DIVISION OF DEVELOPMENTAL DISABILITIES

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

No. 3 **DATE: 4/5/92**

TO: District Program Administrators/Managers

FROM: Sam T. Thurmond
Assistant Director
Division of Developmental Disabilities

SUBJECT: Personnel Actions

This will establish and confirm that effective upon receipt of this Directive, ALL Personnel Actions (PD-505s, IR-101s and Personnel Action Transmittals) will be processed through the Division's Personnel Office. These Personnel Actions MUST be routed to the Division's Personnel Office, Site Code 791A, for my signature. Once the personnel paperwork is sent to the Division's Personnel Office, only District Personnel Liaisons SHOULD contact this office with any questions.

In addition, the following Disciplinary Actions must be coordinated with the Division's Personnel Office:

- Memos of Concern
- Reprimands
- Suspensions
- Terminations During Probation
- Extensions of Probation
- Reversions
- Administrative Leave
- Notice of Charges Letter
- Dismissals

The only individuals authorized to contact the Attorney General's Office regarding personnel matters are the District Program Administrator/District Program Manager, Personnel Manager and Assistant Director. If the District Program Administrator/District Program Manager calls the Attorney General's Office directly, a follow-up call must be made to the Personnel Manager immediately thereafter.

Thank you.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

No. 4 **DATE: 4/7/92**

TO: All Central Office Program Administrators
All District Program Administrators/Managers

FROM: Sam T. Thurmond
Assistant Director
Division of Developmental Disabilities

SUBJECT: Staff Development and Training

Effective May 1, 1992, all activities related to in-service and out-service training for the Division must be coordinated through the Central Office.

This includes the internal design, development and delivery of all staff and provider training as well as the external, contractual procurement of professionals and outside training services.

The following identifies the broad parameters under which this process will be facilitated.

A. Design and Development

1. The Statewide Training Coordinator Committee will establish formal systematic processes to identify and assess statewide training needs.

2. The Statewide Training Coordinator will facilitate the development of all proposed curricula and materials to be utilized for staff and provider training, as well as the review and revision of those currently in existence, to promote statewide consistency.

B. Delivery

All enrollments or attendance at any training session, workshop or conference must be coordinated through the Statewide Training Coordinator or the District Training Coordinator.

External Contract Training

All Requests for Quotes and Requests for Proposals for professional and outside training services must be coordinated through the Statewide or District Training Coordinator for purposes of review, comment and recommendation to management regarding the feasibility of a particular training. This must occur prior to the publication of the Request for Quotes or Proposals.

C. Evaluation and Monitoring

The Statewide Training Coordinator will be responsible for facilitating evaluation and monitoring of all training courses and sessions. Where applicable, this will be done in conjunction with other monitoring functions.

I will administer this Directive through the Statewide Training Coordinator, with input from the District Training Coordinators. The Statewide Training Coordinator is the designated Central Office contact for any questions or clarification.

Thank you.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

No. 5 **DATE: 5/8/92**

TO: All Central Contract Negotiation Teams
All District Program Administrators/Managers

FROM: Sam T. Thurmond
Assistant Director
Division of Developmental Disabilities

SUBJECT: Contract Standards

EFFECTIVE DATE: All Contract Effective Dates

This will establish and confirm that effective with your receipt of this Directive, all contract negotiations will follow the standards listed below:

- Units for 24 hour residential and room and board will be calculated as the number of clients X 365 days. UNIT = DAY

- Units for adult day services, except supported employment, will be calculated as the number of clients X 251 days X a minimum of 7 hours a day (leaving 1 hour per day per Full Time Employee for training, paperwork, meetings, etc.). UNIT = HOUR

- Units for child day clients in center based, no-educational Day Treatment and Training will be calculated as the number of clients X 251 days X 4 hours a day. UNIT = Hour

- Units for transportation to and from the day program are included in the residential rate.

- Units for transportation during the service, e.g., mobile crew going from site to site is included in the adult rate.

- Units for transportation to and from the day program for individuals living at home is not included in the adult day rate. UNIT = TRIP

- Units for support services will be calculated as the number of clients X hours of service. UNIT = HOUR

- Unit rate can be averaged by site for programs.

- Round to whole units before calculating unit costs, e.g., 2.4 = 2.0; 2.6 = 3.0 for adult and child services.

- There are 10 holidays provided in the unit rate calculation. A provider will not be paid for holidays in excess of 10.

- Case Management functions/Full Time Employee will not be included in provider contracts (this does not include on-reservation).

- State funds are not to be used by providers for executive perquisites such as company cars.

Business Operations is designated as the Central Office contact for any questions.

Thank you.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

No. 21 **Date: March 23, 1995**

TO: All Policy Manual Holders

FROM: Roger Deshaies
Assistant Director
Division of Developmental Disabilities

SUBJECT: Cooperative Planning Procedures

EFFECTIVE DATE: Upon Receipt

The Division has collaborated with the Department of Education, Special Education Section, to develop "Cooperative Planning Procedures" in order to ensure continuity for the provision of special education services to individuals who reside in foster or group homes.

The procedures outlined in the document will directly impact District Program Managers, Assistant Program Managers and Case Managers. Please ensure that the document is available to appropriate staff.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 23 **DATE: MAY 21, 1996**

TO: All Policy Manual Holders

FROM: Roger A. Deshaies
Assistant Director
Division of Developmental Disabilities

SUBJECT: Early Intervention Services

EFFECTIVE DATE: Upon Receipt

Employees of the division and contracted providers of early intervention services shall promote and model the following principles, values and best practices in the planning, development and implementation of early intervention services:

At the very heart of family-centered care is the recognition that the family is the constant in a child's life. For this reason, family-centered care is built on partnerships between parents and professionals.

Family-centered care is based, in part, on the belief that all families are deeply caring and want to nurture and support their children. Families, in their natural caregiving roles, build upon their cumulative strengths and on the unique strengths of their individual members.

Families differ in the strategies they adopt to realize their dreams for their children and themselves and in the amount of support they will need from outside systems.

There is no one choice or approach that is right for all families. Family-centered professionals acknowledge and respect this diversity.

Adapted from
National Center for Family-Centered Care

Quality early intervention services include or demonstrate the following, as applicable:

- component of flexibility concerning where and when services are delivered (home, day care home, day care center, provider office, and day or evening hours)

- involvement of providers involved in the delivery of services to the child and family (Day Treatment and Training provider, therapist) in the Individual Family Service Plan process and transition conference through either attendance at the meeting or the provision of reports prior to the meeting and through on-going coordination and communication with other team members

- attendance at trainings in early childhood development as required by the Division

- family active participation in the provision of therapy such as; hands-on demonstration

- use of established developmental curriculum

- provision of a service delivery methodology that is flexible in meeting the child's and family's needs and includes the use of direct and/or consultative models of delivery

- provision of written strategies for implementation to parents and day care providers, and sharing of written strategies for implementation between therapists and day treatment and education/training providers

- participation in staff development and training of day care providers, parents, early intervention providers, provider of therapy services

- provision of child development reports to service coordinators/case managers within 60 days of the placement

- activity of identifying and pursuing all relevant resources, e.g.; family, schools, insurance, Children's Rehabilitation Services, Arizona Health Care Cost Containment System

- application of cultural sensitivity in the provision of service (respect a families values and use the language or mode of communication normally used by the family)

- provision of written guidelines describing levels of service and including acceptable protocol regarding when *to* decrease or increase service levels, e.g., transitions; critical point of development; absence of progress; attainment of skill, and sharing of protocol with families

- use of appropriate methods and procedures to assess the child's needs and family's concerns, priorities and resources

- evaluation of the results of the program, e.g.; parent satisfaction survey

The following models, or a combination thereof, are considered best practices in the delivery of Day Treatment and Training services to children birth to three (3) years of age and their families when requested by the families and identified as a need in the Individual Family Service Plan:

Home (Family-based)

1. Family-based intervention occurs with the intent to provide support and early intervention services in the child's home environment. This occurs on a regular basis generally 1 to 5 times a month from 1 to 1.5 hours per visit, and provides for a 1 to 1 ratio with generally 14 families on a full case load with flexibility based on the needs of each family and the geographical locations of service - 1 to 1. 5 hours of face to face contact is equal to 2.5 hour of actual staff time (planning, paperwork, travel, as well as face to face service contact) for the provision of home-based services.

2. Family Child Care:

   Early intervention services may occur in a family child care home, e.g.; home of the day care provider or extended family member's home when requested by the family and reflected in the Individual Family Support Plan. It is intended to support and include caregivers in the delivery of services to the child and family. This occurs on a regular basis generally 1 to 5 times a month from 1 to 1.5 hours per visit, and provides for a 1 to 1 ratio with generally 14 families on a full case load with flexibility based on the needs of each family and the geographical locations of service. 1 to 1.5 hours of face to face contact is equal to 2.5 hour of actual staff time (planning, paperwork, travel, as well as face to face service contact) for the provision of home-based services. In addition, at least a monthly visit should occur with the family.

Center-based group

1. The center-based group intervention model is intended to provide families with the opportunity to interact with other families and their children. This model provides the opportunity for sharing resources, ideas, asking questions and parent to parent support. This occurs on a regular basis as identified in the Individual Family Service Plan but no less than 1 time a month, generally for 1 to 2 hours in duration, provides for a 1 to 7 child/parent ratio with a home visit component at least 1 time a month.

2. The center-based/unaccompanied child model is intended to provide early intervention services to toddlers, 18 to 36 months of age, in a group setting. This occurs on a regular basis, 1 to 3 days a week, generally 1 to 3 hours in duration and provides for a 1 to 3 toddler ratio. This model includes at least one contact a week with parents either face to face, by phone call, note or home visit. One home visit a month is recommended.

Regular Nursery School or Child Care Center

This model is intended to provide support and services in the child's familiar environment and assist the child to participate in regular developmentally appropriate activities of the group and supply technical assistance to the child care provider or preschool teacher. The duration and frequency would be based on the Individual Family Service Plan, and the natural environment schedule. The ratio would be determined by state licensing requirements and the needs of the child as identified in the Individual Family Service Plan.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 26 **DATE: October 4, 1996**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Foster Care Coordination

EFFECTIVE DATE: Upon Receipt

OVERVIEW

The Department of Economic Security/Division of Children, Youth and Families has the statutory responsibility to receive reports, screen reports, provide temporary foster care as appropriate, notify law enforcement, make a prompt and thorough investigation, take a child into temporary custody as provided, determine whether a child is in need of protective services, offer necessary services to the family and render a written report.

The Department of Economic Security/Division of Developmental Disabilities is not authorized to file dependency petitions but may provide the Division of Children Youth and Families with assistance as necessary to locate an appropriate placement if one is available. Once a case plan is completed and current, the child is adjudicated dependent and determined eligible for Division of Developmental Disabilities services, the Division of Developmental Disabilities will assume responsibility and placement for the child in an appropriate home. **The Division of Developmental Disabilities cannot be responsible for foster care payments until the child has been adjudicated dependent.**

CHILD IS ALREADY DETERMINED ELIGIBLE FOR the Division of Developmental Disabilities SERVICES

Prior to Adjudication:

The Division of Children Youth and Families worker will notify the assigned Division of Developmental Disabilities Case Manager who will assist the Division of Children Youth and Families worker by providing file documentation as requested, assist in locating an appropriate placement and assist in coordinating necessary services. If the child has special medical needs, the Division of

Developmental Disabilities Managed Care Operations may be involved to assist the Division of Children Youth and Families with technical training or identifying an appropriate placement. Access for medical assistance is initially triggered by the Division of Children Youth and Families Case Manager.

The Division of Developmental Disabilities Case Manager provides secondary coordination until the adjudication process is completed.

Following Adjudication:

An Individual Support Plan meeting/case plan staffing will be held within ten (10) days of adjudication jointly with the Division of Children Youth and Families for the orderly transfer of case management and financial responsibilities from the Division of Children Youth and Families to the Division of Developmental Disabilities. The assigned the Division of Developmental Disabilities Case Manager will initiate necessary service authorizations for the child to receive services from the Division of Developmental Disabilities.

CHILD IS POTENTIALLY ELIGIBLE FOR THE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

Prior to Adjudication:

The Division of Developmental Disabilities will make all eligibility determinations within 30 days of a complete application. It is the referral sources' responsibility to ensure all necessary and relevant background information is submitted along with the application.

Following Adjudication:

If the child has been found eligible for the Division of Developmental Disabilities services, a Case Manager will be assigned and an Individual Support Plan meeting/case plan staffing will be held jointly with the Division of Children Youth and Families for the orderly transfer of case management and financial responsibilities from the Division of Children Youth and Families to the Division of Developmental Disabilities. The assigned the Division of Developmental Disabilities Case Manager will initiate necessary service authorizations for the child to receive services from the Division of Developmental Disabilities. If a child is likely to be found eligible, the Division of Developmental Disabilities will assign a Case Manager to begin coordinating activities while the eligibility determination is pending.

DISAGREEMENTS WITH THE DIVISION OF DEVELOPMENTAL DISABILITIES' ELIGIBILITY DETERMINATIONS

If the Division of Children Youth and Families does not agree with an eligibility decision by the Division of Developmental Disabilities, a written request for review shall be sent to the Division of Children Youth and Families and the Division of Developmental Disabilities District Program Managers for review and resolution. The request must provide grounds for the review, outlining specific reasons why it is believed an error was made in denying eligibility. If the eligibility question cannot be resolved by the District Program Managers, the issue will be elevated to the Division of Children Youth and Families Program Administrator and the Division of Developmental Disabilities Eligibility Coordinator for their review and resolution. If the eligibility question cannot be resolved at this level, the issue will be elevated to the Division of Children Youth and Families and the Division of Developmental Disabilities Assistant Directors for review and resolution. Each level has five (5) working days to reach a decision unless a longer period is jointly agreed upon.

This process does not preclude family members from filing a grievance regarding the adverse decision of ineligibility for Division of Developmental Disabilities services.

CHILD HAS SIBLINGS IN THE DIVISION OF CHILDREN YOUTH AND FAMILIES FOSTER CARE

If a child is the Division of Developmental Disabilities eligible and has a sibling in the Division of Children Youth and Families foster care, every effort shall be made to keep the children together in the same foster home and to coordinate arrangements with the Division of Children Youth and Families in order to prevent confusing the parents, foster parents and the court.

THE DIVISION OF CHILDREN YOUTH AND FAMILIES VOLUNTARY PLACEMENT

A child, who is eligible for the Division of Developmental Disabilities services, placed by the Division of Children Youth and Families into foster care on a voluntary basis may receive other appropriate Division of Developmental Disabilities support services. the Division of Children Youth and Families will be responsible for the foster care payment and the Division of Developmental Disabilities will be responsible for support services the Division of Developmental Disabilities determines are appropriate. The case may not be transferred to the Division of Developmental Disabilities as long as the child is in voluntary status, as there is no adjudication of dependency.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 27 (Revision 1) **DATE: May 27,1997**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director. DES
Division of Developmental Disabilities

SUBJECT: Guidelines for Obtaining Legal Services from the Office of the Attorney General

EFFECTIVE DATE: Upon Receipt

The Division of Developmental Disabilities pays for legal services from the Office of the Attorney General. which has attorneys dedicated to the Division of Developmental Disabilities. The attorneys do not have the resources and time to respond to all requests or questions from the Division of Developmental Disabilities workers so requests must be prioritized. Also, Central Office must take the lead in determining which potential precedent setting questions are appropriate for referral to the Office of the Attorney General. In many, cases. Central Office staff can quickly answer questions, drawing on their own knowledge, however, Central Office staff will not attempt to give legal advice and will refer questions to the Attorney General's Office, as appropriate.

Generally, requests for services from the Office of the Attorney General shall be coordinated through the Division of Developmental Disabilities Central Office. The Program Operations Administration is responsible for coordinating requests from the Division of Developmental Disabilities staff for legal_services. Contacts with Assistant Attorneys General should be in accordance with the following guidelines:

General Legal Issues

District staff should direct general legal requests to the Division of Developmental Disabilities Program Operations Administrator or the Division of Developmental Disabilities Compliance and Review Manager in accordance with district procedures. General requests usually are the "Can we do . . ?" or "What are we to do about . . ?" questions. General legal questions usually do not require a written response and are relatively simple for an attorney to answer.

Juvenile. Dependency

Questions which involve new, and/or on-going dependency cases should be referred to the attorney assigned to represent the Department in the dependency case. If the case is in Phoenix. call (602) 542-9875 and ask for the assigned attorney. If the case is in Tucson. call (520) 628-6574. Call (602) 542-9875 and ask to speak to the duty attorney in the Protective Services Section if you have general questions about juvenile court proceedings.

Written Legal Opinions

Requests for formal legal opinions require the approval of the Assistant Director of the Division of Developmental Disabilities. Requests for informal opinions should be addressed to the Assistant Director, Deputy Assistant Director or Program Operations Administrator and must be in writing. Formal and informal opinions require an attorney to invest a considerable amount of time in research and, therefore, must be prioritized with other legal requests.

Regulatory Issues

Issues relating to interpretations of regulatory laws, regulatory action by the Division of Developmental Disabilities and unusual incidents in regulated services should be addressed by the Program Operations Administration's Developmental Homes and Group Home Licensing and Monitoring Managers and Home and Community Based Services Certification Manager, who may elect to involve a regulatory attorney, if appropriate. All attorneys with specific regulatory responsibility for the Division of Developmental Disabilities are located in Phoenix. Attorneys outstationed in Flagstaff, Tucson. Apache Junction, Kingman and Sierra Vista are paid by the Division of Children, Youth and Families and are dedicated to child welfare. dependency and juvenile court issues.

Subpoenas and Court Orders

Any document received from a court or attorney. such as a motion, subpoena, deposition request, records request, etc. must be faxed to the Division of Developmental Disabilities Office of Compliance and Review immediately upon receipt. The Division of Developmental Disabilities Office of Compliance and Review will forward the document to the Attorney General's Office and will coordinate communication between the Division of Developmental Disabilities staff and the Attorney General's Office. The assigned Assistant Attorney General will determine on a case-by-case basis if their presence at a deposition or in Court is needed.

If the subpoena requires immediate action by the Division of Developmental Disabilities, the district staff should call the Attorney General's Office at (602)542-9758 and inform the Division of Developmental Disabilities Compliance and Review Unit as soon as possible at (602)542-0419).

The most, frequently received subpoena at the Division of Developmental Disabilities is for a court appearance when the child is the subject of a dependency petition. In these cases an Assistant Attorney General in the Protective Services Section is involved, not one of the Division of Developmental Disabilities attorneys. Staff should immediately contact the duty attorney in the Protective Services Section at (602)542-9875 to inform the attorney of the subpoena. The duty attorney will direct staff to fax a copy of the subpoena to the Attorney General's Office.

Requests for copies of a case record or specific areas of a case record may be received from a parent/guardian, attorney, insurance company. etc. All requests must be in writing and include a signed release of information from the parent/guardian, if appropriate. The written request must be forwarded to the Division of Developmental Disabilities Office of Compliance and Review and will be handled on a case-by-case basis.

Grievances and Appeals

Grievances and appeals shall be addressed by the Division of Developmental Disabilities Compliance and Review Unit to which Assistant Attorneys General are assigned for legal advice.

Personnel Issues

Personnel related issues which might require advice from the Office of the Attorney General must be directed to the Division of Developmental Disabilities Central Office Personnel Unit.

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DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 28 **DATE: October 4, 1996**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Cellular Phones

EFFECTIVE DATE: Upon Receipt

The Division of Developmental Disabilities will primarily utilize the agency owned cellular phone option. Each District and the Managed Care Unit will, in conjunction with other Central Office Units, purchase a set number of cellular phones and issue them on a "sign-out" basis to Division personnel. Phones may be issued either per event, i.e., home visit, per day or on a more long term or regular basis. Either way, the use of cellular phones is limited to business use only.

Each District/Office will develop a protocol for its allocation of the cellular phones. This protocol will identify the District Administrator responsible for the cellular phones and their allocation. Additionally, this Administrator will be responsible for the inventory, maintenance and monitoring of all cellular phones assigned to their District/Office.

Each District/Office will institute a practice of random review of cellular phone charges.

Privately Owned Cellular Phones

The Division recognizes that on occasion the use of privately owned cellular phones may be appropriate. As with agency owned cellular phones, reimbursement can be received only for use associated with essential work requirements and/or emergency events. Employees can obtain reimbursement by:

a. Submitting cellular phone charges on Travel reimbursement claim form.

b. Attach a receipt/phone bill or other verification of the expense along with a brief description of the phone call, person contacted and duration of the call.

c. ONLY THE TELEPHONE CALL ITSELF IS ALLOWABLE.

Since the Division will make available agency owned cellular phones, no reimbursement will be made to individuals who purchase their own phones UNLESS A PRIOR APPROVAL IS OBTAINED. EACH DISTRICT/OFFICE WILL INCLUDE IN IT'S PROTOCOL THE JUSTIFICATION NEEDED TO OBTAIN PRIOR APPROVAL.

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DIVISION OF DEVELOPMENTAL DISABILITIES
A D M I N I S T R A T I V E D I R E C T I V E

NO. 29 (Revised) **DATE: August 18, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Discharge from a Provider

EFFECTIVE DATE: Upon Receipt

This Administrative Directive cancels and replaces Administrative Directive 29 (Revised) dated February 12, 1997.

The Division of Developmental Disabilities' contract with providers for services includes a termination clause. This clause does not provide any expressed or implied ability of a provider to unilaterally discharge an individual from their program or service.

The Individual Support Plan process identifies the needs of each individual receiving services. Any discussion of movement from one provider setting to another setting or provider can only be addressed through the Individual Support Plan process and in the context of Arizona Administrative Code R6-6-2109.

If the Individual Support Plan identifies the need for an individual to move and the individual or their responsible person disagrees with the proposed move and files a grievance, no move shall occur during the grievance process.

Arizona Administrative Code R6-6-2107 directs that once a vendor has been selected, the vendor may not subsequently refuse to provide services for the consumer based on the difficulty of supports needed by the consumer.

<u>The Division does not pay for vacancies or absences.</u> A vacancy occurs when an individual discontinues service from a vendor/provider and has no intention to continue a service delivery relationship with that vendor/provider. An absence occurs when an individual is authorized for service but does not in fact receive service during the authorized service delivery period. The Division will pay for services only in accordance with the terms and conditions in the applicable contract.

Vendors/providers shall advise the Division's responsible program manager as soon as possible of all service terminations, if the vendor/provider has not been notified by a Division representative. Vendors/providers shall advise the Division's responsible program manager as soon as possible of any extensive or continuous absence so that the Individual Support Plan team may be made aware.

RZ:CC

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 31 **DATE: December 16, 1996**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Change in Title

EFFECTIVE DATE: Upon Receipt

In order to implement a more individual/family focus to service delivery, the Division of Developmental Disabilities will begin referring to Case Managers/Case Manager Supervisors and Case Management, as defined in Arizona Revised Statutes § 36-551, as Support Coordinators/Support Coordinator Supervisors and Support Coordination. Additionally, Individual Service Program Plans will be called Individual Support Plans. All Division staff and contracted providers are expected to begin using this terminology in all communications. Changes will be made to existing policies, publications and forms as they are updated. If you have any questions, contact Caroline Champlin at (602)542-0419.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 32 (REVISED) **Date: December 14, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Case Management Documentation Requirements

EFFECTIVE DATE: Upon Receipt

The following changes in and clarifications of documentation requirements are effective immediately:

ICAP: The Inventory for Client and Agency Planning will be completed at the time of intake and re-determination of eligibility for persons age 6 and older. For children who entered services prior to age 6, the Inventory for Client and Agency Planning will be done at the time of re-determination of eligibility at age 6. This supersedes Chapter 700, Section 705.

Individual Support Plan:

The Individual Support Plan is a flexible person/family centered communication and decision making process, not paperwork. The Individual Support Plan forms are designed to guide the team to discuss four (4) questions regarding the assistance desired from the Division:

1. Where have we been" (DD-215, Review of the Last Individual Support Plan)

2. Where are we now? (DD-217, Team Assessment Summary)

3. Where does the person want to go? (DD-218, Vision of the Future)

4. How are we going to get there? (DD-219, Implementation Plan)

With the exception of the Individual Support Plan Cover Sheet (DD-214), all other forms are supplemental forms to be used if appropriate to the individual's circumstances. For persons who are Division, but not Long Term Care eligible, and who do not receive early intervention, adult day, or residential services, the above questions may be

documented via an Individual Support Plan Cover Sheet and a narrative. In such circumstances, completion of the Implementation Plan (DD-219) is strongly recommended.

The Summary of Professional Evaluations (DD-216) (REVISION) is required for people who are 21 years old or older or who will live in a licensed residential setting. This supersedes the instructions printed on the form and Chapter 800, Section 808.2.

The Transfer Checklist (DD-223) is required for Individual Support Plan teams to document needed actions when planning a move from one worker to another, one residential setting to another, from one district to another, or one program to another (i.e. Elderly Physically Disabled Program). The form does not need to be sent to the Central Office Managed Care Unit. This supersedes Chapter 800, Section 809.5 and Chapter 900, Section 911.

Preferences and Vision of the Future (DD-218) should never be considered “required paperwork” or "another form to fill out." Its purpose is to guide the team to develop a support plan that is based upon the desires and dreams of the individual and family, not the needs of the system, and should be used in the spirit in which it was intended. As indicated in Chapter 800 of the Policy and Procedure Manual, there are circumstances in which it may not be appropriate to use this form, e.g. a person is terminally ill.

Special team meetings or reconvenes may be documented using an Individual Support Plan Cover Sheet and a narrative only.

Case Manager's Review of the Individual Support Plan (DD-500):

This form is to be used to document 90/180 day service plan reviews for Long Term Care eligible individuals. It replaces case manager's progress notes and is not in addition to them: the only entry that should be made in the progress notes is, for example, “90 day review completed this date. See Individual Support Plan section of file". This form is not intended to be completed at the time of the annual Individual Support Plan. This supersedes Chapter 1000, Section 1002.5.
This form should also be used be used as part of the review for an individual in the Ventilator Dependant Program. This replaces the Ventilator Dependant Program Monthly Visit Report: Part 1 (DD-199-1) for Support Coordinators.

One copy of the Support Coordinator’s Review of the Individual Support Plan (DD-500) is filed in the Support Coordination file; and one copy should be sent to the Registered Nurse and filed in the Registered Nurse 's case file.

The Medicaid Agency expects that the review will be conducted within a few days of the due date and at the person's residence. The case manager must make and document timely attempts to schedule the review in accordance with Policy and Procedure Manual Chapter 806.2. If the review is held on a later date or in a location other than the person's home at the request of the individual/family, the file must clearly document the reasons. A visit made to a site other than the individual’s home must be at the request

of the individual/responsible person, not just for the convenience of the Support Coordinator.

Change in the Individual Support Plan (DD-224) (REVISION):

This form is to be used to document changes in objectives, services. or team agreements in the Individual Support Plan. Because the current version (dated 7/96) contains the Notice of Intended Action, a separate notice is not required if the person is funded through state dollars only. If the service is paid for using Long Term Care dollars, then an Long Term Care Notice of Action is required.

The form is printed with multiple copies to allow for completion at a team meeting or Individual Support Plan review. It should be completed during the review, signed, and copies distributed immediately. If the responsible person is not present at the review. or it is used on other occasions, e.g., a provider night use the form to request a change in an objective, or an emergency situation might require a change in services, the form should be sent to the responsible person to sign and return. The form should be sent certified mail, return receipt requested in order to be in compliance with requirements for notices of intended action.

Inactive Status:

An individual who receives no services funded by the Division, is not Long Term Care eligible, and has no current need for active case management support may choose to maintain an "open case" with the Division in order to avoid the reapplication and eligibility determination process should case management support or other services become necessary in the future. In these situations, the case manager must make an annual contact by certified letter reminding the individual/family of the name of the assigned case manager and asking if they want to continue to maintain an "open case" with the Division or have the case manager contact them. For individuals who choose an Inactive Status, no formal Individual Support Plan is required: the certified letter with the signed receipt would in essence be considered the Individual Support Plan.

An individual who has chosen Inactive Status may reactivate Open Status immediately, should the need for assistance change by contacting the case manager by phone, in person or by letter

Third Party Liability

Chapter 1204.2 is modified to read as follows:

"At the initial intake interview, the 'intake worker must:

1. explain to the individual /responsible person that the Division of Developmental Disabilities is the payor of last resort and all other sources of benefits must be utilized first-,

2. request either a copy of the insurance card or the name of the insurance company, address and telephone number of the company, the name of the policy holder, the policy number, the group number and the effective date of the insurance. and

3. request information on any accident settlements or benefits. The information should include the date of the accident, type of accident and amount of the settlement.

The Case Manager must refer the individual/responsible person to any resources as outlined in Section 903 of this Manual, and update the status of the above information at each Individual Support Plan review."

Form DD-393 (Appendix 120O.A) is abolished. Third Party Liability information as outlined above will continue to be collected using intake, Individual Support Plan, and Individual Support Plan Review forms.

Notice of Service System Discharge (DD-075) REVISION:

This Directive supercedes Chapter 1103, 1104 a., & Chapter 2202 b. of the Division's Policy and Procedures Manual. The Notice of Service System Discharge (Revised Letter Format) form is to be used to document closure summaries and notify individuals that they are being disenrolled from Division services. **A separate Notice of Intended Action letter is not required**, as the form provides the necessary notice of appeal rights. The Notice of Service System Discharge must be sent by certified mail, return receipt requested, to the individual/responsible person informing them of the case closure at least 35 days prior to the date of the case closure. The notice must be signed either by the District Manager or designee. This notice does not need to be completed if the person has submitted a written request for discharge. A Long Term Care Member Change Report must be submitted to AHCCCS along with a copy of either the Notice of Service System Discharge or a written discharge request from the individual/responsible person. This form also replaces locally designed case closure summary forms.

Upon the Division's eligibility re-determination outlined in Chapter 500, if the person is determined no longer eligible for the Division of Developmental Disabilities and is currently Long Term Care eligible, in addition to the Notice of Service System Discharge, the Support Coordinator will refer the person to Long Term Care, who will then re-determine Long Term eligibility using the Pre-Admission Screening instrument for the Elderly & Physically Disabled Program. If determined eligible for the Elderly & Physically Disabled Program the Support Coordinator will work with the Elderly & Physically Disabled Program to transition services to ensure continuity. The Transfer Checklist (DD-223) will be required to assist Individual Support Plan teams to consider and document needed actions in the transition. Whether the person is eligible for another Elderly & Physically Disabled Program or not, the Division's services shall continue until the Support Coordinator is notified via the automated AHCCCS Roster that AHCCCS has disenrolled the individual from Long Term Care.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Insert Office Letterhead

Janet Napolitano
Governor

David Berns
Director

Date:

Individual:
D.O.B.:

NOTICE OF SERVICE SYSTEM DISCHARE

Dear:

The Arizona Department of Economic Security, Division of Developmental Disabilities (DDD), hereby notifies you of the decision to discharge _____ from all services provided by DDD effective _____.

This action is being taken for the following reason(s):

If you feel discharge from the Arizona Department of Economic Security, Division of Developmental Disabilities services is not appropriate and you disagree with the decision, you may request an Administrative Review. To do so, you must file a written or oral request for review within 35 days of the date of this letter. You may call, mail, or deliver your request to:

Compliance & Review Unit
Division of Developmental Disabilities, Site code 791A
1789 W. Jefferson, 4th Floor
P.O. Box 6123
Phoenix, AZ. 85005
Telephone (602) 542-0419/Fax (602) 364-2850

If you would like assistance or clarification regarding the Administrative Review process, please contact the person listed below:

Name of Support Coordinator
Address
Phone Number

Sincerely,

Support Coordinator, DES/DDD

Unit Supervisor, DES/DDD

c: client file

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO 33 **Date: December 16. 1996**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Forms Used by Case Managers and Families

No forms, excluding personnel related issues, to be completed by Support Coordinators (case managers), Individual Support Plan teams, or the individual/family/guardian, will be developed or revised and printed for statewide use unless the proposed form or form revision has been submitted to the Statewide Case Management Coordinator. S/he will ensure that the form is reviewed by Case Management Supervisors at the quarterly Statewide Case Management Supervisor meetings held in January, April, July and October. The Case Management Coordinator will incorporate the supervisor's input prior to authorizing printing of the form.

District Program Administrators will ensure they have comparable procedures in place to ensure that locally created forms are necessary, do not duplicate or replace statewide forms approved by the Case Management Supervisor's group, and are consistent with family support principles.

Case Management Supervisors will solicit input from the Support Coordinators in their unit when a form is being developed or reviewed, and will notify the Statewide Case Management Coordinator when it becomes apparent that an approved statewide form needs revision

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Arizona Department of Economic **Security**
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E DI R E C T I V E

No. 34 (Revised) **Date: September 30, 1997**

TO: All Policy Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Mediation Project

EFFECTIVE DATE: Upon Receipt

In conjunction with the Conflict Resolution Section of the Office of the Attorney General, the Division of Developmental Disabilities will be implementing a Mediation Program on October 1, 1997.

