TITLE 404 COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

CHAPTER 9 COMMUNITY SUPPORTS PROGRAM SERVICES

9-001 OVERVIEW OF COMMUNITY SUPPORTS PROGRAM

9-001.01 Purpose: The Nebraska Health and Human Services Developmental Disabilities System (HHS-DDS) offers a system of supports and services intended to allow individuals with developmental disabilities to maximize their independence as they live, work, recreate, and participate in their communities.

The Community Supports Program (CSP) is designed as a pilot program to offer alternatives to the traditional model of services available through HHS-DDS. The traditional model provides for services consisting of day and residential habilitation and respite care, provided only by agencies certified as specialized providers of developmental disabilities services. The CSP allows for a broader array of services to be provided by developmental disability service providers and/or other community (individual or agency) providers. This is intended to give the individual more control over the type of services received and providers of those services, as well as allowing individuals to purchase services other than habilitative training.

The underlying philosophy of the Community Supports Program is to build upon the individual and family strengths and to strengthen and support informal and formal services already in place. The CSP utilizes a self-directed philosophy, designed to provide choice when determining the services and supports that are needed to maximize the independence of the person with a developmental disability. The individual has the right and responsibility to participate to the greatest extent possible in the development and implementation of his or her plan. The CSP is a funding stream that may be utilized either alone or in conjunction with other non-DD funded services and supports, as appropriate for the individual.

9-001.02 Scope: These regulations govern:

1. The provision of an array of community-based services for individuals with developmental disabilities (DD);
2. Funding of those services, including determination of an individual's eligibility and authorization of DD services; and,
3. Standards for CSP providers.

Individuals authorized for the Community Supports Program will not receive Developmental Disabilities System funding for habilitation services. CSP services are not intended to duplicate or replace other services or supports (paid or unpaid) that are available to the individual, including Medicaid State Plan services, Social Services Block Grant services, or services/supports available from other sources.

9-001.03 Legal Authority: The following state and federal laws and regulations give legal authority to the agencies of the Nebraska Health and Human Services System for the establishment, administration, and implementation of these regulations:

1. Developmental Disabilities Services Act (DDSA) (Neb. Rev. Stat. §§ 83-1201 to 83-1226);
2. Nebraska Medical Assistance Program (Neb. Rev. Stat. §§ 68-1018 to 68-1036);
3. Title 202 NAC 1, Determining Ability to Pay for Supports and Services Funded by the Nebraska Department of Health and Human Services;
4. Title XIX of the Social Security Act, including Section 1915(c) of the Social Security Act (Medicaid HCB Waiver); and
5. 42 CFR 440.180 and Part 441, Subpart G.

9-001.04 Amount: Community Support Program services may be authorized and funded at the actual cost of the services, but limited to the amount of the individual's current funding authorization for respite, day, and/or residential services or an annual cap determined by HHS-DDS, whichever is less. The annual cost cap will begin with the month the individual begins receiving community supports.

Individuals enrolled in the Community Supports Program will be subject to the same Ability to Pay requirements in 202 NAC 1 as all others in the DD System.

The cost of Service Coordination is not deducted from the annual funding amount.

The cost of assistive technology, home modifications, and vehicle modifications is not deducted from the annual funding amount. HHS-DDS will determine an annual cap for combined cost of assistive technology, home modifications, and vehicle modifications.

9-001.05 Duration: Individuals who have been authorized to receive services under the Community Supports Program may elect to discontinue those services at any time. If the individual elects to discontinue CSP services and wishes to receive habilitation services, the individual may use his/her previously determined Objective Assessment Process (OAP) funding authorization to purchase the services for which s/he is authorized.

9-002 HHS-DDS Services

9-002.01 Eligibility Criteria

9-002.01A The individual must be a legal resident of the United States and a legal resident of the State of Nebraska.

9-002.01B The individual must have a developmental disability as defined in 404 NAC 2.

9-002.02 Determination of Eligibility: Service Coordination determines eligibility for HHS-DDS funded services and notifies the individual in writing within 14 days of the final decision.

