon discharge as determined by the DD RSA.

2. The development of a discharge plan is to be person-centered, beginning at intake and noting:
    a. An evaluation of additional supports and services by the support coordinator for individuals with waiver services.
    b. An evaluation of additional supports and services by the planning list administrator for individuals on the planning list.
    c. Referral for intake and evaluation by the Regional I & E Team, to determine eligibility and most in need of services, for individuals not in waiver services.
    d. Intensive Out-of -Home support staff have trained the personnel in post-crisis services placement and/or family members regarding all interventions utilized in the out-of-home crisis placement.
    e. Coordination with the family and/or DD service provider on a plan for return to school/educational activities.

3. Upon discharge from the TIS Home, the individual may:
    a. Return to his/her family home or provider placement;
    b. Experience a permanent change in provider location. For individuals in waiver services, a permanent change in provider location will require an assessment evaluation as a result of an approved Individual Service Plan (ISP) addendum based upon the long term interests of the individual and in accordance with DBHDD policies.

4. Out-of-Home Support services and discharge planning case management are to be documented daily by appropriate personnel.

5. Records of pre-service and annual training of TIS Home staff, including names of persons trained, the training source, content, dates, length of training, and copies of certificates received and persons attending must be kept and be readily available.

6. The applicable Field Office is to be immediately notified of the child/youth's admission into the TIS home.

7. The TIS provider is to collaborate with to all applicable parties (Families/Caregivers, Support Coordination Agencies, Provider Agencies, and/or Field Office I & E Teams) in order to establish a comprehensive discharge plan. A discharge plan may include "step downs" to a TIS host home model and then back to family or provider with scheduled maintenance respite in place. The TIS host home provider will be required to follow DBHDD and agency policies and procedures. Host Home provider will be required to follow plan of support determined by the assessment team. Additional support will be provided if authorized.

H-2. TIS HOME RECORD MANAGEMENT

All records must be kept in accordance with requirements of the Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services.*

H-3. TIS HOME DOCUMENTATION OF SERVICES

Providers must document the following in the record of each individual based on the plan to support the individual as determined by the assessment team. The following must be on file for each individual:

1. Dates (beginning and ending) of service.
2. Completed intake/evaluation documents (Psychiatrist, Medical and/or Behavioral Assessment).
3. Determined model of support.
4. Discharge plan.

Additionally documentation of Intensive Out-Of-Home Support services is to:

5. Occur on a daily basis;
6. Include a description of the behavioral interventions utilized;
7. Indicate the training process and identity of the trained caregiver or staff that will support the individual upon termination of crisis supports.

H-4. TIS HOME INDIVIDUAL FILES AND INFORMATION

All individual files and information must be kept in accordance with requirements of the Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services.*

H-5. INDIVIDUAL RIGHTS IN A TIS HOME

All services delivered should be in accordance with Client's Rights Chapter 290- 4-9

H-6. ABUSE IN A TIS HOME

It is expressly prohibited to Mistreat, Abuse, Neglect, Exploit, and Seclude or Restrain any person(s) service in a Crisis Support Home. These include but are not limited to:

1. Physical Abuse- includes but is not limited to such actions as striking, pulling, pushing, twisting body parts, or inflicting any physical injury to an individual by any means. Physical abuse includes directing one individual to physically abuse another individual.

2. Sexual Abuse- includes but is not limited to sexual assault, rape, fondling, sexual exploitation or any sexual interaction.

3. Mental Abuse- includes but is not limited to any action, which creates mental anguish for the individual. These actions include but are not limited to discriminatory remarks, belittlement, derogatory name-calling, teasing, and unreasonable exclusion from conversation or activities and verbal abuse.

4. Neglect- includes but is not limited to the denial of meals, medication, habilitation and other necessities.

5. Exploitation- includes but is not limited to any illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

6. Seclusion, is defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

7. Physical restraints (i.e., mechanical restraints) – are not used as punishment, for staff convenience, or through a behavioral support plan or behavioral management intervention for purposes of restricting a participant's movement. Those devices which restrain movement, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints.

Refer to the Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers.*

H-7. REPORTING AND INVESTIGATION OF DEATHS AND CRITICAL INCIDENTS IN A TIS HOME

Death and/or critical incidents of individuals in service must be reported to the Department of Behavioral Health and Developmental Disabilities according to current fiscal year Provider Manual Part VI Policies Reporting Consumer Deaths and Critical Incidents and Investigating Consumer Deaths and Critical Incidents.