Mediation is a form of dispute resolution whereby trained, neutral mediators help participants define issues and guide the communication process to mutually accepted agreements. The mediator is not a judge and will not decide the outcome of the dispute. The mediator may offer suggestions and help develop options to resolve issues, but the final agreement is made solely by the participants. In order for mediation to be most effective, participants must want to resolve the issues and be willing to work toward that goal.

Mediation may be requested by any affected party and all parties must agree to participate in the process. Division of Developmental Disabilities staff and all providers will, upon request, participate in the mediation process.

Mediation is an alternative to, not a replacement for, the formal grievance process. Mediation is voluntary on the part of individuals/families. At any time in the mediation process, the individual or family member may stop the process and file a formal grievance.

Certain types of issues will not be resolved by mediation such as contract issues, eligibility decisions, personnel issues, programmatic monitoring or licensing issues or issues where the mediation should occur with another agency or entity, i.e., Regional Behavioral Health Authorities, Department of Education, etc. Mediation agreements cannot contradict state and federal laws, rules or regulations.

Mandatory training will be provided to all affected Division staff.

To request mediation, individuals, family members, providers or the Division of Developmental Disabilities staff may contact:

The assigned Support Coordinator or Support Coordinator Supervisor;

The Division of Developmental Disabilities Mediation Coordinator (602)542-0419; or

The Conflict Resolution Section of the Office of the Attorney General:

District I (602)542-4192
District II (520)628-6783
District III (520)819-0113
District IV (520)819-0113
District V (602)542-4192
District VI (520)628-6783

When referring a consumer or their family to mediation (or self referral), any the Division of Developmental Disabilities staff including the Support Coordinator, the Division of Developmental Disabilities Mediation Coordinator or the Conflict Resolution Section representative will complete a written referral form (attached) which includes:

- Name of the individual eligible for services through the Division of Developmental Disabilities;
- District in which the individual resides;
- Date of referral;
- Initiating party's name, address and phone number;
- Responding party's name, address and phone number;
- Other parties identified/requested to attend the mediation meeting; and
- Brief description of the dispute.

The completed referral form will be faxed to the Division of Developmental Disabilities Mediation Coordinator (602)542-6870**,** within one (1) working day of the request for mediation. The Division of Developmental Disabilities Mediation Coordinator will screen the referral to determine if it falls within the guidelines for mediation. The Division of Developmental Disabilities Mediation Coordinator will fax a copy of all referrals to designated District staff.

The Division of Developmental Disabilities Mediation Coordinator will forward appropriate referrals, within one (1) working day of receipt, to the Conflict Resolution Section of the Office of the Attorney General. The Conflict Resolution Section will assign a mediator and schedule the mediation meeting.

If you have questions, please call Jose Castro Palomino at **602-542-0419.**
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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 38 (Revision 1) **DATE: October 20, 1998**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Americans with Disabilities Act

The Division of Developmental Disabilities is required to comply with Titles I and II of the Americans with Disabilities Act. Title I is Equal Employment Opportunities for Individuals with Disabilities. Title Ii is Nondiscrimination on the Basis of Disability in State and Local Government Services. the Division of Developmental Disabilities must fully comply with DES 1-01-06 and DES 1-01-12.

Following are the Division of Developmental Disabilities' policies for Titles I and II:

Definitions

Direct Threat	A significant risk of substantial harm to the health or safety of an employee with individual disability or others in the workplace that cannot be eliminated or reduced by a reasonable accommodation.
Disability	A physical or mental impairment that substantially limits one (1) or more major life activities, or a record of having such an impairment or being regarding as having such an impairment.
Essential Functions	The fundamental job duties an employee must be able to satisfactorily perform with or without a reasonable accommodation.
Interim Accommodation	Temporary measures taken to accommodate a qualified individual with a disability under the Americans with Disabilities Act until the permanent measures can be taken or completed.
Major Life Activities	An activity that the average person in the general population can perform with little or no difficulty, such

	as hearing, seeing, speaking, walking, breathing, performing manual tasks, caring for oneself, learning or working.
Reasonable Accommodation	A change or adjustment to the work environment or job that permits a qualified applicant or employee with a disability to participate in the job application process, to perform the essential functions of a job, or to enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities. An employer is required to make reasonable accommodation for a qualified individual with a disability unless the employer can show that the accommodation would be an undue hardship or would not eliminate a direct threat to the health or safety of the individual or others in the work place.
Substantially Limits	An impairment is substantially limiting when it significantly restricts the duration, manner or condition under which a person can perform a particular major life activity as compared to the average person's ability to perform that same activity. Some impairments may be disabling for one person, but not for another, depending on the stage of the disease or disorder, or the presence of other impairments or factors which combine to make an impairment disabling. An individual does not have to be totally unable to work in order to be considered substantially limited in the major life activity of working. It is enough that the individual is significantly restricted in the ability to perform a class of jobs or a broad range of jobs in various classes as compared to the average person having comparable training, skills and abilities.

<u>Title I</u>

1. Regular Process

   a. An employee who desires an accommodation shall complete a Request for Reasonable Accommodation (J-930, attached) and submit it to his/her supervisor. With the form, the employee shall submit any supporting documentation (which may include medical documentation of diagnosis and limitations) the employee believes the Division of Developmental Disabilities will need to properly evaluate the request and to determine a reasonable accommodation. The employee and supervisor shall discuss

the request. The employee shall also provide written authorization for the release of medical information. The employee and/or the supervisor of the employee requesting the reasonable accommodation may also be asked to submit information needed to determine the essential functions of his/her position. The information shall include, but not be limited to, a job description, the Position Description Questionnaire and the class specifications.

b. The supervisor shall note, on the request, the date and time of receipt.

c. The person receiving the request (supervisor) shall submit it to the Division of Developmental Disabilities/Americans with Disabilities Act Liaison in Central Office within two (2) working days of receipt of the request. Interim accommodations shall be provided as appropriate.

EXCEPTION: If the person receiving the request believes that the employee poses a "direct threat" to him/herself or others, the request shall be handled pursuant to the expedited process detailed in Item 2 of this directive.

d. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison shall determine what additional information is required to properly evaluate the request and shall request additional information from appropriate sources.

   i. If additional medical information is required, the Division of Developmental Disabilities/Americans with Disabilities Act Liaison may request an independent medical evaluation.

   ii. If the accommodation involves a modification of the physical facility, the Division of Developmental Disabilities/Americans with Disabilities Act Liaison shall contact the Office of Facilities Management immediately. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison, with a representative from the Office of Facilities Management, shall assess the cost and modification of the accommodation.

e. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison shall document all requests for additional information and the date of such requests.

f. The Division of Developmental Disabilities Accommodation Review Panel shall make a determination on the request for accommodation within 30 days of the date of receipt of all necessary documentation and provide the employee with written notice of the decision. The Division of Developmental Disabilities/Americans with Disabilities Act Accommodation Review Panel shall base the decision on the Americans

with Disabilities Act, this directive and all information pertinent to the specific request.

g. At the time of the decision, the Division of Developmental Disabilities/Americans with Disabilities Act Liaison shall contact the supervisor or other individuals, e.g., the Office of Facilities Management. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison, with the employee's supervisor, shall facilitate implementation of the decision within 60-90 days unless outlined in Item 3 of this Section, or sooner if possible.

h. The Division of Developmental Disabilities shall exercise good faith in processing requests for accommodation as quickly as possible in light of all surrounding circumstances.

2. Expedited Process for Direct Threat Situations

a. When a supervisor of a person making a request for a reasonable accommodation has cause to believe that the effects of an individual's disability pose a direct threat to the health of him/herself or others in the workplace, the supervisor shall notify the Division of Developmental Disabilities/Americans with Disabilities Act Liaison within 24 hours of the receipt of the request and also contact the Division of Developmental Disabilities Personnel Office for direction.

b. The Division of Developmental Disabilities Americans with Disabilities Act Reasonable Accommodation Panel or the Division of Developmental Disabilities/Americans with Disabilities Act Liaison, as appropriate, shall determine if a direct threat actually exists and if the threat can be reduced to an acceptable level with the accommodation. The panel shall confirm the existence of the direct threat in accordance with DES 1-01-06.D.4.b.i.

c. If the Division of Developmental Disabilities/Americans with Disabilities Act Reasonable Accommodation Panel or the Division of Developmental Disabilities/Americans with Disabilities Act Liaison finds there is a direct threat which can be eliminated through provision of a reasonable accommodation, the Panel or liaison shall:

i. Determine if there are any temporary accommodation measures the Division of Developmental Disabilities can implement to permit the employee to work while the Division of Developmental Disabilities implements the permanent accommodation; and

ii. Make the accommodation as quickly as possible, pursuant to DES 1-01-06.F.1.

3. Good Faith Effort/Good Cause

In determining if the Division of Developmental Disabilities has made a good faith effort to resolve an issue under this directive, the following are examples of factors which may constitute a good cause for delay:

a. The event causing the delay is outside the control of the Division of Developmental Disabilities.

b. The Division of Developmental Disabilities has made a good faith effort to provide interim accommodations while taking necessary steps to implement a permanent reasonable accommodation; and

c. The Division of Developmental Disabilities has advised the employee requesting the accommodation of the delay, the reason for the delay and the date by which the Division of Developmental Disabilities expects to complete the accommodation process.

4. If a reasonable accommodation results in a monetary expenditure, the J-930, Request for Reasonable Accommodation, must be processed.

5. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison shall maintain an inventory of all adaptive equipment with a value greater than $300.

a. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison will establish a tracking number and label the adaptive equipment, maintain an Americans with Disabilities Act equipment inventory and treat the inventory as confidential information at all times. The list will include:

1. The name of the employee;

2. The type of equipment, e.g., type of computer, type of monitor, type of adaptive computer input and adaptive computer output;

3. The date the employee received the equipment;

4. The physical location, i.e., Site Code, Supervisor name, District Program Manager, Cost Center, physical address, etc.; and

5. The date the equipment was sent to surplus.

b. The District Americans with Disabilities Act Liaison is responsible for maintaining an inventory of all equipment purchased as a result of a J-930. This inventory will be updated and sent to the Division of Developmental Disabilities/Americans with Disabilities Act Liaison on a quarterly basis.

c. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison will determine if equipment is available prior to acquiring new equipment by:

1. Reviewing the Division of Developmental Disabilities' equipment inventory list;

2. Reviewing the DMAL Bulletin Board equipment section; or

3. Contacting the Department's Americans with Disabilities Act Coordinator to determine if there is any known equipment available for use. (Once equipment has been identified as Americans with Disabilities Act related, all equipment must remain intact, e.g., computer system components.)

d. When equipment is available from another Division, the equipment transfer form (J-320) will be completed and the inventory report updated. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison will approve all transfers, in advance.

e. When an employee transfers from one Division to another, the District must determine if the equipment can be transferred. If it can be transferred, the J-320 must be completed and sent to the new Division's Americans with Disabilities Act Liaison. If it is not transferable, the equipment becomes Americans with Disabilities Act surplus.

f. All equipment purchased must utilize the State's contracts, when possible. If the item is not covered by a Department or State contract, the Division of Developmental Disabilities Liaison can call the purchasing agent for catalogs, descriptive literature or brochures. For chair assessments, the Office of Loss Prevention may provide technical assistance in determining the chair specifications.

g. All requisitions or ED-013 documents for automated and/or non-automated accessories must clearly identify that the equipment is Americans with Disabilities Act related. Requisitions processed through the Department's Purchasing Office should specify on the

requisitions "RX" field with an "A" (this denotes that it is Americans with Disabilities Act related equipment.)

6. If a reasonable accommodation can be achieved without any fiscal impact, e.g., moving the employee from one work station to another, the supervisor may make the accommodation after notifying the District Program Administrator/District Program Manager or designee without elevating the request to the Division of Developmental Disabilities Americans with Disabilities Act Liaison.

7. The Division of Developmental Disabilities Americans with Disabilities Act Liaison shall maintain a centralized file of all its reasonable accommodation requests and decisions, track Americans with Disabilities Act expenditures and transmit a quarterly report to the Department's Americans with Disabilities Act Coordinator within 30 calendar days of the end of the quarter.

8. Compliance Process

   Any employee who believes the Department has discriminated against him/her on the basis of disability or disagrees with the decision may file a General Employee Grievance (IR-031, attached) or may file a complaint with the Department's Office of Equal Opportunity.

<u>Title II</u>

1. Identify individuals responsible for ensuring the Division of Developmental Disabilities' programs, services or activities are accessible to individuals with disabilities.

   a. The Division of Developmental Disabilities/Americans with Disabilities Act liaison shall have the **responsibility for coordinating** with the Division of Developmental Disabilities administrators and managers to ensure the Division of Developmental Disabilities' programs, services and activities are accessible to individuals with disabilities.

      i. The Division of Developmental Disabilities staff will obtain technical assistance from the Division of Developmental Disabilities/Americans with Disabilities Act Liaison when planning meetings.

   b. Each office shall have a designated staff responsible for ensuring that programs, services. and activities are accessible.

   c. When Americans with Disabilities Act compliance requires structural modification, repair or equipment installation, the designated staff shall notify the Division of Developmental Disabilities/Americans with

Disabilities Act Liaison and monitor the completion of any Americans with Disabilities Act related improvements or repairs for that office.

d. The designated staff shall immediately notify the Division of Developmental Disabilities/Americans with Disabilities Act Liaison when a direct threat situation arises. The designated staff may contact the Job Accommodation Network at 1-800-JAN-7234, the Arizona Office of Americans with Disabilities at 602-542-6276 or the Pacific Disability and Business Technical Assistance Center at 1-800-949-4232 for recommendations for the reduction of the direct threat to a safe level.

e. The designated staff will work with the Office of Facilities Management to ensure the evacuation plan for the office is in compliance with the Americans with Disabilities Act.

2. Disseminate to employees and customers the name of and means of contacting the Division of Developmental Disabilities designees who are responsible for ensuring that the Division of Developmental Disabilities' programs, services and activities are accessible.

a. Quarterly, the Division of Developmental Disabilities/Americans with Disabilities Act Liaison will update and disseminate the names and telephone numbers of the Division of Developmental Disabilities staff who are responsible for ensuring that the Division of Developmental Disabilities' programs, services and activities are accessible.

b. The Division of Developmental Disabilities' customers will be notified by the Department's Americans with Disabilities Act Notice Poster posted in offices and/or Notification Statements on forms, contracts, correspondence and other literature.

3. Establish and implement procedures to inform customers that alternative methods and/or alternative locations are available to individuals with disabilities.

a. Each District Program Administrator/District Program Manager will identify an individual in each office who is responsible to respond to Americans with Disabilities Act Title 11 issues.

b. Designated staff will post the Department's Americans with Disabilities Act Notice Poster and the Federal Equal Employment Opportunity Commission Poster in an area easily visible to customers.

c. Designated staff will place an Americans with Disabilities Act notification statement of documents created and/or revised through their office informing the public of the availability of accommodations to fully

participate in a program, service or activity as well as the availability of alternative format.

d. Designated staff will inform employees how to respond to Americans with Disabilities Act Title 11 issues as they arise on-site and how to elevate the requests to the appropriate area of expertise.

4. Establish time frames that are reasonable for processing requests for accommodation for each program, service and activity.

   a. Accommodations must be provided so the customer receives the program, service or activity within any legally mandated time frame for that particular program, service and/or activity.

      i. When a customer provides advance notice of need for an accommodation, some delay in providing the accommodation to qualified individuals with disabilities may be acceptable, as long as the Division of Developmental Disabilities can provide the program, service or activity within the time frame mandated by law.

      ii. When a customer doesn't provide advance notice, the Division of Developmental Disabilities will need to provide an alternative accommodation in order to provide the program, service or activity in a timely manner.

5. Establish a method /procedure for establishing if an individual requesting an accommodation is a qualified individual if the person's disability is not obvious.

   a. When the customer's disability is not readily apparent, the Division of Developmental Disabilities staff may ask the customer to provide additional documentation of a disability related to the accommodation requested, however, the time frame of the program, service or activity must be met. This request shall be done on a case-by-case basis and must be coordinated with the Division of Developmental Disabilities/Americans with Disabilities Act Liaison. (NOTE: The customer has a right NOT to have an accommodation.)

   b. An employee at any level, who receives a request and cannot provide an effective accommodation within the sphere of their responsibility shall elevate the request to their immediate supervisor as soon as possible and no later than 24 hours from the time of the request.

6. Establish a procedure to provide an effective accommodation when a request is made by a qualified individual.

a. The step-by-step process described below may be completed formally or informally when an accommodation is requested.
The steps are:

i. Identify the program, service or activity in which the individual desires to participate.

ii. Ask the individual with the disability to describe the accommodation they require to participate in a program, service or activity. Solicit suggestions from the individual as to how they may be accommodated and their accommodation preference.

iii. Identify possible accommodations and the potential effectiveness of each one.

iv. Consider the individual's accommodation preference and select the most appropriate accommodation. (NOTE: When you are having difficulty identifying an appropriate accommodation, seek technical assistance by contacting the Division of Developmental Disabilities/Americans with Disabilities Act Liaison.)

v. Deliver the program, service or activity to the individual using the agreed upon accommodation.

vi. Complete the Request for Effective Accommodation (J-930-A, attached) and distribute as indicated on the form.

b. There are several Department resources available to help you during this process if you need assistance, starting with the Division of Developmental Disabilities Americans with Disabilities Act Liaison, however, the responsibility to identify and provide timely accommodation remains with the Designated Staff of the office which has received the request.

7. Establish a procedure to document all requests for accommodation.

a. All requests for accommodations are to be documented by the Division of Developmental Disabilities staff on the Request for Effective Accommodation (J-930A).

b. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison will establish and maintain the centralized the Division of Developmental Disabilities file of all completed Request for Effective Accommodation forms.

c. The completed Request for Effective Accommodation forms shall be retained for five (5) years. After five (5) years, the forms may be sent to the Department's Records Retention for permanent storage.

8. Establish a procedure to document all actions taken in response to a request for an accommodation.

   a. The person receiving the request for accommodation (in person or via telephone) should note on the Request for Effective Accommodation the date and time of the actual receipt of the request. The customer will be given the top copy to verify they have made a request.

   b. The remaining sections of the request shall be given to the designated staff.

   c. The designated staff will document on the J-930-A the actions taken. (NOTE: If for some reason the accommodation is denied, the J-930-A processes must still be followed and treated as a completed request.)

   d. The designated staff will distribute the completed J-903-A as indicated on the form.

9. Establish a schedule and procedure to provide training at regular intervals to the Division of Developmental Disabilities staff who are likely to receive requests for accommodations or who are likely to confront situations where an accommodation is clearly required, though not requested.

   a. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison, with assistance and input from the Office of Organization and Management Development will coordinate the Division of Developmental Disabilities/Americans with Disabilities Act training pursuant to the mandates of the Americans with Disabilities Act Title II Policy. The training will be scheduled to minimize impact on the operation of programs, services and activities.

   b. the Division of Developmental Disabilities administrators and managers will be responsible to ensure supervisory and other appropriate employees complete the Americans with Disabilities Act training course.

   c. the Division of Developmental Disabilities administrators and managers will ensure the Division of Developmental Disabilities employees complete the Americans with Disabilities Act Computer Based Training available on the Department's mainframe within one (1) month of the effective date of this Directive or within the first month of employment with the Division.

10. Establish a procedure and method to document the training provided to Division of Developmental Disabilities employees.

    a. The documentation of the completion of the Americans with Disabilities Act Computer Based Training completion shall be forwarded to the Division of Developmental Disabilities Americans with Disabilities Act Liaison.

    b. The Division of Developmental Disabilities/Americans with Disabilities Act Liaison will maintain documentation on the Division of Developmental Disabilities employees who have completed the Americans with Disabilities Act training and will notify Administrators and Managers of employees who have not completed the appropriate training.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 39 (Revised) **DATE: September 9, 1997**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Choosing a Support Coordinator

EFFECTIVE DATE: Upon Receipt

As part of the intake process, individuals/responsible persons will be informed of the option of choosing a Support Coordinator if a choice is available. Individuals who are currently eligible for services from the Division of Developmental Disabilities will be informed of the option of choosing a Support Coordinator as part of the Individual Support Plan process.

The Support Coordinator Supervisor will insure that individuals/responsible persons will be given an opportunity to meet with Support Coordinator(s) prior to making a choice. If the chosen Support Coordinator has a full case load, the individual/responsible person will be able to meet with the Support Coordinator Supervisor to discuss needs and preferences. The Support Coordinator Supervisor will attempt to match them with another Support Coordinator who has the skills and abilities the individual/responsible person desires. The individual/responsible person may also choose to be placed on a pending list for their 1st choice of Support Coordinator. If the individual chooses placement on a pending list, another Support Coordinator will be assigned in the interim. Support Coordinator Supervisors will insure that the individual/responsible person is placed with the Support Coordinator of choice whenever possible.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 40 **DATE**: September 5, 1997

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Procurement Files

EFFECTIVE DATE: Upon Receipt

This Administrative Directive designates the Division of Developmental Disabilities Central Office as the central repository for all procurement files. The following is a list of items to be maintained in the procurement files. Each item listed may not be applicable for each individual procurement.

a. Original, signed procurement documents to include:

   1. The complete Request for Proposals packet as issued to potential offerors with service specifications for all services being solicited.

   2. Information for Bid and Request for Quote solicitations.

   3. Sole Source and Emergency Procurement requests and approvals/denials.

b. Vendors lists (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-325.E.).

c. Copy of notice for publication (Arizona Revised Statutes § 41-2534). Also, an original of the legal advertisement including a sufficient portion of the page from the newspaper to identify the newspaper and the date of publication or the certification of publication from the newspaper.

d. A register of attendees at Pre-Proposal Conferences (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-327).

e. Original, signed solicitation amendments (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-326.F.).

f. Register of proposal (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-239.A.).

   1. Name of each offeror listed in sequence received.

   2. Name of witness(es) present at public opening.

g. Each proposal with all supporting documents received.

h. Copy of notification to offerors that their proposal is not acceptable and shall not be afforded an opportunity to amend their offer (Arizona Revised Statutes §41-2534, Arizona Administrative Code R2-7-330.B.).

i. Copies of any/all memos, letters, correspondence, notes (as appropriate) relating to the solicitation or procurement.

j. Copy of record of all discussions (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-331). Discussions means oral or written negotiations between the state and an offeror during which information is exchanged about specifications, scope of work, terms and conditions and price set forth in the initial proposal. Communication with an offeror for the sole purpose of clarifications does not constitute "discussion". (Arizona Revised Statutes § 41-2531, Arizona Administrative Code R2-7-301.10).

k. Request for Best and Final Offers (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-332).

l. Response for Best and Final Offers (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-332).

m. Determination of award (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-334A.**)** including evaluation instrument.

n. Basis for awards.

o. Copies of notification of award to each unsuccessful offeror (Arizona Revised Statutes § 41-2534, Arizona Administrative Code R2-7-334.B).

p. Each written determination shall be filed in the applicable procurement or official records (Arizona Revised Statutes §41-2502). Delegation of authority to utilize the competitive sealed proposal process for services stated in the Arizona Taxonomy of Human Services has been granted to the Department by the Department of Administration, State Procurement Office.

q. Copy of contract.

r. All procurement related envelopes received by the Department such as protest, proposal and Best and Final.

s. All return receipts for certified mail that document the date of delivery or other means of documenting delivery.

t. Certification and/or disclosure forms regarding debarment and/or lobbying.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 41 **DATE: September 8, 1997**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Choosing a Service Provider

EFFECTIVE DATE: Upon Receipt

Individuals and families have choice in the selection of a service provider(s), if more than one provider is serving that geographical area. Districts or areas will maintain complete, accurate provider lists by service type. Support Coordinators will have knowledge of community resources. The planning process will be used to identify actions needed to obtain a service provider. The individual/family has the lead role in directing how a service provider is chosen. The Support Coordinator will follow the individual/family's direction in obtaining a service provider.

The following list of activities may assist in the selection of a service provider:

a. Review the list of providers available in the area who deliver the needed service(s) including community resources.

b. Select the provider(s) the individual/family or other party is interested in speaking to, visiting with and/or interviewing.

c. Select the service provider (the individual/family may select more than one provider to deliver any given service).

d. The Support Coordinator will initiate the authorization process for the selected provider(s).

The Support Coordinator will maintain documentation of the above process in the Individual Support Plan.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 42 **DATE: September 9, 1997**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Master File Format

EFFECTIVE DATE: Upon Receipt

Client master files will all be kept in a standardized format (attached). Existing master files will be converted to the standardized format at the first opportunity according to the following schedule:

1. At the time of transfer from one Support Coordinator to another;

2. When an individual changes from inactive to active status; or

3. At the annual Individual Support Plan/Individual Family Service Plan.

Unless otherwise noted in the format, non-essential documents older than one (1) year may be removed to an overflow file. The master file must clearly indicate that one (1) or more overflow files exist. The location of the overflow file must be tracked by the local office so historical information can be retrieved, if needed.

For children who are in foster care, a separate file containing information regarding the biological parents, foster care court reports, case plans, staffing reports, etc., will be kept in the same location as the master file.

When multiple current records, e.g., incident reports or medical records, are generated and they will not fit in the master file, a separate current file may be developed. These files must be kept in the same location as the master file and the master file must clearly indicate the existence of the separate current file.

CLIENT INFORMATION
Section 1

Identifying Information
- Client Detail Report (ASSISTS Information)**
- Placement History*
- Birth Certificate*
- Social Security Card*
- Tribal Census Card
- Alien Registration Card*
- Health Plan Card/Medicare Card/Private Insurance Card**
- Photo, if needed

Legal Information
- Petitions/Court Orders/Minute Entries
- Grievances/Complaints/Appeals
- Guardianship Papers/Power of Attorney*
- Miscellaneous Legal Documents, e.g., probation documents, subpoenas, newspaper clippings regarding legal activity, etc.

Consents
- Master File Access Log**
- Consent for Release of Information
- General Consent Form
- Consent for Behavior Modifying Medications
- Consent for Sedation/Restraint
- Special Consents
- Requests for Records from Other Agencies
- Statement of Client Rights*

Division Intake Information
- Application/Notice of Eligibility*
- Intake Application or Early Childhood Services Application*
- Pre-Pre-Admission Screening*
- Arizona Early Intervention Program Referral Form
- Eligibility Determination/Redetermination(s) Summary of Decision

*Kept permanently in master file
**Most recent kept in master file

CONTACTS
Section 2

Support Coordinator Progress Notes

Miscellaneous Correspondence
- Individual Support Plan/Individual Family Service Plan Notices
- Letters from parents/guardians
- Letters to parents /guardians
- File transfer summaries

Attorney General Contacts

PLANS
Section 3

Plans/Reviews

Strategies/Skill Plans

Program Review Committee/Human Rights Committee Documentation

Other Plans

SERVICES AND PROVIDER INFORMATION

Section 4

Unusual Incident Reports/incident and Injury Reports

Provider Progress Reports
- Home and Community Based Services
- Day
- Residential
- Qualified Mental Retardation Professional Monthly Reviews/Reports
- Early Intervention/Individual Family Service Plan Progress Reports
- Other

Requests for Authorization of Services
- District Referral Forms/SYSMs
- Physician's Orders for Services
- Prior Authorization Requests/Approvals/Denials
- Attendant Care Agreements
- Augmentative Communication Device Request Form
- Environmental Modifications and Repairs Form
- Requests for Durable Medical Equipment/Adaptive Aids
- Physician's Certificate of Need

Referrals for Services
- Behavioral Health Referrals
- Provider Referral Packet/Forms
- Placement Profile
- Vocational Rehabilitation
- Volunteer Services Requests
- Public Fiduciary
- Other Community Agencies

ASSESSMENTS AND MEDICAL INFORMATION

Section 5

Miscellaneous Medical Documentation
- Residential Medical Appointment Reports
- Medical Correspondence

Medical Evaluations
- Physical
- Dental
- Vision
- Audiological
- Nutrition
- Neurological
- Orthopedic
- Other

Behavioral Health Psychiatric Examinations Medication Reviews

Therapy Evaluations and Progress Reports
- Occupational Therapy
- Physical Therapy
- Speech Therapy

Hospitalizations/History
- Discharge Summaries
- SYSM Notices of Hospital Admissions
- Consents for Admission to Hospital
- Medical History*
- Medication History*
- Immunization Record*

Psychological Evaluations**

Other Assessments**
- Inventory for Client and Agency Planning
- Developmental/Educational/Vocational/Residential
- Family Assessments

*Kept permanently in master file
**Most recent kept in master file

BENEFITS
Section 6

Client Funds Information
- Requests for Client Funds
- Public Fiduciary/Guardian Yearly Accountings
- Client Trust Funds System Printouts of Accounts
- Division Billing Forms
- Bank Statements/Group Home Accounts

Long Term Care
- Pre-Admission Screening
- Long Term Care Member Change Form
- Long Term Care Part 1
- Long Term Care Authorized Representative Forms
- Long Term Care Notices
- Correspondence re: Long Term Care
- Cost Effectiveness Studies

Social Security/SSI
- Correspondence and Notices
- Medicare Correspondence and Notices

Assistance to Families and Supplemental Payments Program

Miscellaneous
- Residential Property Inventory**
- Wage Information**
- Life Insurance Policies/Burial Plans*
- Veteran's Administration/Railroad Retirement Benefits Notices/Correspondence
- Food Stamps/Temporary Assistance to Needy Families/Housing and Urban Development

*Kept permanently in master file
**Most recent in master file

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 43 **DATE:** September 18, 1997

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Group Homes

EFFECTIVE DATE: Upon Receipt

In accordance with Arizona Revised Statutes § 36-132(21), Division Group Homes now are licensed by the Arizona Department of Health Services. The Division of Developmental Disabilities will conduct programmatic and contractual monitoring of the services it provides or for which it contracts.

Since the Arizona Department of Health Services will not specify capacity, age and gender in it's license, the Program Monitoring Report will establish, in general terms, the number, ages and gender of clients authorized to reside in each Group Home. The district shall only approve client placements in accordance with the authorized capacity, age and/or gender. Changes may be requested by contacting the Division of Developmental Disabilities Program Monitoring Unit.

Except in cases of emergency, Individual Support Plan team approval shall be obtained prior to a client moving from one Group Home to another and prior to the relocation of a Group Home. In cases of emergency, the district shall coordinate with the service provider regarding the notification of the responsible person when a client moves from one group home to another.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 44 (Revised) DATE: July 16, 2002

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Targeted Support Coordination

EFFECTIVE DATE: Upon Receipt

This revised Administrative Directive replaces Administrative Directive 44, dated October 24, 1997 that is currently found in some Division Policy and Procedures Manuals. This revised Administrative Directive also replaces Section 407.1 of the Division's Policy and Procedures Manual.

Attached are the most current Targeted Support Coordination Guidelines. The attached Guidelines are the same as those dated February 1, 2000, with one slight modification. Item four (4) in the section labeled "Level of Contact" is clarified to indicate where changes in the type and/or frequency of contact should be documented in the case file.

The purpose of Targeted Support Coordination is to deliver individualized and flexible case management services. Even when the individual/family is choosing contact by letter, the contact should be individualized and reflect the needs of the individual and his/her family. Therefore, the use of the standard Targeted Support Coordination Letter shall be discontinued.

RZ:ED:CC

TARGETED SUPPORT COORDINATION GUIDELINES
June 25, 2002

Targeted Support Coordination (also known as Targeted Case Management) is an optional service under the Medicaid State Plan. The Centers for Medicare and Medicaid Services approved Arizona's request to provide Targeted Support Coordination to certain individuals with developmental disabilities effective October 1, 1996. Individuals who are eligible for Medicaid, but who are not eligible for the Arizona Long Term Care System can receive support coordination services through this program. Targeted Support Coordination allows the individual/responsible person to determine how much support coordination they want or need. This program does not provide for the services covered by Long Term Care such as respite, habilitation, etc. The Support Coordinator will assist the individual in accessing supports and community services needed by the individual.

Support Coordination, in the context of family support, consists of activities designed to:

1. Strengthen the role of the family as primary caregivers, thereby reducing dependency upon Division support;

2. Prevent costly, inappropriate and unwanted out-of-home placements and maintain family unity;

3. Reunite families of children with disabilities who have been placed in out-of-home placements, whenever possible;

4. Identify services provided by other agencies to eliminate costly duplication;

5. Strengthen the individual's connection to the community; and

6. Assist families in coordinating medical services through their Medicaid health plan.

Guidelines for Targeted Support Coordination

<u>Identifying Individuals Eligible for Targeted Support Coordination:</u>

1. The criteria for Targeted Support Coordination include individuals not eligible for Long Term Care, but who are enrolled in Medicaid by receiving Supplemental Security Income, Temporary Assistance for Needy Families (formerly known as "Aid to Families with Dependent Children") and/or other means. Individuals who are eligible for the Qualified Medicare Beneficiary or the Specified Low Income Medicare Beneficiary Programs, but who are not eligible for Medicaid, are not eligible for Targeted Support

Coordination. Individuals who receive Medicaid through the Kids Care program are not eligible for Targeted Support Coordination.