9-002.02A Reasons for Ineligibility: Service Coordination will find an individual to be ineligible if:

1. The individual does not meet the criteria listed in 404 NAC 3-002.01:
2. The individual or persons acting on his/her behalf have not supplied needed information. Note: Upon supplying this information, eligibility will be determined.

9-002.03 Waiver Eligibility: An individual is eligible for Community Supports Waiver if s/he:

1. Is authorized for Developmental Disability System Services as defined in regulations governing community-based services for persons with developmental disabilities;
2. Is 21 years old or older;
3. Does not receive services under another 1915(c) home and community-based service waiver;
4. Currently receives ICF/MR services, or meets the ICF/MR level of care criteria (see 404 NAC 9-002.03A);
5. Is eligible for Medicaid;
6. Has received an explanation of ICF/MR services and community-based waiver services;
7. Has elected to receive waiver services;
8. Has documentation of a physical exam within the past 12 months or, if the exam is waived, has written documentation from his/her physician;
9. Has been assessed to benefit from habilitation;
10. Has an Annual Supports Plan (ASP) which identifies the need for CSP services; and
11. Has a waiver eligibility assessment current within the last 12 months.

9-002.03A ICF/MR Level of Care Criteria: HHS-DDS applies the following criteria to determine the need for ICF/MR services:

1. As documented by an evaluation which was made no more than three years before the initial determination of waiver eligibility, has mental retardation or has a severe, chronic disability other than mental retardation or mental illness which:
    a. Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness;
    b. Is manifested before the age of 22 years;
    c. Is likely to continue indefinitely; and
    d. Results in:

(1) In the case of a person under three years of age, at least one developmental delay; or
(2) In the case of a person three years of age or older, a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age:
(a) Self-care;
(b) Receptive and expressive language development and use;
(c) Learning;
(d) Mobility;
(e) Self-direction;
(f) Capacity for independent living; and

2. Can benefit from habilitation directed toward-
   a. The acquisition, retention, and improvement of self-help, socialization, and adaptive skills for the individual's maximum possible independence; or
   b. For dependent individuals where no further positive growth is demonstrable, the prevention of regression or loss of current optimal functional status.

The individual is eligible if he/she meets eligibility requirements initially and on an ongoing basis. This determination is made annually by the HHS-DDS.

9-002.03B Dual Diagnosis: If an individual has a diagnosis of mental retardation or developmental disability and a diagnosis of mental illness, the diagnosis relating to developmental disability must be the primary disabling condition.

9-002.03C Application: An individual desiring to receive CSP service must apply for CSP waiver services and accept CSP services if eligible. To receive CSP waiver services:

1. A slot must be available; and
2. The individual must meet the criteria established for the Community Supports Waiver.

9-002.03D Conditions of Eligibility: The individual (or legal guardian) may request a determination of eligibility through the assigned Service Coordinator or Disability Services Specialist.

1. Individuals must be eligible and have a current authorization for Developmental Disability System habilitation services.
2. A review of eligibility is completed on an annual basis.
3. Ongoing eligibility will be determined when changes in the individual's circumstances occur.

9-002.04 Community Supports Program services may also be available through state aid funding for individuals who are eligible for Developmental Disabilities System services, but are not eligible for the home and community based waiver.

9-002.05 Types: Community support services include:

1. Personal Emergency Response System (PERS):
2. Community Living and Day Supports (CLDS);
3. Respite;
4. Assistive Technology and Supports;
5. Home Modifications; and
6. Vehicle Modifications.

9-002.06 Authorization: Community support services may be authorized if:

1. The individual is eligible for HHS-DDS services;
2. The individual has a DD funding amount authorized; and
3. The need and the amount for the specific service(s) are documented in the Annual Supports Plan (ASP). Individuals eligible for the Community Supports Program design their system of services and supports, based upon their needs and preferences as identified in their support plan.

The ASP is developed by the individual, in cooperation with his/her Service Coordinator and other appropriate persons as identified.

9-002.07 Denial of HHS-DDS Administered Funds: Authorization of community supports may be denied for any of the following reasons:

1. The Legislature has not appropriated sufficient fiscal resources to fund all services for all persons determined eligible for specialized services;
2. The individual fails to meet HHS-DDS eligibility criteria;
3. The eligible individual has not met prioritization criteria;
4. The individual, his/her legal representative, or other person on his/her behalf has not supplied needed information;
5. The individual fails to meet waiver eligibility criteria, if applying for CSP as waiver services;
6. A waiver slot is not available;
7. The individual or legal representative has chosen to receive ICF/MR services;
8. The eligible individual's needs may be met through the use of natural supports or other resources;
9. Funding for requested specialized services is available from other sources;
10. The eligible individual has not met criteria for funding available through legislative mandates or court decisions addressing specific population, groups, or order of services offered;
11. The eligible individual or legal representative has failed to apply for, and accept any federal Medicaid benefits for which s/he may be eligible and benefits from other funding sources within the Department, the State

Department of Education, and other agencies to the maximum extent possible;

12. The eligible individual or legal representative has failed to comply with requirements for continued eligibility of any federal Medicaid benefits for which s/he may be eligible and benefits from other funding sources within the Department, the State Department of Education, and other agencies to the maximum extent possible;
13. The eligible individual or legal representative has not signed documentation required by HHS-DDS;
14. The eligible individual or legal representative has failed to cooperate with, or refused the services funded by HHS-DDS; or,
15. The Annual Supports Plan has not been implemented.

9-002.08 HHS-DDS services will not be funded for individuals who reside in a nursing facility or ICF/MR. Room and board is not included in HHS-DDS funding.

9-002.08A Waiver services will not be furnished to an individual while s/he is an inpatient of a hospital, nursing facility, or ICF/MR. Room and board is not included as a cost that is reimbursed under this waiver.

9-003 DESCRIPTIONS OF COMMUNITY SUPPORTS: The following supports are available under the community supports program.

9-003.01 Personal Emergency Response Systems (PERS): PERS is an electronic device which enables individuals to secure help in an emergency.

The individual may also wear a portable PERS button to allow for mobility.

9-003.01A PERS services are limited to those individuals who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

9-003.02 Community Living and Day Supports (CLDS): CLDS provides the necessary assistance and supports to meet the daily needs of the individual. These services and supports are provided to ensure adequate functioning in the individual's home, as well as assisting the individual to participate in a wide range of activities outside the home. CLDS also provides the necessary assistance and supports to meet the employment and/or day service needs of the individual in integrated, community settings.

9-003.02A Assistance with personal care needs or household activities is available only to those individuals who live alone or with an unpaid caregiver. A paid caregiver is an individual or agency paid to provide services to meet the individual's daily needs. Family members cannot be approved as paid caregivers. This does not include payments made for room and board.

9-003.02B The Community Living and Day Supports service is intended to provide necessary supports for the individual, but is not intended to duplicate or replace other supports available to the individual. Household activities and home maintenance activities are for the purpose of fulfilling duties the individual would be expected to do to contribute to the operation of the household, if it were not for the individual's disability.

9-003.02C Transportation to and from community activities is not covered as a separate component under this service. Fees, membership costs, and equipment costs related to social, leisure, and recreational outings are not covered under this service.

9-003.02D The Community Living and Day Supports service includes the following components:

1. Individual assistance with hygiene, bathing, eating, dressing, grooming, toileting, menstrual care, transferring, or basic first aid. Routine health care supports may be furnished to the extent permitted under Nebraska state law.
2. Supervision and monitoring for the purpose of ensuring the individual's health and safety.
3. Supports to enable the individual to access the community. This may include someone hired to accompany and support the individual in all types of community settings. Individual assistance with money management and personal finances may be provided, but the provider cannot act as the representative payee.
4. Supports to assist the individual to develop self-advocacy skills, exercise rights as a citizen, and acquire skills needed to exercise control and responsibility over other support services, including managing generic community resources and informal supports.
5. Supports to assist the individual in identifying and sustaining a personal support network of family, friends, and associates.
6. Household activities necessary to maintain a home living environment on a day-to-day basis, such as meal preparation, shopping, cleaning, and laundry.
7. Home maintenance activities needed to maintain the home in a clean, sanitary, and safe environment. This may include heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement and as required by law, will be examined prior to any authorization of service. The individual must supply necessary cleaning products and equipment when a provider cleans or cares for household equipment, appliances, or furnishings in the individual's home.
8. Supports to enable the individual to maintain or obtain employment. This may include someone hired to accompany and support the individual in an integrated work setting. Integrated

settings are those considered as available to all members of the community. Payment for the work performed by the individual is the responsibility of the employer. Covered services do not include those provided in specialized developmental disability provider settings, workstations, or supported employment services.

9. Supports to enable the individual to access services and opportunities available in community settings. This may include accessing general community activities, performing community volunteer work, and accessing services provided in community settings such as senior centers and adult day centers. Supports provided under CLDS must be those that are above and beyond the usual services provided in such a setting and not duplicate services expected to be the responsibility of the center.

9-003.03 Respite: Respite is the temporary, intermittent relief to the usual non-paid caregiver from the continuous support and care of the individual. This service is available only to those individuals who live with the usual non-paid caregiver(s). The term "usual non-paid caregiver" means a person who resides with the individual, is not paid to provide services, and is responsible on a 24-hour per day basis for the care and supervision of the individual. Respite cannot be provided by members of the individual's immediate household. These services may be provided in the individual's living situation and/or in the community.

9.003.03A Components of the respite service are:

1. Supervision;
2. Tasks related to the individual's physical and psychological needs; and,
3. Social/recreational activities.

Respite funding is available from one HHSS program source only.

9-003.04 Assistive Technology and Supports (ATS): ATS includes devices, controls, or appliances that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment they live in, thus decreasing their need for assistance from others. HHS-DDS has final authority to determine coverage of ATS.

9-003.04A Approvable items are limited to those necessary to support individuals in their home and must be appropriate to the needs of the individual as a result of limitations due to disability. An assessment will be completed to assist the individual to find an appropriate ATS solution. All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design, and installation.

Examples of ATS include the following items: reachers, magnifiers, hand-held showers, trouser pulls, built-up shoe horns, bowl holders, pan holders, suction brushes, jar and bottle openers, and spring scissors.

9-003.04B Items that are not covered include: items covered or coverable by Medicaid, recreational and/or exercise items, security items, devices or modifications already purchased or completed, computers (some exceptions may apply), furniture or appliances, air conditioners, clothing or bedding, or disposable medical or hygiene supplies.

9-003.05 Home Modifications: Home Modifications are those physical adaptations to the individual's home that are necessary to ensure the health, welfare, and safety of the individual, and/or which enable the individual to function with greater independence in the home.

9-003.05A Approvable modifications are limited to those necessary to maintain the individual in his/her home. Examples of approvable home modifications include:

1. Installing ramps, lifts, door levers, and grab-bars;
2. Building an accessible entrance into the home;
3. Widening interior doors to provide accessible routes of travel within the home to the bedroom, bathroom, and kitchen;
4. Modifying existing bathrooms to add roll-in showers, raised toilets, roll-under sinks; and
5. Adapting electric and plumbing systems to support assistive equipment, such as chair lifts and bathroom facilities.

9-003.05B Approvable modifications do not include adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual. Examples of home modifications that may not be approved include:

1. Home maintenance and repair such as carpeting or roof repair;
2. Access to the basement for use as a storm shelter or recreation;
3. Recreational pools and decks;
4. Remodeling not related to accessibility or disability-related needs;
5. New construction (exception may be made in cases where the existing bathroom cannot be modified for accessibility);
6. Restrictive modifications that replace supervision, such as half-doors, fences, and security items. Items which assist in supervision and are specifically related to the individual's needs due to disability may be considered, if necessary to ensure safety;
7. Central air conditioning; and
8. Adaptations which add to the total square footage of the home.

9-003.05C Conditions of Approval:

1. HHS-DDS must not approve home modifications if the adaptations are available under the Medicaid State Plan or from a third party source.
2. The provider of home modifications must comply with applicable state or local building codes and/or applicable standards of manufacturing, design, and installation.
3. The individual's home must not present a health and safety risk to the individual other than that corrected by the approved home modifications.
4. If the family resides in a rental unit, the family must obtain written assurance from the landlord that the property will be made available to an individual with a disability for a period of at least three years after the funding of approved home modifications by listing the property for rent on www.housing.ne.gov.

9-003.06 Vehicle Modifications: Modifications to vehicles may be made for purposes of accessibility when the vehicle is privately owned by the individual or his/her family and is used to meet the individual's transportation needs. The vehicle must be in good operating condition and modifications must be made in accordance with applicable standards of manufacturing, design, and installation. An assessment will be completed to determine the appropriate vehicle modification solution for the individual.

9-004 ANNUAL SUPPORTS PLAN

9-004.01 Self-Directed Plan: Persons eligible for the Community Supports program must have an Annual Supports Plan developed before the initiation of services. This person-centered and self-directed plan must be individually tailored to address the unique preferences and needs of the person.

9-004.02 Annual Supports Plan Team Members: The individual or the legal representative, if applicable, must determine who will be participants in the planning process. This must include at least the individual, the Service Coordinator, and the legal representative if there is one.

9-004.03 Contents of ASP: The Annual Supports Plan must identify the needs and preferences of the individual and specify how those needs will be addressed. This must include identification of services and supports to be provided within the cost caps of the Community Supports Program, as well as services and supports to be provided by other non-DD funded resources.

9-004.04 Development of ASP: Requests for Community Supports Program funding will likely be for diverse and varied services and supports, some of which may never have been purchased under past service models. The following must be considered and documented when developing the individual's support plan. The HHS Disability Services Specialist will approve ASP's.

These considerations will assist HHS staff before authorizing services to determine whether the requested services/supports are a sound and valid use of the Community Supports Program. Additionally, these considerations will bring consistency and cost efficiency to the types of services/supports purchased. Considerations include:

1. Reasonable attempts must be made to meet the needs through natural supports or through alternate sources of funding before utilizing Community Supports funding.
2. The purpose of the Community Supports program is to, "with reasonable expectation", meet the health and safety needs of individuals with developmental disabilities.
3. Consideration should be given to whether the request enhances the individual's ability to live, work, and recreate in their community.
4. Safeguards or back-up plans need to be in place in the event of failure of the plan to meet the individual's needs. The individual and/or legal representative must be aware of and willing to assume the risks and responsibilities associated with the CSP.
5. Consideration should be given to whether there is a reasonable alternative to the request. (i.e., Is the request "reasonable and prudent" in its use of public funds?)

If a request is denied, attempts should be made to offer reasonable alternatives or help in developing natural or other supports to meet the need.

9-004.05 Semi-annual Review: The team (see 404 NAC 9-004.02) must review the Supports Plan at a minimum semi-annually.

9-005 SERVICE AUTHORIZATION PROCESS

9-005.01 Following the development of the Annual Supports Plan, the individual, legal representative, and family, as appropriate, will work with the Service Coordinator and other designated HHS staff to locate providers to deliver the services. See Provider Contracting section at 404 NAC 9-006.11 for further information regarding this process. HHS staff will use program standards and guidelines to develop appropriate service authorizations based upon the HHS-DDS funding authorization.

9-006 PROVIDER STANDARDS

9-006.01 CSP Providers: Providers of CSP services may be individuals or agencies. All providers of CSP services must be Medicaid providers as described in 471 NAC 2-000. Providers must meet all other established standards and complete the HHS enrollment process in order to be authorized to receive payment for the provision of those services.

Provider contracts are established for a maximum of one year. To continue as a provider, each contract must be renewed annually. Contracts may be terminated at any time it is determined that the provider no longer meets the program standards.

9-006.02 General Standards: All providers of CSP services who have direct contact with the individual receiving CSP services must:

1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people with developmental disabilities;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with developmental disabilities;
6. Exhibit the capacity to:
   a. Assume responsibility;
   b. Follow emergency procedures;
   c. Maintain schedules; and
   d. Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement that the provider is able to perform the services, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

9-006.03 General Conditions: All providers of CSP services must:

1. Not be the usual responsible caregiver or legally responsible relative;
2. Not assign or transfer duties, responsibilities or payment for the authorized service to any entity or person other than the provider named in the service provider agreement;
3. Not provide service before receiving a provider authorization for each service for each individual;
4. Provide services only as authorized in accordance with HHS standards;
5. Accept Medicaid reimbursement as payment in full for the authorized waiver service, with no additional charges made to the individual or family for the authorized waiver service;
6. Accept a rate which does not exceed the amount charged to private-paying persons;
7. Not discriminate in service provision between individuals receiving CSP services and other individuals;
8. Meet applicable licensure or certification requirements and maintain current licensure or certification;

9. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State;
10. Be a United States citizen or an alien who is authorized by the federal government to work in the United States;
11. Provide a Social Security number or federal identification (FID) number to HHS before contracting;
12. Submit claims for service only after the service has been provided and within 90 days;
13. Furnish all financial records at the request of HHS;
14. Permit HHS to monitor and evaluate services by:
    a. Inspecting the setting;
    b. Observing service delivery;
    c. Interviewing the provider or other staff members; or
    d. Similar methods;
15. Permit HHS to recover funds paid erroneously; and
16. Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of any CSP service.

9-006.04 Record Keeping: Providers of CSP services must maintain for six years the following material:

1. Documentation which supports selection and provision of services under the ASP to each individual, including dates of service provision and identification of provider;
2. Financial information necessary to allow for an independent audit;
3. Documentation which supports requests for payment; and
4. Provider agreements.

9-006.05 Reports of Neglect or Abuse: HHS will complete an annual check of the HHSS Central Register of Child Protection Cases, the HHSS Adult Protective Services Central Registry, and the Nebraska State Patrol Sex Offender Registry before entering into an annual provider agreement with individuals providing Community Living and Day Supports service and Respite.

9-006.05A Required Checks: The following persons must sign a statement agreeing to a check of the HHSS Central Register of Child Protection Cases, the HHSS Adult Protective Services Central Registry, and the Nebraska State Patrol Sex Offender Registry:

1. A person applying to be a provider of CSP services, before approval;
2. A provider of CLDS or Respite services, annually;
3. Any member of the provider's household if services will be provided in the provider's home, before approval, and annually thereafter.

9-006.05B Denial of Authorization: HHS must not authorize a person with a substantiated report on the Adult Protective Services Central Registry or an inconclusive report on the Central Register of Child Protection to provide CSP services. If HHS receives substantiated report on the Adult Protective Services Central Registry or an inconclusive report on the Central Register of Child Protection on a current provider or household member when services are in the provider's home, HHS must immediately terminate the provider authorization. HHS must not authorize a person on the Nebraska Sex Offender Registry to provide CSP services.

9-006.06 Criminal History

9-006.06A Felony/Misdemeanor Statements: The following persons must sign a statement giving information about current charges, pending indictments, and convictions regarding felony or misdemeanor actions:

1. A person applying to be a provider of CSP services, prior to approval;
2. A provider of CSP services, annually;
3. Any member of the provider's household if services will be provided in the provider's home, prior to approval and annually thereafter.

9-006.06B Follow-up Information: If additional information is needed to evaluate the criminal history of the provider or household member, HHS will:

1. Obtain a release of information from the provider or household member; and
2. Request information available from law enforcement.

HHS may deny or terminate provider approval of an applicant or provider who refuses to sign a release of information.

9-006.07 Denial/Termination of Provider Agreement: HHS will not approve or will terminate as a provider of CSP services any person who:

1. Has been convicted of, has admitted to, or against whom there is substantial evidence of crimes:
   a. Against a child or vulnerable adult;
   b. Involving intentional bodily harm;
   c. Involving the illegal use of a controlled substance; or
   d. Involving moral turpitude; and
2. Has as a household member a person who has been convicted of, has admitted to or against whom there is substantial evidence of crimes (if services are to be provided in the provider's home):
   a. Against a child or vulnerable adult;
   b. Involving intentional bodily harm;
   c. Involving the illegal use of a controlled substance; or

d. Involving moral turpitude.

9-006.08 Provider's Right to Contest a Decision: A provider of CSP services has the right to appeal for a hearing on an action that has a direct adverse effect on the provider (see 471 NAC 2-003). Hearings are scheduled and conducted according to the procedures in 465 NAC 6-000.

9-006.09 Specific Service Provider Standards: These are the specific standards that persons who provide particular types of CSP services must meet whether operating independently or through an agency. Service providers must meet general provider standards and conditions and standards specific to each service provided.

9-006.09A Personal Emergency Response Systems (PERS): A provider of PERS must:

1. Instruct the individual about how to use the PERS device;
2. Obtain the individual's or authorized representative's signature verifying receipt of the PERS unit;
3. Ensure that response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days per week;
4. Furnish a replacement PERS unit to the individual within 24 hours of notification of malfunction of the original unit while it is being repaired;
5. Update list of responder and contact names at a minimum semi-annually to ensure accurate and correct information;
6. Ensure monthly testing of the PERS unit; and
7. Furnish ongoing assistance when needed to evaluate and adjust the PERS device or to instruct the individual in the use of PERS devices, as well as to provide for system performance checks.

9-006.09B Community Living and Day Supports (CLDS): A provider of CLDS must:

1. Be age 19 or older;
2. Have knowledge of basic first aid skills and of available emergency medical resources, if providing components other than household activities or chore services;
3. If providing services in the individual's home, exercise reasonable caution and care in the home and in the use and storage of the individual's equipment, appliances, tools, and supplies;
4. Have knowledge and understanding of the needs of persons with developmental disabilities; and
5. Have training and/or experience in the performance of the service or similar services.

9-006.09C Respite: A provider of Respite must:

1. Be age 19 or older;
2. Not be a member of the individual's immediate household; and

3. Have knowledge of basic first aid skills and of emergency responses;
4. Agree never to leave the individual alone; and
5. Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as explained by the usual caregiver.

9-006-09C1 Agency Providers: If Respite is provided by an agency, the agency must be licensed and:

1. Employ respite staff based upon their qualifications, experience, and demonstrated abilities;
2. Provide training to ensure that respite staff are qualified to provide the necessary level of care and agree to make training plans available to HHS, if requested; and
3. Ensure adequate availability and quality of service.

9-006.09C2 Out of Home Providers: If Respite is provided outside of the family home, the family must visit the facility or home in which the service is to be provided and agree to the provision of services in that location. The provider must ensure that:

1. The home/facility is architecturally designed to accommodate the needs of the individuals being served;
2. An operable telephone and emergency phone numbers are available;
3. The home/facility is accessible to the individual, clean, in good repair, free from hazards, and free of rodents and insects;
4. The home/facility is equipped to provide comfortable temperature and ventilation conditions.
5. The toilet facilities are clean and in working order;
6. The eating areas and equipment are clean and in good repair;
7. The home/facility is free from fire hazards;
8. The furnace and water heater are located safely;
9. Firearms are in a locked unit;
10. Medications and poisons are inaccessible; and
11. Household pets have all necessary vaccinations.

9-006.09D Assistive Technology and Supports (ATS): A provider of ATS must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation.

9-006.09D1 The Nebraska Department of Education Assistive Technology Partnership (ATP) provides consultation for ATS.

9-006.09D1a Consultation provided by ATP must meet the contractual obligations and terms of the proposal as agreed upon by ATP and HHS-DDS.

9-006.09D1b: ATP must maintain the following in each individual file:

1. The ATP Assessment Report which includes a summary of needs and current support, recommendations, cost estimate, cost coordination, if needed, and recommended vendor;
2. Notice of eligibility or ineligibility of ATS services;
3. Authorization of ATS services;
4. Documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
5. Copy of signed vendor bill and signed consumer acceptance form; and
6. Narrative summary.

9-006.09E Home Modifications: A provider of home modification services must:

1. Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
2. Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;
3. Ensure all products and materials installed conform to specifications. The provider must not use “blemished,” “seconds,” or reused building materials unless otherwise noted in the quote and approved before installation;
5. Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;
6. Warrant all work, materials, and products for a minimum of one year; and
7. Ensure any and all subcontractor’s work will conform to the terms and conditions of this contract and accept sole responsibility.

9-006.09E1 The Nebraska Department of Education Assistive Technology Partnership (ATP) provides consultation for home modification services.

9-006.09E1a Consultation provided by ATP must meet the contractual obligations and terms of the proposal as agreed upon by ATP and HHS-DDS.

9-006.09E1b ATP must maintain the following in each individual file:

1. The ATP Assessment Report which includes a summary of needs and current support, recommendations, cost estimate, cost coordination, if needed, and recommended vendor;
2. Notice of eligibility or ineligibility of home modification services;
3. Authorization of home modification services;
4. Documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
5. Copy of signed vendor bill and signed consumer acceptance form; and
6. Narrative summary.

9-006.09F Vehicle Modifications: A provider of vehicle modification services must:

1. Ensure that the vehicle is in good operating condition;
2. Perform modifications in accordance with applicable standards of manufacturing, design, and installation.

9-006.09F1 The Nebraska Department of Education Assistive Technology Partnership (ATP) provides consultation for vehicle modification services.

9-006.09F1a Consultation provided by ATP must meet the contractual obligations and terms of the proposal as agreed upon by ATP and HHS-DDS.

9-006.09F1b ATP must maintain the following in each individual file:

1. The ATP Assessment Report which includes a summary of needs and current support, recommendations, cost estimate, cost coordination, if needed, and recommended vendor;
2. Notice of eligibility or ineligibility of vehicle modification services;
3. Authorization of vehicle modification services;

4. Documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
5. Copy of signed vendor bill and signed consumer acceptance form; and
6. Narrative summary.

9-006.10 Provider Rates: HHS-DDS establishes a range of rates, including a maximum rate for each CSP service. Rates will be individually negotiated within the established maximum with each provider for each service. Agreed-upon rates will be contingent upon the service to be performed, availability of qualified providers, and the qualifications and experience of the provider. The rates paid to providers of these services must be usual and customary or less for similar services in the community. The rates and amount of services must take into consideration the annual cap amount available to the individual.

9-006.11 Provider Contracting: The following process must be utilized when enrolling providers:

9-006.11A Provider Identification: The individual or legal representative, as appropriate, must identify potential providers for the CSP services. Assistance in locating providers may be given by others such as family members, the Service Coordinator, community members, etc. as appropriate and as needed. Other HHS staff may also serve as resources to assist in identifying providers.

9-006.11B Background Checks: Once a potential provider has been identified, a request will be made for the initial background checks as required by the CSP provider standards to be completed by the designated HHS Service Area staff.

9-006.11C Negotiation: After it has been determined that the potential provider meets the general and specific provider standards, the individual or legal representative will work with that provider to determine the specific tasks to be performed, schedule for provision of services, and the rate requested to be paid to the provider (within the established rate structure). This may be done with the assistance of the Service Coordinator or other HHS staff, as needed.

9-006.11D HHS Approval: When the individual/legal representative and the provider have reached agreement on the services to be provided, schedule, and rate, the contracting process will be completed by designated HHS Service Area staff. This will involve final determination that the provider meets the provider standards, understands the program requirements, and has agreed to provide the services as specified by the support plan for the agreed-upon rate.

9-006.12 Provider Billing and Payment

9-006.12A Billing For Services Delivered: Providers must submit claims and a service calendar, when applicable, for services rendered, to the individual or legal representative for their review and approval.

9-006.12B HHS Approval: Once approved and signed by the individual or designated family member, claims must be submitted to the designated HHS staff for verification, approval, and processing.

9-006.12C Provider Social Security Tax Withholding: HHS withholds Social Security taxes (Federal Insurance Contribution Act, FICA) when:

1. An in-home service is provided by an individual not affiliated with an agency;
2. Services are provided in each calendar year in which the provider is paid a federally determined amount or more for services to one individual. If earnings do not reach this annual amount for FICA service per individual, the amount withheld for that year is refunded.

HHS Finance and Support remits to the Internal Revenue Service an amount equal to the current Social Security tax rate for specified “in-home” services. Half of this amount is withheld from the provider as the employee’s share; the other half is provided by HHS F&S on behalf of the individual employer.

9-006.12D Income Taxes: HHS does not withhold amounts for personal income tax purposes.

9-007 APPEAL PROCESSES

9-007.01 Individual’s Right to Contest a Decision: Individuals in the Community Support Program may appeal decisions made by HHS as specified in 404 NAC 3-002.07.