H-8. NUTRITION SERVICES IN A TIS HOME

1. A minimum of three regularly scheduled, well-balanced meals must be available seven days a week. Meals must be served in the early morning, at midday, and the evening, with the last meal taking place no earlier than 5:00 P.M. Meals must meet the general requirements for nutrition found in the recommended Daily Diet Allowances, Food and Nutrition Board, National Academy of Sciences or a diet established by a registered dietitian. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least one nutritious snack must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu.

2. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.

3. Food received or used in a TIS Home must be clean, wholesome, free from spoilage, adulteration, and mislabeling, and safe for human consumption.

4. A TIS Home must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment. In such case, a copy of required certification related-health, safety, sanitation is available.

5. A TIS Home must maintain a three-day supply of non-perishable foods and water for emergency needs for all individuals receiving services in the Crisis Support Home and staff assigned.

6. A TIS Home must arrange for and serve special diets as prescribed.

7. The TIS Home shows evidence of individual choice and participation in the planning of meals, as appropriate.

H-9. MEDICATION MANAGEMENT IN A TIS HOME

All medication must be kept and administered in accordance with requirements of the Community Service Standards for Developmental Disabilities Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services.*

I. Quality Assurance and Standard Compliance Requirements

In conjunction with DBHDD, the Providers of the DD Crisis Response System should develop performance indicators and outcome measures for each stage of the Georgia Crisis Response System. Once baseline data has been collected, DBHDD will develop specific performance indicators and outcome goals for the system. These indicators and outcomes will allow DBHDD to monitor the crisis response system and make quality improvement decisions based on data collected.

1. Providers of the DD Crisis System must develop a quality assurance system that will generate monthly reports to include, but not limited to, the following:
    a. Reason for crisis call.
    b. Site of crisis (including DBHDD Region).
    c. Demographic information of the individual in crisis (including Medicaid status).
    d. Provider (include a category of none).
    e. Family Involvement.
    f. Final outcome of crisis incident.
    g. Dispatch team response time.
    h. Services received (include a category of none, behavioral health services).
    i. Waiver or planning list status (if yes on planning list, include level of planning list: if yes on waiver, indicate which waiver, including NOW, COMP, ICWP, SOURCE, CCSP, Unknown).
    j. Support coordination agency, if applicable.
    k. Incidences of mobile crisis team dispatch to emergency rooms.
    l. Incidences of intensive in-home and out-of-home crisis supports.
    m. Number of days of use of intensive in-home and out-of-home crisis supports.
    n. Recidivism of individuals and providers in relation to utilization of Georgia Crisis Response System.
    o. Referrals by crisis service providers to Child Protection Services and Adult Protection Services.

2. The Crisis Response System service provider must participate in data collection and generate monthly quality assurance reports for submission to DBHDD- Division of Developmental Disabilities, Outcomes and Quality Assurance Office.

J. STAFFING REQUIREMENTS

Qualifications and Standards of Crisis Response System provider professional staff:

1. Qualifications of Professional Social Worker (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
    a. Clinical social work licensure (LCSW) issued by the State of Georgia that is current and unrestricted AND
    b. Advanced skill in crisis intervention, conducting assessments and/or evaluations, and developing interventions using accepted standards of care AND
    c. Knowledge of federal, state, and local programs that have been developed for people with developmental disabilities including eligibility criteria and how to access these services AND
    d. Advocacy experience and knowledge of the Individuals with Disabilities Education Act (IDEA), and the Americans with Disabilities (ADA) Act and their legal mandates as they relate to special education programs and the rights of people with disabilities.

2. Professional Social Worker Standards:
    a. Social workers must adhere to the values and ethics of the social work profession, utilizing the National Association of Social Workers (NASW) Code of Ethics as a guide to ethical decision making.
    b. Social workers must adhere to clinical practice guidelines outlined in the NASW Standards for Clinical Social Work in Social Work Practice.
    c. In accordance with the NASW Standard for Continuing Professional Education and the Georgia State Composite Board's licensure requirements for Continuing Education Units, clinical social workers should obtain any applicable certifications for crisis intervention curricula approved by DBHDD.

3. Qualifications of Registered Nurse (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
    a. Must be a Registered Nurse with an unrestricted license to practice nursing in the state of Georgia AND
    b. Have experience in caring for individuals with developmental disabilities who are in crisis.