2. Support Coordinators will assist in identifying Targeted Support Coordination eligible individuals by obtaining Medicaid, Temporary Assistance to Families and Supplemental Security Income information on individuals eligible for services from the Division. Eligibility for Targeted Support Coordination shall be noted with a "Y" in the appropriate field, i.e., Supplemental Security Income or Temporary Assistance to Needy Families on the ASSISTS (the Division's automated client tracking system) Benefits and Evaluation Screen. In addition, the individual's Medicaid eligibility shall be noted with a "ZA" on the Billing and Financial Screen in ASSISTS. If the individual's name is not on the Arizona Health Care Cost Containment System Targeted Support Coordination Match List and the Support Coordination knows the individual is receiving Medicaid, the Support Coordinator will consider the individual to be eligible for Targeted Support Coordination and the District Long Term Care Specialist shall be notified.

Level of Contact:

1. Targeted Support Coordination allows the individual/responsible person to choose the frequency of contact. For example, every 30 days, every 90 days or as requested, but minimally, once per year. The type of contact may be in person, by telephone or by individualized letter.

   If the individual is receiving services funded by the Division, the Individual Support Plan team is required to follow the minimum requirements of service review and contact established by Policy and Procedure. An individual/responsible person may choose more frequent contact, but may not choose less.

   The following circumstances require contact as established in the Division's Policy and Procedures Manual:

   a. The individual receives Arizona Early Intervention services. For example, the Support Coordinator must meet with the family every six (6) months for an individual receiving Arizona Early Intervention Program services, however, the family may choose a phone call for the three (3) months between the required reviews.

   b. The individual resides in a Group Home, Adult Developmental Home, or Child Developmental Home.

   c. The individual receives Attendant Care. (See Section 602.1 of the Division's Policy and Procedures Manual).

d. If the individual is receiving a service funded by the Division that requires an objective/outcome, such as habilitation or therapies, there must be a review of the Individual Support Plan/Individualized Family Service Plan every six (6) months. This may be as simple as reviewing progress notes from the providers, verifying whether progress has been made, whether objectives should continue, etc. (See Chapters 600 and 1000 of the Division's Policy and Procedures Manual for further information).

The type and frequency of contact must be documented for all Targeted Support Coordination eligible people. See the Documentation section of these guidelines for details.

2. Once the individual has been determined eligible for Targeted Support Coordination eligible, the Support Coordinator shall verify whether the individual has a current (within the last 6 months) Individual Support Plan/Individualized Family Service Plan. If there is not a current plan, please see item four (4) of the Individual Support Plan/Individualized Family Service Plan section of these guidelines. In addition, the Support Coordinator will contact the individual/responsible person to fully explain the Targeted Support Coordination program and allow the person to identify the type and frequency of contact desired.

a. For a foster child for whom the Division has custody, the foster family will choose the level of contact. Foster families may choose to meet with the Support Coordinator more often than the required 30 days. For a foster child in Child Protective Services custody or Tribal custody, the choice will be given to the foster family and this choice communicated to the legal guardian.

b. When the guardian/responsible person does not live with the individual, the guardian/responsible person makes the choice of the level of Targeted Support Coordination contact on behalf of the individual served. The Support Coordinator will need to clarify with the guardian/responsible person if he/she wants to be present at the meeting, wishes to be contacted by telephone or receive a follow up letter.

3. If there is a current (within the past 6 months) Individual Support Plan/Individualized Family Service Plan in the file, the Support Coordinator will contact the individual/responsible person to explain the Targeted Support Coordination Program, and to allow them to choose the type and frequency of contact. The preference is for the Support Coordinator to make this initial Targeted Support Coordination contact in person or by telephone. Once the individual/responsible person chooses the type and

frequency of ongoing contacts the Individual Support Plan/Individualized Family Service Plan will be updated and the date of this update shall be the annual Individual Support Plan/Individualized Family Service Plan date. The type and frequency must be documented on the Individual Support Plan/Individualized Family Service Plan or review.

4. The individual/responsible person may choose to change the level of Targeted Support Coordination at any time and the Support Coordinator will document this choice in a progress note. In addition, the level of contact should be documented in the Plan Section of the case record on the Individual Support Plan/Individualized Family Service Plan Document, DD-500, or on the most current review. Minimally, however, the Support Coordinator must offer a choice of the type and frequency of Targeted Support Coordination to the individual/responsible person at least annually and document this choice in the Individual Support Plan/Individualized Family Service Plan.

Individual Support Plan/Individualized Family Service Plan:

1. An annual Individual Support Plan/Individualized Family Service Plan is required for all Targeted Support Coordination eligible individuals. The Plan shall be individualized, flexible and document what makes sense for the individual (please see Administrative Directive 32 for further information). At a minimum, the Plan shall address the type and frequency of support coordination contact chosen by the individual/responsible person, as well as a discussion/ review of the individual's needs.

   It is important that Support Coordinator's remain cognizant of the Division's Mission and of the Family Support Principles when delivering Targeted Support Coordination. Even though there are limited funds for services, there is much a Support Coordinator may do to assist individuals in accessing the supports he/she might need from the community. Support Coordinators may assist individuals in gaining access to needed medical, social, educational and other support services that may consist of the following:

   a. Informing individuals of options, including medical services and behavioral health services available from AHCCCS Health Plans based upon assessed needs.

   b. Coordinating and participating in the Individual Support Plan/Individualized Family Service Plan meetings including developing, revising and monitoring the plan.

c. Locating and coordinating social, educational and other resources to meet the individual's needs.

d. Providing necessary information to providers about any changes in the individual's functioning to assist the provider in planning, delivering and monitoring services.

e. Referring to the Arizona Long Term Care System, as appropriate.

2. If the individual/responsible person is choosing contact by letter, the Support Coordinator will send a letter that is appropriate to the individual's needs/circumstances. If the letter is the annual plan, the contact letter should be attached to a signed Individual Support Plan/Individualized Family Service Plan Cover Sheet (DD-214), and be sent by registered mail, return receipt requested. The date that the letter is sent will be considered the date of the Individual Support Plan/Individualized Family Service Plan review. All Targeted Support Coordination contact letters shall be placed in the Plan section of the file.

3. If the individual/responsible person is choosing to hold the Individual Support Plan/Individualized Family Service Plan over the phone, the Support Coordinator will fill out the Cover Sheet (DD-214), write a narrative and send both to the individual/responsible person for signature within 15 working days of the phone conversation.

   The Support Coordinator should keep copies of the documents and note in the progress notes that it was sent for signature. The Individual Support Plan/Individualized Family Service Plan should be sent registered mail, return receipt requested (if the planning meeting was not done in-person); the return receipt will be filed as proof the letter/Individual Support Plan/Individualized Family Service Plan was sent if the documents are not returned.

4. For individuals showing up on the Targeted Support Coordination List and there is no current Individual Support Plan/Individualized Family Service Plan, a contact should be made by phone or in-person to develop the annual plan and to fully introduce the individual/responsible person to service systems. The Individual Support Plan/Individualized Family Service Plan, whether done by telephone or in person, will be completed within 10 working days after the Support Coordinator has been notified that the individual is eligible for Targeted Support Coordination. Thereafter, contact will be made at the request of the individual/responsible person and the choice reviewed at least annually.

   If the Support Coordinator is unable to contact the individual/responsible person by phone or in-person to schedule the Individual Support

Plan/Individualized Family Service Plan within 10 working days, a letter will be sent to the person attempting to schedule the planning meeting. If there is no response to this letter within 30 days, a second letter will be sent via certified mail, return receipt requested, giving the individual/responsible person 30 days to respond. If there is still no response, the Support Coordinator and his/her supervisor will decide whether the individual should be placed in an inactive status or discharged from the Division of Developmental Disabilities. The procedures identified in Chapter 1100 of the Division's Policy and Procedures Manual and Administrative Directive 32 shall be followed.

Documentation of Targeted Support Coordination Contacts:

1. The date that the Support Coordinator is notified of Targeted Support Coordination eligibility, whether by the family, the Targeted Support Coordination Match List, or other means shall be documented in a Progress Note in the case record. The initial Targeted Support Coordination contact, as well as all further contacts and assistance provided to the individual/responsible person shall also be documented in the case record. If additional written narratives of the review are completed, they will be placed in the Plan Section of the case record and referenced in the Progress Notes.

2. The appropriate ASSISTS screen must be updated and a copy placed in the Plan section of the case record to reflect the new review date. Changes in demographic information, insurance information, annual Individual Support Plan (ISP)/Individualized Family Service Plan (IFSP) date, etc. should be updated in ASSISTS and filed in the appropriate section of the case record.

Inactive Status/Case Closure:

1. If the individual/responsible person does not want Targeted Support Coordination, but wants to maintain his/her eligibility with the Division, the procedures regarding "inactive status" as noted in Administrative Directive 32 of the Division's Policy and Procedures Manual will be followed. Individuals receiving direct services from the Division may not choose "inactive status." The Support Coordinator will update the appropriate ASSISTS screens, i.e., remove the "ZA" code from the Billing and Financial Screen and change the case status to "I" when the code becomes available for the Client Primary Record Screen. The District Long Term Care Specialist shall be notified so the individual can be removed from the AHCCCS/Targeted Support Coordination Match List.

2. If the individual/responsible person wishes to reactivate any kind of contact, the Support Coordinator will insure the individual is added back to

the Targeted Support Coordination List and will update the automated system accordingly. In addition, the Support Coordinator shall make sure there is a current Individual Support Plan (ISP)/Individualized Family Service Plan (IFSP) and the type and frequency of contact chosen by the individual/responsible person is documented. The District Long Term Care Specialist shall be notified so the individual can be added back to the AHCCCS/Targeted Support Coordination Match List.

3. If the individual/responsible person requests case closure, the Support Coordinator shall follow the procedures in Chapter 1100 of the Division's Policy and Procedures Manual. The District Long Term Care Specialist shall be notified so the individual can be removed from the AHCCCS/Targeted Support Coordination Match List.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 45 **DATE: April 2, 1998**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Supplemental Nutritional Feeding

EFFECTIVE DATE: Upon Receipt

This Administrative Directive provides criteria for the evaluation and authorization of supplemental nutritional feedings (oral-enteral formula) for people eligible for Long Term Care covered services through the Division of Developmental Disabilities. This directive addresses the issue of medical necessity, assessment and authorization of non-specialty formula.

I. Criteria for medical review and prior authorization:

A. The request must be made by the Primary Care Physician or physician specialist, OR a physician assistant. A request made by a physician specialist must be routed through the Primary Care Physician for continuity of care. Requests shall be routed through appropriate channels of the health plan or to the Prior Authorization Nurse in Managed Care Operations for fee-for-service.

1. Items to be submitted for medical review include:

a. all current diagnoses;
b. current or recent (within 6 months) laboratory data: chemistry panel, iron binding studies, etc.;
c. growth chart with current height and weight history. A family history of unusual growth patterns, i.e., emaciated, short stature, etc. should be included, as appropriate;
d. history of ambulation or physical activities;
e. history of gastrointestinal health;
f. current nutritional assessment and a summary of client/caregiver education done by a registered dietitian;
g. three (3), five (5) or seven (7) day diary of dietary intake, as appropriate;

h. speech or occupational therapy evaluation related to any oral-motor, dentition, chewing or swallowing problems, as appropriate
i. current medications including an analysis of possible medication/nutrient interaction affecting absorption;
j. all alternative approaches to the use of oral-enteral formulas attempted and the outcomes; and
k. specific goals of oral-enteral formulas with a follow-up and weaning plan over a specific time frame.

B. Monitoring of the client's progress on the oral-enteral formula is the responsibility of the Primary Care Physician or designee and shall include:

1. nutritional assessment follow-up at the following intervals:
   a. clients less than five (5) years - every three (3) months;
   b. clients five (5) to fourteen (14) years - every six (6) months; and
   c. clients over fourteen (14) years - annually.

2. alternatives to commercially prepared formulas should be considered whenever possible including blenderized foods for clients beyond the normal formula age (3 years) if possible.

C. Clients who are eligible for the Women, Infant and Children program should be encouraged to use that program first. The Division of Developmental Disabilities fee-for-service or the subcontracted health plan will make up the difference between the Women, Infant and Children program authorized amount and the Primary Care Physician requested amount.

II. Client Management

A. Clients should be followed by:

1. the health plan;
2. the agency providing the formula;
3. the Division of Developmental Disabilities Managed Care Operations for fee-for-service.

III. Authorization Process

A. Definitions

1. Enteral - "within or by way of the intestine." For the purposes of this Directive, enteral will mean the delivery of nutritional feedings to the

intestinal tract by way of a feeding tube such as naso-gastric, oral-gastric, gastrostomy, jejunostomy or a gastrostomy button.

2. Oral - any nutritional formula or food that Is ingested by mouth.

B. Authorization Guidelines

1. Authorization for oral-enteral formula or supplemental nutritional feedings will be granted if the following criteria are met and deemed medically necessary by the health plan medical director or the Division of Developmental Disabilities medical director for fee-for-service:

   a. the client is at or below the 1Oth percentile on the appropriate growth chart for their age and gender for greater than three (3) months; or
   b. the client has reached a plateau in growth and/or nutritional status for greater than six (6) months (pre-pubescent); or
   c. the client has demonstrated a decline in growth status within the last three (3) months; and
   d. the client requires more than 50% of nutritional intake from a supplemental formula; and
   e. absorption problems as evidenced by emesis, diarrhea, dehydration, weight loss and intolerance to milk or formula products have been ruled out; and
   f. unsuccessful trials of alternatives such as blenderized foods have been documented.

2. All documentation will be submitted by the prior authorization nurse for evaluation by the health plan medical director or the Division of Developmental Disabilities medical director for fee-for-service.

3. Re-authorization for supplemental nutritional feeding formula will be determined by the age of the client (based on the nutritional evaluation for age set forth in 1.B.1 of this directive).

SAMPLE
ENTERAL ASSESSMENT

Client's Name ID# DOB Gender
Address Phone
Caregiver's Phone (if different)
PCP Phone
Prescribing Practitioner Phone
Current Medications and Dosages
Diagnoses

Functional Limitations - Note Which Require Oral-Enteral Feedings:

Height (estimated, stated or measured) inches
Weight (estimated, stated or measured) pounds

Recent Weight Change? pounds over months

Ideal Body Weight Range pounds

Bowel Function normal diarrhea constipated incontinent
Current Feeding Pattern-oral-enteral both (% of each)
Type of Foods or Formula
Feeding Schedule
Chewing Difficulties, e.g., dentition, neuromuscular dysfunction, etc.

Swallowing Problem, e.g., aspiration, neuromuscular uncoordination, etc.

Swallowing Evaluation no _yes/Date of Evaluation

Speech Therapy for Swallowing no yes/Date of Rx

Length of Time on (circle one) ORAL or ENTERAL Therapy:

< 3 months 3 - 12 months> 12 months

List food/lactose and other intolerances

Current Oral-Enteral Order: Formula Kcal/d

Frequency Rate and Duration

Approximate Percentage of Daily Calorie Requirements Currently Being Supplied by a Meal Replacement Product (oral-enteral formula)

< 25% 26-50% 51 - 75%>75%

Feeding Tube-none nasogastric_gastrostomy jejunostomy

Ventilation none full time part time

Other Assisted Breathing Device no yes/type

Can the client use a non-prescribed food in place of enteral formula, e.g., blenderized foods, milk shakes, etc-

Is caregiver capable of providing such a substitute? Explain

If the client is currently on oral-enteral formula, is there a plan for weaning to table foods, blenderized foods or other alternatives?_yes_no

If yes, what is the plan and over what time frame?

History of previous attempts to decrease or discontinue oral-enteral formula usage including dates, number, manner and results of attempts by the client and caregiver.

Has the client/caregiver been given nutritional education? What was the response?

What is the plan to monitor the client's height, weight and growth pattern?

Other relevant information

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 46 (Revision 1) **DATE: July 16, 2002**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Reporting Information to Human Rights Committees

EFFECTIVE DATE: Upon Receipt

The Division of Developmental Disabilities (Division) will provide the following to Human Rights Committees:

- Incidents of possible abuse or neglect.
- Violations of rights.
- Administration of medication which changes the individual's behavior either directly or as a side effect.
- Aversive or intrusive programs.
- Client intervention techniques for medical treatment, i.e., a medical or dental appointment.
- Research proposals in the field of developmental disabilities which directly involve individuals receiving services.
- All behavioral emergency measures as stated in Arizona Administrative Code R6-6-901, et seq.
- Copies of residential monitoring compliance reports and summaries of homes monitored in the area along with corrective action plans.
- Copies of all Individual Support Plans in which the team has not reached consensus, as requested by any member of the team.
- Copies of Unusual Incident Reports and resulting investigations involving the Division.
- Copies of "substantiated/unsubstantiated" reports from Adult Protective Services and Child Protective Services.
- Theft of client property and money.
- Medication errors including theft or missing medications.
- Incidents and circumstances that pose a threat to the physical or emotional well-being of an individual or staff member.
- Property damage/destruction.

- Notification (within 24 hours) of serious incidents, i.e., death, violation of rights.
- Reports of special investigations received by the Division.
- Copies of provider investigations, subsequent analysis of report findings and corrective action plans.

All Human Rights Committee Members shall sign a confidentiality statement each year. Re-disclosure of confidential information is prohibited.

RZ:JCP:CC

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 47 (Revised) **DATE: May 15, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director

SUBJECT: Therapeutic Leave and Bedhold

Effective Date: July 1, 2003

For individuals residing in an Intermediate Care Facility for the Mentally Retarded or a Nursing Facility, therapeutic leave shall not exceed 9 days and bedhold days shall not exceed 12 days per calendar year.

If you have questions, contact Brian Lensch at (602)542-0419.

RZ:BL:CC
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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 48 **Date: June 15, 1998**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Timelines for responding to requests for changes to authorized levels of service

EFFECTIVE DATE: Upon Receipt

When a member of the Individual Support Plan Team requests a change to the authorized level of service for a client, the Support Coordinator shall schedule a meeting of the team members within 30 days of the request. If the parent/guardian or client cannot be present at an Individual Support Plan meeting within the 30 day timeline, the meeting will be scheduled at their earliest convenience.

Once the Individual Support Plan team has reviewed the request and makes their recommendations to the division, the division shall approve or deny the recommendations within 5 working days. If the recommendations are approved, the change in service levels shall be input into ASSISTS within 5 working days.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 49 **Date: June 15. 1998**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Sharing Information

EFFECTIVE DATE: Upon Receipt

This policy states the conditions under which information shall be shared during the placement process with parents/guardians of persons with developmental disabilities who are potentially at risk, or who potentially place others at risk.

At the time of placement, the following procedures shall be followed:

1. In the case where an individual's behaviors can pose danger to other residents or staff, non-personally identifiable information will be shared with guardians of other residents of the home. Either the agency director or designee or Division staff will ensure the information is provided to the guardian.

2. For people who are currently in placement or using out-of-home respite in situations of potential risk, the Support Coordinator in conjunction with the Individual Support Plan team will identify the appropriate person to inform the family.

In cases of emergency placement, the checklists capturing potential safety concerns for everyone in the home must be made available to the guardian/family of the individual moving in.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 50 **Date: June 15. 1998**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Safety

EFFECTIVE DATE: Upon Receipt

Prior to any out-of-home respite or residential placement (including emergencies), the DD-097 (HCBS Pre-Service Meeting Documentation), DD-223 (Transfer Checklist) and any other pertinent forms shall be completed to gather general care information and identify potential safety concerns to prevent risk to the individual, other residents, staff and the public.

Upon referral and prior to placement, the Division shall share copies of Individual Support Plans, Behavior Treatment Plans, and medical records including behavior controlling medications with the service provider. This must be completed before the person is accepted for any planned residential placement. The provider must also complete an information checklist for the individual referred highlighting potential safety concerns to prevent risk to the individual, other residents, staff and the public.

The Individual Support Plan team will identify in the Individual Support Plan appropriate means to deal with potential safety risks including, but not limited to training, inoculations, and staffing as needed. The Individual Support Plan team, in consultation with law enforcement, Behavioral Health, the Administration for Children Youth and Families, or other individuals/agencies as appropriate, will develop planned responses to known problems prior to placement.

If, after following these procedures, the final determination is that the placement may not be safe, alternate arrangements must be considered.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 51 (REVISED) **DATE: September 12, 2001**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Autism

EFFECTIVE DATE: Upon Receipt

This Directive supercedes section 502.4.4 of the Division of Developmental Disabilities Policies and Procedures Manual in its entirety.

"Autism" is defined in Arizona Revised Statutes § 36-551(6) as a condition characterized by severe disorders in communication and behavior resulting in limited ability to communicate, understand, learn and participate in social relationships.

Acceptable documentation of autism must include a statement by, or evaluation from, a licensed psychiatrist or a licensed psychologist with experience in the area of autism identifying a diagnosis of Autistic Disorder (DSM Code 299.00). Rarely, in older records, autism may also be called Kanner's Syndrome and/or early infantile autism. While a diagnosis of Autistic Disorder is one of the criteria that must be met, the opinion of the psychiatrist or psychologist is not by itself final or binding without adequate documentation and support for the diagnosis and related functional impairment. The record should clearly support that the individual meets the diagnostic criteria for Autistic Disorder (See DSM-IV diagnostic criteria, attached).

Medical and/or psychological records that refer to “autistic tendencies”, “autistic behavior”, “autistic-like disorder” or an “autistic spectrum disorder” are insufficient to establish eligibility. Individuals age six (6) and over who have a diagnosis of Pervasive Developmental Disorder, Pervasive Developmental Disorder, Not Otherwise Specified, Asperger’s Disorder or Childhood Disintegrative Disorder are not eligible.

If the records do not clearly and consistently establish that the person meets the diagnostic criteria for Autistic Disorder, the application for eligibility determination or redetermination shall be referred to the Eligibility Review Committee prior to an eligibility decision.

Diagnostic Criteria for 299.00 Autistic Disorder
(DSM-IV pp. 70-71)

A. A total of six (or more) items from (1), (2) and (3), with at least two from (1), and one each from (2) and (3):
   (1) qualitative impairment in social interaction, as manifested by at least two of the following:
      (a) Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.
      (b) Failure to develop peer relationships appropriate to developmental level.
      (c) A lack of spontaneous seeking to share enjoyment, interests or achievements with other people (e.g. by a lack of showing, bringing, or pointing out objects of interest).
      (d) Lack of social or emotional reciprocity.
   (2) qualitative impairments in communication as manifested by at least one of the following:
      (a) Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime).
      (b) In individuals with adequate speech, marked impairment in the ability to sustain or initiate a conversation with others.
      (c) Stereotyped and repetitive use of language or idiosyncratic language.
      (d) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.
   (3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
      (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
      (b) apparently inflexible adherence to specific, nonfunctional routines or rituals
      (c) stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole-body movements)
      (d) persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 53 (Revised)

DATE: December 14, 2004

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Cost Effectiveness Studies

EFFECTIVE DATE: Upon Receipt

This Directive supercedes Chapter 900, Section 905 in its entirety.

Home and Community Based Services provided under the Arizona Long Term Care System must be cost-effective when compared to the cost of an Intermediate Care Facility for the Mentally Retarded. Written Cost Effectiveness Studies (form DD-234) are required by the Arizona Health Care Cost Containment System (AHCCCS) for Long Term Care eligible persons as identified below:

- Each quarter, the Cost Effectiveness Study report is posted to the Division's Intranet web page under "Standard Reports/Month End/Client".

  The report is run on February 15, May 15, August 15 and November 15. The report identifies Long Term Care eligible individuals whose monthly service costs for the past three months exceed 80% of the current, regular institutional rate. To insure all payments are posted, the report is run 45 days after the period. For example, the May 15th report includes payments for January, February and March.

  The services included in the Cost Effectiveness Study are:

- Attendant Care
- Day Treatment (Adult)
- Day Treatment (Child)
- Employment Related Services
- Habilitation (Hourly)
- Habilitation (Daily)

- Home Health Aid
- Home Health Nurse
- Housekeeping
- Nursing Respite
- Respite
- Transportation

In some cases, additional costs may be associated with the Cost Effectiveness Study Worksheet. These costs are commonly referred to as the member's Share of Cost. The Share of Cost is calculated by comparing the member's income to their allowable expenses. If the member's income is greater than the allowable expense, the excess amount is their Share of Cost. A member's income may include payments from Survivor or Veteran's Benefits, Social Security Disability Insurance, retirement pensions or other sources. As these payments change, so will their Share of Cost. AHCCCS calculates this cost and posts it in their computer system. When the Cost Effectiveness Study Worksheet is entered, the Share of Cost automatically reduces the member's institutional rate, thereby increasing the overall percent of cost. The District Long Term Care Specialist can assist District staff to identify this figure so that it can, if appropriate, be included in each individual's Cost Effectiveness Study Worksheet. Long Term Care eligible individuals who qualify for Supplemental Security Income will not have a Share of Cost, however, those receiving other income <u>may</u>.

- The Long Term Care Specialist distributes the report to Support Coordinators and, within 30 days, a Cost Effectiveness Study must be completed for each individual identified in the report and returned to the Long Term Care Specialist who will enter it in the AHCCCS computer system at the CA160 screen within 60 days of the report.

  The Cost Effectiveness Study is a "projection" of costs three months into the future, therefore, it is possible that individuals named on the Cost Effectiveness Study report will have costs projected to be under 80%. Regardless, the Support Coordinator must complete a Cost Effectiveness Study if the individual's name appears on the report.

  Each Cost Effectiveness Study must be signed by the Support Coordinator Supervisor (for those below 100%) or the District Program Manager/ Administrator (for those above 100%). This signature assures that all appropriate Cost Effectiveness Study Policies and Procedures have been followed.

  AHCCCS generates a monthly report that identifies individuals who had previously been above 80% of the institutional costs. For these individuals who are now below 80%, a new Cost Effectiveness Study must be completed and entered in the AHCCCS computer system at the CA160 screen within 60 days of the report.

- For individuals who are eligible for the **ventilator dependent program,** a Cost Effectiveness Study shall be completed by the Support Coordination Team (Ventilator Dependent Program Manager and the Support Coordinator). The completed Cost Effectiveness Study will be submitted to the Health Care Services Office, Medical Services Manager and a copy will be maintained in the individual's case record. Health Care Services staff will insure the Cost Effectiveness Study is entered in the AHCCCS computer system at CA160.

- When an individual is being **discharged from an institutional placement,** e.g., Intermediate Care Facility for the Mentally Retarded, Arizona State Hospital, Skilled Nursing Facility, etc., a Cost Effectiveness Study must be completed by the Support Coordinator prior to the move. The costs used for the study should be those proposed for the new placement, not from the institutional placement.

The completed Cost Effectiveness Study will be reviewed by District placement personnel and if the costs are below 100% of the appropriate institutional level and the move is approved, copies will be sent to the District Long Term Care Specialist and maintained in the individual's case record. The Long Term Care

Specialist will insure the Cost Effectiveness Study is entered in the AHCCCS computer system at CA160.

In addition to the Cost Effectiveness Study, a Discharge Plan consistent with the Division's Policy Manual, Sections 809.5 and 910 must be in place prior to the move. *Note: it is advisable to complete an analysis of costs prior to* <u>*any*</u> *and all placement changes, e.g., group home, developmental home, etc.*

- When the completed Cost Effectiveness Study generates a percentage between 80% and 100%, the Support Coordinator will document how the team intends to reduce costs (cost reduction plan). For e*xample, "The team has discussed current services and has identified possible alternatives so that overall costs may be reduced in the near future. The team will reevaluate reduction strategies at the next plan meeting.*"

The completed Cost Effectiveness Study and the cost reduction plan must be maintained in the individual's case record. A copy of the Cost Effectiveness Study shall be submitted to the Long Term Care Specialist. The Long Term Care Specialist will insure the Cost Effectiveness Study is entered in the AHCCCS computer system at CA160.

Until the Cost Effectiveness Study is brought below 80%, the Support Coordinator will be required to complete and submit a Cost Effectiveness Study quarterly. The Long Term Care Specialist will insure the Cost Effectiveness Study is entered in the AHCCCS computer system at CA160.

If the completed Cost Effectiveness Study generates a percentage below 80%, a cost reduction plan will not be required. The Long Term Care Specialist will insure the Cost Effectiveness Study is entered in the AHCCCS computer system at CA160.

- When the completed Cost Effectiveness Study generates a percentage over 100%, the Support Coordinator will meet with the individual's planning team and District administration to decide which of the following options should be pursued:

  1. Request a higher medical rate through Health Car Services

     The Support Coordinator submits documentation for Health Care Services to review the appropriate use of a higher medical institutional rate. The Support Coordinator must complete a justification packet that includes the following information:

     - ✓ Narrative describing the person's current status and need level. This narrative should address the individual's diagnosis, medical and/or behavioral conditions, current

living arrangement, provider or family care schedule and any other helpful information.

- ✓ Current nursing assessment
- ✓ Plan to reduce costs
- ✓ Current Cost Effectiveness Study
- ✓ Any other information that will assist Health Care Services staff in evaluating the request
- ✓ Current Individual Support Plan

2. Request a higher behavioral health rate through the Behavioral Health Unit.

   The Support Coordinator submits documentation for the Behavioral Health Unit to review the appropriate use of a higher behavioral health institutional rate. The Support Coordinator must complete a justification packet that includes the following:

   - ✓ Narrative describing how the person meets the criteria. This narrative shall contain the person's psychiatric diagnosis, most recent psychiatric and psychological evaluations, description of how the person has difficulty adapting to community life, description of substance abuse issues (if applicable) and a description of criminal offenses (if applicable).
   - ✓ Cost Effectiveness Worksheet
   - ✓ Plan to reduce costs
   - ✓ Current Behavior Treatment Plan
   - ✓ Any other information that will assist the Behavioral Health Unit in evaluating the request
   - ✓ Current Individual Support Plan

   Note: <u>Health Care Services or the Behavioral Health Unit will inform the Long Term Care Specialist of authorizations for higher institutional rates (medical and behavioral) with the approval time period. If costs continue at the higher level, a request should be resubmitted in advance of the approval expiration. Should the approval expire or be denied, the institutional rate will revert back to the regular institutional rate and the Support Coordinator must initiate review of the other remaining options listed above.</u>

3. Request approval from AHCCCS to exceed 100% of the institutional rate

   The Support Coordinator must complete and send a packet of information to the District Long Term Care Specialist. This option may be used after a request for a higher rate is pursued and denied from Health Care Services or the Behavioral Health Unit, or in cases where Health Care Services or

the Behavioral Health Unit authorized up to the limit of their authority, and the District wants to pursue having all costs covered with Long Term Care funding. In rare cases, this option may be pursued prior to other options. The packet will include the following information:

- ✓ Narrative describing person's medical, functional and behavioral status
- ✓ Current Individual Support Plan (and Individual Education Plan if in school)
- ✓ Current Cost Effectiveness Study
- ✓ Behavior Treatment Plan (and, information regarding effectiveness), as appropriate
- ✓ Medication individual is receiving
- ✓ Description of services to be received
- ✓ Discussion of individual's recent placements, including those that failed
- ✓ Description of other system involvement (e.g. Regional Behavioral Health Authority, school, etc.)
- ✓ Other information as requested by AHCCCS

After review and approval by the District Long Term Care Specialist and the District Program Administrator/Manager, the District Long Term Care Specialist will send the packet to AHCCCS. If AHCCCS denies the request, the Cost Effectiveness Study calculation entered to the computer system at CA160 will be adjusted to reflect Medicaid approved costs up to but not exceeding 100% of institutional cost. Continuation of costs exceeding 100% must be approved by the District Administration and paid with state funds. The Support Coordinator will advise the authorizer to adjust payments accordingly.

4. Reduce costs to below 100% within 6 months of identification

The AHCCCS Medical Policy Manual provides that when the cost is expected to be below 100% within the next six months, justification must be added to the Cost Effectiveness Study and documented in the case file.

If services are reduced, the Support Coordinator must follow the Individual Rights and Responsibilities Notification procedure. If it is unlikely that costs can or will be reduced in the six month period, the Support Coordinator is responsible for initiating a review of other options.

Once the Support Coordinator completes the Cost Effectiveness Study and costs are found to exceed 100%, the Support Coordinator must submit the calculation to the District Long Term Care Specialist so that it can be entered in the AHCCCS computer system at CA160. In addition,

the Support Coordinator should immediately consult with their supervisor, area manager, nurse, contract staff, etc. The Support Coordinator may need to call special team meetings to address the high costs. Team members (including providers) should be notified that current costs exceed institutional levels and overall costs must be reduced by the end of the 6 month period. The following may be discussed by the Planning Team:

- ✓ Reducing service units (reducing staffing levels)
- ✓ Alternative placements

If, at the end of six months, costs have not been reduced to below 100%, the Support Coordinator must notify the District Long Term Care Specialist, the District Program Administrator/Manager and the Long Term Care Program Administrator.

If the District Administration approves services above the 100% Cost Effectiveness threshold, these costs must be paid with state funds. The Support Coordinator will advise the authorizer to adjust payments accordingly. The revised Cost Effectiveness Study (below 100%) will be filed in the case record and a copy must be submitted to the Long Term Care Specialist. The Cost Effectiveness Study calculation previously entered in the AHCCCS computer system at CA160 will be adjusted to reflect Medicaid approved costs up to but not exceeding 100% of institutional cost.

In some cases, AHCCCS will allow the Division to limit the amount of service cost to the individual's approved institutional rate. This option is only available for individuals living in their own or family's home, including Individually Designed Living Arrangements. The option is not available for individuals residing in licensed residential settings such as group homes, child foster or adult developmental homes.

For this option to be approved, the Division must have offered the individual/responsible party an alternative placement in a more cost effective setting. The individual and/or their responsible party must have refused that offer.

If District Administration denies use of state funds, the Support Coordinator should initiate termination of service costs in excess of 100%. The Support Coordinator must advise the member/responsible party of the cost effectiveness limitations and discuss other options. The Support Coordinator must also follow the Individual Rights and Responsibilities Notification procedures. If the member chooses to remain in their current placement, even though the District cannot provide all of the services that have been assessed as medically necessary (including those ordered by

the member's Primary Care Physician), a risk agreement/contract must be written. This agreement should document the amount and type of service the District can cost effectively provide, the placement/service options offered to the member, the member's choices with regard to those options, the risks associated with the decrease in service amounts and any plans the member/responsible party has to address those risks (e.g. paying privately for services above 100%, volunteer services, etc.). The member/responsible party's signature on the agreement documents his/her acknowledgement of the service limitations and risks.

5. Consider possible institutional placement

   The Support Coordinator must first document all other options considered and the reasons they were not successful and submit for review by the District Program Administrator /Manager. The Planning Team must discuss the lack of appropriate, cost effective alternatives for the individual and discuss the potential for institutional placement.

The Support Coordinator will submit the completed Cost Effectiveness Study worksheet to the District Long Term Care Specialist. The Long Term Care Specialist will insure the Cost Effectiveness Study is entered in the AHCCCS computer system at CA160.

District Administration may continue current costs while any of the above options are being pursued. If after 6 months, costs continue beyond 100% without AHCCCS approval, the Cost Effectiveness Study calculation in CA160 must be adjusted to reflect AHCCCS approved costs up to but not exceeding 100% of institutional cost.

CRITERIA FOR USING THE HIGHER CES RATE
Effective: 10/1/2003

I. $304.25 PER DAY OR $9,254.27 PER MONTH is the "**Regular**" Cost Effectiveness Study rate. It is used under all circumstances except as otherwise shown below.

II. See "Hacienda Intermediate Care Facility for the Mentally Retarded" rate below the "**Medical**" Cost Effectiveness Study rate. It shall be used under the following circumstances. Client must qualify for at least one of the following:

1. Dialysis.

2. C-Pap. These are ventilators without a rate. However, if you need further information, talk to your district nurse.

3. Bi-Pap. These are ventilators without a rate. However, if you need further information, talk to your district nurse.

4. New ventilator (before entering Ventilator Dependent Program, first 30 days)

5. Post Ventilator (90 days).

6. Deteriorationg terminal client with supporting documentation; terminal means client has approximately 6 months to live and needs skilled care every 3 hours--or more frequently--around the clock (with Hospice not providing services).

7. With or without a trach; small volume nebulizer treatments and suctioning required every 3 hours or more frequently around the clock, or two or more of the following: monitors that need to be watched continually--oxygen; pulse oximeters; apnea monitor; severe cardiac condition.

8. Group home clients who require more than 4 skilled nursing visits per day, e.g., insulin, respiratory.

9. Medical group home clients (where there are full time nurses as paid staff).

10. Other circumstances as recommended by the Individual Support Plan which would require support beyond the typical Intermediate Care Facility for the Mentally Retarded placement as reviewed and approved by the Health Care Services Medical Services Manager. (e.g. 2 person lift or medical issues such as uncontrolled seizures with as needed meds.)

The documentation must support the use of higher level of care. This documentation should be similar to the documentation submitted to AHCCCS to justify those individuals who are over 100% of the cost of the Intermediate Care Facility for the Mentally Retarded. Health Care Services will not consider a specific diagnosis for the higher Cost Effectiveness Studies rate, such as Prader Willi Syndrome, because some Prader Willi clients require no intervention. We will not consider a higher rate because of an acute condition.

HACIENDA DE LOS ANGELES' ICF-MR

SERVICE DESCRIPTIONS and RATES

Level I includes patients who do not have a tracheostomy and are not C-Pap, Bi-Pap or ventilator dependent. Rate-$330.58 PER DAY or $10,055.14 PER MONTH.

Level II includes patients who have a tracheostomy, receiving 60 minutes or more of respiratory care per day and/or receiving enteral feeding by pump, or require continuous oxygen on a permanent basis, not for an acute condition, but are not C-Pap, Bi-Pap or ventilator dependent. Rate $407.69 PER DAY or $12,400.56 PER MONTH.

Level III includes patients who are C-Pap, Bi-Pap or ventilator dependent on a permanent basis, not for an acute condition. Rate $473.06 PER DAY or $14,388.90 PER MONTH.

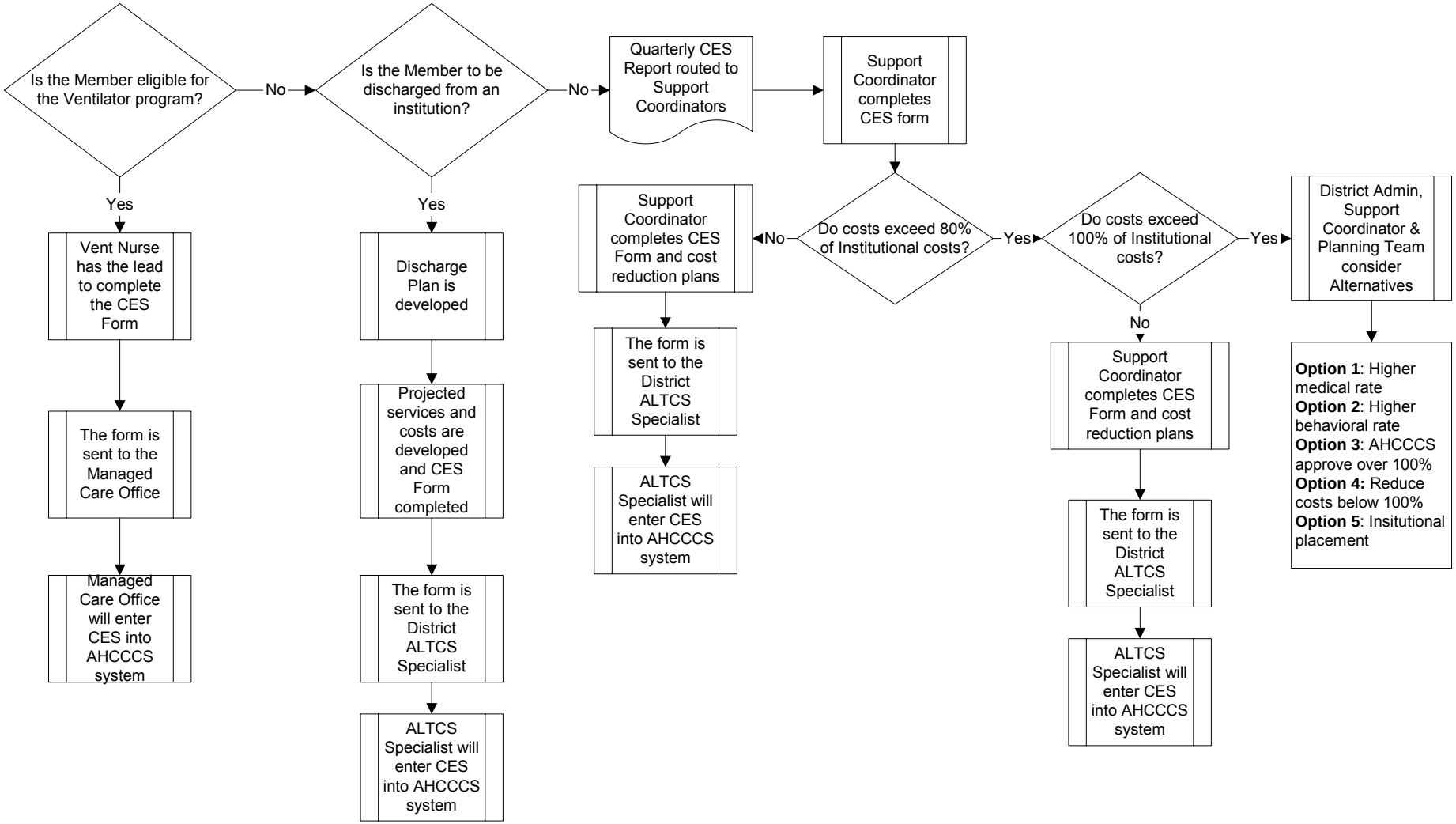
Placement of patients within the levels described above is solely at the discretion of the Division of Developmental Disabilities through Health Care Services.

III. $516.00 PER DAY or $15,695 PER MONTH for individuals who are Long Term Care eligible and at least one or more of the following:

1. Has a mental health diagnosis and significant difficulties adapting to community life;
2. Has a substance abuse disorder and significant difficulties adapting to community life;
3. Has been charged with a crime of sexual violence, including but not limited to, rape, statutory rape, and child molestation;
4. Has been charged with acts directed toward strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization;
5. Has committed one or more violent crimes, such as murder, attempted murder, arson, first-degree assault, kidnapping, or use of a weapon to commit a crime.

The Division's Behavioral Health Unit Supervisor and/or Medical Director must approve any District request to use this rate. The District must submit sufficient documentation to demonstrate the individual qualifies for the higher rate in Group III.

Division of Developmental Disabilities
Cost Effectiveness Study Flowchart



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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 54 **DATE: November 9,1999**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Courtesy Support Coordination

EFFECTIVE DATE: Upon Receipt

Courtesy support coordination is defined as services provided to an individual/responsible person or family during a temporary absence from their area or district to another area or district of the state. Courtesy support coordination is provided by the receiving area or district before and during the temporary absence and will end once the individual returns to his/her home area or district.

The following guidelines are general in scope and each situation must be treated on a case by case basis to ensure, to the maximum extent possible, a continuity of supports and services in the new setting. If it becomes evident that the individual intends to remain in the new area or district, the courtesy status should end and the case transferred in accordance with Section 910 of the Division of Developmental Disabilities Policies and Procedures Manual.

As soon as the Support Coordinator in the home district becomes aware that the individual will be temporarily out of the area or district he/she will notify, in writing, his/her supervisor of the individual's intention to temporarily reside out of the area or district. The supervisor will transfer this information to his/her District Program Administrator/District Program Manager with a request assignment of a courtesy Support Coordinator in the receiving area/district. The District Program Administrator/District Program Manager will transmit the notification to the receiving District Program Administrator/District Program Manager. The notification will contain the following information:

1. Individual's name, date of birth, documented disabilities, ASSISTS identification number and funding status (Long Term Care or state only).

2. Name(s) of family members who will be with the individual, responsible person, relationship to individual and their telephone numbers.

3. Address (including ZIP code) of temporary residence (if known).

4. Planned date of move and anticipated length of stay.

5. Reason(s) for move (if known).

6. Name, telephone number and site code of the current Support Coordinator.

The District Program Administrator/District Program Manager in the receiving district will transfer the notification to the appropriate supervisor for assignment of a courtesy Support Coordinator. The supervisor will assign a Support Coordinator in accordance with Section 404 of the Division of Developmental Disabilities Policies and Procedures Manual. The sending Support Coordinator is then notified of the name, telephone number and site code of the courtesy Support Coordinator.

The sending Support Coordinator and the courtesy Support Coordinator will discuss issues and make decisions regarding the responsibilities of both Support Coordinators including who will schedule and facilitate the annual Individual Support Plan; who will review the Individual Support Plan and effect needed changes and who will send copies to the team members. In all cases, the courtesy Support Coordinator will send copies of all documentation to the sending Support Coordinator. The Support Coordinator "closest" to the situation will write incident and unusual incident reports.

In complex situations, it may be necessary to address the following, in writing:

1. Long Term Care/health plan notifications and enrollments.

2. Primary care physician identification and therapist/specialist referrals.

3. School enrollment and outstanding educational issues.

4. Durable medical equipment/adaptive equipment.

5. Service needs and referrals to new providers.

6. Program Review Committee and Human Rights Committee involvement.

7. Funding issues such as billing, etc.

8. Behavioral health needs.

9. Notification to Managed Care for individuals using a ventilator; monthly visit requirements, etc.

10. Anticipated visits by family, friends, etc.

11. Contacts and follow-ups on individuals receiving Targeted Support Coordination.

Once the individual returns to his/her home area, the sending Support Coordinator will assume all responsibilities.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 55 **DATE: December 2, 1999**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Referral Process for Group Homes

EFFECTIVE DATE: Upon Receipt

This Directive will implement the following objectives:

1. To provide individuals and/or families with reasonable choices regarding residential options giving consideration to personal preferences.

2. To insure the Division of Developmental Disabilities makes appropriate service referrals to agencies.

3. To insure Districts maintain current and accurate information regarding available residential resources to effectively address needs.

Each District shall designate at least one person to serve as a coordinator for group home referrals, both inter- and intra-district. A District has the option of designating a committee to serve in this capacity. The District will establish a process to insure this person or committee has access to current and accurate information regarding group home resources available in the District.

The following process will be used in regard to the identification of people needing placement in a group home:

A. Needs will be identified in the Individual Support Plan process. This includes individuals seeking initial placement in a group home or people who want a different group home. The Individual Support Plan Team will define the urgency of the need for placement (or change of placement) and will include timelines.

   The Support Coordinator will forward a completed referral packet ("Where I Live Preference Checklist" and/or Individual Support Plan forms) to the District Coordinator/Committee within five (5) days of the Individual

Support Plan meeting. If the referral is to another District, follow the same process. For individuals who are minors, refer to Section 912.5 of the Division of Developmental Disabilities Policy and Procedures Manual. The District Coordinator/Committee will assign a priority code as follows:

1. Health and safety
2. Present need, but health and safety not currently threatened
3. Future need

The Coordinator/Committee will identify existing group home options and will insure the options are allowed in contract, certified and registered and licensed. Financial resources will also be considered. Priority will be given to suitable vacancies. If an existing option is not available for a priority 2 or 3 the person will be put on a waiting list, if they choose. Additional review by District management will be required if the setting cost exceed 80% of Intermediate Care Facility for the Mentally Retarded cost.

B. The District Coordinator/Committee will send the referral packet to appropriate providers and will request a response within 10 working days of receipt, unless it is a priority 1. For priority 1 situations, the District Coordinator/Committee will call the provider and request an immediate response.

The Coordinator/Committee will review provider responses of interest. Responses must include a description of available services and a projection of costs to serve a particular individual. The Coordinator/Committee will share appropriate responses with the Support Coordinator. The Support Coordinator will contact the individual/responsible person and establish how the individual/responsible person wants to explore the options available and discuss the level of involvement the individual/responsible person wants from the Support Coordinator. The Support Coordinator will offer the individual/responsible person the following information to assist with selection:

"Looking for the Right Fit" (DDD-1OOOAPAMNA) Licensing/Monitoring performance information
Contract information

Providers will be encouraged to provide any available information regarding the agency.

C. The individual/responsible person will inform the Support Coordinator of the choice of providers (if a choice is available).

D. If the placement cost exceeds 80% of the cost of an Intermediate Care Facility for the Mentally Retarded placement, the District will review the preference and then inform the individual/responsible person and the Support Coordinator of the approval. The District then authorizes the agency to provide the service.

To determine if this Directive is effective in achieving the defined objectives, the following strategies will be used:

1. The Core Indicator Project, specifically the question, "Did you choose where you live?" If this Directive is implemented properly, the individual/responsible person's access to reasonable options will be enhanced.

2. A "Where I Live Preference Checklist" may be completed. The District will then review the survey and compare it to the individual's living situation. If the residential setting reflects a majority of the individual/responsible person's choices, this Directive is being correctly implemented.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 56 **DATE: December 13,1999**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Compliance with Group Home Monitoring Rules

EFFECTIVE DATE: Upon Receipt

The results of program monitoring reviews indicate that, at any given time, a significant number of group home settings that contract with the Division of Developmental Disabilities are operating in compliance with all rule requirements. Some group home providers, however, have demonstrated an inability or unwillingness to comply with the rules contained in the Arizona Administrative Code (Arizona Administrative Code) R6-6-801, et seq. and R6-6-901, et seq. (Articles 8 and 9). In order to recognize and address the lack of compliance with the rules, the following procedure is directed:

1. Every six (6) months, the Division of Developmental Disabilities Program Monitoring Unit will distribute a report summarizing group home provider compliance with Articles 8 and 9. This report will identify patterns of rule violations over time and by subject, e.g., rights, medications, training, etc. The six month report will be shared with the service provider, district administrator, budget administrator and others, as directed.

    a. The District will assess the six month report to verify that service providers are operating in high or average compliance with rule requirements.

        i. The District will issue a Notice of Concern (example attached) to each service provider operating in the below average range.

        ii. A face to face meeting will be held between the District and each provider operating in the below average range during two (2) consecutive review periods. The purpose of this meeting is to jointly develop a corrective action plan.

iii. A plan to transition the care of the Division of Developmental Disabilities clients to other contracted service providers will be initiated by the District for each provider operating in the below average range during three (3) consecutive review periods.

b. The District will assess the six month report for other significant patterns of non-compliance, e.g., patterns of violations by subject, repeat violations of a specific rule, etc. If the assessment identifies a significant pattern of non-compliance with rules, the District will intervene with necessary action. This action may include a Notice of Concern, a face to face meeting to develop a corrective action plan, a transition of care plan, etc.

EXAMPLE

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1789 W. Jefferson - P.O. Box 6123 - Phoenix, AZ 85005

Jane Dee Hull
Governor

John L. Clayton
Director

Notice of Concern

Date

Jane Doe, Executive Director
AAA Residential Services
1234 Main Street
Anywhere, AZ 87654

Dear Ms. Doe:

During the six month period of time from July 1, 1999 through December 31, 1999, the group homes operated by AAA Residential Services were found to be in below average compliance with rule requirements. This pattern demonstrates an inability or unwillingness by your agency to comply with the rules contained in the Arizona Administrative Code for group homes serving individuals with developmental disabilities.

You are directed to implement the necessary systems to ensure high or average compliance in the operation of your group home settings. If you are unable to operate your programs in accordance with these requirements, you will be required to work jointly with the Division to develop an acceptable corrective action plan.

If you have any questions or would like to arrange for technical assistance, please give me a call at 602.555.1212.

Sincerely,

Mary Brown
District Program Administrator
Division of Developmental Disabilities

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 57 (Revised)

DATE: December 14, 2004

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Disclosure and Restricted Use of Social Security Numbers

EFFECTIVE DATE: Upon Receipt

The Federal Privacy Act, 5 U.S. Code § 552a (1974) provides that a state agency cannot require, as a condition for receiving any right, benefit or privilege provided by law, the disclosure of an individual's Social Security Number unless:

1. The records system predates 1975 and used Social Security Numbers as identifiers, or

2. It has received special permission from Congress to require a Social Security Number.

The Division of Developmental Disabilities does not meet either criteria and, therefore, **cannot** require an individual or family to disclose their Social Security Number.

The Division's rules on applying for admission contain several references to providing Social Security Numbers (Arizona Administrative Code R6-6-401 (B)(1)(b), (B)(1)(j) and (B)(2)(a). Arizona Administrative Code R6-6-401 (F) states that the Division shall not consider an incomplete application. These rules appear to violate the Federal Privacy Act.

In order to meet the requirements of the Federal Privacy Act, the following actions are required:

1. A request for an individual with developmental disabilities' or family members' Social Security Number is voluntary on their part.

2. Eligibility or access to services cannot be denied if an individual or family member chooses not to disclose their Social Security Number.

3. When requesting an individual's or family member's Social Security Number for any reason, including application for eligibility, the individual or family member must be informed that disclosure is voluntary.

Effective January 1, 2005, Arizona Revised Statute 44-1373 provides for restricted use of social security numbers. Employees of the Division shall not:

1. Intentionally communicate or make an individual's Social Security Number available to the general public.

2. After January 2005, print an individual's Social Security Number on any card required for the individual to receive services from the Division.

3. Transmit an individual's Social Security Number over the Internet unless the connection is secure or the Social Security Number is encrypted.

4. Require use of an individual's Social Security Number to access a website, unless a password or unique identification number or other authentication device is also required to access the site.

5. Print an individual's Social Security Number on any materials that are mailed, unless state or federal law requires the Social Security Number to be on the document to be mailed.

    - This does not prohibit mailing of a copy of a document in which the Social Security Number was included on the original document before January 1, 2005.

    - Mailing documents that include the Social Security Number sent as part of an application or enrollment process, or to establish, amend, or terminate a contract is permissible.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 58 **DATE: September 8, 2000**

TO: Policies and Procedures Manual Holders

FROM: Roger A. Deshaies
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Case Management Pilot

EFFECTIVE DATE: Upon Receipt

House Bill 2077 was passed in the 1999 legislative session. This bill authorizes the establishment of case management pilot projects. This pilot will provide a range of choices of case management services through contracts or agreements between the Division and the following options:

- state employees
- organizations
- individuals
- parents or family members of consumers
- consumers

The pilot will run in western Maricopa County, District II and District VI. This Directive outlines the role of liaisons and also defines the quality assurance plan. All questions should be addressed to Ron Barber at 520-628-6800.

I. Role of the Liaison for Paid Individuals and Provider Agencies

In order to support individuals and agencies who contract to provide support coordination through the pilot, a District staff will be identified as a liaison for each. The role of the liaison and the activities outlined below are designed to build and strengthen the pilot support coordination system. The liaison's primary goal is to form a partnership with the pilot support coordinator/provider agency.

A. The liaison will assist with enrolling pilot support coordinators in Support Coordinator Core and other training as necessary and as outlined in the individual training plan. For individual providers this may include providing assistance in carrying out the assignments between training and reviewing

a copy of the support coordinator's training plan. The provider agency will maintain the training plan for its employees and ensure completion.

B. The liaison will assist and coordinate completion of those activities/tasks that the contracted support coordinators are restricted from doing, i.e., eligibility re-determination, service authorization, etc.

C. Liaisons will meet with individual and agency providers on a monthly basis to address training issues, identify and resolve barriers, share information and discuss service provisions. Liaisons will be available to assist pilot support coordinators as needed.

D. Liaisons will attend at least one home visit or planning meeting per year per support coordinator.

E. Liaisons will work with the District Long Term Care Specialist to complete Long Term Care and Targeted Support Coordination file audits on pilot cases assigned to individual providers. The liaison will coordinate with agency supervisors to complete required audits.

F. Case files will be reviewed by the assigned liaison before transferring from an individual provider to another support coordinator. The supervisor from a provider agency will be responsible for reviewing case files prior to transfer.

G. Liaisons will work with the District's Quality Assurance Team to identify and resolve barriers and share information.

II. Role of the Liaison for Consumer/Family Support Coordinators

In order to support consumers and families who provide support coordination through the pilot, a District staff will be identified as a liaison. The role of the liaison and the activities outlined below are designed to build and strengthen the pilot support coordination system. The liaison's primary goal is to form a partnership with the pilot support coordinator.

A. The liaison will assist with enrolling pilot support coordinators in Support Coordinator Core and other training as necessary and as outlined in the individual training plan. For consumers and family members, this will include providing assistance in carrying out the assignments between trainings. The liaison will review a copy of the support coordinator's training plan.

B. The liaison will be responsible for ensuring completion of those tasks identified by the consumer/family as ones on which they will need assistance from state staff.

C. Liaisons will meet with pilot support coordinators on a monthly basis during the first quarter of assignment and on an as-needed basis after that to address training issues, identify and resolve barriers, share information and discuss service provision. Consumers/family members may be invited to staff meetings or receive meeting minutes to stay abreast of changes in policy, deadlines, etc.

D. Liaisons will work with the District Long Term Care Specialist to complete Long Term Care and Targeted Support Coordination file audits on pilot cases assigned to consumers/families.

E. Case files will be reviewed by the liaison before transferring to another support coordinator.

F. Liaisons will work with the District's Quality Assurance Team where they can identify and resolve barriers and share information. This group will also review and make recommendations to the District Administration when a consumer or family member should no longer serve as the support coordinator due to issues of abuse, neglect, fraud or making decisions that are not in the best interests of the person they are supporting.

III. Quality Assurance Plan

The Quality Assurance Plan is designed to address the implementation phase of the Case Management Pilot. The activities identified will ensure that pilot support coordinators receive the necessary training and ongoing support to be successful; that barriers are identified and resolved quickly; that systems requirements are met; and that families who choose pilot support coordination receive quality support coordination.

A. Each participating District will identify a Quality Assurance Team which will be responsible for overseeing the District's compliance with the Quality Assurance Plan and providing support and leadership to the District staff implementing the pilot.

1. The Quality Assurance Team might include a support coordinator who is not participating in the pilot, quality assurance staff, the Long Term Care Specialist, a provider and a family member or consumer who is not participating in the pilot.

2. The Quality Assurance Team will be involved in reviewing any concerns raised about a family's or consumer's ability to provide support coordination.

3. Each member of the Quality Assurance Team will sign a confidentiality at the beginning of each meeting.

B. Each District will assign a liaison to each pilot support coordinator and agency. Depending on the number of pilot support coordinators/agencies, a coordinator may be designated. The role of the liaison is described previously in this Directive. Opportunities for liaisons to meet and share will be encouraged at the District and state level.

C. Each pilot support coordinator will complete an individual training plan and maintain a record of training which will be available for review. A copy of signed confidentiality forms will be submitted to the liaison.

D. A checklist (see attached) of support coordination activities/responsibilities will be completed for each case assigned to a consumer/family member which clearly identifies those activities that the pilot support coordinator needs state staff to complete, i.e., ASSISTS date entry, money management, etc. This will be submitted to the liaison within 90 days of assignment.

E. Each family who selects a pilot support coordinator will receive a letter from the Division welcoming them to the pilot and informing them of appropriate contacts within the District if they have any concerns, questions or feedback about support coordination.

F. Data collected from pilot surveys, Long Term Care and Targeted Support Coordination file audits on family satisfaction will be reviewed to address individual issues immediately and analyzed to determine ongoing satisfaction.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 59 (Revised) **DATE: December 11, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Foster Home Transition Process

EFFECTIVE DATE: Upon Receipt

The Department will promote stability for foster children in out-of-home care by minimizing placement moves and, when moves are necessary, by providing services to make placement changes successful for the child.

Case managers shall provide or arrange services to foster children in out-of-home placement and their caregivers as specified in the Individual Support Plan to support the placement and meet the child's health and developmental needs: physical (including medical and dental), emotional, educational, social and behavioral. For unplanned placement changes, available services to prevent the necessity of a placement change shall be assessed. Services may include an assessment by or consultation with a licensed psychologist or psychiatrist to determine the best interest of the child.

If the child receives services through a Regional Behavioral Health Authority (RBHA) contracted agency, consultation should be obtained from the child's therapist or other treatment team members. If applicable, a meeting of the Child and Family Team should be called as soon as possible to determine if additional services may help to stabilize the placement and avoid removal. The formation of a Child and Family Team should be considered for a child, enrolled with a Regional Behavioral Health Authority, whose placement is at risk of disruption.

Parents and all interested parties shall be notified if a change in placement is considered. If the licensed foster parent initiates a request for the child to be moved, ask the foster parent to document the request in writing.

A change in placement shall be made only after full consideration in a case conference unless an emergency situation exists. Whenever possible, the case conference shall be held at least 14 days prior to the date of the child's move. The case conference, shall at minimum, be attended by the case manager, the supervisor and the out-of-home care provider. If applicable, consider recommendations from the Child and Family Team.

At the case conference:

- Inform the out-of-home care provider of the intent to move the child, if the provider did not request the placement change;
- Discuss the reason a placement change is being considered;
- Develop a placement transition plan, including plans for:
    - communication between the current and proposed caregivers before, during and after the placement change;
    - pre-placement visits between the child and proposed caregivers;
    - maintaining connections between the child and the current caregivers after the placement change, if appropriate;
    - support services to the child, current caregivers, and/or proposed caregivers during the transition period, and
    - timeframes for the transition period.

Foster Home Transition Process:

A.R.S. § 8-515.05(A) requires the department to:

- Inform a licensed foster parent of the department's intent to remove a child from a licensed foster home and place the child in another foster care placement;
- Give the specific reason for the intended removal.

This requirement does not apply when the removal from a licensed foster home, excluding a shelter provider and receiving foster parent, is to:

- Protect the child from harm or risk of harm;
- Place the child in a permanent placement;
- Reunite the child with siblings;
- Place the child in a kinship foster home;
- Place the child in a least restrictive setting or in a therapeutic setting; or
- Place the child in accordance with the Indian Child Welfare Act (ICWA).

A.R.S. § 8-515.05(B) states that if the licensed foster parent disagrees with the removal, the licensed foster parent must inform the department of the disagreement within 24 hours of being informed. When the department is informed of the foster parent's disagreement, a case conference must be convened to review the reasons for the removal. The licensed foster parent and a member of the Foster Care Review Board who participates on Removal Review Team meetings shall participate in the case conference.

A.R.S. § 8-515.05(C) requires the department to hold the case conference within 72 hours, excluding weekends and holidays, of being informed of the licensed foster parent's disagreement with the removal. The department must inform the licensed

foster parent and the Foster Care Review Board of the time, date and location of the case conference.

A.R.S. § 8-515.05(D) states that if, as a result of the case conference, the department intends to remove the child and the licensed foster parent continues to disagree with the removal and the child:

- Is in the court ordered physical custody of the licensed foster parent, the Foster Care Review Board member shall provide a recommendation to the court regarding the removal of the child prior to the change physical custody; or
- Is not in the court ordered physical custody of the licensed foster parent, the department shall advise the foster parent of the conflict resolution process and shall expedite the process.

A.R.S. § 8-515.05(C) and (D) require that the child remain in the current placement pending a court order for removal or the outcome of the expedited conflict resolution process.

Implementation and Procedures Guide

If the licensed foster parent, excluding a shelter care provider or receiving foster home, disagrees with the plan to move the child, inform the foster parent of the 24 hour time frame to request a Foster Home Transition case conference to review the reasons for the change of placement.

Inform the foster parent that the foster parent is not entitled to a Foster Home Transition case conference when the change of placement is for one of the following reasons:

- protect the child from harm or risk of harm;
- place the child in a permanent placement;
- reunite the child with siblings;
- place the child in a least restrictive setting or in a therapeutic setting; or
- place the child in accordance with Indian Child Welfare Act .

The change of placement shall be made only after completion of the Foster Home Transition process when:

- The child is in a licensed foster home, excluding a shelter care provider and receiving foster home;
- The change of placement is for a reason other than those listed above; and
- The foster parent disagrees with the removal of the child.

If the department is informed of the foster parent's disagreement with the removal, a Foster Home Transition case conference shall be convened to review the reasons for the removal. The case manager, the case manager's supervisor, the licensed foster

parent, and a member of the Foster Care Review Board who participates in a Removal Review Team shall participate in the case conference.

A case plan staffing conducted prior to a planned placement change may be considered notice of the placement change and substitute for the case conference if the out-of-home provider attends the case plan staffing in person or by telephone, the planned placement change is documented in the case plan, and all requirements of the case conference are met.

The department shall hold the Foster Home Transition case conference within 72 hours, excluding weekends and holidays, of being informed of the licensed foster parent's disagreement with the change of placement.

The Department shall inform the licensed foster parent and the Foster Care Review Board representative of the time, date and location of the Foster Home Transition case conference. Other qualified professionals/persons may be invited to participate during all or part of the case conference. A foster child age 12 or older or may participate if appropriate.

Convene the Foster Home Transition case conference. With the participants, identify the reason for the planned removal and review the circumstances that resulted in the decision to remove the child. Obtain the recommendation of the Foster Care Review Board Removal Review Team volunteer regarding removal of the child from the foster home. If applicable, obtain the recommendation of the Child and Family Team.

If, at the conclusion of the case conference, the plan to remove the child continues and the child is in the court ordered physical custody of the licensed foster parent, initiate a Motion for Change of Physical Custody.

If, at the conclusion of the case conference, the plan to remove the child continues, the foster parent continues to disagree with the removal and the child is not in the court ordered physical custody of the licensed foster parent, schedule an expedited Conflict Resolution Conference to occur within three working days after the Foster Home Transition case conference. The participants, at minimum, are the licensed foster parent, case manager, the supervisor, and the District Program Manager or other management level designee. The expedited Conflict Resolution Conference may be held in person or by telephone at a time and place mutually agreed upon. Other individuals may attend if they agree to maintain confidentiality and sign a Confidentiality Agreement (FW-254). If the Foster Home Transition case conference included the participants required by the Conflict Resolution Conference, a Conflict Resolution Conference is not necessary.

Convene the Conflict Resolution Conference. With the participants, identify the reason for the planned removal and the outcome of the Foster Home Transition case conference including the recommendation of the Foster Care Review Board Removal Review Team volunteer.

If at the conclusion of the Conflict Resolution Conference, the plan to remove the child continues and the foster parent continues to disagree with the removal, the foster parent may submit a written request, within 10 days of the Conflict Resolution Conference, for review by the Assistant Director. The Assistant Director will review the request for reconsideration.

If, as a result of the expedited conflict resolution process, Assistant Director review, or court order for removal, the final decision is to remove the child:

- Unless there are extenuating circumstances, meet the child and the foster parent within three working days to develop a placement transition plan including plans for:
    - communication between the current and proposed caregivers before, during, and after the placement change;
    - pre-placement visits between the child and proposed caregivers;
    - maintaining connections between the child and the current caregivers during the transition period;
    - support services to the child, current caregivers, and/or purposed caregivers during the transition period; and
    - timeframes for the transition period.

Request for Removal of a Foster Child

I/We _____, am/are formally requesting that the Arizona Department of Economic Security, Division of Developmental Disabilities remove _____from my/our foster home.

Name: _____ Date: _____

Name: _____ Date: _____

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 60 (Revision 3) **DATE: August 11, 2005**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Assisted Living Center Guidelines

EFFECTIVE DATE: Upon Receipt

The Division supports the use of Assisted Living Centers as a residential option within the guidelines outlined in this directive. Under no circumstances will an Assisted Living Center or Assisted Living Facility be used for Respite.

Definitions:

"Assisted Living Center" or "Center" means an assisted living facility that provides resident rooms or residential units to eleven or more residents. A Center may be licensed to provide one of three levels of care listed below, as defined by the Arizona Department of Health Services:

"Supervisory care services" means general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and assistance in the self-administration of prescribed medications.

"Directed care services" means programs and services, including personal care services, provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions.

"Personal care services" means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medications and treatments by a nurse who is licensed pursuant to Arizona Revised Statutes Title 32, Chapter 15 or as otherwise provided by law.

To insure the appropriateness of a placement in an Assisted Living Center, the following must be documented:

1. The individual is over the age of 60, however, the team can recommend exceptions for approval by the Assistant Director.

2. A nursing home is the only other alternative available or the team feels an Assisted Living Center best meets the needs, desires and capabilities of the individual.

3. Alternate placements were considered and the reasons why they were not appropriate. Assisted Living Center placement cannot be the only placement option considered and cannot be used as an "emergency" placement alternative.

4. The individual and/or guardian clearly understand the alternative placement options.

5. The guardian, individual and the Support Coordinator have visited the proposed center.

6. The individual will be placed with a similar age group as the other individuals living in the Center and not segregated based on disability.

7. The supports identified in the Individual Support Plan/Person Centered Plan can be provided by the Center.

8. The individual must be given the choice to live by his or herself or to have a roommate by completing the attached Assisted Living Center/Single Occupancy Form. This form shall be filed with the Individual Support Plan and reviewed at least annually, however, the individual may change their choice at any time by updating the form.

9. The Support Coordinator and others can monitor the setting frequently. Monitoring by the Support Coordinator, through on site visits, will be conducted every 30 days for the first quarter and every 90 days thereafter.

10. The District Program Manager/designee has reviewed the above documentation and concurs the guidelines have been met prior to the authorization of services.

When identifying potential Assisted Living Centers, the following conditions are recommended:

*Private room *(unless the individual chooses to have a roommate as noted above)*
*Room includes a private in-room bathroom *(unless the individual chooses to have a roommate as noted above)*
*Space allows for separation of sleeping area and living area
*An inside door lock

*Food preparation space
*Doorbell or door knocker
*Individual mailbox
*Variety of on site and off site activities and events from which to choose
*Transportation
*Indoor and outdoor common areas
*Weekly housekeeping service
*Weekly laundry service
*Monthly newsletter or calendar of events

If any concerns or suspected violations are noted during monitoring visits, staff will report their observations and concerns to the Department of Health Services, Assisted Living Licensure at 602 674-9775 and will complete an incident report.

RZ:AC:CC:KS:CC

Assisted Living Center/Single Occupancy

❑ Assisted Living Center

❑ Alzheimer's Pilot Facility

Member Name: _____ AHCCCS ID#: _____

Program Contractor: _____

I understand that, as an ALTCS member, I can choose to live by myself or have a roommate in an Assisted Living Center.

My choice for staying at _____ is (check one choice below): Assisted Lving Center Name

❑ Single Occupancy (one person per room)

❑ Shared Occupancy (at least 2 persons per room)

❑ Shared Occupancy until Single Occupancy becomes open

I understand that I may change my decision at any time and still remain at this facility.

_____	_____
Signature	Date
_____	_____
Printed Name	Relationship to Member

I hereby CHANGE my choice. My new choice is (check one choice below):

❑ Single Occupancy

❑ Shared Occupancy

❑ Shared Occupancy until Single Occupancy becomes open

_____	_____
Signature	Date
_____	_____
Printed Name	Relationship to Member

cc: ALTCS Case Management File
Member/Representative
Assisted Living Center (original)

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 61 **DATE: January 29, 2001**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Placement of Children in Foster Care

EFFECTIVE DATE: Upon Receipt

Children who are wards of the Court, placed in the care, custody, and control of the Department of Economic Security, Division of Developmental Disabilities are required by statute to be placed in settings licensed by the Division, called Child Developmental Foster Homes. Foster children with developmental disabilities, may also be placed into Administration for Children, Youth, and Family's licensed foster homes, if the placement is assessed and found to be in the child's best interest.

Exceptions to this directive require a written plan that will result in moving the child into a licensed setting within 30 days, and approval from the Assistant Director. Court approval is required for a foster child to remain in an unlicensed, non-relative placement.

RZ:ks

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 62 **DATE: February 26, 2001**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director, DES
Division of Developmental Disabilities

SUBJECT: Definition of a Residential Day

EFFECTIVE DATE: Upon Receipt

The Division of Developmental Disabilities bills eligible individuals in residential care or their representative payee for a portion of the individual's benefits. Arizona Revised Statutes § 36-562.A. states: "…credit shall be given for any periods of temporary absence, such as for home visits, vacations or other purposes."

Various interpretations of how this credit shall be granted have developed over time. To clarify and standardize this procedure, the definition of a billable day that is in the Division's contracts shall be used.

One residential day shall be defined as follows:

> If an individual is receiving services at 11:59 p.m. of any day, that day shall be considered a full service day and no credit shall be given. If the individual is not receiving services and is temporarily absent at 11:59 p.m., credit for the day shall be given for that absence.

This eliminates the past procedures where 24 hours were required to elapse before a day's credit could be given.

If you have any questions, please call David Daines at 602.542.6890.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 64 (Revision 1) **DATE: October 28, 2002**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Waiting List

EFFECTIVE DATE: Upon Receipt

This Administrative Directive supercedes Section 906 of the Division of Developmental Disabilities' (Division) Policies and Procedures Manual.

Definition and Purpose

The Waiting List is the official register of persons needing the type, duration and/or intensity of services described in the person's Individual Support Plan, but who are unable to receive them due to funding limitations or unavailability of a provider.

The purpose of the Waiting List is to insure available resources are equally distributed to individuals and families statewide based upon prioritized needs as established below. Each District is allocated funding to address the needs of individual's eligible for services. The Division is prohibited from exceeding the legislative appropriation.

A.R.S. § 36-552.C
A.R.S. § 36-557.D

Support Coordination Procedures

The Support Coordinator will complete the service evaluation process and make appropriate service referrals. When it has been determined the service is not available, it shall be deemed "waiting" and entered into ASSISTS as described below. All service plan components shall be recorded, updated or terminated by the Support Coordinator in ASSISTS within five (5) working days of the initial, annual or review Individual Support Plan.

All service plan components shall be assigned one (1) of four (4) dispositions of priority. Support Coordinators will consider the following principles when assigning a priority:

E. Emergency Need: Court ordered or Support Coordinator finds substantiated abuse or neglect as determined by Adult or Child Protective Services or a death in the family or significant illness which would necessitate emergency placement.

I. Immediate Need: Long Term Care services needed within 30 days of the individual's enrollment in the Arizona Long Term Care System or a family crisis where respite could prevent an out of home placement or early intervention services within 15 days of the development of the Individual Family Service Plan or out-of-home school district placements for educational purposes within 15 days of the development of the Individual Education Plan.

C. Current Need: Individual Support Plan request for services which is unmet due to funding or provider availability; the need date is within 12 months or initial entry.

F. Future Need: Individual Support Plan request which has a start date greater than 12 months, but less than 24 months from the date of the initial entry on the Waiting List.

All Waiting List entries with priorities of "E" or "I" shall reflect service need dates (start dates) equal to or no greater than 30 days from the referral date (date service is recorded on the Individual Support Plan). Monthly reports will be generated including services with priorities of "C" or "F". District staff will review the reports and re-evaluate or re-prioritize the needs.

District Management shall establish procedures for external review and periodic re-assessment of priority and need. Purging shall be implemented only after the consumer or responsible person has requested removal or has failed to respond to two (2) inquiries, one of which shall be written.

The Support Coordinator will update the individual/responsible person regarding waiting list status at each Individual Support Plan review or more frequently if needed.

District Management Procedures

District Management shall establish quality control activities to insure Waiting List information is complete and up-to-date. At the end of each calendar year, each District shall generate a Waiting List document that has less than a 5% error rate.

It is the responsibility of the District Management staff to assist Support Coordinators in identification and development of resources to meet individual needs. As resources become available, staff must award resources to individuals in accordance with the priorities noted above.

If the individual is not Long Term Care eligible, the District will:

a. establish whether the individual is eligible for any appropriated waiting list funds; and

b. establish whether the District has any other funds available for the provision of the services within their allocation.

Additionally, staff should follow these guidelines:

a. is the resource "fixed" or "movable"? A fixed asset is a service that can only be delivered in one system or area such as a vacancy in a group home or day program. A movable asset is a service that can be adapted or transferred to meet the individual's needs;

b. which individual, within the District, has precedence to be removed from the Waiting List? Review priorities;

c. is the District able to meet the need; and

d. does the District have a resource which is not being utilized and may benefit an individual in another District.

<u>ASSISTS Instructions</u>

Support Coordinators will insure the following information is on the ASSISTS Waiting List Update screen:

a. individual's name, date of birth and ASSISTS identification number;

b. individual's service eligibility;

c. a description of the service needed (ASSISTS service code);

d. a description of the service priority (see above);

e. the date the service is recorded on the Individual Support Plan (referral date);

f. the requested start date of the needed service;

g. the status of the service:

C. change of provider;

F. funding not available;

P. provider not available; or

N. future need.

h. the date the service was closed from the Waiting List;

i. choice of service location; and

j. indicate if comment was provided on the Comment Screen.

The following information must be entered when completing the Waiting List Update Comment Screen:

a. service description;

b. service status;

c. referral date; and

d. comment (not to exceed one (1) screen line).

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 66 **DATE: October 11, 2001**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Individual Support Plan for Limited English Speaking Persons

EFFECTIVE DATE: Upon Receipt

In an effort to deliver quality customer service, Support Coordinators who are proficient in the Spanish language are authorized to conduct, prepare and deliver the Individual Support Plan in Spanish when working with limited English speaking persons. Support Coordinators who are not proficient in the Spanish language will arrange for the services of an interpreter. This includes the quarterly, semi-annual and annual reviews. It is not the Support Coordinators responsibility to translate the plans and reviews into English or Spanish.

The plans and reviews will be translated into English or Spanish, within 15 days of completion, by a translation service. The Statewide Case Management Consultant will keep a current list of the translation services and make it available to Support Coordinators. Support Coordinators are responsible to send the plan to the translation service.

RZ:GA:CC

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 67 (Revision 1) **DATE: May 10, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Summer Programs

EFFECTIVE DATE: Upon Receipt

This Administrative Directive defines the appropriate use of Division supports in relation to summer programs for children. The Division offers supports to individuals to maintain and promote their capacity for independence. Children, while out of school, may require ongoing supports to continue skill development. This may be accomplished in many ways: attending Extended School Year, staying at home with family, accessing community summer programs, etc. The Support Coordinator will assist the family in actively pursuing an extended school year program.

If the above options do not exist or are not adequate for the child's Individual Support Plan objectives, the Support Coordinator may assist the family in accessing additional support over the summer. These supports may be offered in conjunction with integrated summer community programs. As a general guideline, Division sponsored programs should not exceed 4 hours per day, 5 days per week, unless individual needs indicate other wise. While the Division does not fund day care, if a full-time child care program is necessary, the Support Coordinator should assist the family in locating an appropriate provider.

RZ:PL:CC

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 68 **DATE: November 8, 2001**

TO: Policy and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Behavioral Health Database

EFFECTIVE DATE: December 1, 2001

The information in this Administrative Directive is an addition to the information regarding Behavioral Health in Chapter 1400 of the Division's Policy and Procedures Manual.

Definition and Purpose

A Behavioral Health Database has been developed to assess where improvements can be made in the Division's Behavioral Health Program. The Behavioral Health Database is a computer program that will be used to acquire data to track, trend, and evaluate the quality of behavioral health services being provided to Long Term Care members.

Behavioral Health Database Procedure

It will be the responsibility of the Support Coordinator or assigned District designee to ensure the database is continuously updated for those individuals receiving behavioral health services from a Long Term Care System Primary Care Physician or a Regional Behavioral Health Authority.

More specifically, the database needs to be completed and/or updated for the following activities:

A. For **all** Division Long Term Care eligible individuals receiving behavioral health services from a Long Term Care System Primary Care Physician or a Regional Behavioral Health Authority.

B. The Primary/Qualified Behavioral Health Professional will be tracked as well as dates of the consultations, therefore, if the person is enrolled with

a Regional Behavioral Health Authority, the consultation date will be updated (at a minimum) quarterly. If not enrolled with a Regional Behavioral Health Authority, the screen will be updated as changes occur. This database will track who is enrolled with a Regional Behavioral Health Authority, who is receiving psychiatric medications from their Long Term Care Primary Care Physician or Regional Behavioral Health Authority Psychiatrist, an individuals mental health diagnoses, and timeliness of consultations with Primary/Qualified Behavioral Health Professional.

C. The database will be updated for individuals who enter a secure facility. Secure Facilities are defined as the Arizona State Hospital, a Psychiatric Hospital, a Psychiatric Health Facility, a Residential Treatment Center, or a Jail. A new entry will be completed for each admission to a secure facility including discharge dates and as to where the person was discharged. The database will allow for identification of high users of secure facilities, monitor average length of stays, placement problems, and lack of appropriate community based services.

D. The database will track and trend individuals who are under a Behavioral Health Court Order for treatment. The Support Coordinator or District designee will only complete this screen for individuals who have been given one of the three court orders: Danger to Others/Danger to Self, Persistently and Acutely Disabled, or Gravely Disabled. A new entry will be completed each time the person is given a Behavioral Health Court Order. Once the entry is complete with all the data, the information will move into history when the screen is closed (to obtain a historical picture). The database will allow for identification of those individuals who receive more than one Behavioral Health Court Order.

E. The database will track and trend behavioral health crises. A behavioral health crisis is defined as an incident that requires interaction by the outpatient behavioral health crisis system or police. The Support Coordinator or District designee will complete the database for each behavioral health crisis. A new entry will be completed each time the person has a behavioral health crisis. Once the entry is complete with all the data, the information will move into history when the screen is closed (to obtain a historical picture). The database will allow for identification of frequency of crises, location, entities involved, and timeliness of resolution.

F. The database will track and trend behavioral health service issues, including psychiatric medication issues and behavioral health appeals. The Support Coordinator or District designee will complete this screen for each issue and/or behavioral health appeal the individual encounters. A new entry will be completed each time there is a behavioral health service or psychiatric medication issue. Once the entry is complete with all the

data, the information will move into history when the screen is closed (to obtain a historical picture). The database will allow for identification of frequency of issues (service and medication) and/or appeals, what services are not being provided or delayed and why, and timeliness of resolution.

G. The database will be used by the Managed Care's Behavioral Health Unit to track cost effectiveness studies and second level clinical reviews. The Support Coordinator or assigned designee will be able to view the data, but is not responsible to input any data.

H. Various reports will be generated from the database, which will aid Division personnel to track, trend assess, and determine where improvements can occur in the behavioral health delivery system.

I. Statewide data quality checks of 10 files per quarter, for one year will be conducted to ensure utilization of behavioral health database.

RZ:LL:CC

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 69 **DATE: December 19, 2001**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Discharge/Transition of Individuals with Severe Behavioral Challenges

EFFECTIVE DATE: Upon Receipt

When an individual with severe behavioral health challenges is placed into a Psychiatric Hospital Setting, the Support Coordinator will begin discharge planning immediately and District Personnel will attend a hospital staffing within 72 hours. Support Coordinators should, if possible, attend all subsequent hospital staffings. If the individual does not have a setting to return to after discharge, the Support Coordinator will:

1. Involve staff responsible for contracting with Provider Agencies as soon as possible;

2. Begin the Person Centered Planning Process; and

3. Ensure that staff from the Behavioral Health System are invited to all planning sessions.

Use of the "**Discharge/Transition Checklist for Individuals with High Risk Behavioral Challenges"** (attached) is mandated when planning discharge from an inpatient setting for individuals with severe behavioral challenges. The form can also be used when someone with behavioral challenges moves from one setting to another. The form is intended to provide reminders to the team about important areas to consider and should be used to plan for the discharge/move.

"The Emergency Contact Plan" (attached) is intended to record very basic information about the person that would be helpful to others coming in to assist in a crisis situation, such as crisis mobile team members or police officers. The form should be completed at the discharge/transition-planning meeting and updated as necessary. The representative from the Behavioral Health System should assist in filling out the form and the same information should, if possible, be on file with The Regional Behavioral Health System. The Emergency Contact

Plan should be kept in an easily accessible place in the setting, but it should never be posted.

The Emergency Contact Plan does not take the place of **The Behavior Treatment Plan.** Begin development of the behavior treatment plan prior to discharge, so that the person is discharged with at least a rough draft of the plan that eventually gets submitted to the Program Review Committee. This initial plan may be called a "Crisis Plan". It should have information about precursors/antecedents and creative strategies for preventing challenging behaviors. It should give staff ideas for teaching replacement behaviors and it should let staff know whom to call when a crisis occurs.

RZ:JM:CC

Directions for using the Discharge/Transition Checklist for individuals with high-risk behavioral challenges.*

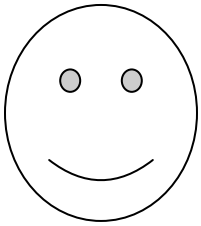
*Mandatory for individuals with high risk behavioral challenges.

1. The Emergency Contact Plan is intended to record very basic information about the person that would be helpful to others coming in to assist in a crisis situation, such as a crisis mobile team member or a police officer. The form should be kept in a file or drawer, not displayed.
2. This reminds team members to make sure that all staff who will work with the individual is familiar with the Emergency Contact Plan, and where it is kept.
3. Providers should be encouraged to have their direct care staff participate in the Person Centered/ Individual Support Planning process. If this is not possible, the staff should be made fully aware of all the documents generated by the planning process, so that they know the individual as well as possible.
4. Pre-placement visits are always recommended to increase the likelihood of a successful placement.
5. It is important that provider staff report to the team how the pre-placement visits went, so this information can be used in the planning process.
6. It is recommended that one of the planning meetings be held in the new setting so team members can see the setting and identify areas that need attention. If this is not possible, the team should discuss how to ensure that the setting is safe.
7. It is important that there is a schedule for the day of discharge to increase the success of the placement.
8. The daily routine should be developed before the individual moves into the setting, and be revised as necessary.
9. See above.
10. All staff should have completed CIT training.
11. The Behavioral Health System's crisis plans should be developed with input from the person's team.
12. This reminds teams to make sure that crisis plans are made available to the right individuals within the Behavioral Health System. It varies from area to area how this is accomplished.
13. This area needs to be addresses for individuals with medical issues.
14. Teams should develop a behavior treatment plan including a crisis plan prior to discharge. This may become the rough draft to the Behavior Treatment Plan that gets reviewed by the Program Review Committee, and it may require many revisions.
15. All staff should be familiar with the behavior treatment/crisis plan prior to discharge.
16. If teams suspect that an individual may have interactions with the police, they are asked to discuss ways to prepare so these interactions will be as positive as possible. This may for example involve informing the police department about the residence being in the neighborhood.

17. Teams should identify who the treating psychiatrist will be after discharge, and if possible schedule an appointment.
18. Reminds teams to make sure that there is an adequate supply of medications upon discharge.
19. Reminds teams to make sure that all the important phone numbers are available at the setting.
20. Reminds teams to make sure crisis numbers are posted at the home.
21. Reminds teams to consider ways to make sure the setting is a positive part of the community.
22. This should be part of the behavior treatment plan; this is an extra reminder.
23. Teams are encouraged to set up monitoring schedules to ensure that everything goes well with placements. This is a way to catch problems early so the placement is not jeopardized.
24. Teams should clearly define criteria for when teams should reconvene. It may not be necessary for the whole team to reconvene, but it is helpful for key individuals to meet to address issues as they come up. Teams should identify who is responsible for calling the team back together.
25. Reminds the team to gather as comprehensive a family history as possible, to help in planning for the individual.
26. If any risk assessments, such as the Prevention Discussion Guide, were used, please attach.

EMERGENCY CONTACT PLAN FOR

Photo



WHAT MAY BE PRESENTED IN AN EMERGENCY

1.

2.

3.

4.

5.

NAME: _____
GOES BY: _____

MEDICAL/ PHYSICAL/COMMUNICATION LIMITATIONS

-
-
-
-

DO NOT

-
-
-
-
-

RECOMMENDED INTERVENTIONS

-
-
-
-

EMERGENCY CONTACTS			
	NAME	**PHONE NUMBER**	**PHONE NUMBER**
Provider			

Therapist			
Guardian			
Support Coordinator			
Case Manager			

Directions for using the Emergency Contact Plan*

* Please note that this form does not take the place of the behavior treatment plan. It is to be kept in a file or drawer, to be used only during emergencies when individuals new to the person are involved in an emergency situation, to help them deal more effectively with the person.

1. **Photo:**
   Please put a recent photograph of the individual in this section.

2. **What may be presented in an emergency:**
   Please write what you would expect the person to do in an emergency situation.

3. **Name, goes by:**
   Record the person's nickname here if applicable.

4. **Medical/physical/communication limitations:**
   Record any medical, physical or communication limitations that might effect an emergency situation, such as: has epilepsy, walks with a cane, is deaf, etc.

5. **DO NOT:**
   This is the section where you will record things that absolutely will set the person off, such as: talking loudly, giving orders, touching on the arm, etc.

6. **Recommended interventions:**
   In this space put down interventions that have worked in the past to help calm the person, such as: giving enough personal space, calling a relative or friend to talk them through the crisis, rocking in a rocking chair, etc.

7. **Emergency contacts:**
   Record the names of individuals who need to know about or could be helpful in a crisis situation.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 70 **DATE: March 1, 2002**

TO: Policy and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Well Woman Checks

EFFECTIVE DATE: Upon Receipt

This Directive defines requirements for exceptions to the annual Pap test for all female clients. All women will have an annual breast exam. A Pap test will be completed annually unless the Individual Support Plan/Person Centered Plan team and the Medical Practitioner determine it will be less often, but no longer than every three years.

During the annual medical review and physical exam, the practitioner will perform the Pap test unless a prior determination has been made that the test will be done every three years.

Women needing general anesthesia for Pap tests will be reviewed prior to the physical exam date to determine if annual tests are optimum for each woman. Women needing general anesthesia for their entire physical exam will receive a Pap test and breast exam during their annual physical.

Criteria to be met for allowing a greater than one-year time frame and no longer than three years include:

1. Two or more negative Pap tests in the recent past;

2. Woman is not known to be sexually active;

3. Woman requires general anesthesia in order for the procedure to be accomplished;

4. No known history of cervical or ovarian cancer; and

5. The woman, or her legal representative, must agree to the three-year time frame.

RZ:LC:KS:CC

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 71 **DATE: February 6, 2002**

TO: Policy and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Medicaid in the Public Schools

EFFECTIVE DATE: Upon Receipt

Overview

The purpose of this guideline is to provide assistance to staff in supporting a consistent approach, statewide, regarding the Division's coordination efforts with the Medicaid in the Public Schools Program. The approach is that services will be understood to be complementary between home and school unless there is indication of harm to the child or of conflicts in approach.

It summarizes the Medicaid coverage under the Arizona Health Care Cost Containment System for services rendered by providers of Local Education Agencies. Local Education Agencies include public school districts, charter schools and the State Schools for the Deaf and Blind. It also defines strategies to support the Division's policy on coordination of services to children, and their families, served by both the Division and the school.

Program Description

Medicaid in the Public Schools Program through the Arizona Health Care Cost Containment System covers both school age children who are Medicaid Long Term Care eligible and members supported by the Division's Targeted Support Coordination. The member has to be at least 3 years of age but younger than 22 years of age and have been determined by the school to be eligible for special education and related services. As this is a Medicaid program, all covered services under this program must be determined to be medically necessary. This program covers medically necessary services identified in the child's Individual Education Plan. The requirement for prior authorization of services is met by the identification of a service in the Individual Education Plan. Other forms of prior authorization or prescriptions are not needed for this program. Children eligible for the Kids Care program are not eligible for the Medicaid in the Public Schools Program. The medically necessary service must be

required for the purpose of developing, improving or maintaining skills required for the child to receive education through the school.

School districts have an option of participating in the Medicaid in the Public Schools Program. The Division receives a listing of the current participants on a regular basis from the Arizona Health Care Cost Containment System.

Third party liability for Medicaid in the Public Schools is processed by a third party liability agent contracted by the Arizona Health Care Cost Containment System.

Covered Services

The following assessment, diagnostic and evaluation services, as well as services included in the child's Individual Education Plan, are covered under this Program:

- Behavioral Health Services;
    - Nursing Services;
    - Physical Therapy;
    - Occupational Therapy;
    - Speech Therapy; and
    - Transportation (only on those days when other covered services are provided).

Refer to the Arizona Health Care Cost Containment System Medical Policy Manual Chapter 700, Medicaid in the Public Schools, for detailed information on services, e.g., description of benefit, conditions, limitations and exclusions.

Coordination Strategies

The Division's policy is to coordinate planning activities across agencies to achieve the best outcomes for children and their families, whether or not the child is eligible for Medicaid services. The Medicaid in the Public Schools Program offers the state of Arizona, and its programs participating in Medicaid reimbursement, increased opportunities to maximize resources for children who are school age through improved coordination efforts. This is **not** to suggest that services provided to a child eligible for the Division will be reduced because the child is receiving the same service from the public school. For example; it would not be appropriate to consider reducing services to a child merely on the fact that the child is receiving physical therapy from both the school and the Division. In each situation the reason(s) why the physical therapy is being provided may differ. The child may be receiving therapy through the Division to improve his/her positioning during mealtime to impact the child's ability to eat and

thereby improve his/her nutritional status. At school the child may be receiving therapy to maintain his/her range of motion in his right hand for the purpose of writing.

More exactly, all efforts should be designed to enhance the capacity of the Division and the schools to coordinate efforts for children who are school age and their families.

Examples of possible outcomes/expectations of coordination efforts of Division staff with school personnel:

Coordinate assessment activities: Contact the school teacher, with parental approval, regarding the Division's planning of a particular therapy assessment for a child. This coordination may include conversations between the support coordinator, teacher and family regarding the expected outcomes of the assessment i.e.; the assessment should render a complete view of the child. An outcome may be that the school provides for this years assessment need in a particular area and the Division does so the following year.

Coordinate the provision of services: Contact the school teacher, with parental approval, regarding the coordination of strategies in the provision of services, if indeed, the service is being provided to accomplish similar goals/outcomes so to coordinate similar techniques across settings; home and school, i.e., positive behavioral supports.

As indicated previously, services will be understood to be complementary between the home and school unless there is indication of harm to the child or of conflicts in approach.

Families should be referred to their school, starting with the teacher, regarding any questions related to the Medicaid in the Public Schools Program. Division staff questions, related to the Program, should be raised to their supervisors.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 72 **DATE: July 30, 2002**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Determination of Medical Necessity for High Frequency Chest Wall Oscillation Vests

EFFECTIVE DATE: Upon Receipt

This Directive defines the approval criteria for the Department of Economic Security/Division of Developmental Disabilities' (Division) provision of High Frequency Chest Wall Oscillation Vests (vests). In many cases, conventional chest physiotherapy, flutter valve or other medically accepted therapies are effective treatments to adequately mobilize pulmonary secretions that will meet the individual's medical needs and a vest will not be approved in such circumstances. In the limited situations where physiotherapy, flutter valve or other medically accepted therapies are ineffective or there are clearly documented medical contraindications to use of such therapies, a vest may be medically necessary. All cases will be reviewed on a case-by-case basis by the Division's Medical Director to determine coverage for a vest. The following criteria are to be used in determining coverage for vests:

There is a condition with the inability to adequately mobilize pulmonary secretions, such as cystic fibrosis, and sufficient documentation of the diagnosis and condition are provided; and

1. Physiotherapy, flutter valve and other medically accepted therapies have been utilized and found to be ineffective and sufficient documentation of the treatment and results are provided to a pulmonologist; and after review of such documentation, the device is recommended by a pulmonologist who provides a written recommendation and forwards all documentation to the Medical Director; or

2. There is documentation of intolerance of or other contraindication to placement of the individual in the proper position for physiotherapy and sufficient documentation of such a condition is provided for review by a pulmonologist; and after review of such documentation, the device is recommended by a pulmonologist who provides a written recommendation and forwards all documentation to the Medical Director.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 73 **DATE: July 16, 2002**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Representative Payee

EFFECTIVE DATE: Upon Receipt

In addition to the requirement in Section 1302 of the Division's Policies and Procedures that providers will not be representative payee for their clients, this Directive prohibits agency board members from being representative payees except for members of their own families.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 74 **DATE: November 4, 2002**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Foster Care Grievances

EFFECTIVE DATE: Upon Receipt

Division policy directs support coordinators to educate consumers, families, and guardians about the process for filing grievances and appeals on the denial, reduction, suspension, or termination of medically necessary acute care health services. This practice ensures that consumers have their right to due process upheld as well as their right to direct and determine their own lives.

The situation of foster children in the legal care and custody of the Department/Division is somewhat different. In rare cases, a foster child may not have a parent or relative, a foster parent, or a guardian ad litem who is willing to file a grievance on their behalf. When there is no other willing authorized party, the Division support coordinator must advocate for the child. In these cases, the Office of Consumer and Family Support will support the support coordinator to file a grievance on behalf of the foster child.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 75 **DATE: November 27, 2002**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Therapy No-Shows/Absences/Cancellations
Therapy Re-Assessments/Re-Evaluations

EFFECTIVE DATE: January 1, 2003

EXPIRATION DATE: January 1, 2005

This Directive supercedes Section 602.14.6 a., b. and h. Billable Units (Therapies) of the Division's Policies and Procedures Manual dated October 1,2000.

No Shows/Absences/Cancellations:

A. Therapy assessments/evaluations and re-assessments/re-evaluations:

The Division of Developmental Disabilities will not pay for no-shows/absences/cancellations, regardless of notification.

B. Treatment sessions:

No-shows/absences for treatment sessions will only be paid when therapists travel to locations other than a the therapy office, center or clinic. These no-shows will be paid at one half (1/2) of the treatment rate, but only when notice is not provided to therapist to avoid the travel. Cancellations will NOT be paid.

No-shows/absences/cancellations for treatment sessions, when in an office, center or clinic will **NOT** be paid regardless of notification.

Evaluations/Assessments and/or Re-evaluations/Re-assessment:

A. Evaluations/Assessments:

Evaluations/Assessments will be authorized for initial evaluation/assessment or when there has been a lapse of the therapy service for twelve (12) months or more. Evaluations/Assessments must be planned by the Individual Support Plan/Individualized Family Service Plan team and written into the Individual Support Plan/Individualized Family Service Plan document.

Evaluations/Assessments will be authorized and paid utilizing the evaluation codes and rates. One unit is authorized and paid for Evaluation/Assessment. This includes contact time, documentation and reporting time and consultation/coordination with others.

B. Re-evaluations/Re-assessments:

Re-evaluations/Re-assessments will be authorized only when there has been a lapse of the therapy service for six (6) months or more. Re-evaluations/Re-assessments must be planned by the Individual Support Plan/Individualized Family Service Plan team and be written into the Individual Support Plan/Individualized Family Service Plan document.

Treatment sessions should be utilized for standardized testing when needed; additional sessions/time/units will **NOT** be authorized. Evaluations/Assessments or Re-evaluations/Re-assessments will **NOT** be authorized when on-going treatment is in place.

Re-evaluations/Re-assessments will be authorized and paid utilizing the appropriate evaluation codes. A Re-evaluation/Re-assessment is no more than 1 1/2 hours of contact time, documentation and reporting time and consultation/coordination with others and travel time. However, the rate billed and paid will never exceed the contracted evaluation rate for an evaluation that requires “2 –3 hours of therapist’s time including travel”.

Re-evaluations/Re-assessments will be authorized, billed and paid as follows:

When travel is involved the contracted evaluation rate for “2 – 3 hours of therapist’s time including travel” applies.

When Re-evaluations/Re-assessments are provided in a center, clinic or a therapy office the contracted evaluation rate for “<= 2 hours of therapist’s time…” applies.

Definitions:

No show: A therapist travels to an appointment and the individual is not there or is not able to receive the service.

Absence: The individual is not available for the scheduled session. There may or may not be notification.

Cancellation: The therapist has been notified by the individual/family/caregiver/or other representative that the session cannot occur.

Evaluation/Assessment: A comprehensive testing of the individual’s current functional levels as determined by standardized testing.

Re-evaluation/Re-assessment: The review and update of a previous evaluation/assessment.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 76 (Revised) **DATE: September 19, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Incident Reporting and the Risk Incident Management System

EFFECTIVE DATE: Upon Receipt

This Administrative Directive provides complete information on incident reporting and the Risk Incident Management System (RIMS). This Directive supercedes the Policies and Procedures found in Chapter 2100 of the Division's Policy and Procedures Manual and complements the Department of Economic Security's Policy and Procedures regarding incident management.

I. Purpose and Background

The purpose of incident management is to assist in promoting the health, safety and welfare of persons with developmental disabilities through active reporting, investigating, tracking and trending of incidents and the implementation of both individual-specific and systemic corrective actions and prevention strategies.

The Division of Developmental Disabilities has developed a comprehensive Risk Incident Management System (RIMS). The computerized Risk Incident Management System (RIMS) database provides the platform for the reporting and input of incidents, tracking the notification of key personnel and agencies, the assignment of personnel to fact-find or investigate incidents, tracking incidents to closure and completing follow-up actions. The Risk Incident Management System (RIMS) is also used for incident trending and analysis.

The Risk Incident Management System (RIMS) captures incidents for all individuals enrolled with the Division regardless of funding source and/or whether or not a service was being provided to the individual at the time of the incident.

II. Definitions of Incidents and Serious Incidents

A. **An Incident** is defined as an occurrence, which could potentially impact the health and well being of an individual enrolled with the Division or to the community. If the incident is determined to be "serious" as defined in this Directive, the Serious Incident protocol (section II. B of this directive) should be followed.

- **Incidents include, but are not limited to:**

a) death of individual;
b) potentially dangerous situations due to neglect of the individual;
c) allegations of sexual, physical, programmatic, verbal/emotional abuse;
d) suicide threats and attempts;
e) individual missing;
f) accidental injuries which may or may not result in medical intervention;
g) violation of an individual's rights (see Chapter 1500 of the Division's Policy and Procedures Manual);
h) provider and/or member fraud;
i) complaints about a community residential setting, resident or the licensee;
j) allegations of inappropriate sexual behavior;
k) use of behavior management techniques not part of a behavior treatment plan;
l) theft or loss of individual's money or property;
m) use of emergency measures;
n) medication errors such as:
    1. wastage of a Class II substance;
    2. giving medication to the wrong individual;
    3. wrong method of medication administration;
    4. wrong dosage administered; or
    5. missed medications, etc.
o) community disturbances in which the individual or the public may have been placed at risk;
p) serious work related illnesses or injuries (Division employees);
q) threats to Division employees or state property; and non-consumer/non-employee accidents on state property;
r) circumstances which pose a threat to health, safety or welfare of individuals such as loss of air conditioning, loss of water or loss of electricity;
s) unplanned hospitalization or emergency room visit in response to a illness, injury, medication error;
t) unusual weather conditions or other disasters resulting in an emergency change of operations;
u) provider drug use.

B. **Serious Incident** is defined as a serious and extraordinary event involving an individual, facility or employed/contracted personnel. A

serious incident poses the threat of immediate death or severe injury to a person, substantial damage to individual or state property, and/or widespread interest in the news media. More specific definitions include the following:

a) all deaths;
b) poses a serious and immediate threat to the physical or emotional well being of an individual or staff member;
c) severe personal injury – physical injury that creates a reasonable risk of death, causes serious or permanent disfigurement, or serious impairment of a consumer's health;
d) property damage estimated in excess of $10,000;
e) involves theft or loss of an individual's money or property of more than $1,000;
f) involves reporting to law enforcement officials because a Division-enrolled individual is missing and presumed to be in imminent danger;
g) involves reporting to law enforcement officials due to possession and/or use of illegal substances by individuals or staff/providers;
h) results in a 911 call due to a suicide attempt by an individual; or
i) involves an incident or complaint from the community that will be/is reported on the front pages of the newspaper or on television/radio.

III. Risk Incident Management System (RIMS) Definitions

The following definitions are used when entering incidents into the Risk Incident Management System (RIMS) Database: (See Incident Reporting Matrix for guidance as to which Incidents are mandatory or optional for entry into the Risk Incident Management System (RIMS)).

- **Accidental Injury** is defined as a non-intentional or unexpected injury.

- **Category** is defined as the main classification of incidents. For example, verbal abuse is a category of Other Abuse. The Risk Incident Management System tracks incidents by type, then category. Each category is leveled.

- **Client Missing** is defined as an incident in which an individual with alone time, as defined in his/her Individual Support Plan, is missing longer than the plan states or when an individual without planned alone time is missing and is at risk of harm.

- **Community Complaint i**s defined as a complaint from the community that puts an individual or the community at risk of harm.

- **Death** is defined as "expected" (natural), "unexpected" (unnatural) or "no provider present". **Expected deaths** refer to deaths from long-standing, progressive medical conditions or age-related conditions, e.g. end-stage cancers, end-stage kidney or liver disease, HIV/AIDS, end-stage Alzheimer's/Parkinson's Disease, severe congenital malformations that have never been stabilized, etc. **Unexpected deaths** include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarcts or strokes, trauma/abuse, sudden deaths from undiagnosed conditions, or generic medical conditions, e.g. seizures, pneumonia, falls, etc., that progress to rapid deterioration. **No provider present** refers to deaths of individuals living independently or with family and no provider is present around the time of the death. **If a provider is present around the time of the death, the "expected" or "unexpected" categories should be used.**

- **Emergency Measures** is defined as the use of physical management techniques (CIT level II) or behavior modifying medications in an emergency to manage a sudden, intense or out of control behavior.

- **Fact-finding** is an informal inquiry conducted to objectively verify the details of an incident and the possible need for corrective action or an investigation.

- **Human Rights Violation** is defined as a violation of an individual's dignity or personal choice, such as violations of privacy, the right to open mail, send and receive phone calls, access to one's own money, choosing what to eat, etc. (see Chapter 1500 of the Division's Policy and Procedures Manual).

- **Individual/Client/Consumer** is defined as a person enrolled with the Division of Developmental Disabilities.

- **Investigation** is a systematic collection of facts/information for the purpose of describing and explaining an incident.

- **Legal** is defined as an incident of alleged provider fraud, client exploitation through using an individual to gain monetary or personal rewards, or the possession or use of illegal drugs by provider or state staff.

- **Medication Error** is defined as the administration of medication in an incorrect manner. This includes: giving medication to the wrong individual, administering medication in the wrong method, giving the wrong dosage or not giving medication at all.

- **Neglect** is defined as a pattern of conduct resulting in a deprivation of food, water, medication, medical services, shelter, or other services necessary to maintain physical or mental health. Neglect is an intentional health and safety violation against an individual, such as lack of attention to physical needs failure to report health problems or changes in health condition, sleeping on duty or failure to carry out a prescribed treatment plan. In the case of children, the definition includes the inability or unwillingness of a parent, guardian or custodian of a child to provide that child with supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, unless the inability of a parent or guardian to provide services to meet the child with a disability is solely the result of unavailability of reasonable services.

- **Other** is defined as incidents, which involve behavioral episodes without the use of physical restraints, hospitalizations or treatment at an emergency medical facility due to medical conditions or illness.

- **Physical Abuse** is defined as intentional infliction of pain or injury to an individual.

- **Property Damage/Theft** is defined as damage or theft of state property in a consumer-related incident, or the theft or damage of an individual's property.

- **Programmatic Abuse** is defined as aversive stimuli techniques not approved as part of a person's plan. This can include isolation, restraints or not following an approved plan and/or treatment strategy.

- **Provider** is defined as any person, entity or person hired by the entity, which is paid, through contract or agreement, to deliver services to any individual.

- **Sexual Abuse** is defined as any inappropriate interactions of a sexual nature toward or solicited from an individual with developmental disabilities.

- **Suicide** is defined as:

  1) attempted suicide with medical and/or police involvement; or
  2) threatened suicide - a statement from an individual that he/she wants to commit suicide.

- **Type** is defined as the main reason for the incident. For example, Medicaid fraud, client exploitation and provider drug use are categories

of incidents under the type legal issues. Incidents in the Risk Incident Management System (RIMS) are tracked by type and category.

- **Verbal/Emotional Abuse** is defined as ridiculing, demeaning, threatening, derogatory or profaning remarks directed at a Division enrolled individual.

IV. Reporting Requirements

First and foremost, take whatever actions are necessary to resolve the emergency and insure the person's health and safety, which may include calling 911 or taking other emergency action.

A. Certain people, such as medical professionals, psychologists, social workers, support coordinators, peace officers and other people who have the responsibility for the care of a child or a vulnerable adult are designated by law as mandatory reporters.

If these people have a reasonable basis to suspect that abuse or neglect or exploitation of the individual's property has occurred, they are required to report such information immediately to a peace officer or protection services worker, i.e., Adult/Child Protective Services, Tribal Social Services. Please refer to Chapter 2000 in the Division's Policies and Procedures Manual for additional information regarding mandated reporting.

B. ***Serious Incidents*****,** as described in the definition section above, are to be reported and written as soon as possible, but no later than 24 hours after the incident.

Within 24 hours of a Serious Incident, the following actions must be taken:

- Notification of the incident by the provider to the District. Districts have after hours reporting systems if the incident occurs after hours or on weekends.

- Notification of the Serious Incident from the District to the Assistant Director or his/her designee. The Assistant Director or designee carries an on-call cell phone for serious incident reporting, 24 hours a day.

- District personnel must enter the incident into the Risk Incident Management System (RIMS) database within 24 hours or the

next business day if the incident occurs over a weekend or holiday.

- *Notification to Responsible Person,* e.g., guardian or family member - The responsible person shall be notified unless otherwise specified in the Individual Support Plan/Individualized Family Service Plan. The procedures for notification of the responsible person shall be coordinated between the service provider and the support coordinator. The support coordinator or designated District staff member shall ensure notification of the responsible person of an incident within 24 hours after the incident. The responsible person shall also be notified of any follow up actions that occurs.

- *Notification to the Arizona Health Care Cost Containment System* - The Assistant Director, or designee, must report serious incidents related to abuse and/or neglect involving an Arizona Long Term Care eligible member by phone to the Arizona Long Term Care System designated telephone number within 48 hours of the incident's occurrence.

- *Notification to the Department* - The Assistant Director or designee will notify Department officials as indicated by the Director or Deputy Director.

C. ***All other incidents*** listed in the definitions section of this Directive (see page 2 and 3 of this Directive) must be reported to the District by the close of the next business day following the incident and be entered by designated District personnel into the Risk Incident Management System (RIMS) database within 48 hours of notification (if applicable). (See Incident Reporting Matrix for guidance as to which Incidents are mandatory or optional for entry into the Risk Incident Management System (RIMS)).

Events occurring after normal business hours must meet the above reporting requirements.

V. Reporting Forms

A. All incidents meeting the criteria of the Risk Incident Management System (RIMS) and all Serious Incidents must be entered into the Risk Incident Management System (RIMS) as defined in this directive.

- The Risk Incident Management System (RIMS) is the computerized database for reporting and input of incidents by

Division employees for incidents involving individuals enrolled with the Division.

B. Other ways to document an Incident

- The Division's Incident Report Form (DD-191) may be used to report incidents (or the information can be directly entered into the Risk Incident Management System (RIMS)). For incidents not involving a consumer, the DD-191 should be used, as these incidents are not captured by the Risk Incident Management System (RIMS).

- A provider's own internal incident report form may be used to record incidents as defined in this Directive. The provider can also use the Division's Incident Report Form (DD-191).

C. Incident Reports shall:

- be written clearly, objectively and in order of occurrence, without reference to the writer's opinion. Keep in mind these reports are available to family/guardians and are considered legal documentation;
- include demographic details about the individual:
  1. Full name
  2. Address
  3. Date of Birth
  4. ASSISTS ID Number
- include the staff names and titles who witnessed or who were involved in the incident;
- include a description of the incident including all known facts, location and the date and time incident occurred;
- include causes of injury (if applicable);
- state whether or not the responsible person was notified and, if not, why;
- include whether or not law enforcement, Adult/Child Protective Services or Tribal Social Services have been contacted;
- include signatures and names of the person completing the report and his/her supervisor and any additional comments;
- be completed for each individual involved in the incident and reference other individuals by initials only; and
- be maintained in the individual's primary record maintained by the Support Coordinator and by the provider completing the report.

VI. Fact-Finding, Investigations and Reporting to Other Appropriate Agencies

The Division may initiate an investigation of any incident. Except when such action would compromise the investigation, the Division should notify the service provider of the onset of an investigation.

Division staff are responsible for entering incidents in the Risk Incident Management System (RIMS), notifying and assigning appropriate personnel to initiate fact-finding or investigations and ensuring that Adult Protective Services, Child Protective Services, Tribal Social Services and/or Law Enforcement are notified of incidents mandated by law.

The District Program Administrator/Manager or designee is responsible to define the scope of the review.

Fact-finding/Investigations should be concluded within 30 days from incident notification date. An investigation can be extended an additional 30 days if more time is needed.

A. Protective measures must be taken immediately to ensure that the person is safe and secure.

B. Investigations are initiated within 24 hours of notification or the next business day for the following incidents:

- Allegations of physical abuse which results in medical treatment or police involvement;
- Allegations of sexual abuse;
- High risk incidents of individual missing;
- Attempted suicide;
- Unexpected deaths;
- Allegations of neglect that involve imminent danger; and
- Accidental injuries involving hospitalization.

C. Fact-Findings are initiated within 10 days of notification for:

- Allegations of physical abuse which does not result in medical/police intervention;
- Allegations of verbal/emotional, or programmatic abuse;
- Community complaints;
- State property damage or theft above 100 dollars;
- Client property damage or theft over 25 dollars;
- Expected deaths;
- Allegations of human rights violations;
- Allegations of neglect that involve potential danger;

- Accidental injuries that resulted in medical intervention; and
- Legal issues involving allegations of fraud, client exploitation or provider drug use.

The results of fact-finding may indicate the need for a formal investigation.

VII. Qualified Review/Investigative Staff

The District Program Administrator/Manager is responsible to assign only qualified Division personnel to complete investigations. Division personnel assigned to conduct investigations will meet the following qualifications:

a. have demonstrated ability to be objective;

b. can maintain confidentiality;

c. can complete the task within assigned time frames;

d. have expertise regarding the particular situation; and

e. have no conflict involving the situation.

The staff assigned to investigate any incident must have successfully completed investigation training offered by the Division.

The investigation may involve a review of the provider's incident reports, as well as a review of other records maintained in the provision of services. An investigation will typically include interviewing the person reporting the incident, the service provider and/or individuals who might have additional information or insight regarding the incident.

If an external investigation is initiated, the Division may delay its investigation until Office of Professional Standards, Child Protective Services, Adult Protective Services, Tribal Social Services or law enforcement personnel have completed their investigation, to avoid potential conflicts. If another agency is involved, the assigned Division employee must coordinate investigation efforts with that agency.

VIII. Referral to Other Investigative Agencies

The Assistant Director or the Office of Compliance and Review may refer incidents for investigation to the Office of Professional Standards. An external investigation request may be made for incidents involving:

a. potential criminal activity;

b. possible misconduct by a Division or service provider's employee; or

c. fraud (this type of incident will also be referred to AHCCCS, as appropriate).

IX. Incident Closure and Corrective Actions

A. An incident is complete when:

- the fact-finding or investigation is completed for incidents requiring such action and is reviewed by the District Program Administrator/Manager or designee;
- recommendations for corrective action are identified and provided to appropriate Division and provider personnel;
- corrective action plans, if needed, are both requested of and received from the provider, and
- designated District personnel have verified the information entered into the Risk Incident Management System (RIMS) and have verified that all corrective actions have been completed. Corrective action plans should be completed no later than 60 days from the request for a plan.

B. Corrective actions may be individual-specific or systemic.

An example of an individual-specific corrective action would be requiring the person's team to reconvene to discuss the incident and review the need for any changes in the Individual Support Plan/Individualized Family Service Plan to ensure the health and safety of the individual.

Systemic corrective actions may require the provider to rewrite or clarify agency policy, recommend specialized training of staff, or require other quality improvement actions to increase the ability of the provider to improve the health and well-being of individuals served.

C. The individual's team should review all incidents for the effectiveness of services and assess risk as part of the Individual Support Plan/Individualized Family Service Plan and update process.

D. The Division's Program Monitoring staff (at the Central Office and District Level) should review all incidents for the residential placement to be monitored prior to the visit to identify any areas that may warrant extra monitoring.

X. Trending for Quality Improvement

Trending is an essential component of the Risk Incident Management System (RIMS).

A. District specific monthly data analysis report will be compiled by the District Quality Management lead and submitted to the Quality Management unit which includes the Quality Administrator and will include:

- total incidents by type and category, provider and consumer;
- total allegations of abuse, neglect and exploitation, sorted by provider and consumer, along with identification of whether or not the allegation was substantiated; and
- a narrative analysis of findings, patterns, areas of concern and recommended actions for quality improvement.

A Statewide Incident Summary Report will be prepared by the Division's Central Office designee quarterly and annually and will include:

- total incidents by type and category by district, provider and consumer;
- total allegations of abuse, neglect and exploitation sorted by district, consumer and provider, along with the identification of whether or not the allegations were substantiated; and
- a narrative analysis of findings, patterns, areas of concern and recommended actions for quality improvement.

Incident Summary reports will be provided to the Quality Administrator, the Assistant Director and to designated personnel.

The Division Management Team and Statewide Quality Management Committee will formally review the summary reports on a quarterly basis.

If the District or Statewide Incident Summary Reports indicate any areas of concerns or patterns, focus studies will be completed by the Central Office designee, District Quality Management leads or by Program Monitoring staff (at the District or Central Office level). If any areas of concerns or patterns are confirmed by the focus studies, corrective actions will be recommended for quality improvement.

XI. Information Sharing

Incident reports will be made available to:

- the Human Rights Committees as prescribed in Administrative Directive 46;
- the individual/responsible person(s);
- others who are bound by confidentiality on a need to know basis; and
- other requests should be directed to the Office of Compliance and Review.

Investigative reports and action plans are confidential. Investigative findings and corrective action plans should be summarized in the Risk Incident Management System (RIMS) and a secured hard copy kept at the District level.

XII. Audits

Computer and desk audits will be conducted to determine the timeliness and accuracy of reports, investigations and implementation of corrective actions. Quality reports of the system will also be used to identify patterns of user concerns, e.g. entering an incident into the incorrect type or category, common data entry errors, that indicate the need for additional training, technical assistance or management information system changes.

XIII. Mortality Review Process

Please see the Mortality Review Policy, Directive 80 for information on the actions that need to be completed in regards to a death of an individual served by the Division.

XIV. Fraud

A. Goal

The goal of this policy is to define the procedure for prevention, detection and reporting of fraud and abuse within Department of Economic Security/Division of Developmental Disabilities.

B. Objectives

The objectives of this policy are to:

a. prevent or detect fraud and abuse;

b. delineate reporting requirements; and

c. define investigative procedures.

C. Definitions

- **ABUSE,** in this section, means practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary or which fail to meet professionally recognized standards for health care. Member abuse is defined in Chapter 2000 of the Division's Policy and Procedures Manual along with necessary reporting procedures.

- **AHCCCS** means the Arizona Health Care Cost Containment System

- **FRAUD** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act, which constitutes fraud under applicable state or federal law.

- **POTENTIAL** means that in one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

- **PRELIMINARY INVESTIGATION** means if the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation by the Office of the Attorney General AHCCCS Fraud Control Unit.

- **PREVENTION** means to keep something from happening.

- **PRIMARY CONTACT** is the central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to AHCCCS in the manner prescribed in this policy.

- **PROVIDER** means a person or entity who subcontracts with the Division for the delivery of services to members.

- **REMIT ADVICE** means a document which details the status of each line item in a provider claim, by client specificity. It reports the resolution for each line as paid, denied or pended. Reason codes are attached and summarized for those lines denied.

D. Policy

Following is a description of the processes utilized to detect and prevent fraud and abuse, a description of reporting requirements and investigative procedures:

a. Claims Edits

All claims are edited through a computerized system. When a claim is entered in the system for payment, the system checks to insure that a completed authorization is in place. The system edits prevent payment for incomplete or absent authorizations and/or duplicate claim submittals.

The Division also segregates the duties of service authorization and claims processing.

b. Post Processing Review of Claims

The Division reviews detailed "remit advices". Additionally, the Auditor General does an annual audit of the Arizona Long Term Care Services program including claims processing and payment.

c. Provider Profiling and Credentialing

All providers must meet the specific qualifications outlined in the Division's Central Office Policy and Procedures Manual, Chapter 500. All providers of Arizona Long Term Care Services must be registered with AHCCCS. Health Plans under contract with Division are responsible for credentialing acute care providers.

A.A.C. R6-6-700, R6-6-800, R6-6-1000, R6-6-1100 and R6-6-1500

d. Prior Authorization

All services must be prior authorized by Support Coordinators. Additional prior authorization occurs within the guidelines set forth in Chapter 800 of the AHCCCS Office of the Medical Director Policy Manual.

e. Utilization/Quality Management

The Division shall comply with the requirements set forth in the AHCCCS Medical Policy Manual.

f. Contract Provisions

All providers shall comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" or the terms of the "Individual Service Agreement".

g. Reporting

All Division employees and providers shall comply with this Chapter. The Manager of the Division's Office of Compliance and Review shall report potential incidents to AHCCCS utilizing the AHCCCS prescribed form (Appendix 2100.D).

RZ:LL

INCIDENT REPORTING MATRIX

INCIDENTS INVOLVING CONSUMERS (Categories)	MANDATORY INPUT INTO RIMS	OPTIONAL INPUT INTO RIMS	IT IS A SERIOUS INCIDENT WHEN….
1. Death	Yes	No	All instances
2. Sexual abuse	Yes	No	It is a serious and immediate threat.
3. Physical abuse	Yes	No	It is a serious and immediate threat
4. Programmatic abuse	Yes	No	It is a serious and immediate threat
5. Verbal/Emotional abuse	Yes	No	It is a serious and immediate threat
6. Suicide: Attempts Threats	Yes No	No Yes	Emergency intervention is needed
7. Neglect	Yes	No	A person is in imminent danger
8. Accidental injury: Hospitalization Medical intervention No medical intervention	Yes Yes No	No No Yes	Severe; Risk of death; serious impairment of health/disfigurement
9. Missing: High risk consumer Low Risk consumer	Yes No	No Yes	Imminent danger to self or others
10. Exploitation	Yes	No	Sexual issues; money or property > $1000.00
11. Community complaint (Threat to consumer)	Yes	No	Poses a serious threat; community or client at risk of harm; newsworthy of media
12. Rights violation	Yes	No	It is a serious and immediate threat
13. Provider and/or consumer fraud (Medicaid Fraud)	Yes	No	$1000.00 or more
14. Threats to staff or property	No	No	Threat of immediate harm
15. Theft or loss of consumer property or	Yes, if $25.00 or more	Under $25.00	$1000.00 or more

money			
16. Damage to state property	Yes, if tied to consumer & >$100.00	Yes, if tied to consumer & < $100.00	Excess of $10,000.00
INCIDENTS INVOLVING CLIENTS (Categories)	MANDATORY INPUT INTO RIMS	OPTIONAL INPUT INTO RIMS	IT IS A SERIOUS INCIDENT WHEN….
17. Damage to provider property	No	No	Excess of $10,000.00
18. Drug use/possession by consumer, staff or provider	Yes, if tied to a consumer	No	Reporting to law enforcement
19. Unplanned hospitalization, Emergency room visit due to medical condition or illness	No	Yes	Serious and immediate threat
20. Newsworthy by media	Yes, if meets criteria for another category	No	Will be/is reported in the newspaper or on television/radio
21. Inappropriate sexual behavior	No	Yes	
22. Community disturbance	No	Yes	
23. Medication Error	No	Yes	
24. Use of Emergency measure	No	Yes	
25.*Accident on state property- (Non-consumer or non-employee)	No	No	
26.*Unusual weather conditions resulting in emergency change of operations	Yes, if meets criteria for another category	No	Serious and immediate threat and tied to a consumer
27.*Serious work related illness or injury of staff	No	No	Referral to Disease Control

(Possibility of contagion)			

*Notification of Incidents #25-27 should be sent to the Department of Economic Security/Risk Management Unit along with all incidents involving state operated facilities/individuals.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 77 **Date:** February 25, 2003

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Qualified Vendors and Early Intervention

EFFECTIVE DATE: Upon Receipt

Purpose and Background

To improve the Division's ability to support infant and toddler development as an integrated process the Division is anticipating transitioning to a more integrated service delivery model wherever possible. The opportunities for frequent communications for coordination of efforts among team members is key to an integrated service delivery model.

To this direction and in light of the introduction of the Qualified Vendor System this Directive is intended to inform staff on some specialized handling of Early Intervention services.

Process

1. Upon completion of the initial, review or annual Individualized Family Service Plan, if day treatment and training/special instruction is identified to meet a planned outcome the Support Coordinator shall <u>first</u> offer the family choice of a day treatment and training/special instruction provider.

2. If the Plan also identifies physical therapy, occupational therapy, and/or speech therapy as services to meet planned outcomes and the family's choice of provider for day treatment and training/special instruction also has contracts through the Qualified Vendor process for any or all of these services, the family shall automatically be assigned these services through this provider.

3. If a child and family, upon intake, have been receiving therapy services, they may choose to remain with that therapist, if the therapist is a Qualified Vendor or chooses to become a Qualified Vendor with the Division.

As we consider and plan a system of services that enhances integration, lets identify and discuss other impacts and implications.

RZ:IF:CC

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 78 – (Revision 1) **Date:** March 25, 2003

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Transition to the Qualified Vendor System

EFFECTIVE DATE: March 15, 2003

EXPIRATION DATE: September 30, 2003

Policy: The needs of individuals receiving services through the Division of Developmental Disabilities, as defined in the Individual Support Plan/Individualized Family Service Plan, are matched to providers of service. As part of the transition to the Qualified Vendor System, current providers of those services must confirm that the individual's needs, as defined in the Individual Support Plan/Individualized Family Service Plan are being met and that the provider plans to continue to meet those needs after June 30, 2003.

Applicability: This policy applies to the services listed below when delivered by an agency or by a Professional Independent Provider (a person who is licensed or certified under Title 32, Arizona Revised Statutes who provides services for consumers as a qualified vendor and is not an employee or subcontractor of a provider agency). The services included in this transition process are:

Home-Based Services:
Attendant Care; Habilitation,
Community Protection and Treatment Hourly;
Housekeeping; and
Respite

Day Treatment and Training Services:
Day Treatment and Training, Adult;

Day Treatment and Training, Children (After-School); and Day Treatment and Training, Children (Summer)

Developmental Home Services:
Habilitation, Vendor Supported Developmental Home (Child and Adult)

Independent Living Services:
Habilitation, Individually Designed Living Arrangement

Group Home Services:
Habilitation, Community Protection and Treatment Group Home;
Habilitation, Group Home; and
Habilitation, Nursing Supported Group Home

Professional Services:
Home Health Aide;
Nursing;
Occupational Therapy;
Physical Therapy; and
Speech Therapy

Other Services:
Transportation.

Services provided by individual independent providers are not included in the Qualified Vendor System because the individual independent providers are not required to become qualified vendors through this process. Services provided by individual independent providers will continue to be purchased by the current method.

Transition Process Approach:

1. The Division will confirm the service needs through the Individual Support Plan/Individualized Family Service Plan review and update process. Each individual served must have at least one Individual Support Plan/Individualized Family Service Plan update/review since July 1, 2002. This update will serve as the confirmation of service needs and as the process that has matched service needs to providers.

2. Providers will confirm and provide assurance that they are meeting needs as defined in the Individual Support Plan/Individualized Family Service Plan. Each provider will provide assurance in writing that they are meeting the needs of the individual as defined in the Individual Support Plan/Individualized Family Service Plan and that they plan to continue to meet the needs. Upon receipt of the assurance from the provider, the support coordinator will confirm that the services being provided match the needs as described in the individual's Individual Support Plan/Individualized Family Service Plan.

3. If an individual is receiving services from an agency or a Professional Independent Provider(s) who does not become a Qualified Vendor, the Division will implement the process for selecting a different provider who is a qualified vendor or who is an Individual Independent Provider (a person who is qualified to provide services, has a provider identification number and an individual service agreement with the Division to provide services). The transition to the qualified vendor or individual independent provider will occur prior to July 1, 2003.

Procedures:

1. Division confirmation/definition of service needs in the Individual Support Plan/Individualized Family Service Plan and matching to providers of service

A. To ensure all individuals have a current Individual Support Plan/Individualized Family Service Plan the Division has produced a list from ASSISTS of all persons authorized for services who have an outdated Individual Support Plan/Individualized Family Service Plan (review date prior to 7-1-02). The order of the list is:
   1. District
   2. Office
   3. Support coordinator name
   4. Individual name and ASSISTS ID
   5. The date of the last review

B. The list does not include persons who are not receiving services (D01) or persons for whom no services have been provided within 30 days of becoming eligible (Z01) Placement Codes.

C. The list has been distributed to the District Program Administrator/Manager or designee, who will disseminate the information to Supervisors.

D. Supervisors will provide the list to the appropriate support coordinators who will:
   a. Update ASSISTS if the last review date indicated is not correct; or
   b. Schedule the Individual Support Plan/Individualized Family Service Plan review by March 21, 2003.

E. The District Program Administrator/Manager or designee will monitor completion of the updates and ensure each individual in the District has an updated Individual Support Plan/Individualized Family Service Plan.

2. Provider Assurance

A. The Division will produce a Transition Service List by District, by provider and by individual name of all individuals with current service authorizations. The list will be in order by Provider for all services included in the qualified vendor application process. (Attachment A)

B. The Division will produce a corresponding Provider Assurance form for each individual on the service list. (Attachment B)

C. The Transition Service List and the Provider Assurance forms will be distributed to the District Program Administrator/Manager or designee.

D. The timeline and actions required to obtain the Provider confirmation are:

<u>April 1 – April 8, 2003</u>
The District Program Administrator/Manager or designee facilitates the review and verification of the Service List to confirm its accuracy, identify any changed circumstances or changed providers, and identify those persons for whom an Individual Support Plan/Individualized Family Service Plan has not been updated since June 30, 2002, etc.

- The District Program Administrator/Manager or designee will remove from the list any person(s) no longer being served by that provider.
- The District Program Administrator/Manager or designee will add the person to the list of the appropriate provider and will create a Provider Assurance Form for the person receiving services.
- The District Program Administrator/Manager or designee will remove the Provider Assurance Forms for persons without current Individual Support Plan/Individualized Family Service Plan review dates, will confirm that an Individual Support Plan/Individualized Family Service Plan update has been scheduled and will send the Provider Assurance Form to the provider following the Individual Support Plan/Individualized Family Service Plan review.

<u>April 8, 2003</u>
The District Program Administrator/Manager or designee will send the Provider Assurance Form to the provider with a letter of explanation (Attachment C). The letter includes a statement that if the provider is not planning to apply for QV status, please sign and return the Letter immediately to allow for planning the change of providers.

April 8 – April 29, 2003
Providers review the Provider Assurance Forms for persons authorized to receive services from their organization and note exceptions on the Assurance Form and/or indicate confirmation that they are meeting the needs of the person and that they intend to continue to meet the needs of the person.

If the Provider is not going to continue with all currently provided services, they will be asked to notify the District Program Administrator/Manager or their designee.

April 29, 2003
Providers return to the District Program Administrator/Manager or designee, the signed Provider Assurance forms confirming that they are meeting the needs of the person and plan to continue to meet the needs as defined in the Individual Support Plan/Individualized Family Service Plan. The provider will identify any exceptions which may include the person is no longer receiving that service from them.

May 1, 2003
The Division Contracts Management Section notifies the District Program Administrator/Manager or designee on a weekly basis of the provider's who have become Qualified Vendors. The Notice is to include identification of the services for which the provider has signed a Qualified Vendor Agreement.

May 1 – June 1, 2003
District Program Administrator/Manager or designee monitors return of the Provider Assurance Forms, and matches the returned Provider Assurance Forms to the Service Lists to ensure all persons receiving services have a Provider Assurance Form.

District Program Administrator/Manager or designee forwards the provider assurance form to the support coordinator. The support coordinator:

- matches the provider assurance form services to the individuals Individual Support Plan/Individualized Family Service Plan,
- resolves any differences between the individuals needs as stated in the Individual Support Plan/Individualized Family Service Plan and the provider assurance form,
- signs the provider assurance form confirming the services being provided match the needs as defined in the Individual Support Plan/Individualized Family Service Plan, and
- returns the provider assurance form to the District Program Administrator/Manager or designee.

May 1 – June 1, 2003

Once a provider has become a qualified vendor, the District Program Administrator/Manager or designee takes the necessary action to authorize services effective July 1, 2003 and forwards the provider assurance form to the support coordinator for inclusion in the case record.

3. Changes of provider during the Transition Period (April 1, 2003 – June 30, 2003)

A. Change in providers

1. The needs of individuals who are changing providers during this process will be documented in the Individual Support Plan/Individualized Family Service Plan and an Individual Support Plan/Individualized Family Service Plan meeting including the current provider will be held.
2. The provider selection process will be followed to identify a new provider.
3. Changes in provider of service occurring after June 1, 2003 must be to Qualified Vendors or Individual Independent Providers.
4. When there is a change in providers, the confirmation letter with an attachment (the screen print authorization or the actual authorization) will be sent to the Provider to obtain confirmation that they will meet the needs of the individual now and intend to continue to meet the needs of the individual after June 30, 2003.

B. If the current agency or Professional Independent Provider does not become a qualified vendor, the District Program Administrator/Manager will notify the appropriate Supervisors/Support Coordinators that a change in service provider is needed.

1. The Support Coordinator will follow the Qualified Vendor provider selection policy and process in assisting the individual and/or their family in identifying a new provider.

RZ:DM:CC

Attachment A:

Transition Services List

The Division's Management Information Systems staff will provide the Transition Services List on April 1, 2003 to the District Program Administrator/Manager or designee.

The purpose of the list is to provide identification of all persons authorized to receive services through the Division from an agency or Independent Professional Provider.

The list will be in the following order:

By District
By Provider
By Name of the Person authorized to receive service

The list will include for each person identified the name of the service(s) received, the name of the Support Coordinator and the date of the last Individual Support Plan/Individualized Family Service Plan update.

Attachment B

PROVIDER ASSURANCE FORM - Transition to the Qualified Vendor Process

(Computer generated report)

Provider ID: 123456789SA **Provider Name:** Bajema/Dobias/Moraga/Sanabia/Thompson, Inc.

Support Coordinator: Johnny Smith **Client District Office:** D5B

Client ID: 0009876543 **Client Name:** Janie Jamison

I am currently meeting the needs of this individual for the service(s) as defined in the Individual Support Plan/Individualized Family Service Plan which are listed below and I intend to continue to provide the service(s) after June 30, 2003, contingent upon receipt of an authorization from the Division.

Services Provided:	YES	NO	Provide comment as needed
HAB			
RRB			

Provider Signature: _____Date _____

☐ My signature below indicates that: Bajema/Dobias/Moraga/Sanabia/Thompson , Inc. does **not** intend to apply to be a Qualified Vendor with the Division of Developmental Disabilities.

Provider Signature: _____Date _____

For DDD Support Coordinator Use Only: I have reviewed the services as defined in the Provider Assurance Form (above) and confirm that the services being provided match the individual's needs as defined in the ISP/IFSP.

Support Coordinator Signature: _____Date _____

Attachment C Letter to Providers

DISTRICT LETTERHEAD
557 Transition Letter to Providers

Date

Provider Name
Provider Address

Dear Re: Transition to Qualified Vendor Process

Arizona Administrative Code (A.A.C.) R6-6-2113 requires current service providers to submit written assurance to the Division that the consumers' needs are being met as described in the person's Individual Support Plan/Individualized Family Service Plan.

The attached Provider Assurance Form(s) contain the names of the people served by your agency and the service(s) you are authorized to provide for each. The list does not include people served under the Voucher System and these names do not need to be added to your list. The Voucher authorizations will not be affected by the change to the Qualified Vendor Process.

If your agency is not planning to apply for Qualified Vendor Status, please check the appropriate box and sign and return the enclosed Provider Assurance Form(s).

If you believe you are meeting the person's needs as identified in the Individual Support Plan/Individualized Family Service Plan and would like to continue to provide these services after June 30, 2003, please check the appropriate box for each service you intend to continue to provide, and return it to me at the above address within fifteen working days.

If there are people who are not on this list that you are serving, please provide their names, services provided and if possible, ASSIST ID on the blank form provided and be sure to indicate your intention to continue to provide or not provide service. Please complete a separate form for each person receiving services.

Upon receipt of your written assurance, confirmation that you are a Qualified Vendor, and review of the Individual Support Plan/Individualized Family Service Plan, the District will issue a continuing authorization effective July 1, 2003.

If you have any questions, please contact_____.

Sincerely,
District Program Manager/Administrator

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 79 **DATE: March 5, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Prevention/Risk Assessment

EFFECTIVE DATE: March 1, 2003

The use of the Prevention/Risk Assessment tool (DDD-1309AFORNA) is now mandatory by Support Coordinators for the types of individuals listed below. Its results must be referenced in the Individual Support Plan or be appended at least annually.

- Presence of or recent history (past three (3) years) of a life threatening behavior, e.g., ingesting foreign objects;
- Other medical or behavioral issues which could potentially jeopardize quality of life, e.g., frequent falls resulting in fractures;
- One or more serious incidents of any type recorded during the past year (as defined in Administrative Directive 76, Incident Reporting and the Risk Incident Management System;
- Other life events suggesting a re-evaluation of risks and prevention activities, e.g., death of a close relative, diagnosis of diabetes;
- Only those in residential placements (group homes, intermediate care facilities, etc.).

Although It is intended for use only with individuals in residential placements, if a Support Coordinator or the team feels it would be useful in other situations, e.g. someone living in their own home, they are encouraged to use it.

As always, the Division values the balancing of risks with rights and choices. The emphasis on prevention should not result in careless dismissal of rights, preferences, or lifestyle. The thoughtful introduction of preventive behavior on the part of the caregiving/support system is the goal. The unique assets an individual with developmental disabilities brings to the table should always be first considered and should always be the preferred vehicle for prevention - education, skill building, adaptive supports, etc., are sometimes the ounce of prevention that is needed.

Please ensure the orientation of all Support Coordination staff, supervisors and others to these instructions. Incident investigations, monitoring, Long Term Care audits, etc., will include items to assess our success in implementing more preventative strategies for the next year that evaluate whether a risk assessment should have been done and whether it is adequate. Toward this end, I am asking the supervisors group to develop a supporting *Instruction*s document to aid in orientation, training, etc. by the summer.

Thank you.

RZ:CC

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 80 (Revised) **DATE: February 7, 2006**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Mortality Review

EFFECTIVE DATE: **Upon Receipt**

I. **Purpose**: To improve care for current consumers by a systematic examination of deaths.

II. **Notification Procedure**:

The Support Coordinator should be notified immediately when an individual who is eligible for services from the Division dies. An incident report shall be completed and entered into the Risk Incident Management System (RIMS) by the Support Coordinator or their supervisor within 48 hours of notification of a death.

The Support Coordinator will notify the responsible person or next of kin, if they have not already been notified. The Support Coordinator or designee will also immediately notify the appropriate District Manager/Administrator/designee. Within 24 hours of notification of a consumer's death, all service authorizations must be closed in FOCUS with the date of death effective date. Support coordination (CMG/CPG) and Bereavement Counseling offered to support the family may remain authorized for 90 days after the Division being notified. If staff become aware of any service utilization after the date of the consumer's death, it should be reported into the Risk Incident Management System.

If Health Care Services staff is notified of a death, they will notify the Central Office on-call person within 24 hours.

The District Manager/Administrator/designee will notify the Assistant Director/designee or the Division's on-call line within 24 hours of being notified of a death, as well as Adult or Child Protective Services as

required by statute. The District Manager/Administrator/designee will also notify the Human Rights Committee District liaison.

Central Office designees will notify the Department of Economic Security (DES) Risk Management if the death may give rise to a liability claim against the state.

III. **Review Procedure**:

A. District Review

1. All deaths are to be reviewed jointly by the Support Coordinator and his/her supervisor within 30 days, in order to identify apparent issues relating to care or cause of death.

2. The Support Coordinator or designee will enter the following information, as applicable, relating to the death into the Risk Incident Management System (RIMS):

- Member's underlying primary medical conditions
- Detailed circumstances of the death (What happened? Where did it happen? Was a provider present? Did providers follow policy such as calling 911 and performing CPR? Had member been ill? What is the suspected cause of death, if known?)
- Was Hospice involved?
- Did the member have a DNR (Do Not Resuscitate) order in place?
- Had CPS/APS been involved within the last year?
- Has Health Care Services been asked to get Health Plan records for additional review?
- Is there litigation pending?
- Is there further investigation underway?

3. The District will send the primary case file to Central Office within 60 days after being notified of the death.

B. Quality Management Administrator Review

1. The Quality Management Administrator reviews the mortality information documented in the Risk Incident Management System (RIMS) and requests any further information, as necessary.

2. The Quality Management Administrator then assigns the death into one of the following categories:

Level A—these include deaths that are expected and/or anticipated, due to natural causes, such as terminal illness or congenital anomalies. Level A deaths typically would also include members who lived with family or independently and were not receiving any services from the Division.

Level B—these include deaths that are not expected and/or are sudden, such as trauma or pneumonia that progresses to respiratory failure. These deaths require a closer inspection into the circumstances surrounding the death and assessment of any systemic issues which should be addressed. Other situations where Level B is indicated include: aspiration, coroner cases, law enforcement/911 calls, unexpected circumstances, unusual or suspicious circumstances, and problems with emergency or other medical care.

3. The Quality Management Administrator/designee requests death certificates and autopsy reports when indicated.

4. The Quality Management Administrator requests Managed Care Operations to gather additional medical records for review when indicated.

5. The Quality Management Administrator tracks mortality information in a database specifically designed to collect information related to all member deaths.

6. The Quality Management Administrator communicates via the Risk Incident Management System (RIMS) the status of the mortality review and when the case is considered closed. Any recommendations are shared in the summary by the Quality Management Administrator.

7. Based on the information reviewed by the Quality Management Administrator, cases will be selected from the Level B deaths to present to the Mortality Review Committee at their next quarterly meeting. The selected cases are felt to warrant additional review by the Committee and demonstrate situations where recommendations for systemic improvement can be made.

C. Mortality Committee Review

1. The Committee shall discuss each selected case and identify any changes in practice, training, or processes that may positively affect future care and treatment. The Committee shall report in writing their recommendations to the Management Team.

2. Within 30 days of receiving an action recommendation, the Management Team shall report their disposition of the recommendation/s and steps they are taking to respond to the recommendations of the Mortality Review Committee.

3. Following the Mortality Review Committee review, the case shall be closed unless it is referred for Level C review.

D. Review Level C - Root Cause Analysis review

1. A Root Cause Analysis, which will follow the general protocols recommended by the Joint Commission on Accreditation of Health Care Organizations, will be arranged by the Quality Management Administrator and will be conducted on cases recommended to the Assistant Director by the Mortality Review Committee or as requested by the Assistant Director.

2. No more than three (3) Root Cause Analyses shall be conducted in a fiscal year.

3. The Quality Management Administrator shall monitor the implementation of recommendations from a Root Cause Analysis.

IV. **Process**

A. The Mortality Review Committee shall consist of the Statewide Quality Management Committee in Executive Session. The Committee shall meet at least quarterly.

B. The Quality Management Administrator shall issue annually a Mortality Review & Analysis, which will aggregate, analyze and summarize mortality data and actions taken for system improvements.

C. The Quality Management Administrator is responsible for monitoring the mortality review process and conducting integrity checks, including protecting any privacy rights of the deceased.

D. Autopsies should always be requested for children in foster care. For all other deaths, requests should be made whenever it is possible that something can be learned from the death. Consent for an autopsy rests with the responsible person or next of kin, unless the county attorney or coroner is involved. A request for an autopsy should follow these steps in priority order:

1. Arizona Revised Statute 11-597 provides for County Medical Examiners to complete an autopsy and outlines when this is required.
2. When the Medical Examiner does not identify a need for an autopsy, the Division can request the family to authorize an autopsy, at the expense of the Division, when the Division's Medical Director believes there are unanswered questions surrounding the death.

3. Autopsy reports will be requested by the Quality Management Administrator/designee.

E. Death Certificates will be requested by the Quality Management Administrator/designee.

F. Reviewers and all others involved with these processes shall in all cases exhibit compassion and sensitivity to next of kin, caregivers, and others who cared about the individual.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 81 **DATE: June 16, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Extended Employment Services

EFFECTIVE DATE: July 1, 2003

The Division's Employment Program provides training and ongoing supports to persons engaged in work. The program includes the following services: Individual Job Coaching including Job Support Modifiers, Supported Employment, Sheltered Employment and Transportation. The choice of services is decided by the Individual Support Plan Team. The Team will also determine specific strategies, frequency and duration of service(s). During transitional stages the team may identify a higher level of frequency than the minimum levels noted below. Title XIX funds cannot fund employment services that are otherwise available to the person through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). A person may use more than one employment service type simultaneously.

Employment services through the Division are available to Arizona Long Term Care System eligible adults and non-Long Term Care eligible adults. Employment service supports for non-Long Term Care eligible adults are dependent upon available state funding.

Referral Process to Vocational Rehabilitation

The Support Coordinator may make a referral for Vocational Rehabilitation services using the following referral priority sequence:

1. Students in successful school to work programs or others who would be in jeopardy of being unemployed without support.

2. People who have had a job and are currently out of work.

3. People who have expressed a strong desire to work and who have, in sequence noted:

    - Demonstrated skills and experiences
    - Family and friends focusing on and supportive of the person's desire to work
    - Neighborhood informal and formal supports
    - Clear preferences

4. People with extraordinary job support needs.

5. People who have not expressed a desire to work.

The referral is made to the Vocational Rehabilitation office closest or most convenient to the person being referred. The Referral Form (DDD1328AFORNA) is used in making the referral.

Planning the Individual Plan of Employment

The Support Coordinator will work with the Individual Plan of Employment team:

- To represent the Division and the recommendations of the Individual Support Plan/Person Centered Plan team to the Vocational Rehabilitation counselor;
- To identify which records exist within the Division which provide insight into the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choices of the person;
- To suggest additional information regarding the person's life experiences and contributions in order to identify a job consistent with the person's entire life; demonstrated skills, experiences, home, family, friends, neighborhood, informal supports, preferences, connections and need for accommodation.

The Vocational Rehabilitation counselor will initiate a meeting with the Division's Support Coordinator to discuss and obtain agreement that employment supports will be available for the person if the person will need such supports. The Vocational Rehabilitation Coordination of Extended Supported Employment form will be used to document these activities.

Implementing the Individual Plan of Employment

The Division's Support Coordinator will be involved with the team in monitoring the person's progress in achieving employment outcomes and in making decisions regarding changes in strategies or outcomes.

Closure of Vocational Rehabilitation Services

The responsibility for payment for extended employment services is transferred to the Division when a decision is made that the person is successfully employed. Rehabilitation Services Administration defines successful employment as follows:

a. The employment outcome has been achieved, or achieved to the extent possible, consistent with the persons' abilities, capabilities, interests and informed choice;

b. The employment outcome is in the most integrated setting possible, consistent with the persons' informed choice;

c. (For persons requiring extended Employment Support Services) The person is no longer receiving employment support services using Vocational Rehabilitation funds.

The Vocational Rehabilitation Counselor will initiate a meeting to discuss and obtain agreement from the Division's support coordinator regarding:

- meeting the above criteria,
- the type(s) of ongoing employment supports needed by the person, and
- the date for transferring payment responsibility to the Division.

The Vocational Rehabilitation Coordination of Extended Supported Employment form will be used to document the results of this meeting. The Vocational Rehabilitation counselor will continue to monitor the job placement for as long as is necessary (a minimum of 90 days) to ensure that the employment is successful. The counselor will work with the Support Coordinator during this time to address any outstanding rehabilitation related employment issues.

Under some circumstances, a person may no longer be eligible for federally funded Vocational Rehabilitation supports. The Vocational Rehabilitation Counselor will make this decision in collaboration with the Division's Support Coordinator, along with an agreed upon date to transfer employment supports responsibility to the Division.

Following is a description of the covered Extended Employment Services:

Individual Job Coaching

This service provides regular contacts with the person employed and with the employer. This service must be provided individually. This person's job pays at least minimum wage.

The goals of this service are:

- To support the person in employment;
- To help the employer affect any employment related concerns;
- To look for or create opportunities for the person to work without government supports.

Service Settings

Individual job coaching is provided only to a person who is working in the public work force in an integrated setting.

Integrated setting means a setting typically found in the community in which the applicant or eligible individual interacts with individuals without disabilities, other than individuals without disabilities who are providing services to those applicants or eligible individuals, to the same extent that individuals without disabilities in comparable positions interact with other persons (Section 12C of the Rehabilitation Act; 29 U.S.C. 709 (c))

Supported Employment

This service provides regular contacts with the person employed and the employer. This service may be provided individually or in a group.

The job being supported pays minimum wage unless the employer has an approved sub-minimum wage certificate with the Department of Labor.

The goals of this service are:

- To support the person in employment;
- To help the employer affect any employment related concerns;
- To create and look for opportunities to assist the person to progress to Individual Job Coaching or to work without government supports.

Service Settings

Supported employment is provided only to a person who is working within the public work force in an integrated setting. The job may involve either:

a. being directly hired and employed by a community employer (individual placement) and supported employment services provided by a community program, or

b. being hired and supported by a community program but working within the community as a member of a group, enclave, or as a temporary worker.

Sheltered Employment

This service provides supervised employment with a person who is employed in a non-integrated work environment.

The job being supported pays minimum wage unless the employer has an approved sub-minimum wage certificate with the Department of Labor.

The goals of this service are:

- To support the person in employment by providing work within an non-integrated work environment;
- To create and look for opportunities to assist the person to obtain work through Supported Employment, Individual Job Coaching supports, or to work without government supports.

Service Settings

Sheltered employment is provided in facility based, non-integrated employment settings.

Job Support Modifiers

This service provides additional supports that may be necessary to assist the person in maintaining or re-obtaining employment. This service may include job development and placement, interpreter supports and other types of supports when specifically identified on the Individual Support Plan by team agreement.

The goals of this service are to make continued successful employment possible by:

- Helping a person to be re-employed after losing a job, or
- Providing services (not provided as part of Individual Job Coaching, Supported Employment and Sheltered Employment) which meet a person's specialized needs within a job setting.

Service Settings

Job support modifiers are available, as needed, to any person receiving Individual Job Coaching, Supported Employment or Sheltered Employment.

Transportation

This service provides transportation only for the purpose of getting to and from an employment site. In general, for persons employed and earning at least minimum wage, transportation would be a condition of employment and therefore the person's responsibility.

Transportation may include authorizations for payments, as needed, to either community program providers (if the person does not have available transportation) or to public transit, bus tickets etc.

The goal of this service is to:

- To transport persons, who do not otherwise have transportation available to them, to get to or from work.

This service is not used to transport persons to the provider facility, if different from the work site, or to return the person from the work site back to the program provider facility. The exception to this is when a person works in a job part time and then is served at a provider facility the remainder of the day, transportation may be used to transport this person from the job to the provider facility.

Division staff need to look for or create opportunities for the person to work without government transportation supports.

The following apply to all employment services:

Service Requirements

Before any of these services within the Division's employment program can be authorized, the following requirements must be met:

a. The Individual Support Plan/Person Centered Plan must identify needs and outcomes consistent with employment services descriptions and service settings.

b. The Individual Support Plan/Person Centered Plan must determine the need for these services using the assessment and plan development processes described in Chapters 700 and 800 of the Division's Policies and Procedures Manual.

Target Population

The Individual Support Plan/Person Centered Plan team must determine the need for employment services for any adult who chooses to work.

Provider Types and Requirements

Designated District staff will ensure all contractual requirements related to employment service providers are met before an employment service can be initiated. All providers of Arizona Long Term Care System Services must be certified by the Department of Economic Security, Office of Licensure, Certification and Regulation and registered with AHCCCS prior to initiation of employment services.

Service Evaluation

- The provider must submit a written progress report on Individual Support Plan/Person Centered Plan outcomes related to the provision of employment services monthly to the Support Coordinator. The report must address the progress or lack of progress toward the achievement of the outcomes and the overall goal of integrated employment. The Support Coordinator must review these reports on at least a quarterly basis. If there is no progress in the timeline specified on the Plan the team must reassess the outcomes and determine the on-going appropriateness of the outcomes, strategies and services.

- Employment services must be added to the Cost Effectiveness Report by the Support Coordinator for anyone over 80% of the Intermediate Care Facility for the Mentally Retarded cost.

Service Closure

Service closure should occur in the following situations:

- The person has obtained integrated competitive employment and is working independently.
- The person has reached retirement age and chooses to seek post-retirement supports.
- The person declines employment services.
- The person moves out of state.
- Other alternative resources, e.g., transportation, become available and government support is no longer needed.

A notice of intended action must be sent in accordance with Section 2202 of the Division's Policies and Procedures Manual or the Member Rights and Responsibilities Notification in accordance with AHCCCS.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 82 **DATE: July 30, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Changes in Rates and Billing Requirements for Day Treatment and Training, Adult

EFFECTIVE DATE: July 1, 2003

This Administrative Directive revises the rates for Day Treatment and Training, Adult included in the rate schedules published July 1, 2003 as well as the current billing requirements in the Request for Qualified Vendor Applications (RFQVA) for Day Treatment and Training, Adult. In particular it:

- Increases the rates for Day Treatment and Training, Adult from those that were published July 1, 2003

- Directs Qualified Vendors to bill per client hour as opposed to 15-minute increments. Qualified Vendors may round to the nearest hour using the convention of 29 minutes or less round down, 30 minutes or more round up.

- Allows Qualified Vendors that do not provide transportation to include up to an hour a day per consumer (when the consumer is not present because the consumer arrives late or leaves early) in the daily ratio and to be paid for that time

- Maintains the 1:1 and 1:2 rates which are currently in effect. These rates are not affected by this change because these are sufficient to cover all costs. These rates are the same as the adopted rates for Habilitation, Support – 1:1, $16.80; 1:2, $10.50.

The following provides further detail on these changes.

Increased Rates

The tables below show for Day Treatment and Training, Adult the adopted rates published July 1, 2003 and the new rates effective with this Administrative Directive. The rates to be paid to Qualified Vendors for Day Treatment and Training, Adult services beginning July 1, 2003 are the rates in the column labeled "Adopted Rate Effective 8/1/03." These rates replace the rates in the schedules published July 1, 2003.

Service Code	Description	Unit of Service	Adopted Rate 7/1/03 Rate Schedule	Revised Adopted Rate
Day Treatment and Training, Adult				
DTA	Day Treatment and Training, Adult - Staff : Consumer Ratio Of 1:2.5 To 1:4.5	Program Hour	$8.20	$8.60
DTA	Day Treatment and Training, Adult - Staff : Consumer Ratio Of 1:4.51 To 1:6.5	Program Hour	$6.00	$6.25
DTA	Day Treatment and Training, Adult - Staff : Consumer Ratio Of 1:6.51 To 1:8.5	Program Hour	$5.00	$5.20
DTA	Day Treatment and Training, Adult - Staff : Consumer Ratio Of 1:8.51 To 1:10.5	Program Hour	$4.45	$4.55

Modified Rates				
Service Code	**Description**	**Unit of Service**	**Adopted Rate 7/1/03 Rate Schedule**	**Revised Adopted Rate**
Rural The Division established a separate rate for this service in the rural areas of the state. This modified rate is authorized on a program basis and has a premium over the standard rate for this service. The Qualified Vendor shall bill the Division this modified rate only after it receives authorization from the DDD Program Administrator/Manager or designee. The general guideline for authorizing the modified rate for rural areas is that the potential client base of the program size has fewer than 20 consumers in a 40 mile radius.				
DTA	Rural Day Treatment and Training, Adult - Staff : Consumer Ratio Of 1:2.5 To 1:4.5	Program Hour	$9.20	
DTA	Rural Day Treatment and Training, Adult - Staff : Consumer Ratio Of 1:4.51 To 1:6.5	Program Hour	$7.00	$7.20
DTA	Rural Day Treatment and Training, Adult - Staff : Consumer Ratio Of 1:6.51 To 1:8.5	Program Hour	$6.00	$6.15
DTA	Rural Day Treatment and Training, Adult - Staff : Consumer Ratio Of 1:8.51 To 1:10.5	Program Hour	$5.45	$5.50

Billing

Currently the Request for Qualified Vendor Applications requires Qualified Vendors to round units to the nearest quarter hour. However, effective with this Administrative Directive, vendors shall round units to the nearest hour. For rounding purposes, 29 minutes or less are rounded down to the nearest hour, 30 minutes or more are rounded up to the nearest hour.

The Request for Qualified Vendor Applications (Section 7, Day Treatment and Training, Adult, Unit of Service, item 1, page 7-26(a)) will be amended as follows:

> Total hours for consumers or direct service staff shall not include the time spent during transportation to/from the program. For both consumers and direct service staff, units shall be recorded on the *per consumer* and *per direct service staff* basis, shall be expressed in terms of hours and shall be rounded to the nearest hour, as illustrated in examples below:

- If total hours for a consumer or direct service staff were equal to 3 hours and 5 minutes, round the total to 3 hours
- If total hours for a consumer or direct service staff were equal to 5 hours and 24 minutes, round the total to 5 hours
- If total hours for a consumer or direct service staff were equal to 6 hours and 48 minutes, round the total to 7 hours

Billable Hour Per Day When Consumer is Late or Leaves Early Due to Independent Transportation Caused Absence

Currently the Request for Qualified Vendor Applications provides that only hours during which the consumer attended the program are included in the calculation of the daily ratio and the Division will not pay for any absences.

This Administrative Directive revises that policy to allow Qualified Vendors **that do not provide transportation** for a particular consumer to include up to one hour per day if that consumer arrives after his/her scheduled arrival time on that day or if that consumer leaves before his/her scheduled departure time on that day. **This assumes that there is a regular schedule in place for that individual.** The calculation of the daily ratio will use the billable hours. In no event shall the Qualified Vendor submit a claim for more than the number of hours authorized for the consumer.

Determining the Appropriate Billing Rate

The Request for Qualified Vendor Applications (Section 7, Day Treatment and Training, Adult, Unit of Service items 1 and 2, pages 7-26 and 7-26(a)) will be amended to reflect the above provision as well as the following:

1. The basis of payment for this service is the daily ratio rate. To determine the appropriate billing rate for each day this service is provided, the Qualified Vendor shall:
   a. Divide (the total billable hours consumers attended the program in a day including the hours allowed as described above), excluding hours for behaviorally or medically intense consumers with a specially authorized rate) by (the total direct service staff hours with consumers present at the program in a day, excluding hours related to behaviorally or medically intense consumers with a specially authorized rate); and
   b. Use the resulting quotient, which is the number of consumer billable hours per direct service staff hours and can be stated as "1: (result from step a.)" staff to consumer ratio, to find the appropriate staff to consumer ratio rate on the rate schedule.

For example, if the number of hours attended by all consumers in a program plus the hours allowed as described above (excluding behaviorally or medically intense consumers with a specially authorized rate) totaled 109.75 hours for a day, and the number of hours worked by direct service staff when consumers were present at the program (excluding hours related to behaviorally or medically intense consumers with a specially authorized rate) totaled 28.25 for that day, then the calculation would be:

- Total billable consumer hours divided by total direct service staff hours = 109.75 / 28.25 = 3.885
- This program's ratio for this day is 1:3.885

2. Absences. Absences do not constitute a billable unit except as provided for above. An absence factor was built into the model rates. The Division will not compensate Qualified Vendors for any absences. For example, if a consumer stays in the day program for two hours in the morning, then leaves for two hours, and then returns for three hours, and all activity takes place within the same program day, total hours for this consumer shall be equal to five.

3. If the consumer permanently stops attending the Qualified Vendor's facility, then the Qualified Vendor shall notify the Division's Program Administrator/Manager or designee. The Qualified Vendor shall not bill the Division for vacancies.

Note: The following statement in the service specification explains "on behalf of" for the purpose of direct care. For direct service staff, the Qualified

Vendor must keep daily records of the number of hours each direct service staff spends providing direct services to consumers in the program. Only the time when consumers are present at the program shall be counted as direct service. Total time shall not include any time spent during transportation to/from the program. Staff time related to behaviorally or medically intense consumers who have a specially authorized rate shall be recorded separately.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 83 **DATE: August 11, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Choice - Selection of Providers

EFFECTIVE DATE: July 1, 2003

Purpose: The purpose of this Directive is to define the procedures for the consumer or the consumer's representative to select a provider from a list of Qualified Vendors or Individual Independent Providers and for the Division to ensure the needs of the Consumer as defined in the Individual Support Plan/Individualized Family Service Plan are matched with a provider that is able to meet those needs.

Background: The Division is implementing a process for purchasing Home and Community Based Services that includes the following primary components:

1. Developing a Qualified Vendor application process, evaluation of the applications and agreements for the delivery of statewide community developmental disability services resulting in a directory of Qualified Vendors from which to purchase services.

2. Creating a directory of Qualified Vendors based on applications received that meet specific criteria defined in the Procurement Rules.

3. Establishing, reviewing and updating reimbursement rates for the purchase of services for persons with developmental disabilities in the Arizona Long Term Care System and the state funded program.

4. Purchasing community developmental disability services from provider organizations, Professional Independent Providers and Individual Independent Providers that have submitted a Qualified Vendor application, have become qualified as a vendor and have signed a Qualified Vendor Agreement or an Individual Service Agreement with the Division.

5. Reimbursing Qualified Vendors for the provision of community developmental disability services based on published rates or negotiated rates.

6. Issuing authorizations to Qualified Vendors who have been selected to provide the service for a specific consumer.

7. Establishing a process for the consumer or the consumer's representative to select a provider from a list of Qualified Vendors or Individual Independent Providers.

8. Maintaining an open and continuous process of accepting applications to become a Qualified Vendor.

Applicability: This procedure applies to the selection of a provider of community developmental disability services. The selection may be of Qualified Vendors made up of provider organizations, Professional Independent Providers or Individual Independent Providers that have submitted a Qualified Vendor application and became qualified as a vendor and have signed a Qualified Vendor Agreement. If an Individual Independent Provider chooses not to become a Qualified Vendor, they may remain an Individual Independent Provider by meeting required qualifications and completing a certification process and entering into an Individual Service Agreement with the Division.

This procedure applies when:

1. A consumer who is new to the service system is seeking a provider.

2. There is a change in a Qualified Vendor requested in the Individual Support Plan/Individualized Family Service Plan at the time of the annual review. This request does not require an explanation and the Division shall accommodate the request, to the extent appropriate and practical as determined solely by the Division.

3. The consumer's needs change and the current provider or providers are no longer able to meet the consumer's needs.

4. The consumer or the consumer's representative requests a change outside an Annual Review. The consumer/responsible person must state in writing or must report to the Support Coordinator for incorporation into the Individual Support Plan/Individualized Family Service Plan notes, the rationale for changing providers and a description of the opportunities given to the current Qualified Vendor to address the consumers concerns. For consumers over the age of three, changes must be documented on a Change in the Individual Support Plan Form (DD-224). For children in the Arizona Early Intervention Program, the chosen Qualified Vendor will be documented directly on the Individualized Family Service Plan with the date and the responsible person's signature.

PROVIDER SELECTION PROCESS

I. Consumer/Responsible Person Has Identified or Wishes to Choose an Individual Independent Provider:

The Individual Independent Provider must be certified with the Arizona Health Care Cost Containment System and must have completed the Individual Service Agreement/requirements prior to service delivery.

1. The Individual Support Plan/Individualized Family Service Plan process identifies the need for services funded by the Division.

2. The team has the option to complete the Individual Attributes Checklist (DDD-1332AFORNA – attached) to assist in the Individual Independent Provider match process. The Individual Attributes Checklist will be filed in the consumer's case file in the referral section.

3. Services are reviewed and approved per the Division's Statewide Service Approval Process (Service Approval Matrix - attached). The Support Coordinator initiates the service approval process within five (5) working days from the date of identified need.

4. The district will maintain a list of Individual Independent Providers for the consumer/responsible person to choose from. Identification of the Individual Independent Provider is documented in the Individual Support Plan/Individualized Family Service Plan.

5. The district designee completes the Rate Assessment with the consumer/responsible person. The Rate Assessment will be filed in the consumer's case file in the referral section.

6. Once the service is approved, the Support Coordinator/designee documents the consumer/responsible person's choice of provider on the service authorization form and follows the District's Authorization Process.

II. Consumer/Responsible Person Knows or Wishes to Choose a Qualified Vendor:

1. The Individual Support Plan/Individualized Family Service Plan process identifies the need for services funded by the Division.

2. The team completes the Individual Attributes Checklist (DDD-1332AFORNA - attached) which is required for the Qualified Vendor match process. The Consumer/Responsible Person indicates whether they will contact the potential providers to assess availability or if the Support Coordinator or designee will assist. The Support Coordinator documents the choice on the Individual Attributes Checklist (DDD-1332AFORNA - attached).

3. Services are reviewed and approved per the Division's Statewide Service Approval Process (Service Approval Matrix - attached). The Support Coordinator initiates the service approval process within five (5) working days from the date of identified need.

4. The District shall maintain a Qualified Vendor Directory including objective and factual attributes about each Qualified Vendor to assist the consumer/responsible person in their selection. The Support Coordinator/designee will assist the consumer/responsible person in matching the Consumer's attributes with the Qualified Vendor attributes.

   If the Support Coordinator/Division staff is asked to make a recommendation regarding a provider, **DO NOT RECOMMEND ANY SPECIFIC PROVIDER.** Explain to the consumer/responsible person that the Directory has all the Qualified Vendors that meet the qualifications and are certified to provide the service. **WE ARE PROHIBITED FROM MAKING ANY SPECIFIC RECOMMENDATIONS.** If the Support Coordinator/designee is identified as the person to confirm availability, they must be unbiased in contacting Qualified Vendors.

5. The consumer/responsible person identifies which Qualified Vendors they wish to choose among.

6. The consumer/responsible person or Support Coordinator/designee will notify the Qualified Vendor(s) of service need and the Consumer's attributes. The Qualified Vendor has **two (2)** working days to make contact with the consumer/responsible person or express interest in providing services to the consumer.

7. Identification of the Qualified Vendor is documented in the Individual Support Plan/Individualized Family Service Plan. If the Qualified Vendor is identified outside of the Individual Support Plan meeting then it must be documented on a Change in the Individual Support Plan Form (DD-224). For children eligible for the Arizona Early Intervention Program, the chosen Qualified Vendor will be documented directly on the Individualized Family Service Plan with the date and the responsible person's signature. For consumers who use a voucher or utilize a provider who has a generic identification number, no documentation is required when changing Qualified Vendors outside the plan meeting.

8. The Support Coordinator/designee verifies or provides contact information to the available Qualified Vendor and consumer/responsible person in order for an interview to take place.

9. Once the consumer/responsible person approves the Qualified Vendor and the Support Coordinator is notified:

   a. The Support Coordinator/designee confirms the Qualified Vendor and Consumer/Responsible Person match.

b. The Support Coordinator/designee documents the Consumer/Responsible Person's choice of Qualified Vendor on the service authorization form and follows the District's Authorization Process.

10. If the Qualified Vendor indicates "no", they are not able to serve the person at this time due to inability to meet the specific needs of the consumer or lack of available providers then the Support Coordinator/designee will offer the Consumer/Responsible Person the choice of waiting for the Qualified Vendor to have a provider (wait listing the service), or choosing another provider through Qualified Vendor Directory or the list of Independent Providers or have a Qualified Vendor Auto-assigned.

11. If the Consumer/Responsible Person does not approve the available provider then the Support Coordinator/designee will offer the Consumer/Responsible Person the choice of another provider through Qualified Vendor Directory or the list of Independent Providers or have a Qualified Vendor Auto-assigned.

III. Auto-Assignment Process: When the Consumer/Responsible Person Does NOT Want to Choose (Limited to Qualified Vendors):

1. Support Coordinator or District designee will identify available, appropriate, and interested Qualified Vendors from the local directory.

2. Forward the list of available Qualified Vendors to the Central Office Designee (Phone # 602-542-6090) for auto-assignment.

3. If only one Qualified Vendor is available, then that one will become the assigned Qualified Vendor.

What to send to Central Office Designee for Auto-Assignment:

- Support Coordinator's Name, telephone number, email and district
- The names and provider ID of the available Qualified Vendors
- You may email or call the Central Office Designee at (602) 542-6090 with the information.
- Within 48 hours you shall receive a response back from the Central office Designee identifying the auto-assigned Qualified Vendor.

Qualified Vendors and the Arizona Early Intervention Program for Day Treatment and Training/Special Instruction and Therapies:

Upon completion of the initial, review or annual Individualized Family Service Plan, if Day Treatment and Training Special Instruction is identified to meet a planned outcome the Support Coordinator shall first offer the family the choice of a Day Treatment and Training Special Instruction provider.

If the Plan also identifies physical therapy, occupational therapy, and/or speech therapy as services to meet planned outcomes and the family's choice of provider for Day Treatment Training Special Instruction also has contracts

through the Qualified Vendor process for all or any of these services, the family shall automatically be assigned these services through this Qualified Vendor.

If a child and family, upon intake, have been receiving therapy services, they may choose to remain with that therapist, if the therapist is a Qualified Vendor or chooses to become a Qualified Vendor with the Division.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 84 **DATE: September 18, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Changes to Eligibility Requirements

EFFECTIVE DATE: September 18, 2003

This Administrative Directive describes amendments to Arizona Revised Statutes § 36-559 regarding eligibility for the Division and cooperation with the Arizona Long Term Care System eligibility process. This change goes into effect on September 18, 2003.

Eligibility (Arizona Revised Statutes § 36-559)

As part of the application process, the Pre-PAS screening tool (DD-099) is completed to determine if a referral will be made to the Arizona Long Term Care System. The Pre-PAS screening tool will now include a question regarding the financial resources of the child or adult applying for services. When a Division applicant is referred to the Arizona Long Term Care System for an eligibility determination, the applicant must first be determined financially eligible or ineligible for the program. Applicants with financial resources that exceed the required limits may qualify for the Arizona Long Term Care System by creating a trust that is approved by AHCCCS. If an applicant voluntarily refuses to establish a trust approved by the AHCCCS administration, the applicant will be denied admission to the Division of Developmental Disabilities.

For children ages birth to three, if the Pre-PAS indicates the child does not have financial resources that would affect Arizona Long Term Care eligibility, the Division will provide Early Intervention services as identified in the Individualized Family Service Plan. If at any time the Division is informed that the child is financially ineligible for the Arizona Long Term Care program and the applicant voluntarily refuses to establish a trust approved by the AHCCCS administration, the Division will use only Part C funding to support the child and family.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 85 **DATE: September 18, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Changes to the Schedule of Financial Contribution for State-Funded Service Recipients

EFFECTIVE DATE: September 18, 2003

This Administrative Directive describes amendments to Arizona Revised Statutes § 36-562, regarding financial contributions for state funded services. This change goes into effect on September 18, 2003.

Changes to Cost of Care Contributions (Arizona Revised Statutes § 36-562)

Individuals receiving state funded services that have a trust, annuity, estate or assets that exceed $2000 will be required to make a financial contribution for the actual cost of programs and services provided by the Division. In billing a trust the department is not limited to trust income but will also bill the trust body.

Individuals who meet the financial eligibility requirements for federal Social Security Supplemental Income benefits or the financial eligibility requirements for the Arizona Long-Term Care System are not affected by this requirement.

Individuals and responsbile parties affected by this financial contribution requirement may make applications to AHCCCS for Arizona Long Term Care System eligibility determination. If eligible for the Arizona Long Term Care System, the individual will not receive a bill for the actual cost of programs and services. This requirement does not affect children receiving services through the Arizona Early Intervention Program.

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DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 86 **DATE: September 19, 2003**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Protocol for Clients Who Are at High Risk If Missing

EFFECTIVE RECEIPT: Upon Receipt

This Administrative Directive is designed to provide information on actions required when a vulnerable individual leaves a Division funded service site and is at risk of harm while unsupervised in the community. This Directive is an exception to the reporting timeframes for missing persons in Administrative Directive 76.

A vulnerable individual is defined as a person who is at potential risk of harm while unsupervised in the community. He or she may be a danger to self or others, require medication to control a condition such as diabetes or seizure disorder or lack essential survival skills such as the ability to communicate or move safely about the community. The Individual Support Plan team shall assess the potential risk of an individual who may leave his or her service site without supervision and shall note the results of that assessment in the Individual Support Plan. If the individual has prescribed medication, the Team shall contact the primary care physician and/or psychiatrist to determine if a potential medical risk may arise if the individual goes without prescribed medication for any length of time. This shall be noted in the plan.

Unless the individual's plan states otherwise, the following must occur:

Provider Responsibilities:

When a vulnerable individual leaves a Division funded setting without required supervision, the provider staff will:

1. Conduct a search of the immediate area.
2. If the individual is not located within 15 minutes, provider staff will notify the program supervisor/other staff to assist with the search.

3. If the individual is not found within thirty minutes, the provider must notify law enforcement agencies (e.g. Police, Sheriff's Office) in both the immediate and surrounding communities and the parent/guardian.
4. To assist in locating the individual, also contact the following entities during the search: hospitals, shelters, jails and bus stations.
5. If the individual is not located within one hour, the provider must notify the Division by speaking directly to Support Coordination staff during regular business hours or by calling the District after hours reporting system on evenings and weekends.
6. The provider will report the following information to the Division and submit a written incident report within 24 hours.
    a) Age of individual
    b) General description of the person
    c) Time and location of disappearance
    d) Efforts to locate individual
    e) Vulnerability
    f) Means of communication
    g) Medical or special needs
    h) Precursors to disappearance
    i) Time police and parents/guardian notified
    j) Other entities contacted
    k) Legal status, e.g., foster care, probation

If the individual is located within one hour, the provider will notify the parent/guardian immediately and provide notification to the Division within 24 hours.

Media Involvement:

The decision to contact the media for assistance in locating an individual will be a collaborative agreement between the Division, law enforcement officials, parent/guardian and the provider.

- Prior to contact with the media, the provider will obtain verbal or written authorization from the parent/guardian. The approval must be documented in the provider and the Division records.

- As authorized, the provider will work directly with law enforcement officials by providing essential information about the individual to be released to the media. Law enforcement will make the request for release of the vulnerable individual's information to the media.

- Support Coordination will immediately notify the District's Program Administrator/District Program Manager or designee when a media release is requested.
- The District Program Administrator/District Program Manager will notify the Division's Assistant Director or designee for notification to the Department's Director and Public Information Officer.

- The individual's Team will meet to discuss the incident within 30 days to review the appropriateness of the current plan and Risk Assessment Tool.

RZ:CC

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE DIRECTIVE

NO. 87 Revised **Date: July 27, 2005**

TO Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Program & Contract Monitoring Corrective Action Plans

EFFECTIVE DATE: Upon Receipt

Background:
The Division works in partnership with community providers of service to our mutual consumers. However, the ultimate accountability for the delivery of services rests with the Division as the funding agency. Periodically, performance problems arise that, for the most part, are resolved by communication, clarification, technical assistance, and other collaborative strategies. **This directive is focused on situations where those strategies did not result in performance improvements or those situations where the performance problems pose an imminent threat to consumer well being.**

Policy:
The Division and its contracted providers must ensure services are safe and supportive of individuals receiving services. The Division's program and contract monitoring activities provide oversight of services around a set of minimum expectations as documented in Statute, Rule, and contract.

Procedure:
When, as a result of program review or contract monitoring, deficiencies are identified, the responsible provider will be required per A.R.S. 36-557 to submit a Corrective Action Plan outlining the steps to remediate the deficiency from both an individual and systemic perspective. Corrective Action Plans must include specific, measurable steps for remediation, timelines for completion of each step and the name of the manager responsible for implementation of each step. (See Corrective Action Plan template.)

Providers may request reconsideration of any deficiency by submitting a reconsideration request in writing to the Division's Quality Assurance Unit within 20 working days of being notified of the deficiency. A written reconsideration

decision response will be sent to the provider within 10 working days. If, after reconsideration, a provider continues to disagree with an identified deficiency, a request for review must be submitted in writing to the Division's Assistant Director within 10 working days of the reconsideration decision notice to the provider. The Assistant Director will review the request for reconsideration and respond within 10 working days.

Corrective Action Plans must be submitted within 20 working days following notification to the provider of a deficiency, or sooner as indicated in the written notice if the deficiency is critical as determined by the Division.

The Division will review the submitted Corrective Action Plan to ensure it sufficiently addresses the identified deficiencies. Written notification of acceptance of the Corrective Action Plan or the need for additional actions will be sent to the provider within 20 working days. The Division's Quality Assurance staff will follow-up on the implementation and completion of the Corrective Action Plan with the provider.

If an adequate Corrective Action Plan is not submitted (after clarification of need with the provider), if a Corrective Action Plan is not adequately implemented, or if health and safety deficiencies are repeated in subsequent reviews, the Division may consider implementing the following actions in a hierarchical fashion. At the discretion of the Division, steps could be skipped depending on the scope and severity of deficiencies (see attached flow sheet). This decision shall be a product of ongoing consultations with the Department's Procurement Officer and assigned Attorney General staff:

1. **Letter of Concern**: With Central Office Quality Management Unit concurrence, the District Program Manager sends a letter to the provider agency outlining the concerns, including identification of specific Rule and contract violations. The Letter of Concern establishes strict timeframes for corrective action. The provider agency is encouraged to collaborate with the District in addressing the concerns if necessary.

2. **Notice to Cure**: The Division's Assistant Director sends a letter to the provider agency documenting the critical concern and the expectations for correction. New client authorizations to the agency (or component of the agency) may be frozen as the Chief Executive Officer and/or Board Chair of the agency negotiates an action plan with the Division administration; the Division may require public notification; the Division may impose a 10% withhold on payments until Plans of Correction are satisfactorily implemented. Withheld money is reimbursed upon completion of the Corrective Action Plan. (See Qualified Vendor contract Standard Terms and Conditions Sections 6.4.1.4, 6.5.7.3, and 6.9.6).

3. **Right to Assurances**: The Department's Procurement Officer sends a demand letter to the provider agency requiring the provider agency to give written assurances of intent to perform, pursuant to Terms and Conditions Section 6.9.1. The demand may include a payment withhold and/or public notification.

4. **Notice Of Intent to Suspend/Terminate the Contract:** The Department's Procurement Officer sends a letter to the provider agency notifying it of the Department's intent to suspend the provider contract in whole or in part. (See Qualified Vendor contract Standard Terms and Conditions Section 6.10.6)

In all of the above correspondence, the following should be included:

Administrative Remedies:
Per R6-6-2116, under the authority of A.R.S. 36-557, when disputes are unable to be resolved by mutual agreement after reconsiderations have been requested and considered, providers can request in writing that the Department procurement officer consider and issue a final decision on the dispute. Appeals from decisions of the Department procurement office may be made to the Department Office of Appeals as authorized in A.R.S. 41-1991, 41-1992 (a) through (C), excluding any references to review by the Appeals Board, and A.R.S. 41-1993(A).

Corrective Action Plans:

A Corrective Action Plan is requested from the provider agency (in writing) when deficiencies are found during a program review or contract monitoring activity.

he provider agency submits a Corrective Action Plan within 20 working

When the corrective action plan is approved, the District monitors the implementation and completion of the Corrective Action Plan by the provider agency.

Reconsideration of Findings Requests:

The provider agency can request (in writing) a reconsideration of findings within 20 working days following notification.

The Division reviews the reconsideration and a written decision is sent to the provider agency within 10 working days.

If the provider agency continues to disagree with the findings and need for a Corrective Action Plan, the provider agency can request a review (in writing) within 10 working days by the Division's Assistant Director. The AD responds within 10

Failure of Provider Agency to Respond:

If an adequate Corrective Action Plan is not submitted, not adequately implemented, or if health and safety deficiencies are repeated in subsequent reviews, the following actions may be implemented in a hierarchical cumulative fashion:

See reverse

Step 1:

Letter of Concern

This is a letter initiated by the District Program Manager, with the approval of Central Office Quality Management, to the provider agency notifying them of evaluated concern status. This letter will identify specific rule and contract violations and establish strict timeframes for corrective action. Appeal rights should be outlined in the letter.

Step 2:

Notice to Cure

This is a letter signed by the Division's Assistant Director notifying the agency of critical concern status and the expectation of an immediate response and Corrective Action Plan. The Notice to Cure may include one or more of the following:

Requirement of public notification,
10% withhold of payments until Corrective Action Plan completed,
No new clients can be served in a specified service site(s), specified District/Area of the Division, or the entire agency.

Step 3:

Right to Assurances

This is a letter signed by the Department's Procurement Officer demanding the provider agency provide written assurances of its intention and ability to meet contract expectations. The Right to Assurances may include one or more of the following:

Requirement of public notification,
10% withhold of payments until Corrective Action Plan completed,
No new clients can be served in a specified service site(s), specified District/Area of the Division, or the entire agency.

Step 4:

Notice of Intent to Suspend/Terminate the Contract

This is a letter signed by the Department's Procurement Officer and indicates the Department's intent to suspend the contract in whole or in part.

Corrective Action Plan

Agency: _____ Site (if Applicable): _____

Date Corrective Action Plan Submitted: _____

Finding #1: (insert summary of finding)					
Goal/Objective	**Actions Already Taken to Remedy** (please number steps individually)	**Start Date**	**End Date**	**Responsible Person/Title**	**Interim Update/ Evaluation/ Results**
	Activities/Actions to be Taken to Remedy Finding and Address Potential Systems Issues (please number steps individually)	**Start Date**	**End Date**	**Responsible Person/Title**	**Interim Update/ Evaluation/ Results**

Finding #2: (insert summary of finding)					
Goal/Objective	**Actions Already Taken to Remedy** (please number steps individually)	**Start Date**	**End Date**	**Responsible Person/Title**	**Interim Update/ Evaluation/ Results**
	Activities/Actions to be Taken to Remedy Finding and Address Potential Systems Issues (please number steps individually)	**Start Date**	**End Date**	**Responsible Person/Title**	**Interim Update/ Evaluation/ Results**

Finding #3: (insert summary of finding)					
Goal/Objective	**Actions Already Taken to Remedy** (please number steps individually)	**Start Date**	**End Date**	**Responsible Person/Title**	**Interim Update/ Evaluation/ Results**
	Activities/Actions to be Taken to Remedy Finding and Address Potential Systems Issues (please number steps individually)	**Start Date**	**End Date**	**Responsible Person/Title**	**Interim Update/ Evaluation/ Results**

Finding #4: (insert summary of finding)					
Goal/Objective	**Actions Already Taken to Remedy** (please number steps individually)	**Start Date**	**End Date**	**Responsible Person/Title**	**Interim Update/ Evaluation/ Results**
	Activities/Actions to be Taken to Remedy Finding and Address Potential Systems Issues (please number steps individually)	**Start Date**	**End Date**	**Responsible Person/Title**	**Interim Update/ Evaluation/ Results**

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 88 **DATE: April 2, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Individual Rate Assessments

EFFECTIVE DATE: Upon Receipt

Purpose:

This Directive describes the process by which Independent Provider rates will be determined.

It also describes the process for completion of individual rate assessment reconsiderations when a consumer/responsible person is not in agreement with an individual rate assessment outcome.

Procedure:

When a consumer/responsible person chooses an Independent Provider for Home and Community Based Services, an individual rate assessment is completed to determine the Independent Provider rate. The Support Coordinator or designated District staff will complete the Rate Assessment Tool with the consumer and his/her responsible person based on professional judgment, observation and input from the consumer and his/her responsible person. The consumer or responsible person can request a copy of the Rate Assessment Tool from the Support Coordinator or obtain it on the Division's web site at www.de.state.az.us/ddd by clicking on the "Provider Information for Consumers and Families" button. A completed rate assessment is available only with the consent of the legal representative.

The individual rate assessment may be reassessed when there are significant changes that affect the individual as determined by the Support Coordinator or when requested by the individual or their responsible person. The Rate Assessment Tool should be completed at least every three years.

Consumers or responsible persons are encouraged to request “reconsideration” of the individual rate assessment if they have a concern about the outcome. A consumer or responsible person may request that the individual rate assessment be “reconsidered” either verbally or by writing to the Support Coordinator within twenty working days of notification of the rate (after the initial implementation of the rate setting). There is no cost to the consumer or responsible person for the second assessment.

Upon receipt of the verbal or written request:

- The Support Coordinator will work with the Supervisor and District designees to identify a second level assessor to complete the reassessment. The second individual rate assessment will be completed by a District staff person not directly involved with the first rate assessment. The second individual rate assessment will be conducted within 30 working days of the written request.

- The results of the second rate assessment, if different from the original, will be used to establish the rate whether it is higher or lower.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 89 **DATE: May 18, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Assistance to Families

EFFECTIVE DATE: Upon Receipt

This Directive supercedes section 605 of the Division of Developmental Disabilities' Policies and Procedures Manual.

Program Definition and Goals

Assistance to Families provides direct payments to vendors or eligible families on behalf of an individual with a developmental disability living in the family home, or (for an adult) in either the family or her/his own home. The purpose of Assistance to Families is to support the family's effort to maintain the health and safety of its family member with a disability in the family home, thereby preventing out-of-home placement; or to support adults to live in their own homes, thereby preventing placements in more restrictive settings.

Eligible Supports

Only authorized supports may be purchased with Assistance to Families funds. Authorized supports are those recommended by the Individual Support Plan team and approved by the District Program Manager/Administrator or designee. The Division will only approve supports that can be purchased at a reasonable cost and that support the health and safety of the individual.

The amount of assistance will be determined by the District Program Manager/Administrator or designee up to $400 per month for on-going assistance or up to $4800 for one-time assistance. Individuals may only request one-time assistance once per calendar year.

Assistance to Families cannot be used to supplement the level of services already furnished to the family or individual under Division contracts with service providers.

Assistance to Families may not be used for food purchases except for physician recommended nutritional supplements not covered elsewhere.

Assistance to Families cannot be used to purchase services otherwise readily available to the family or individual under the Long Term Care Program. Assistance to Families is not available to individuals living in developmental homes or group homes.

Other service options must be explored by Individual Support Plan team members and applications for alternative services or benefits and proof of outcome are required These alternatives might include:

a. Arizona Long Term Care System;

b. income supplements such as Supplemental Security Income, Social Security Benefits, Supplemental Security Disability Income, Railroad Retirement, Veteran's Assistance, Temporary Assistance to Needy Families, General Assistance and Emergency Assistance;

c. housing benefits available through Housing and Urban Development or other sources;

d. Vocational Rehabilitation;

e. tort feasors;

f. education programs;

g. child support and adoption subsidies;

h. AHCCCS, Medicare, Indian Health Services and private health insurance; or

i. Supplemental Payments Program and benefits furnished under the Older Americans Act.

Eligibility

All individuals/families must meet the following criteria during any month wherein Assistance to Families is received:

a. enrolled in the Division's service system;

b. financial participation in the purchase of the support by parent, other close relative, legal guardian or (in the case of an adult with a developmental disability) by the individual her/himself, as required; and

c. implement a plan to reduce the need for assistance over the next six (6) months if the request is for on-going assistance.

Individuals who have failed to take all reasonable steps to enroll in the Long Term Care program are not eligible for Assistance to Families.

All Supervisors must check to see if Assistance to Families has been approved when accepting transfers from other Districts. If the individual is receiving Assistance to Families, it must be stopped unless the sending District will continue the funding. A new application must be submitted to the receiving District if the sending District is not going to continue the funding.

Determination of Participation by the Individual/Family/Responsible Person

The Assistance to Families program forms a partnership between individuals/families and the Division in meeting the needs of children or adults who live at home, or (for some adults) in independent or supported living arrangements not contracted as residential programs by the Division.

As with other Division programs, Assistance to Families is a needs based program. To be eligible for Assistance to Families the individual or his/her family must demonstrate their financial participation in the costs of the support, as required.

In the case of an adult with a developmental disability living in her/his own home, the individual must be able to demonstrate how much of her/his income is devoted to shelter, food, other living expenses and Individual Support Plan approved program costs before an Assistance to Families payment can be approved. The individual's remaining resources are available for personal and incidental expenses.

When a family requests Assistance to Families, the Division Support Coordinator and family/individual shall complete the Request for Assistance to Families Request Worksheet and Agreement. The Support Coordinator/Individual Support Plan team shall review these documents and forward them, with a recommendation, to the District Program Manager/Administrator or designee. The packet must reflect the support recommended to be purchased with Assistance to Families and the type and amount of family or individual support (and the individual's own level of participation).

The Support Coordinator/Individual Support Plan team must review Assistance to Families awards every six (6) months.

Guidelines for Approving Assistance to Families

In evaluating requests for Assistance to Families, the District Program Manager/Administrator (or designee) shall consider the following factors:

a. the availability of Assistance to Families Funds;

b. the likelihood that Assistance to Families will support the family's integrity and prevent the need for residential placement or that it will foster smooth transition to more independent living (for an adult with a developmental disability);

c the age and/or health status of the parents/family members;

d. the complexity of the individual's needs, the stress which these place on the family and the family's ability to respond to that stress;

e. the degree of parental/familial participation in the cost of the support relative to their means;

f. the anticipated duration of the need; and

g. the degree to which the family/individual is already receiving other Division funded services.

Payments and Receipts

Services are authorized and participation/co-payments identified on the Assistance to Families Request Worksheet and Agreement (attached). Initial Assistance to Families payments may be made in advance of the actual purchase of the support. Subsequent payments, however, may only be made when the initial/prior payment has been verified as expended for the authorized purpose through receipts. Receipts must be submitted within 30 days of disbursement of the funds.

Receipts must be pre-printed and specifically identify the support purchased. Under extenuating circumstances, hand written receipts may be acceptable, but must include the name, address and phone number of the vendor as well as clearly identify the support purchased. Receipts totaling less than the advanced sum will result in a reduction of the subsequent payment or, in the event of a one-time purchase, must be accompanied by receipts and change totaling the amount of the Assistance to Families award. Receipts exceeding the authorized amount will not result in an increase in the subsequent payment. Failure to provide receipts totaling the amount of the award will result in loss of eligibility for the program.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 90 **DATE: June 17, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Monitoring of Psychotropic Medications, Herbal and Over-the Counter Remedies and Aroma Therapy

EFFECTIVE DATE: Upon Receipt

This Administrative Directive applies to Division consumers who receive any services provided by contractors of the Division.

1) Psychotropic medications, by definition, affect the Central Nervous System and therefore have behavior modifying potential. Under Arizona Administrative Code 901, et seq., all antidepressants, mood stabilizers, antipsychotic medications and medications prescribed to improve concentration or reduce hyperactivity require a behavior management plan.

2) Any medication, including homeopathic remedies, prescribed for the sole purpose of altering behavior (such as Propranolol, Clonidine or Tenex for aggression) must also have a Behavior Treatment Plan. Though these medications have other medical uses, such as in the treatment of high blood pressure, in situations where they are clearly prescribed for behavioral reasons, a Behavior Treatment Plan is required.

3) Recently, there has been increase in the use of herbal remedies to treat a variety of conditions, including psychiatric illnesses. This has occurred despite the fact that there is no Food and Drug Administration regulation of the purity and quality of these products. For this reason and many others, changing a Division consumer to herbal supplements for the sole purpose of avoiding the writing of a Behavior Treatment Plan is not acceptable and should be documented as inappropriate treatment.

   Herbal supplements such as St. John's Wort, Kava Kava, Valerian Root and Ginkgo Biloba, among others, are psychoactive substances and have direct effects on the Central Nervous System. Thus, they also have behavior modifying potential. As such, they should be treated in the same fashion as psychotropic

medications and do require development of a Behavior Treatment Plan, however, the same "Sunsetting Guidelines" for the review of psychotropic medications can also be used to discontinue Program Review Committee reviews of herbal remedies when appropriate.

Another reason the use of herbal remedies should be monitored by Program Review Committees is that they are just as capable of causing side effects as psychotropic medications and may interfere with the daily activities of the individual. Herbal remedies may also cause side effects due to their interaction with prescribed medications. For example, St. John's Wort, if taken with the Selective Serotonin Reuptake Inhibitor antidepressants, such as Prozac, Paxil, Zoloft and others, can result in significant toxicity. There are also known interactions with other medications for medical conditions, such as Cyclosporin (an immunosupressant medication used to prevent rejection in organ transplantation) and Coumadin (a commonly used anticoagulant or blood thinner).

For these reasons, herbal remedies should be used with great caution with persons with developmental disabilities. Support Coordinators are reminded to ensure that Primary Care Physicians know about all herbal supplements and vitamins an individual is taking, because of the possible drug interactions with other medications.

4) Vitamin supplements do not require a Behavior Treatment Plan, however, excessive doses of vitamins can result in toxicity.

5) Scheduled, prescribed medications for sleep, such as Trazodone (Desyrel), do require monitoring. Prescribed, <u>non-scheduled</u> sleep preparations of any type are not permissible as they are pro re nata (PRN) medications, leaving doctor's orders open to interpretation by non-professionals.

6) The use of over-the-counter sleep preparations such as Benadryl, Melatonin and others, administered at the discretion of the staff person in a group home, is clearly prohibited by Arizona Administrative Code 901, et seq.

7) Aromatherapy: An aromatherapy scent may be sprayed in the air in an individual's room only at the individual's request or with the informed consent of the individual and/or the legally responsible party. No behavior treatment plan is needed for the use of aromatherapy, but the individual's team should be fully included in the decision-making process concerning aromatherapy and the decision should be documented in the Individual Support Plan. It is important to emphasize that the spray may <u>not</u> be sprayed in the person's face, as this would be considered a noxious stimuli.

To summarize, all behavior-modifying medications require a Behavior Treatment Plan. This definition is extended to herbal remedies due to their psychoactive and thus

potentially behavior modifying properties. Non-scheduled or “as needed” sleep preparations are not allowed, whether prescribed or over-the-counter. Aromatherapy does not require a Behavior Treatment Plan, but must be done with the consent of the individual or their legal guardian.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 91 (Revised) **DATE: October 4, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Changes in Rates and Billing Requirements for Day Treatment and Training, Children

EFFECTIVE DATE: July 1, 2004

This Administrative Directive revises the rates for Day Treatment and Training, Children included in the rate schedules published July 1, 2003 as well as the current billing requirements in the Request for Qualified Vendor Application (RFQVA) for Day Treatment and Training, Children. In particular, it:

- Provides Qualified Vendors a grace period of 30 minutes per day per child for late or early arrival in order to bill or account for the required staffing.

- Maintains the 1:1 and 1:2 rates which are currently in effect. These rates are not affected by this change because these are sufficient to cover all costs. These rates are the same as the adopted rates for Habilitation, Support – 1:1, $16.80; 1:2, $10.50.

The following provides further detail on these changes.

Billing

Currently, the Request for Qualified Vendor Application requires Qualified Vendors to round units to the nearest quarter hour. However, effective with this Administrative Directive, vendors shall round units to the nearest hour. For rounding purposes, 29 minutes or less are rounded down to the nearest hour, 30 minutes or more are rounded up to the nearest hour.

The Request for Qualified Vendor Application, Section 7, Day Treatment and Training, Children, Unit of Service, item 1 will be amended as follows:

Total hours for consumers or direct service staff shall not include the time spent during transportation to or from the program. For both consumers and direct service staff, units shall be recorded on a *per consumer* and *per direct service staff* basis, shall be expressed in terms of hours and shall be rounded to the nearest hour as illustrated in the examples below:

- If the total hours for a consumer or direct service staff were equal to three (3) hours and five (5) minutes, round the total to three (3) hours;
- If the total hours for a consumer or direct service staff were equal to three (3) hours and 34 minutes, round the total to four (4) hours;
- If the total hours for a consumer or direct service staff were equal to one (1) hour and 48 minutes, round the total to two (2) hours

Billable Hour per Day When Consumer Is Late or Leaves Early Due to Independent Transportation Caused Absence

Currently, the Request for Qualified Vendor Application provides that only hours during which the consumer attended the program are included in the calculation of the daily ratio and the Division will not pay for any absences.

This Administrative Directive revises that policy to allow Qualified Vendors **that do not provide transportation** for a particular consumer to include up to one half hour per day if that consumer arrives after his/her scheduled arrival time on that day or if that consumer leaves before his/her scheduled departure time on that day. **This assumes that there is a regular schedule in place for that individual.** The calculation of the daily ratio will use the billable hours. In no event shall the Qualified Vendor submit a claim for more than the number of hours authorized for the consumer.

Determining the Appropriate Billing Rate

The Request for Qualified Vendor Application, Section 7, Day Treatment and Training, Children, Unit of Service, items 1 and 2, will be amended to reflect the above provision as well as the following:

1. The basis for payment for this service is the daily ratio rate. To determine the appropriate billing rate for each day this service is provided, the Qualified Vendor shall:

    a. Divide (the total billable hours consumers attended the program in a day including the time allowed as described above, excluding hours for consumers who have intense medical or behavioral needs and have a specially authorized rate), by (the total direct service hours with consumers present at the program in a day, excluding

hours for consumers who have intense medical or behavioral needs and have a specially authorized rate); and

b. