# r Tiers/Rate Category and Additional Staffing Services

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

Presented by the Division of DD

December 10, 2021

D·B·H·D·D

# Agenda –Part 1

| Topics |
| --- |
| The Tiers/Rate Category |
| Additional Staffing (AS) and Eligibility |
| Enhanced AS and Eligibility |
| Steps in Obtaining AS |
| Adverse Actions |
| Staying Informed/Communication |

# Explaining the Tiers/Rate Categories

- The tiered/rate category rates, referred to as rate categories, provide Individuals with various needs staffing and support in Community Residential Alternative (CRA) Settings.
- Rates for Community Residential Alternative (CRA) services are “tiered” based on an individual’s assessed needs, with higher rates paid for individuals with greater needs
- Needs are assessed through the Supports Intensity Scale (SIS) and Health Risk Screening Tool (HRST)
- Each individual is assigned to one of seven assessment levels, which are cross-walked to four rate tiers

# Tiers/Rate Categories Calculations

Tiers/Rate Categories are calculated using the **HRST** and **SIS** scores.

| | | |
|---|---|---|
| **Support Intensity Scale (SIS)<br>+<br>Health Risk Screening (HRST)** | **=** | **ASSESSMENT LEVEL** |

| | | |
|---|---|---|
| **Assessment Level<br>+<br>Healthcare Facility Regulations Division (HFRD) Licensed Capacity (with the exception of Host Homes)** | **=** | **TIERED/RATE CATEGORY** |

# Tiers/Rate Category Assessment Levels

| Assessment Level | Support Needs |
|---|---|
| Level 1 | Mild support with monitoring/prompting<br>No support for medical or behavioral needs |
| Level 2 | Modest to Moderate with monitoring/prompting<br>Little/no support for medical or behavioral needs |
| Level 3 | Modest to Moderate<br>Significant support in medical or behavioral needs |
| Level 4 | Moderate to High with physical assistance needed |
| Level 5 | Most significant supports with physical assistance needed |
| Level 6 | Exceptional medical needs with enhanced supports needed |
| Level 7 | Exceptional behavioral needs with enhanced supports needed |

# Determination Assessment Levels

**Figure 4: Assessment Levels Criteria**

| Assessment Level | Supports Intensity Scale | | Health Risk Screening Tool |
|---|---|---|---|
| | Sum of Sections 2A, 2B, and 2E* | Section 1B (Behavioral) | |
| **1** | 8 to 24 | Less Than 7 | Low Risk (HCL 1-2) |
| **2** | 25 to 30 | Less Than 7 | Low Risk (HCL 1-2) |
| **3.1** | 0 to 30 | 7 to 10 | Low Risk (HCL 1-2) |
| **3.2** | 0 to 30 | Less Than 11 | Moderate Risk (HCL 3-4) |
| **4** | 31 to 36 | Less Than 11 | Low or Moderate Risk (HCL 1-4) |
| **5** | 37 to 52 | Less Than 11 | Low or Moderate Risk (HCL 1-4) |
| **6** | Any | Less Than 11 | High Risk (HCL 5-6) |
| **7** | Any | 11 to 26 | Any |

*Section 2A relates to Home Support Needs, 2B to Community Support Needs, and 2E to Health and Safety Needs

# Converting the Assessment Levels to Categories

| Residential Licensing Capacity | Category | Unit of Service | Rate | Allocated Staff Hrs. (Per Person Per week) |
|---|---|---|---|---|
| **4-Person** | Tier/Category 1 (Level 1) | 1 Day | $154.74 | 45.3 |
| **4-Person** | Tier/Category 2 (Level 2) | 1 Day | $214.80 | 55.3 |
| **4-Person** | Tier/Category 3 (Level 3, 4) | 1 Day | $239.73 | 66.5 |
| **4-Person** | Tier/Category 4 (Level 5, 6, 7) | 1 Day | $254.36 | 80.5 |
| **3-Person** | Tier/Category 1 (Level 1) | 1 Day | $178.53 | 53.7 |
| **3-Person** | Tier/Category 2 (Level 2) | 1 Day | $235.05 | 60.3 |
| **3-Person** | Tier/Category 3 (Level 3, 4) | 1 Day | $261.48 | 73.7 |
| **3-Person** | Tier/Category 4 (Level 5, 6, 7) | 1 Day | $277.44 | 88.7 |
| **1-2 Person (Host Home)** | Tier/Category 1 (Level 1, 2, 3, 4) | 1 Day | $149.45 | DAILY |
| **1-2 Person (Host Home)** | Tier/Category 2 (Level 5, 6, 7) | 1 Day | $185.25 | DAILY |

*Rates for CRA- Group Home and Host Home include an absence factor that adds a premium to the daily rate- based on a 365-day year. Thus, rates represent annualized annual reimbursement over 344 billing days.*

# Group Home Staff Hour Matrix
## *Four-Member Residences*

| | Category 1 Level 1 | Category 2 Level 2 | Category 3 Levels 3, 4 | Category 4 Levels 5, 6, 7 |
|---|---|---|---|---|
| **"Covered" Home Hours** | | | | |
| Hours in a Week | 168.0 | 168.0 | 168.0 | 168.0 |
| Hours that Members Are Out of the Home (w/o Home Staff) | (30.0) | (30.0) | (30.0) | (30.0) |
| Allowance for Day Program Absences | 3.0 | 3.0 | 3.0 | 3.0 |
| **Total Covered Hours for Residence per Week** | **141.0** | 141.0 | 141.0 | 141.0 |
| Daytime Hours | 85.0 | 85.0 | 85.0 | 85.0 |
| Overnight Hours | 56.0 | 56.0 | 56.0 | 56.0 |
| | | | | |
| **Staff Hours** | | | | |
| Number of Staff on Shift During Daytime Hours | 1.0 | 1.0 | 2.0 | 2.0 |
| Number of Staff on Shift During Overnight Hours | 1.0 | 1.0 | 1.0 | 2.0 |
| **Base Staff Hours** | **141.0** | **141.0** | **226.0** | **282.0** |
| | | | | |
| "Floating" FTE Per Week[1] | 1.0 | 2.0 | 1.0 | 1.0 |
| **Anticipated Floating Hours per Week** | **40.0** | **80.0** | **40.0** | **40.0** |
| **Total Hours per Home per Week** | **181.0** | **221.0** | **266.0** | **322.0** |
| **Hours per Client per Week** | **45.3** | **55.3** | **66.5** | **80.5** |

# Group Home Staff Hour Matrix
## *Three-Member Residences*

| | Category 1 Level 1 | Category 2 Level 2 | Category 3 Levels 3, 4 | Category 4 Levels 5, 6, 7 |
|---|---|---|---|---|
| **"Covered" Home Hours** | | | | |
| Hours in a Week | 168.0 | 168.0 | 168.0 | 168.0 |
| Hours that Members Are Out of the Home (w/o Home Staff) | (30.0) | (30.0) | (30.0) | (30.0) |
| Allowance for Day Program Absences | 3.0 | 3.0 | 3.0 | 3.0 |
| **Total Covered Hours for Residence per Week** | **141.0** | 141.0 | 141.0 | 141.0 |
| Daytime Hours | 85.0 | 85.0 | 85.0 | 85.0 |
| Overnight Hours | 56.0 | 56.0 | 56.0 | 56.0 |
| | | | | |
| **Staff Hours** | | | | |
| Number of Staff on Shift During Daytime Hours | 1.0 | 1.0 | 1.0 | 2.0 |
| Number of Staff on Shift During Overnight Hours | 1.0 | 1.0 | 1.0 | 1.0 |
| **Base Staff Hours** | **141.0** | **141.0** | **141.0** | **226.0** |
| | | | | |
| "Floating" FTE Per Week[1] | 0.5 | 1.0 | 2.0 | 1.0 |
| **Anticipated Floating Hours per Week** | **20.0** | **40.0** | **80.0** | **40.0** |
| **Total Hours per Home per Week** | **161.0** | **181.0** | **221.0** | **226.0** |
| **Hours per Client per Week** | **53.7** | **60.3** | **73.7** | **88.7** |

# Understanding the Matrix – Example

*Example: Licensed 3- Person House with a Tier 4 Individual…..*

| | Category 1 Level 1 | Category 2 Level 2 | Category 3 Levels 3, 4 | Category 4 Levels 5, 6, 7 |
|---|---|---|---|---|
| "Covered" Home Hours | | | | |
| Hours in a Week | 168.0 | 168.0 | 168.0 | 168.0 |
| Hours that Members Are Out of the Home (w/o Home Staff) | (30.0) | (30.0) | (30.0) | (30.0) |
| Allowance for Day Program Absences | 3.0 | 3.0 | 3.0 | 3.0 |
| **Total Covered Hours for Residence per Week** | **141.0** | 141.0 | 141.0 | 141.0 |
| Daytime Hours | 85.0 | 85.0 | 85.0 | 85.0 |
| Overnight Hours | 56.0 | 56.0 | 56.0 | 56.0 |
| | | | | |
| Staff Hours | | | | |
| Number of Staff on Shift During Daytime Hours | 1.0 | 1.0 | 1.0 | 2.0 |
| Number of Staff on Shift During Overnight Hours | 1.0 | 1.0 | 1.0 | 1.0 |
| **Base Staff Hours** | **141.0** | **141.0** | **141.0** | **226.0** |
| | | | | |
| "Floating" FTE Per Week[1] | 0.5 | 1.0 | 2.0 | 1.0 |
| **Anticipated Floating Hours per Week** | **20.0** | **40.0** | **80.0** | **40.0** |
| **Total Hours per Home per Week** | **161.0** | **181.0** | **221.0** | **226.0** |
| **Hours per Client per Week** | **53.7** | **60.3** | **73.7** | **88.7** |

**Total Covered hours per week =141**
**Daytime 85 (Daytime) + 56 (Overnight)**

| **Daytime hours: 85 hours** | **Overnight hours: 56 hours** |
|---|---|
| 16 hours day times 7 days =112 hours are daytime hours<br><br>Automatically Assumption in day service to remove 30 hours.<br><br>112 daytime hours - 30 day service hours =82 hours<br><br>Add in 3 hours for day program absences = 85 hours | 8 hours daily x 7 days = 56 hours |

# Understanding the Matrix – Example Continued

*Example: Licensed 3- Person House with a Tier 4 Individual…..*

| | Category 1 Level 1 | Category 2 Level 2 | Category 3 Levels 3, 4 | Category 4 Levels 5, 6, 7 |
|---|---|---|---|---|
| "Covered" Home Hours | | | | |
| Hours in a Week | 168.0 | 168.0 | 168.0 | 168.0 |
| Hours that Members Are Out of the Home (w/o Home Staff) | (30.0) | (30.0) | (30.0) | (30.0) |
| Allowance for Day Program Absences | 3.0 | 3.0 | 3.0 | 3.0 |
| **Total Covered Hours for Residence per Week** | **141.0** | 141.0 | 141.0 | 141.0 |
| Daytime Hours | 85.0 | 85.0 | 85.0 | 85.0 |
| Overnight Hours | 56.0 | 56.0 | 56.0 | 56.0 |
| | | | | |
| Staff Hours | | | | |
| Number of Staff on Shift During Daytime Hours | 1.0 | 1.0 | 1.0 | 2.0 |
| Number of Staff on Shift During Overnight Hours | 1.0 | 1.0 | 1.0 | 1.0 |
| **Base Staff Hours** | **141.0** | **141.0** | **141.0** | **226.0** |
| | | | | |
| "Floating" FTE Per Week[1] | 0.5 | 1.0 | 2.0 | 1.0 |
| **Anticipated Floating Hours per Week** | **20.0** | **40.0** | **80.0** | **40.0** |
| **Total Hours per Home per Week** | **161.0** | **181.0** | **221.0** | **226.0** |
| **Hours per Client per Week** | **53.7** | **60.3** | **73.7** | **88.7** |

**Base Staff Hours**

**Tier Staff Hours = 226 per week**

**170 (2 staff) +56 (1 overnight)**

| **Assumption: 2 staff during daytime hours** | **Overnight hours: 56 hours** |
|---|---|
| 85 hours per week x 2 staff =170 hours | 8 hours daily x 7 days = 56 hours |

# Understanding the Matrix – Example Continued

*Example: Licensed 3- Person House with a Tier 4 Individual…..*

| | Category 1 Level 1 | Category 2 Level 2 | Category 3 Levels 3, 4 | Category 4 Levels 5, 6, 7 |
|---|---|---|---|---|
| "Covered" Home Hours | | | | |
| Hours in a Week | 168.0 | 168.0 | 168.0 | 168.0 |
| Hours that Members Are Out of the Home (w/o Home Staff) | (30.0) | (30.0) | (30.0) | (30.0) |
| Allowance for Day Program Absences | 3.0 | 3.0 | 3.0 | 3.0 |
| **Total Covered Hours for Residence per Week** | **141.0** | 141.0 | 141.0 | 141.0 |
| Daytime Hours | 85.0 | 85.0 | 85.0 | 85.0 |
| Overnight Hours | 56.0 | 56.0 | 56.0 | 56.0 |
| | | | | |
| Staff Hours | | | | |
| Number of Staff on Shift During Daytime Hours | 1.0 | 1.0 | 1.0 | 2.0 |
| Number of Staff on Shift During Overnight Hours | 1.0 | 1.0 | 1.0 | 1.0 |
| **Base Staff Hours** | **141.0** | **141.0** | **141.0** | **226.0** |
| | | | | |
| "Floating" FTE Per Week[1] | 0.5 | 1.0 | 2.0 | 1.0 |
| **Anticipated Floating Hours per Week** | **20.0** | **40.0** | **80.0** | **40.0** |
| **Total Hours per Home per Week** | **161.0** | **181.0** | **221.0** | **226.0** |
| **Hours per Client per Week** | **53.7** | **60.3** | **73.7** | **88.7** |

**Total hours per home per week = 266**

| **Tier 88.7 hours per week per individual** | **Floating FTE** |
|---|---|
| 88.7 tier x 3 individuals =266 hours per week | Please note the Forty-hour floating FTE hours are within the total 266 hours<br><br>226 + 40 = 266 |

# Examples of Calculating a House

- Reminder: The standard staffing for a house requires at least 1 staff on shift whenever one or more individuals are present

- Reminder: The rate tier to which a person is assigned has assumed staffing levels

*The number of staff hours assumed for a home could look like the following examples…*

# Example

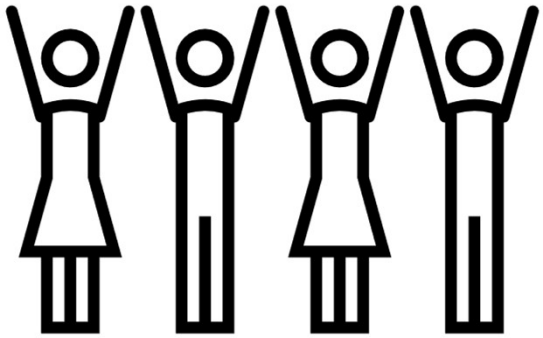
| 4 Person Licensed Home | TIER LEVEL | DAILY CRA RATE | Allocated Weekly Staff Hours in Base Rate | Daily Hours in Base Rate |
|---|---|---|---|---|
| Person 1 | 3 | $239.73 | 66.5 | 9.5 |
| Person 2 | 3 | $239.73 | 66.5 | 9.5 |
| Person 3 | 2 | $214.80 | 55.3 | 7.9 |
| Person 4 | 4 | $254.36 | 80.5 | 11.5 |
| Total Hours | | | 268.8 | 38.4 |

= This example equals ONE full-time employee on site 24/7 AND an additional staff for 14.4 hours per day for the provider to schedule as needed to meet the needs of the individuals in the home.

*Note: this is one example of a staffing pattern, but actual staffing can vary by day and by home*

# House Staff Schedule Examples 1-3

Next, we will examine 3 different examples of staff schedules that a provider could staff the previously described home (Remember this is a 4- person licensed home with two individuals at the tier 3 rate, one individual at the tier 2 rate and one individual at the tier 4 rate) …



# Example 1: STAFFING SCHEDULE 4-PERSON

| | MON | TUES | WED | THURS | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| 7am-3pm | | | | | | John | John |
| 7am-3pm | | | | | | Timmy | Timmy |
| 7am-10am | Sally | Sally | Sally | Sally | Sally | | |
| 7am-10am | Patrick | Patrick | Patrick | Patrick | Patrick | | |
| 9am-3pm | Day Servs | Day Servs | Day Servs | Day Servs | Day Servs | | |
| 11am-9pm | | | | | | Bobby | Bobby |
| 3pm-11pm | Daniel | Daniel | Daniel | Daniel | Daniel | Matt | Matt |
| 3pm-11pm | Richard | Richard | Richard | Richard | Richard | Melanie | Melanie |
| 4pm-8pm | Sally | Sally | Sally | Sally | Sally | | |
| 11pm-7am | Marcus | Marcus | Marcus | Marcus | Marcus | Sue | Sue |
| TOTAL: | 34 hrs | 34 hrs | 34 hrs | 34 hrs | 34 hrs | 49 hrs | 49 hrs |

# Example 2: STAFFING SCHEDULE 4-PERSON

| | MON | TUES | WED | THURS | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| 7am-10am | Sally | Sally | Sally | Sally | Sally | | |
| 7am-3pm | Erika | Erika | Erika | Erika | Erika | Patrick | Patrick |
| 8am-3pm | | | | | | Timmy | Timmy |
| 3pm-11pm | Daniel | Daniel | Daniel | Daniel | Daniel | Bobby | Bobby |
| 3pm-11pm | Richard | Richard | Richard | Richard | Richard | Melanie | Melanie |
| 4pm-7pm | Sally | Sally | Sally | Sally | Sally | | |
| 11pm-7am | Marcus | Marcus | Marcus | Marcus | Marcus | Sue | Sue |
| TOTAL: | 38 hrs | 38 hrs | 38 hrs | 38 hrs | 38 hrs | 39 hrs | 39 hrs |

# Example 3: STAFFING SCHEDULE 4-PERSON

| | MON | TUES | WED | THURS | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| 7am-9:30am | Sally | Sally | Sally | Sally | Sally | | |
| 7am-9:30am | Henry | Henry | Henry | Henry | Henry | | |
| 7am-3pm | | | | | | Patrick | Patrick |
| 7am-3pm | | | | | | Charles | Charles |
| 3pm-11pm | Daniel | Daniel | Daniel | Daniel | Daniel | Bobby | Bobby |
| 3pm-11pm | Richard | Richard | Richard | Richard | Richard | Melanie | Melanie |
| 11pm-7am | Marcus | Marcus | Marcus | Marcus | Marcus | Sue | Sue |
| 11pm-5am | Mary | Mary | Mary | Mary | Mary | Tenesha | Tenesha |
| | | | | | | | |
| TOTAL: | 35 hrs + | 35 hrs + | 35 hrs + | 35 hrs + | 35 hrs + | 46 hrs | 46 hrs |

# What Is Additional Staffing (AS)?

- Provided to individuals with a high level of functional, medical, or behavioral needs who require direct support or oversight beyond the level provided within traditional service descriptions
- May be authorized to provide higher ratio of staff
- Authorized on a temporary basis

Can be used in conjunction with:

- Community Living Supports Services
- Community Residential Alternative Services
- Community Access Group Services

For full-service definition, please see *Part III Policies and Procedures for COMP, Chapter 1700 and Appendix H*
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

# Enhanced Supports- Additional Staffing Services Eligibility

Must meet eligibility requirements outlined in COMP Part III Chapter 1700 and NOW/COMP Part II Appendix H
https://www.mmis.georgia.gov/portal/

1. Extraordinary placement circumstances
2. Extraordinary needs
3. DBHDD clinical assessments
4. Documented need in ISP
5. Other documentation such as crisis safety plan and behavioral support plan

*Please visit Appendix H for more information on the provider documentation submission requirements (records, IDD-C upload, etc..)*

# Enhanced Additional Staffing Requirements

## INDIVIDUAL

Individual Profile – the individual must have the following:

1. "Yes" to questions 2, 3, or 4 on the individual's current SIS-C or SIS-A supplemental questions.

2. Exceptional Behavior Support Needs score of 7 or higher on the individual's current SIS-C or SIS-A

| Service | Unit | Rate |
|---|---|---|
| Additional Staffing, Basic | 15-Min. | $4.67 |
| Additional Staffing, Enhanced | 15-Min. | $5.01 |

**AND**

## STAFF PROFILE

All staff billing at an enhanced rate must meet one of the following:

1. Current Registered Behavior Technicians (RBT); and/or
2. Current Certification for Direct Support Professionals through National Association for the Dually Diagnosed (NADD); and/or
3. Current Positive Behavior Support Training Curriculum 3rd edition Completion (American Association on Intellectual and Developmental Disabilities (AAIDD))

# Steps to Obtain AS

1. **Get a billable provider number for AS**
2. **Submit an Enhanced Supports Request**
3. **The Regional Field Office reviews request and processes.**

# Step 1: Ensure Provider Has a Billable AS Number

1

## Get a billable number for AS

- Provider must have a billable AS number for at least one I/DD approved active site.
- Provider can request a number through DBHDD Central Office by sending an email and attaching a copy of their current insurance to:

MHDDAD-serviceAPPS@dbhdd.ga.gov

and

Genevieve.McConico@dbhdd.ga.gov

# Step 2: Submit an Enhanced Supports Request

2

## Submit an Enhanced Supports Request

| | |
|---|---|
| Application | https://dbhdd.Georgia.gov/provider-toolkit-0 |
| Needed Documentation | • Describe all current services<br>• Provide justification for additional services |
| Submit | Region#enhancedsupports.dd@dbhdd.ga.gov |

# Step 2: Submit an Enhanced Supports Request

## 2 Submit an Enhanced Supports Request

| Utilization Manager | |
|---|---|
| **Region 1**<br>**To be announced**<br>Region1enhancedsupports.dd@dbhdd.ga.gov | **Region 4**<br>Vacant<br>Region4enhancedsupports.dd@dbhdd.ga.gov |
| **Region 2**<br>Darletha Charleston<br>Region2enhancedsupports.dd@dbhdd.ga.gov | **Region 5**<br>Patricia Speight-Oney<br>Region5enhancedsupports.dd@dbhdd.ga.gov |
| **Region 3**<br>Rhonda Flint<br>Region3enhancedsupports.dd@dbhdd.ga.gov | **Region 6**<br>Pamela Byrd<br>Region6enhancedsupports.dd@dbhdd.ga.gov |

| Documents/Records Needed with Submission of Application |
|---|
| BSP, Safety/Crisis Plan, Behavior Data Summaries and Tracking |
| Medical Support Plan |
| Healthcare Plans and Protocols |
| Relevant Legal Documentation |
| Recent Incident Reports |
| Current Home Staff Schedule and Requested Home Staff Schedule |
| Additional Information: Service Plans, School Records, IEPs, Personal Statement from Past Caregivers, Proof of Home Modifications, Doctor's Notes, updated HRST, Hospitalizations, etc. |

# Step 3: Request Reviewed by the Region

3

## Request Reviewed by the Region

- Utilization Managers (UM) reviews request and documentation within **5** business days
- Provider has **10** business days to submit additional information
- Enhanced support request determination within **60-90** business days

| Request Approved | More Information Requested | Request Denied |
|---|---|---|
| UM requests clinical assessment team to complete Nursing Assessment and/or Behavior Assessment (CABS). | UM sends a request via email for more information with details on what information is needed. | UM denies request based on Appendix H outline. See NOW/COMP Part II Manual Appendix H. |

# How to Appeal a Denial

- An individual has the right to appeal a decision.
- The appeal process and instructions are outlined in the Adverse Action – also known as the denial letter – which is sent to the individual/guardian via certified mail. The AA is also uploaded in IDD-C and notification is sent to the provider, relevant DBHDD staff and the Support Coordinator.
- There are 2 options to appeal – a division review and a fair hearing. The individual retains their right to a hearing if they request a division review first.
- To appeal, an individual (and/or guardian as applicable) must provide written request to DBHDD within 30 days of receipt

# References

**NOW/COMP Manuals:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/20/Default.aspx

**Rate Study**: https://dbhdd.georgia.gov/waiver-service-provider-rates-study

**Assessment Level Overview:** Residential and Respite Cost Study | Georgia Department of Behavioral Health and Developmental Disabilities

**Enhanced Supports Services Request Template:**
https://dbhdd.georgia.gov/provider-toolkit-0

# How Do I Stay Informed?


**If you have any questions,**
**please reach out to our Provider Information network:**

**https://dbhdd.georgia.gov/be-connected**

# Today's agenda- Part 2

- Additional Staffing
- Enhanced Supports Services Request Templates
- Provider Activities of Daily Living (ADL) Template
- Processing AS Requests at Regional Field Offices
- Submit Enhanced Supports Request Packet to the Region Enhanced Support Mailbox
- Questions & Answers


# Additional Staffing- New information for Provider Templates

# Enhanced Supports Services Request Template

**Enhanced Supports Services Request Templates**
**Additional Staffing and Exceeding Units**

**DBHDD Region:** ____

**Participant's Name:** ____
**CID#:** ____

**Initial** ☐ **Renewal** ☐ **Revision** ☐

**Submission Date to Region:** ____
**Requested Start Date of Enhanced Supports Services:** ____ **Requested End Date of Enhanced Supports Services** ____

---

**Name of Agency:** ____ **Person Submitting Request/Title:** ____

**Contact Information of Person Submitting Request:** ____ **Office** ____ **Cell** **Email Address:** ____

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**To prevent gaps in approval, please be sure to submit a completed request form including all required documentation after updating HRST 120-90 days before requested start date for renewals and 30-45 days before requested start date of revision or initial request. Note that incomplete requests will not be processed and will be returned. Please review Appendix H in Part II Chapters 600 – 1200 Policies and Procedures for Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) General Manual prior to submitting this request for a Clinical Assessment.**

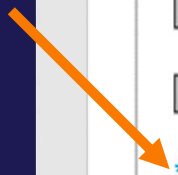
**Note that submission of this document is a request and not an approval. To ensure payment, prior approval must be granted prior to delivery of any enhanced service. For timely processing of renewal requests, please submit 120-90 days prior to the previous approval expiration.**

**Note that submission of this document is a request and not an approval. To ensure payment, prior approval must be granted prior to delivery of any enhanced service. For timely processing of renewal requests, please submit 120-90 days prior to the previous approval expiration.**

**Service Requesting Enhanced Supports:** (*check all that apply*)

☐ Community Living Supports ☐ Community Residential Alternative ☐ Community Access Group

☐ Specialized Medical Equipment ☐ Specialized Medical Supplies



***Note: If you are submitting for more than one service you must send the ADL Template for each service if AS-Medical is being requested.**

| CHECKLIST: PERTINENT RECORD DOCUMENTATION | | | |
|---|---|---|---|
| ☐ | Current BSP, Behavior data analysis monthly summary reports & graphing | ☐ | Recent progress notes (case management, residential) |
| ☐ | Current Safety/Crisis Plan | ☐ | Relevant legal documentation |
| ☐ | Current Medical support plan, Healthcare Plans/protocols | ☐ | Recent incident reports |



| | |
|---|---|
| ☐ | Additional information: service plans, school records, IEPs, personal statement from past caregivers, proof of home modifications, doctor's notes, hospitalizations etc. |

**Basis of Funding Request for Enhanced Support Services**

*Please complete selections below by checking boxes and/or filling in designated spaces*

**Extraordinary Staffing Requirements: Enhanced paraprofessional, direct care staffing ratios either shared or one on one service delivery related to the direct care of the participant.** ☐ Medical ☐ Behavioral ☐ Medical and Behavioral ☐ Communication Facilitator (Deaf Services)

**Additional Staffing Template for Community Living Supports (CLS)**

**Provider Name for CLS:** **Provider Number for CLS** **Provider Number for Additional Staffing**

**CLS Address:**

| ☐ **Lives with Family/Caretaker** | ☐ **Lives on own** | ☐ **2 Person-Shared Arrangement** | ☐ **3 Person -Shared Arrangement** |
|---|---|---|---|
| Standard Maximum CLS Extended: Average of 6 hours daily | Standard Maximum CLS Extended: Average of 6 hours daily | Standard Maximum 2 Person CLS Extended: Average of 11 hours daily | Standard Maximum 3 Person CLS Extended: Average of 15 hours daily |

**Participant who is requesting Additional Staffing:**

Enter number of hours individual participates in Day Services or Other Community Activities per week and stipulate times. (Include: CAG,CAI,SE,CIE,PreVoc,…) (Insert 0 if individual does not participate)

Enter Current Additional Staffing Hours Per Week if applicable for Participant:

**First Initial and Last Initial of Other Individual Living in Home if Shared-Arrangement and CID#**

Enter number of hours individual participates in Day Services or Other Community Activities per week and stipulate times. (Include: CAG,CAI,SE,CIE,PreVoc,…) (Insert 0 if individual does not participate)

Enter Current Additional Staffing Hours Per Week if applicable:

**First Initial and Last Initial of Other Individual Living in Home if Shared-Arrangement and CID#**

Enter number of hours individual participates in Day Services or Other Community Activities per week and stipulate times. (Include: CAG,CAI,SE,CIE,PreVoc,…) (Insert 0 if individual does not participate)

Enter Current Additional Staffing Hours Per Week if applicable:

A. **Staffing Summary:** ***Attach the current home staff schedule and the requested new home staff schedule if shared arrangement. Attach Current Additional Staffing Letters for individual and housemates if applicable.***

**1) Please explain individual's need and what prompted request for Additional Staffing (AS) i.e.: change in condition or continuation due to the following extraordinary needs….**

**2) Describe all current services (including frequency and units) the participant is receiving, and the justification of why additional services are needed outside of the current authorized services.**



B. **Explain the usage of hours within the single or shared model. If using a shared model, please explain the usage of hours in the home and attach the current home staff schedule:**

C. **Please state the number of additional hours being requested and how those hours will be utilized including time frames and days of the week? Please provide the new staff schedule of the standard maximum hours for all in home with the requested staffing for the additional hours. Information should also include times that the natural support is available and if any issues preventing natural support from contributing support.**

D. **Additional Staffing (AS) has two rates: basic and enhanced. The enhanced rate of AS may be accessed for staff with specified qualifications. Please state justification and staff credentials if requesting an enhanced AS rate:**

**Basis of Funding Request for Enhanced Support Services**

*Please complete selections below by checking boxes and/or filling in designated spaces*

**Extraordinary Staffing Requirements: Enhanced paraprofessional, direct care staffing ratios either shared or one on one service delivery related to the direct care of the participant.** ☐ Medical ☐ Behavioral ☐ Medical and Behavioral ☐ Communication Facilitator (Deaf Services)

**Additional Staffing Template for Community Residential Alternative (CRA)**

**Provider Name for CRA** **Provider Number for CRA site:** **Provider Number for Additional Staffing**
**CRA Address:** **HFR Licensed Capacity:**

☐ **Community Living Arrangement** ☐ **Personal Care Home** ☐ **Host Home**

| | |
|---|---|
| **Participant who is requesting Additional Staffing:**<br>Enter Current Tier Category for Participant from PA:<br>Enter Assessed Direct Care Tier Hours for Participant:<br>Enter Current Additional Staffing Hours Per Week if applicable: | Enter number of hours participates in Day Services or Other Community Activities per week and stipulate times. (Include CAG, CAI, SE, CIE, PreVoc, …) (Insert 0 if individual does not participate) |
| **First Initial and Last Initial of Other Individual Living in Home and CID#**<br>**Current Tier Category from PA** **Assessed Direct Care Tier Hours**<br>Enter number of hours participates in Day Services or Other Community Activities per week and stipulate times. (Include: CAG,CAI,SE,CIE,PreVoc,…)<br>(Insert 0 if individual does not participate)<br>Enter Current Additional Staffing Hours Per Week if applicable: | |

**First Initial and Last Initial of Other Individual Living in Home and CID#**

**Current Tier Category from PA** **Assessed Direct Care Tier Hours**

Enter number of hours participates in Day Services or Other Community Activities per week and stipulate times. (Include: CAG,CAI,SE,CIE,PreVoc,…)

(Insert 0 if individual does not participate)

Enter Current Additional Staffing Hours Per Week if applicable:

**First Initial and Last Initial of Other Individual Living in Home and CID#**

**Current Tier Category from PA** **Assessed Direct Care Tier Hours**

Enter number of hours participates in Day Services or Other Community Activities per week and stipulate times. (Include: CAG,CAI,SE,CIE,PreVoc,…)

(Insert 0 if individual does not participate)

Enter Current Additional Staffing Hours Per Week if applicable:

A. **Staffing Summary:** ***Attach the current home staff schedule and the requested new home staff schedule. Attach Additional Staffing Letters for individual and housemates if applicable.***

1) **Please explain individual's need and what prompted request for Additional Staffing (AS) i.e.: change in condition or continuation due to the following extraordinary needs….**

2) **Describe all current services (including frequency and units) the participant is receiving including day services and the justification of why additional services are needed outside of the current authorized services.**

B. **Explain the usage of hours within the single or shared model. If using a shared model, please explain the usage of hours for each resident in the home and attach the current home staff schedule:**

C. **Please state the number of additional hours being requested and how those hours will be utilized including time frames and days of the week? Please provide the new staff schedule of the utilization of tier hours for all in home with the requested staffing for the additional hours. Information should also include times that the natural support is available and if any issues preventing natural support from contributing support.**

D. **Additional Staffing (AS) has two rates: basic and enhanced. The enhanced rate of AS may be accessed for staff with specified qualifications. Please state justification and staff credentials if requesting enhanced AS Rate:**

**Basis of Funding Request for Enhanced Support Services**

*Please complete selections below by checking boxes and/or filling in designated spaces*

**Extraordinary Staffing Requirements: Enhanced paraprofessional, direct care staffing ratios either shared or one on one service delivery related to the direct care of the participant.** ☐ Medical ☐ Behavioral ☐ Medical and Behavioral ☐ Communication Facilitator (Deaf Services)



**Additional Staffing Template for Community Access Group (CAG)**

**Provider Name for CAG:**

**CAG Name/Address:**

A. **Current Hours Attending CAG:**

B. **Additional Staffing (AS) hours requested:** **Justification of need (include specific duties):**

C. **Please state strategies used such as lowering group ratio, attempts at using approved alternatives to human support (seatbelts, helmets, etc.), and/or using internal resources such as potential sharing staff with others in facility/group setting with similar extraordinary needs:**

D. **Additional Staffing has two rates: basic and enhanced. The enhanced rate of AS may be accessed for staff with specified qualifications. Please state justification/credentials if requesting enhanced AS Rate**

**Additional Staffing Template for Community Access Group (CAG)**

**Provider Name for CAG:**
**CAG Name/Address:**

A. **Current Hours Attending CAG:**

B. **Additional Staffing (AS) hours requested:** **Justification of need (include specific duties):**

C. **Please state strategies used such as lowering group ratio, attempts at using approved alternatives to human support (seatbelts, helmets, etc.), and/or using internal resources such as potential sharing staff with others in facility/group setting with similar extraordinary needs:**

D. **Additional Staffing has two rates: basic and enhanced. The enhanced rate of AS may be accessed for staff with specified qualifications. Please state justification/credentials if requesting enhanced AS Rate**

**Exceeding Maximum Units ($3,800) of Specialized Medical Supplies (SMS)** **Complete and attach the Itemized Budget Template*

**SMS Provider Name:**

**Justification of need:**

**Exceeding Maximum Annual Units ($5,200) of Specialized Medical Equipment (SME)** **Complete and attach the Budget Template/3 Quotes*

**SME Provider Name:**

**Justification of need:**

| COMPLETE PACKET SUBMISSION SUMMARY<br>120-90 days before requested start date for renewals and 30-45 days before requested start date of revision or initial request | | |
|---|---|---|
| Updated HRST in Data System | Completed Enhanced Supports Services Request Template | Completed Enhanced Support Services Budget Template |
| | | |



| | | |
|---|---|---|
| Crisis/Safety Plan submission is required for all Additional Staffing requests.<br><br>AS- Medical: Completed ADL Template | Behavior Support Plan is required for all requests related to behavior<br><br>Behavioral Data (12 Months or Previous Approval Period) presented in a clear and decipherable summary & graphic format | Home Staff Schedules<br>1) Current Home Staff Schedule<br>**2)** Proposed Staff Schedule with additional Supports |
| | | |

| Completion of Enhanced Supports Request Templates | | |
|---|---|---|
| **Justification** | **Providers in Community Group Settings** | **For SMS and SME** |
| 1) Additional hours or additional staff | 1) List all participants served in the setting, | 1) Medical diagnosis or condition |
| 2) Current utilization of hours within assigned tier level categories and | 2) the participants' assessment levels and | 2.) Physician Orders |
| 3.) State how you plan to use the additional hours requested. | 3.) direct support hours provided to each participant. | 3) Itemized Budget Template |

**Activities of Daily Living (ADLs)**

*Activities of daily living (ADLs) are basic tasks that must be accomplished every day for an individual to thrive.*

***All request for Additional Staffing- Medical must include the attachment, Provider ADL Template.***

***The form is in the Provider Toolkit. https://dbhdd.georgia.gov/provider-toolkit-0#toolsddproviders***

| Examples of information to include in request for behavior supports |
| --- |
| The submitted documentation/data must be comprehensive and accurately reflect multiple types of data to support the request that may include but not limited to the following **in summary and graphic format (do not submit raw data/tracking sheets).** |
| • Monthly Frequency (the number of days during the month during which behavior occurs);<br>• Daily Episodic Rate (the number of times behavior occurs within a day);<br>• Duration (length of time behavior occurs before ceasing or de-escalating to a manageable level);<br>• Time of Day (times of day behavior occurs to the nearest hour);<br>• Setting (location or environment in which behavior occurs, e.g. in/around home, at doctors office, etc.);<br>• Severity (extent of injury or damage resulting when behavior occurs);<br>• Intensity (extent of intervention needed for behavior to cease or de-escalate to a manageable level, e.g., verbal/gestural prompt, remove from area, physical blocking, brief manual restraint, multiple staff, crisis intervention, mobile crisis team, law enforcement, hospitalization, arrest); and<br>• Level of staff support (ratio of staff [e.g., 1:2, 1:1] and type of supervision [e.g., line of sight, within arm's reach] support provided throughout the day during the time period under review) |

# Behavior Supports

The clinical justifications/recommendations are data driven with analyses and documentation provided by the BSS providers. Residential providers should be discussing any concerns with data analysis and documentation with their BSS provider. The community providers should already be in regular dialogue with the BSS provider to know/understand the BSP, what data means month to month, and should be letting the BSS provider who developed the Behavior Support Plan know about any new behaviors or issues that are occurring, not contacting the DBHDD Regional Behavior Analyst (RBA).

# Behavior Supports

**BEHAVIOR SUPPORT PLAN AND SAFETY/CRISIS PLAN**

Name: Daffy "Duck" Holdon DOB: 4/27/59
Location of Program: Atlanta
Handy Provider Agency: Happy CLA Home

Implementation Date: February 2021 Review Date: February 2022

**Assessment Procedures**
Record Review
Direct Behavior Observations
Functional Assessment Interviews
Functional Analysis
Reinforcement inventory

**Background Information**

# BEHAVIOR SUPPORT PLAN MONTHLY REVIEW

Name: Daffy "Duck" Holdon DOB: 4/27/59
Location of Program: Atlanta
Handy Provider Agency: Happy CLA Home

**Month/Year: August 2020**

**Target Behaviors to Decrease**
Data for the target behaviors indicates the following:

- Verbal aggression increased from 5 to 25 times per month;
- Physical aggression also went up from 1 to 7 times;
- Staff documented 2 episodes of elopement;
- ISB increased slightly from 0 to 1.

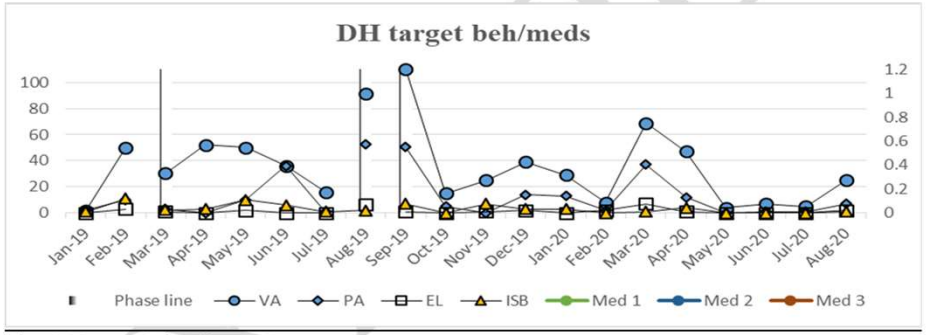
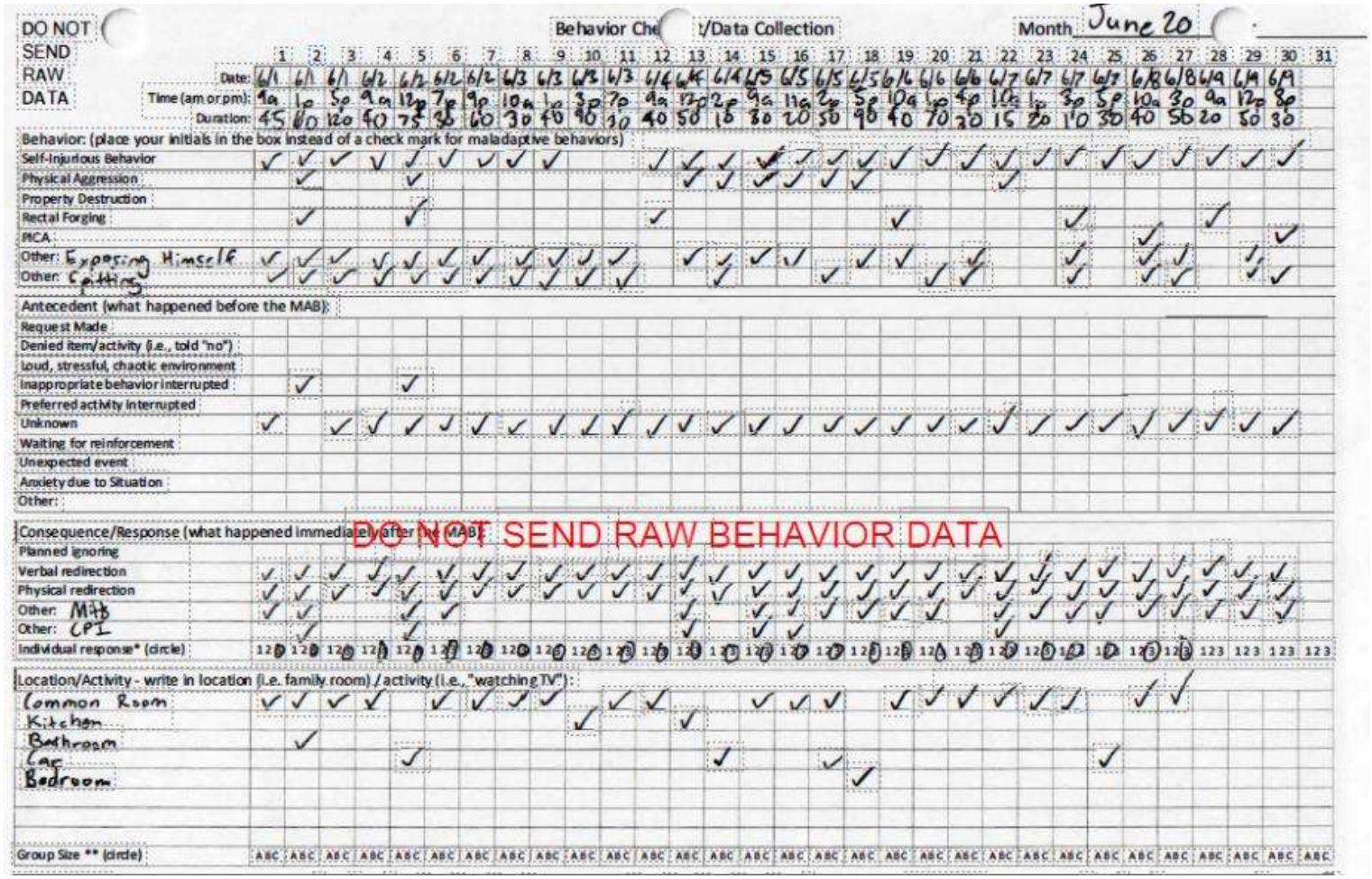



Fig. 1 Target behaviors

BSC: 2 hr. – monthly behavior report and data entry
BSS: 3 hrs. – direct observation in the group home

*Minnie Mouse, MS, BCBA*
Minnie Mouse, MS, BCBA
Behavior Analyst
404-777-7777
Minnie.Mouse@Handyprovideragency.com

Date Completed: 9/15/2020


DO NOT SEND RAW DATA
Behavior Che /Data Collection
Month June 20
Date:
Time (am or pm):
Duration:
Behavior: (place your initials in the box instead of a check mark for maladaptive behaviors)
Self-Injurious Behavior
Physical Aggression
Property Destruction
Rectal Forging
PICA
Other: Exposing Himself
Other: Spitting
Antecedent (what happened before the MAB):
Request Made
Denied item/activity (i.e., told "no")
Loud, stressful, chaotic environment
Inappropriate behavior interrupted
Preferred activity interrupted
Unknown
Waiting for reinforcement
Unexpected event
Anxiety due to Situation
Other:
Consequence/Response (what happened immediately after the MAB):
Planned ignoring
Verbal redirection
Physical redirection
Other: MAB
Other: CPI
Individual response* (circle)
Location/Activity - write in location (i.e. family room) / activity (i.e., "watching TV"):
Common Room
Kitchen
Bathroom
Car
Bedroom
Group Size ** (circle)

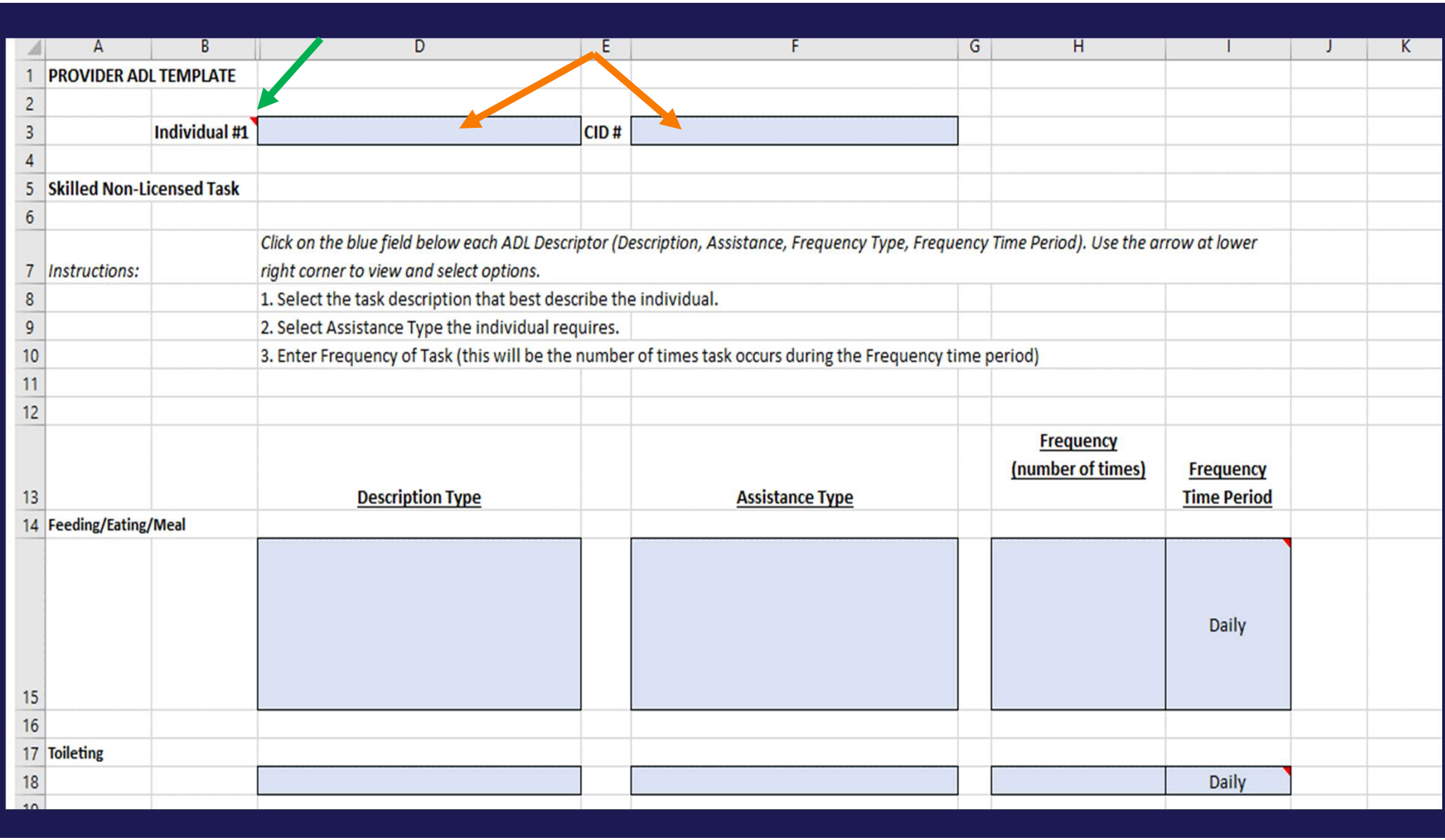
**Field Office Contacts for Enhanced Supports Requests**
**Additional Staffing (CRA/CLS/CAG) and Exceeding Maximum Units (SMS/SME)**

| Region | Position Title | Staff Name | E-mail |
|---|---|---|---|
| 1 | Utilization Manager | Email R1 Enhanced Support Box | Region1enhancedsupports.dd@dbhdd.ga.gov |
| 2 | Utilization Manager | Darletha Charleston<br>Darletha.Charleston@dbhdd.ga.gov | Region2enhancedsupports.dd@dbhdd.ga.gov |
| 3 | Utilization Manager | Rhonda Flint<br>Rhonda.Flint@dbhdd.ga.gov | Region3enhancedsupports.dd@dbhdd.ga.gov |
| 4 | Utilization Manager | Email R4 Enhanced Support Box | Region4enhancedsupports.dd@dbhdd.ga.gov |
| 5 | Utilization Manager | Patricia Speight-Oney<br>Patricia.Speight-Oney@dbhdd.ga.gov | Region5enhancedsupports.dd@dbhdd.ga.gov |
| 6 | Utilization Manager | Pamela Byrd<br>Pamela.Byrd@dbhdd.ga.gov | Region6enhancedsupports.dd@dbhdd.ga.gov |

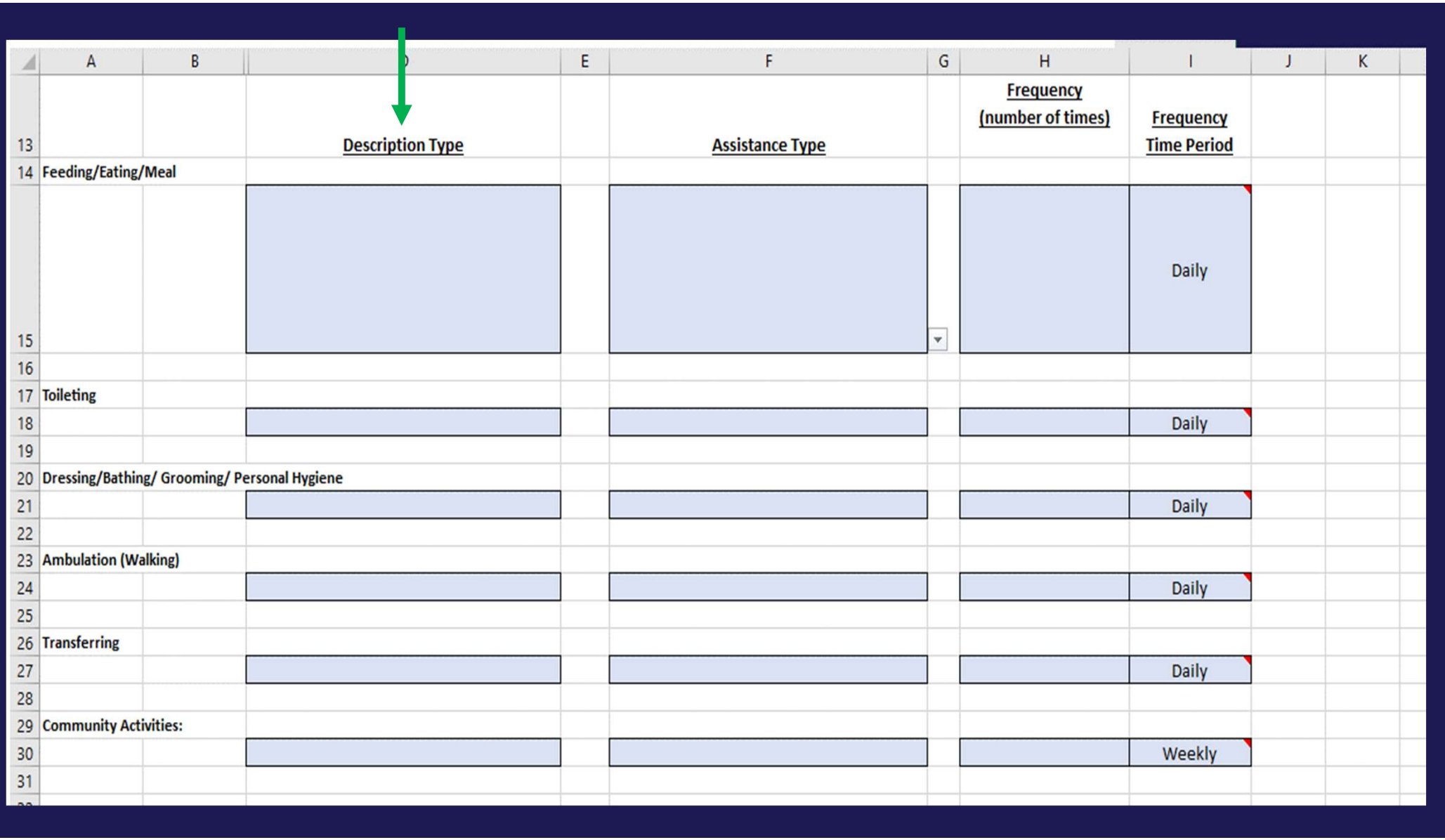
# Provider ADL Template

# Activities of Daily Living

- Feeding/Eating/Meals
- Toileting
- Dressing/Bathing/Grooming/ Personal Hygiene
- Ambulation
- Transferring
- Community Activities



| | A | B | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **PROVIDER ADL TEMPLATE** | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | **Individual #1** | | **CID #** | | | | | | |
| 4 | | | | | | | | | | |
| 5 | **Skilled Non-Licensed Task** | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | *Instructions:* | | *Click on the blue field below each ADL Descriptor (Description, Assistance, Frequency Type, Frequency Time Period). Use the arrow at lower right corner to view and select options.* | | | | | | | |
| 8 | | | 1. Select the task description that best describe the individual. | | | | | | | |
| 9 | | | 2. Select Assistance Type the individual requires. | | | | | | | |
| 10 | | | 3. Enter Frequency of Task (this will be the number of times task occurs during the Frequency time period) | | | | | | | |
| 11 | | | | | | | | | | |
| 12 | | | | | | | | | | |
| 13 | | | **Description Type** | | **Assistance Type** | | **Frequency (number of times)** | **Frequency Time Period** | | |
| 14 | **Feeding/Eating/Meal** | | | | | | | | | |
| 15 | | | | | | | | Daily | | |
| 16 | | | | | | | | | | |
| 17 | **Toileting** | | | | | | | | | |
| 18 | | | | | | | | Daily | | |



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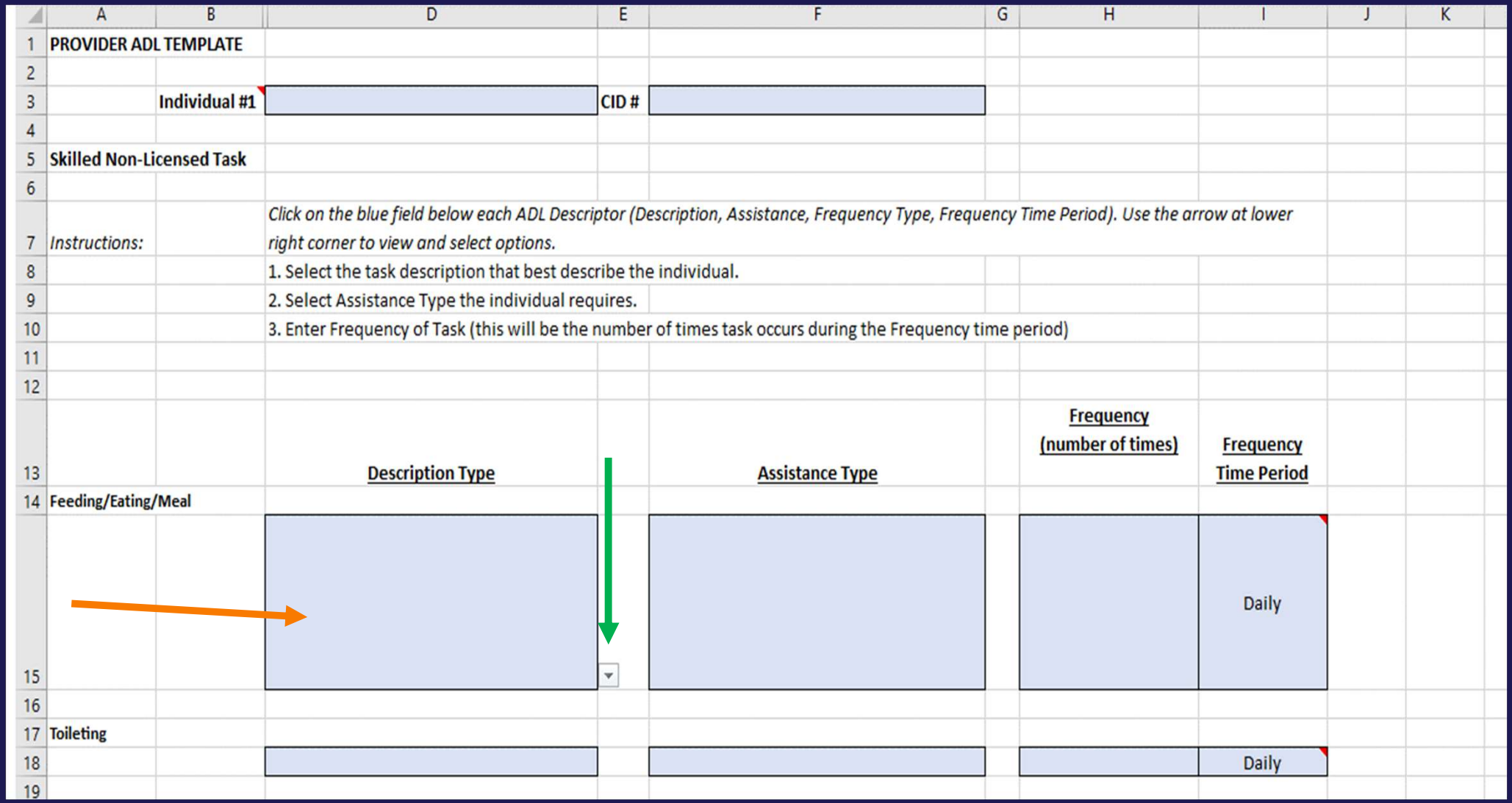
|---|---|---|---|---|---|---|---|---|---|---|
| 13 | | | Description Type | | Assistance Type | | Frequency (number of times) | Frequency Time Period | | |
| 14 | Feeding/Eating/Meal | | | | | | | | | |
| 15 | | | | | | | | Daily | | |
| 16 | | | | | | | | | | |
| 17 | Toileting | | | | | | | | | |
| 18 | | | | | | | | Daily | | |
| 19 | | | | | | | | | | |
| 20 | Dressing/Bathing/ Grooming/ Personal Hygiene | | | | | | | | | |
| 21 | | | | | | | | Daily | | |
| 22 | | | | | | | | | | |
| 23 | Ambulation (Walking) | | | | | | | | | |
| 24 | | | | | | | | Daily | | |
| 25 | | | | | | | | | | |
| 26 | Transferring | | | | | | | | | |
| 27 | | | | | | | | Daily | | |
| 28 | | | | | | | | | | |
| 29 | Community Activities: | | | | | | | | | |
| 30 | | | | | | | | Weekly | | |
| 31 | | | | | | | | | | |



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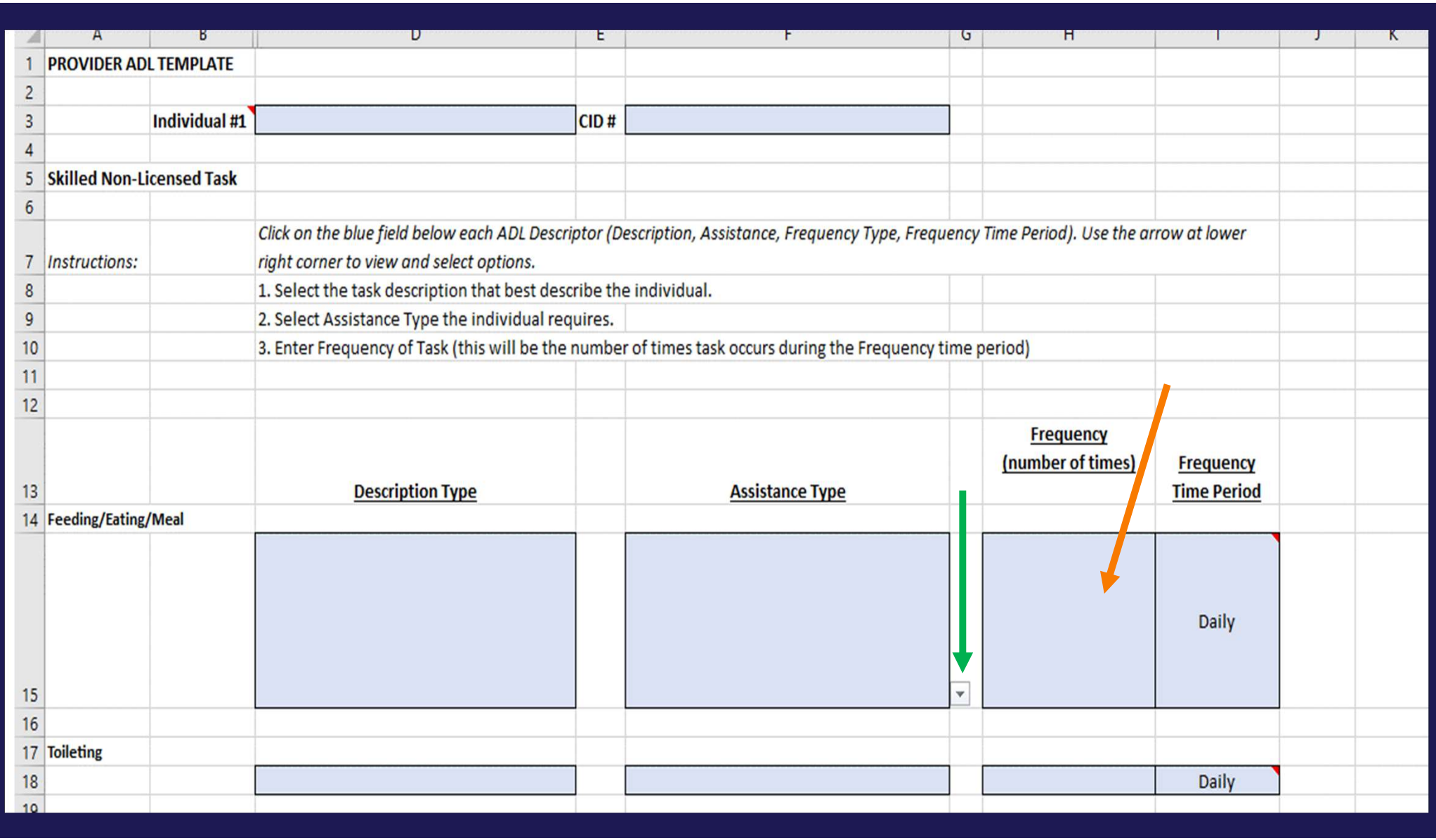
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **PROVIDER ADL TEMPLATE** | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | **Individual #1** | | **CID #** | | | | | | |
| 4 | | | | | | | | | | |
| 5 | **Skilled Non-Licensed Task** | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | *Instructions:* | | *Click on the blue field below each ADL Descriptor (Description, Assistance, Frequency Type, Frequency Time Period). Use the arrow at lower right corner to view and select options.* | | | | | | | |
| 8 | | | 1. Select the task description that best describe the individual. | | | | | | | |
| 9 | | | 2. Select Assistance Type the individual requires. | | | | | | | |
| 10 | | | 3. Enter Frequency of Task (this will be the number of times task occurs during the Frequency time period) | | | | | | | |
| 11 | | | | | | | | | | |
| 12 | | | | | | | | | | |
| 13 | | | **Description Type** | | **Assistance Type** | | **Frequency (number of times)** | **Frequency Time Period** | | |
| 14 | **Feeding/Eating/Meal** | | | | | | | | | |
| 15 | | | | | | | | Daily | | |
| 16 | | | | | | | | | | |
| 17 | **Toileting** | | | | | | | | | |
| 18 | | | | | | | | Daily | | |
| 19 | | | | | | | | | | |



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| 12 | | | | | | | | | | |
| 13 | | | **Description Type** | | **Assistance Type** | | **Frequency (number of times)** | **Frequency Time Period** | | |
| 14 | **Feeding/Eating/Meal** | | | | | | | | | |
| 15 | | | | | | | | Daily | | |
| 16 | | | | | | | | | | |
| 17 | **Toileting** | | | | | | | | | |
| 18 | | | | | | | | Daily | | |
| 19 | | | | | | | | | | |

| | A | B | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **PROVIDER ADL TEMPLATE** | | | | | | | | | |
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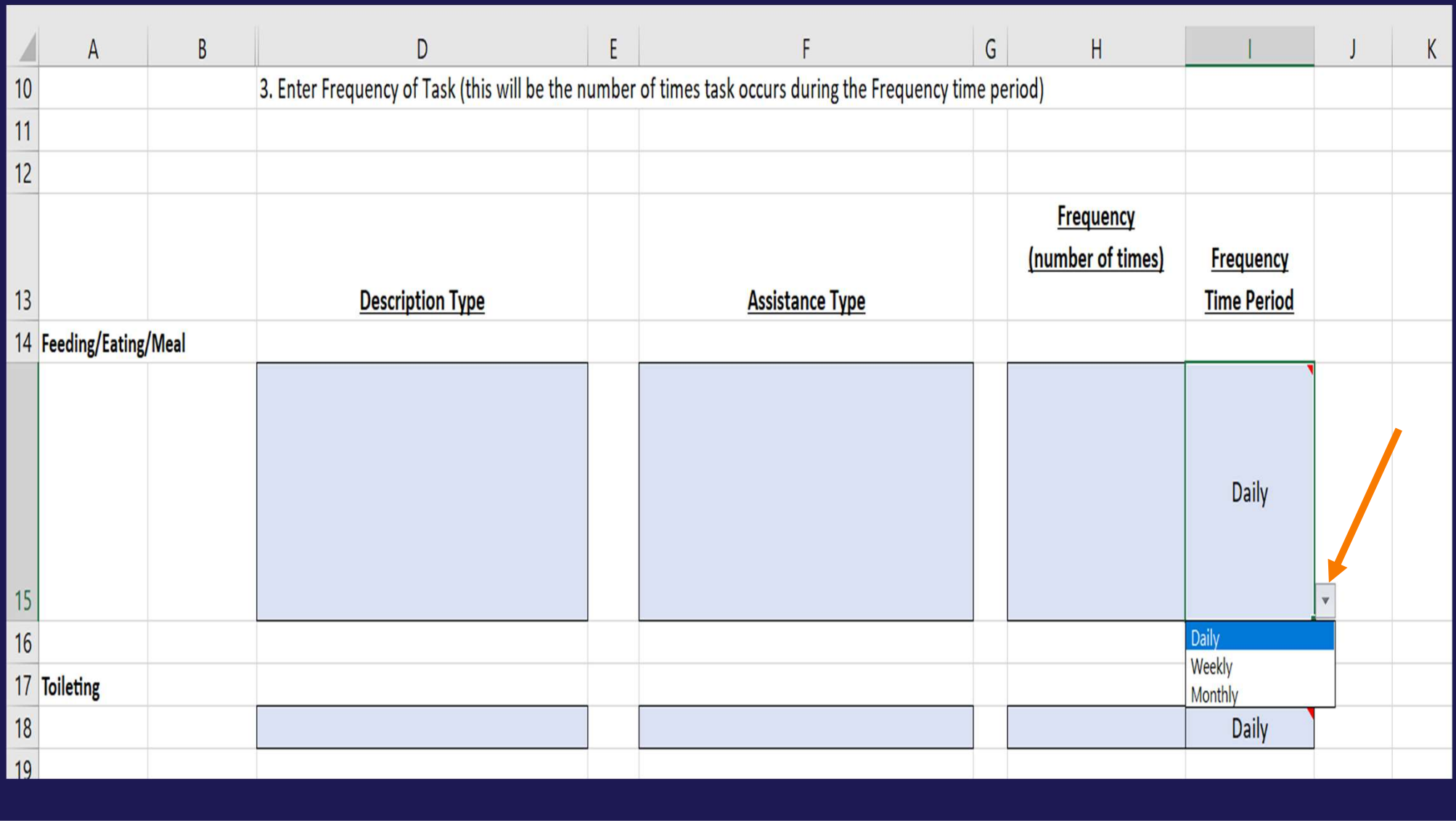
| 15 | | | | | | | | Daily | | |
| 16 | | | | | | | | | | |
| 17 | **Toileting** | | | | | | | | | |
| 18 | | | | | | | | Daily | | |
| 19 | | | | | | | | | | |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3. Enter Frequency of Task (this will be the number of times task occurs during the Frequency time period)
11
12
13
Description Type
Assistance Type
Frequency (number of times)
Frequency Time Period
14
Feeding/Eating/Meal
15
Daily
16
Daily
Weekly
Monthly
17
Toileting
18
Daily
19

# Selection Choices of Description Types for ADLs

| Activity of Daily Living | Description Type |
|---|---|
| Feeding/Eating/Meal | ▪ Verbal reminding & encouragement/standing by to assists/application of adaptation devices. Meal: Warming, cutting, serving prepared food/meal planning/helping prepare meals/snacks/cooking full meal<br>▪ Spoon feeding/special adaptation eating utensils/measurement of intake and output<br>▪ Inability to sit upright/suctioning/difficulty swallowing/total assistance with feeding. Proxy Enteral Feeding-Bolus |
| Toileting | ▪ Preparing toileting supplies/equipment/assisting with clothing during toileting/occasional help with toileting hygiene (cleaning/wiping) occasional help with catheter or colostomy/standby to assist<br>▪ Assisting on/off bedpan/assisting with the use of urinal/assisting with toileting hygiene/assisting with feminine hygiene needs/changing briefs/changing external catheter/emptying catheter bag/changing colostomy or urostomy bag<br>▪ Total assistance with toileting |

# Selection Choices of Description Types for ADLs

| Activity of Daily Living | Description Type |
|---|---|
| Dressing/Bathing/Grooming/Personal Hygiene | ▪ Dressing: Selects clothes/occasional help with zippers/buttons/socks/shoes. Bathing: Assist with bath water/supplies, minimal assistance in & out of tub for safety. Grooming: Verbal Prompt/laying out supplies/comb & brush hair<br>▪ Dressing: Consistent Assistance with all activities. Bathing: Assist with bathing/drying, assistance in & out of tub. Grooming: Assistance with shaving and brushing teeth/oral care. Wash & dry hair.<br>▪ Dressing: Total assistance with dressing. Bathing: Total assistance with bathing. Grooming: Total assistance with grooming/hair/skin care (prescribed). Total assistance with edema/wound/burn/stoma. |
| Ambulation (Walking) | ▪ Standing by to assist/assistance with putting on and off brace<br>▪ Use of gait belt/assistance with steadying walk and using steps/weaken state/assistance with wheelchair and ambulation<br>▪ Total Care should not be asked for ambulation just transfers. |

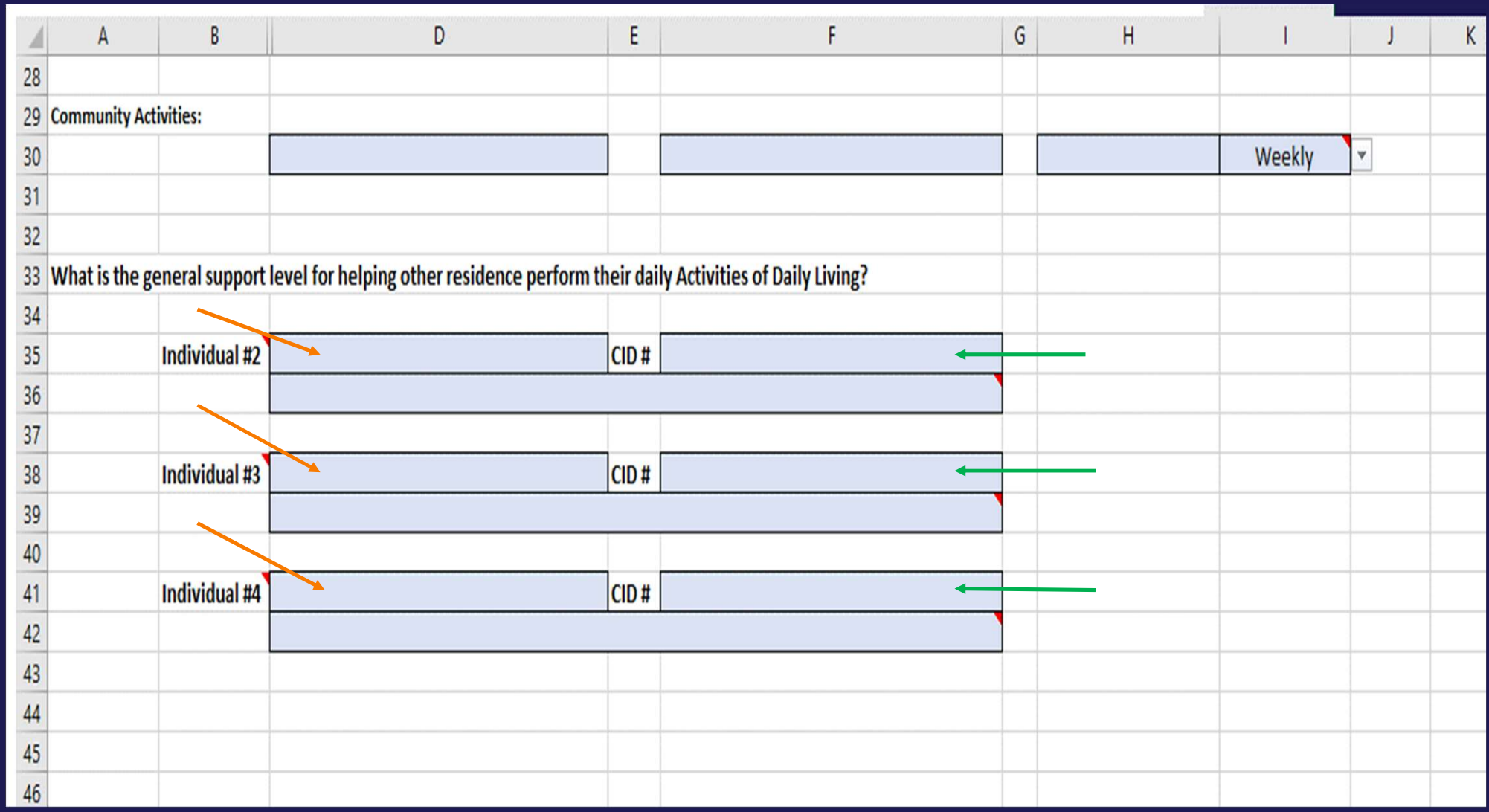
# Selection Choices of Description Types for ADLs

| Activity of Daily Living | Description Type |
|---|---|
| Transferring | ▪ Helps with positioning (adjusting/changing position)/minimal assistance in rising/standby to assist.<br>▪ Non-ambulatory/poor balance/weakened states/at risk for falls/hands-on assistance with rising from a sitting to a standing position/extensive assistance with positioning or turning/in training for use of adaptive equipment/skin care is needed.<br>▪ Unable to assist with transfer/Mechanical device used. Total assistance with positioning or transferring from bed to chair. |
| Community Activities | ▪ Preparing a shopping list/picking up extra items.<br>▪ Going to the store/assistance with shopping for all items/assistance with picking up medications/assistance with putting items away.<br>▪ Pushing wheelchair, unable to assist with transfers, total assistance with shopping, total assistance with picking up medications, total assistance with putting items away. |

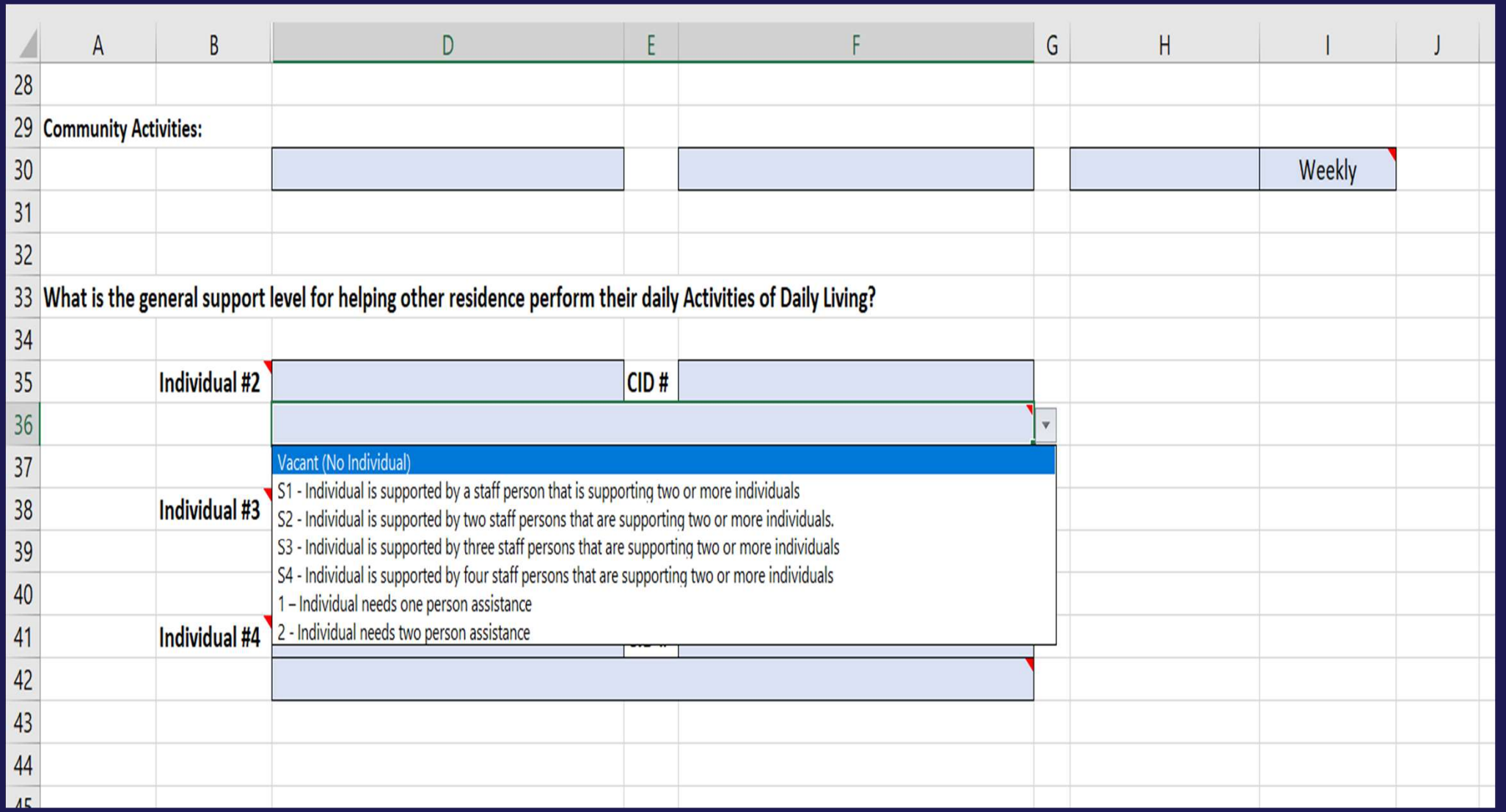
# Assistance Type

| |
|---|
| S1 - Individual is supported by a staff person that is supporting two or more Individuals. |
| S2 – Individual is supported by two staff persons that are supporting two or more Individuals. |
| S3 – Individual is supported by three staff persons that are supporting two or more Individuals. |
| S4 – Individual is supported by four staff persons that are supporting two or more Individuals. |
| 1 – Individual needs one person assistance |
| 2 – Individual needs two-person assistance |

| | A | B | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|
| 13 | | | Description Type | | Assistance Type | | Frequency (number of times) | Frequency Time Period | | |
| 14 | Feeding/Eating/Meal | | | | | | | | | |
| 15 | | | | | | | | Daily | | |
| 16 | | | | | | | | | | |
| 17 | Toileting | | | | | | | | | |
| 18 | | | | | | | | Daily | | |
| 19 | | | | | | | | | | |
| 20 | Dressing/Bathing/ Grooming/ Personal Hygiene | | | | | | | | | |
| 21 | | | | | | | | Daily | | |
| 22 | | | | | | | | | | |
| 23 | Ambulation (Walking) | | | | | | | | | |
| 24 | | | | | | | | Daily | | |
| 25 | | | | | | | | | | |
| 26 | Transferring | | | | | | | | | |
| 27 | | | | | | | | Daily | | |
| 28 | | | | | | | | | | |
| 29 | Community Activities: | | | | | | | | | |
| 30 | | | | | | | | Weekly | | |
| 31 | | | | | | | | | | |


Community Activities:
Weekly
What is the general support level for helping other residence perform their daily Activities of Daily Living?
Individual #2
CID #
Individual #3
CID #
Individual #4
CID #

| | A | B | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|
| 28 | | | | | | | | | | |
| 29 | Community Activities: | | | | | | | | | |
| 30 | | | | | | | | Weekly | | |
| 31 | | | | | | | | | | |
| 32 | | | | | | | | | | |
| 33 | What is the general support level for helping other residence perform their daily Activities of Daily Living? | | | | | | | | | |
| 34 | | | | | | | | | | |
| 35 | | Individual #2 | | CID # | | | | | | |
| 36 | | | | | | | | | | |
| 37 | | | | | | | | | | |
| 38 | | Individual #3 | | CID # | | | | | | |
| 39 | | | | | | | | | | |
| 40 | | | | | | | | | | |
| 41 | | Individual #4 | | CID # | | | | | | |
| 42 | | | | | | | | | | |
| 43 | | | | | | | | | | |
| 44 | | | | | | | | | | |
| 45 | | | | | | | | | | |
| 46 | | | | | | | | | | |
| 47 | | | | | | | | | | |
| 48 | | | | | | | | | | |
| 49 | | | | | | | | | | |


A
B
D
E
F
G
H
I
J
28
29
Community Activities:
30
Weekly
31
32
33
What is the general support level for helping other residence perform their daily Activities of Daily Living?
34
35
Individual #2
CID #
36
37
Vacant (No Individual)
38
Individual #3
S1 - Individual is supported by a staff person that is supporting two or more individuals
S2 - Individual is supported by two staff persons that are supporting two or more individuals.
39
S3 - Individual is supported by three staff persons that are supporting two or more individuals
40
S4 - Individual is supported by four staff persons that are supporting two or more individuals
1 – Individual needs one person assistance
41
Individual #4
2 - Individual needs two person assistance
42
43
44

| | A | B | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|
| 13 | | | Description Type | | Assistance Type | | Frequency (number of times) | Frequency Time Period | | |
| 14 | **Feeding/Eating/Meal** | | | | | | | | | |
| 15 | | | Inability to sit upright or suctioning or difficulty swallowing or total assistance with feeding or Proxy Enteral Feeding Bolus | | 1 – Individual needs one person assistance | | 6 | Daily | | |
| 16 | | | | | | | | | | |
| 17 | **Toileting** | | | | | | | | | |
| 18 | | | Total assistance with toileting | | 2 - Individual needs two person assistance | | 8 | Daily | | |
| 19 | | | | | | | | | | |
| 20 | **Dressing/Bathing/ Grooming/ Personal Hygiene** | | | | | | | | | |
| 21 | | | Dressing: Total assistance w/dressing. Bathing: Total assistance w/bathing. Grooming: Total Assistance w/grooming/hair/skin care/(prescribed). Total Assistance w/edema/wound/burn/stoma. | | 1 – Individual needs one person assistance | | 2 | Daily | | |
| 22 | | | | | | | | | | |
| 23 | **Ambulation (Walking)** | | | | | | | | | |
| 24 | | | Total Care should not be asked for ambulation just transfers. | | N/A | | 0 | Daily | | |
| 25 | | | | | | | | | | |
| 26 | **Transferring** | | | | | | | | | |
| 27 | | | Unable to assist with transfer/Mechanical device used. Total assistance with positioning or transferring from bed to chair. | | 2 - Individual needs two person assistance | | 5 | Daily | | |
| 28 | | | | | | | | | | |
| 29 | **Community Activities:** | | | | | | | | | |
| 30 | | | Pushing wheelchair, unable to assist with transfers, total assistance with shopping, total assistance with picking up medications, total assistance with putting item away. | | 1 – Individual needs one person assistance | | 4 | Weekly | | |

What is the general support level for helping other residence perform their daily Activities of Daily Living?

| | | | | |
|---|---|---|---|---|
| Individual #2 | Cindy Camelia | CID # | 111111111 | |
| | S2 - Individual is supported by two staff persons that are supporting two or more individuals. | | | |
| Individual #3 | Daisy Dandelion | CID # | 222222222 | |
| | S2 - Individual is supported by two staff persons that are supporting two or more individuals. | | | |
| Individual #4 | Penelope Primrose | CID # | 333333333 | |
| | S2 - Individual is supported by two staff persons that are supporting two or more individuals. | | | |

# Attach completed Provider ADL Template with the Additional Staffing Packet

# Processing AS Requests at Regional Field Offices

# Process changes

The processing of Additional Staffing requests is being decentralized with a goal of speeding the review and approval and allowing more direct communication between DBHDD and requesting providers.

Requests are sent to the Regional Field Office Enhanced Support Mailbox and reviewed by the Utilization Manager

The Utilization Manager will forward requests for the appropriate clinical review.

Office of Health and Wellness clinicians affiliated with the Region receiving the request review the request and relevant assessments.

# IMPORTANT: Additional Staffing Billing

All of the processes and assessments and reviews described in this training are for naught if you are seeking Additional Staffing and have not applied for and received your billing number for Additional Staffing.

Applying for the number after applying for Additional Staffing for an individual will result in lengthy delays in being able to bill.

# Submit Enhanced Supports Request Packet to the Region Enhanced Support Mailbox.

# Initial Submissions

**Initial Requests must be submitted 30 to 45 days prior to the expected start date. Earlier submissions are acceptable.**

**Initial submissions within 60 days of a new ISP may result in additional questions from the Regional Field Office regarding the change in circumstance and the reason the additional staffing request was not addressed in the ISP.**

# Immediate Needs

**Immediate and Critical Needs due to Changes in Condition and/or Changes in Circumstances can be addressed through policy 02-443.**

**Review the policy closely before considering this approach.**

**Additional Staffing approved through the Immediate and Critical process is TEMPORARY unless an AS request is submitted.**

# Renewal Submission Deadlines

**Renewal Requests must be submitted 90 to 120 days prior to the expiration of the current authorization.**

**Most AS approvals expire on the individual's birthday and go for the year. This allows the provider as much as 275 days to prepare and submit a timely request.**

**It is the responsibility of the provider to track AS renewals. Regardless of how many you have, it is less than the single Utilization Manager at the Regional Field Office has to process.**

# Delays

- The Office of Field Operations takes responsibility for many issues with the Additional Staffing process, even back to the Exceptional Rate process.

- When a delay is a Regional Field Office or clinician issue, we make every effort to prevent negative impact on providers. This will continue to improve in the coming months.

# Sources of Delay: Initial Review of Requests

- All submissions, whether complete, incomplete, necessary or unnecessary, must be reviewed by a Regional Utilization Manager. This is a time intensive process for a handful of staff with an increasing number of requests.

- DBHDD needs the assistance of all providers to eliminate:
  - Requests for staff provided for within the assigned tier
  - Requests for AS when an individual does not have the service for which AS is being requested (yes – it happens)
  - Requests with missing, incomplete or raw behavioral data

# Improving the Process

- Regional Utilization Managers will log and return incomplete requests quickly and with clear indication of what is missing; provider names and submitting staff will be noted. We hope that rapid return of these requests will help providers clearly understand the expectation and stop incomplete submissions.

- Regional Utilization Managers will log and return requests that do not meet minimum requirements, those that ask for staff already covered by tiered funding, and those deemed unnecessary for any other reason.

- Providers who continue to send incomplete or unnecessary submissions will be asked to repeat this training and/or tiers training.

- RSAs will schedule meetings with leadership of Providers who continue to miss submission deadlines for renewals; steps to correct this problem will be expected and results will be tracked.

# Adverse Action Letters

Adverse Action letters will continue to be sent to individuals or guardians, with email copy to the provider, when a clinical assessment results in a service reduction.

Regions will not reduce Prior Authorizations for Additional Staffing until the appeal period has passed or the appeal process is complete.

# Adverse Action Letters

Adverse Action letters will also be sent to individuals or guardians, with email copy to the provider, when a provider fails to submit a renewal request.

This letter will include a statement to the individual or guardian explaining that (name of provider) failed to submit documentation and/or data required by the Federal Centers for Medicare/Medicaid Services, the Georgia Department of Community Health and DBHDD.

# Adverse Action Letters

DO NOT rely upon this appeal process as an extension of the time to submit requests. As already mentioned, frequent failure to meet submission deadlines will have negative consequences for the provider.

If providers disagree with the approved hours for AS, they should follow the process outlined in the Adverse Action Letter and respond to request a review. Do not contact the DBHDD clinicians directly to ask for another review or bring up other information to ask the clinician to change their AS recommendations.


Questions?


BE D·B·H·D·D
Georgia Department of Behavioral Health & Developmental Disabilities
D·B·H·D·D