4. Professional Registered Nurse Standards:
    a. The Registered Nurse is committed to promoting health through assessment, nursing diagnosing, planning, intervention, evaluation and treatment of human responses when faced with a crisis. The Registered Nurse employs a purposeful use of self as its art and a wide range of nursing, psychosocial and neurobiological theories and research evidence as its science.
    b. The Registered Nurse will adapt the American Nurses Association Code of Nursing standards and use these standards as comprehensive holistic assessment prior to engaging in any plan to resolve a crisis. The Registered Nurse will be directly involved in all aspect of crisis intervention by utilizing the nursing process.

5. Qualifications of Licensed Practical Nurse (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
    a. Must be a Practical Nurse with an unrestricted license to practice nursing in the state of Georgia under the supervision of a Registered Nurse **AND**
    b. Have experience in caring for individuals with developmental disabilities who are in crisis.

6. Professional of Licensed Practical Nurse Standards:
    a. The Licensed Practical Nurse must accept the responsibilities as an accountable member of the health care team **AND**
    b. Shall function within the limits of educational preparation and experience as related to assigned duties **AND**
    c. Function with other members of the health care team in promoting and maintaining health, preventing diseases and disabilities in order to obtain optimal health, utilizing the nursing process under the supervision of the Registered Nurse.

7. Qualifications of Behavioral Specialist (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
    a. Possess a minimum of a Master's degree in psychology, behavior analysis, education, social work or a related field **AND**
    b. Possess specialized training and education in behavioral analysis and positive behavioral supports for people with developmental disabilities by provision of evidence of a minimum of thirty-five (35) hours of training and education in behavior analysis and behavioral supports for individuals with developmental disabilities, which may include college transcripts and/or copies of training certificates or evidence of national certification as a Board Certified Behavior Analyst through documentation of a certificate from the Behavior Analyst Certification Board **AND**
    c. Have at least two years' experience in behavioral supports evaluation and services for people with developmental disabilities.

8. Behavior Specialist Standards: Behavior Specialists are to adhere to the *Best Practice Standards for Behavioral Support Services.*

9. Qualifications of Physician:
    a. Graduate of medical or osteopathic college; **AND**
    b. Licensed by the Georgia Composite Board of Medical Examiners.

K. Definitions

1. Crisis Services: Occur through intensive on-site or off-site supports. This system will be an alternative to emergency room care, law enforcement involvement, and/or institutional placement. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services.

2. Crisis Support Home: A home that serves up to four (4) individuals who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions, which have not responded to Intensive-In-Home Support services.

3. Developmental Disability: An individual is determined to have developmental disability by a professional licensed to make this determination. The developmental disability is attributable to a significant intellectual disability, or any combination of a significant intellectual disability and physical impairments. The developmental disability manifests before the individual attains age 22 years and is likely to continue indefinitely.

4. Intensive Case Management: is a time-limited service that connects the individual in crisis to the necessary services and supports to ameliorate the crisis situation, coordinates with stakeholders to assure the development of a discharge plan from crisis support services, and ensures follow up on recommended supports/services.

5. Mobile Crisis Team: The mobile crisis team is composed of personnel with differing levels of expertise and training. Depending on the crisis, different team compositions may be dispatched. A minimum of three team members, including a behavior specialist, licensed clinical social worker, and a direct support staff, will respond to each mobile dispatch.

6. Safety Officer: An individual who provides support related to safety issues during the provision of GCRS-DD service. This individual is to have safety related training and dressed in a safety related uniform. A GRCS-DD safety officer must not carry any form of a weapon (such as a gun, any form of a "billy club", baton", hand cuffs, taser gun).

7. Temporary Intermediate Support (TIS) Home: A TIS Home is to serve no more than four children ages 10 thru 17 years of age, who are diagnosed with a developmental disability and are undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. Placement in a TIS home is to only occur as a last result and after a clinical determination for this level of placement has occurred.

Part II

Section 3

Request for Conversion
(Appendix: A)

Provider Manual

For

Community Developmental Disabilities Providers

Fiscal Year 2017

Georgia Department of Behavioral Health and Developmental Disabilities

July 2016

To obtain Request for Conversion Form, please go to:

http://dbhdd.georgia.gov/developmental-disabilities-services

PART III

Block Grant Funding Requirements

Title XX Social Services Block Grant for DD Services

Provider Manual

For

Community Developmental Disabilities Providers

Fiscal Year 2017

Georgia Department of Behavioral Health and Developmental Disabilities

July 2016

PART III

Block Grant Funding Requirements

TITLE XX SOCIAL SERVICES BLOCK GRANT

Congress passed Public Law 93-647, or Title XX of the Social Security Act (SSA), in 1974 to make federal funds available for states to provide social services which address the needs of each individual state. Social Services Block Grant (SSBG) funds are used to provide a variety of services to Georgia's citizens, including vulnerable children and adults who need protection, persons with IDD, and the elderly.

The Department of Human Resources prepares an annual report to inform the Secretary of the U.S. Department of Health and Human Services and the people of Georgia of the intended use of the funds the State is to receive under provision of the Act. This annual report is called the Report on the Intended Use of Title XX Social Services Block Grant Funds. The following description of services to persons with IDD (I) and the statements on limitations/assurances on the use of the grants (II) are taken from the Report on Intended Use.

I. SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Services for persons with developmental disabilities are services or activities to maximize the potential of persons with disabilities, help alleviate the effects of disabilities, and to enable persons served to live in the least restrictive environment possible. Component services or activities may include personal and family counseling, respite care, family support, recreation, transportation aid to assist with independent functioning in the community and training in mobility, communication skills, the use of special aides and appliances and self-sufficiency skills.

II. LIMITATION/ASSURANCES ON USE OF GRANTS

The Georgia Department of Human Resources gives assurance that Title XX Social Services Block Grant funds will **NOT** be used:

1) For the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility; or
2) To provide cash payments for costs of subsistence or to provide room and board (other than cost of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service); or
3) For payment of the wages of any individual as a social service (other than payment of wages of welfare recipients employed in the provision of day care services); or
4) For the provision of medical care; or
5) For social services provided in and by employees of any hospital, skilled nursing facility, or prison, or to any individual living in such institution. The only exceptions to this limitation are services to an alcoholic or drug dependent individual or rehabilitation services; or
6) For the provision of any educational service which the state makes generally available to its residents without cost and without regard to their income; or
7) To provide child care services unless such services meet applicable standards of State and local law; or
8) For the provision of cash payments as a service.

III. APPLICATION FOR SERVICE

Each individual or family unit shall have the right to apply for Social Services Block Grant Services without delays in the application process. Application for services may be made by the applicant or by a relative, friend, neighbor or legal guardian acting responsibly on behalf of the person needing the service. The application should be made to Field Office 's designated point of entry.

IV. ELIGIBILITY

All recipients of Social Services Block Grant (SSBG) funded services must be physically located in the State of Georgia.

- **Non School Aged Adults** – SSBG funded services may be provided to non-school aged adults with a documented programmatic need and a current diagnosis of IDD/developmental disability.
- **School Aged Individuals** – School aged individuals may be provided non-education-related services with a documented programmatic need and a current diagnosis of IDD/developmental disability.
- **Pre-School Aged Individuals** –SSBG funded services may be provided to pre-school aged individuals with a documented programmatic need and a current diagnosis of IDD/developmental disability.

V. BEGINNING THE SERVICES

Once eligibility is determined, the service must be provided with reasonable promptness. Reasonable promptness is defined as within fifteen (15) calendar days. If the service is temporarily unavailable, the individual should be placed on a Planning List.

VI. PLANNING LIST (Waiting Lists)

Planning Lists will be maintained in accordance with Division Policy.

VII. SERVICES TO PERSONS RESIDING IN INSTITUTIONS

In most instances, services to persons residing in institutions are the responsibility of staff of the facility. Accordingly, Social Services Block Grant funds may not be used for the provision of social services that are the inherent responsibility of the institution. Those facilities which are Intermediate Care Facilities or Skilled Nursing Facilities and which receive funding under Title.

XVIII (Medicare) and/or Title XIX (Medicaid) are required either to provide social services or arrange for them with qualified outside resources. In these facilities and in any other where an investigation indicates that social services are an inherent responsibility of the institution, Social Service Block Grant Services to eligible persons are limited to assisting an individual and/or family to seek admission to the institution, and/or supporting or augmenting the discharge plan of the facility for the individual. If social services are not an inherent responsibility of the institution, Social Services Block Grant services may be delivered to eligible persons.

Number VIII is missing

IX. DOCUMENTATION OF SERVICE PROVISION

- Contractors are responsible for the documentation of service delivery in compliance with the terms of the provider contract.

- **Reporting of Services - Services delivered must be reported in compliance with the terms of the provider contract.**

X. NOTIFICATION OF THE CONSUMER OF SERVICE TERMINATION

A. Notification to the consumer must follow a decision by the agency to terminate services. Form 5536, included below, and shall be used. **(Note: Even though space is available on this Form, the Form should not be used to notify a consumer of eligibility for service. Form 5536 should only be used to notify a client of termination of service.)** In cases of termination of service, services must continue through the ten- (10) day notice period and the notification process must be (1) adequate and (2) timely.

1. **Adequate notice** is defined as a written communication (Form 5536) that includes a statement of the specific action the agency intends to take, the reason for the intended action, explanation of the individual's right to request a fair hearing and the circumstances under which services are continued if a hearing is requested.

2. **Timely notice** is defined as the notice being mailed or hand delivered to the consumer at least ten (10) calendar days before the date the action is to become effective. No action shall be taken to terminate services during the ten- (10) day notice period. If the consumer does not request a hearing before the expiration of the tenth (10th) day, the services shall be terminated after the tenth day has passed.

B. **Waiver of Timely Notice -** The following are situations in which timely notice (10 calendar days) is not required but adequate (written) notice shall be given not later than the effective date of action:

1. The agency received a clearly written statement signed by consumer that he/she no longer wishes to receive services.

2. The whereabouts of the consumer are unknown and mail to him/her has been returned by the Post Office indicating no forwarding address. Returned mail should be filed in the service record.

3. The consumer moves to another State and the move is documented by the agency.

4. The consumer was informed in writing, at the time the services began, that the service would automatically terminate at the end of a specified period.

5. A change in either Federal/State law or policy requires automatic service adjustments for categories of service recipients.

XI. CONSUMER GRIEVANCES

Providers shall make a grievance and appeal process available to aggrieved consumers in compliance with Federal regulations governing the Social Service Block Grant, and policy and procedure promulgated by the Division and the State of Georgia.

Georgia Department of Human Resources
NOTIFICATION FORM FOR TITLE XX SOCIAL SERVICES

Agency Name: _____
DATE: _____
CASE ID: _____

Your application for social services has been given careful consideration. The following determination has been made

I. A. INITIAL DETERMINATION: You have been determined eligible/ ineligible for the following Title xxx Social Services:

Reason (if ineligible)

B. REDETERMINATION: You have been determined eligible/ineligible for the following Title xx Social Services effective .
The following Title xx Social Services have been/will be terminated:

Reason if (ineligible)

II. You are still eligible for these Title xx Social Services:

However, if the following services will be:

A. Reduced effective:
Reason: _____

B. Terminated effective:
Reason:
_____

III. LIMITED ELIGIBILITY

You have been determined eligible for the following Title xx services_____
You have been determined ineligible for the following Title xx services_____

If for any reason you disagree with this decision you may request a hearing. You may request a hearing orally or in contacting this agency within 10 days of the date given at the top of this form. This agency will be glad to furnish the form (s); help you in filing your appeal and in any way possible to prepare for the hearing.

The hearing will be held in your county by a hearing officer. You may be represented at the hearing by legal counsel or other spokesperson. If you would like an attorney, contact this agency which can provide information about legal services that may be available in your community at no cost to you.

_____

Form 5536 (Rev. 05-00) **Signature of Agency Representative**

Georgia Department of Human Resources
Title XX Administration

PART IV

General Policies and Procedures

Provider Manual

For

Community Developmental Disabilities Providers

Fiscal Year 2017

DBHDD Policy Stat enables community providers of mental health, developmental disabilities and/or addictive diseases services to have access to all DBHDD policies that are relevant for community services. DBHDD Policy Stat can be accessed online anytime at http://gadbhdd.policystat.com. Beginning in April 2012, the placement of policies in DBHDD Policy Stat replaced the policies previously included in the Provider Manuals for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers. By virtue of their contract or agreement with DBHDD, providers are required to comply with DBHDD policies relevant to their contracted services and/or according to the applicability as defined in the policy itself.

Additional information about how to utilize DBHDD Policy Stat is included in the following policy: Access to DBHDD Policies for Community Providers, 04-100.

Georgia Department of Behavioral Health and Developmental Disabilities

July 2016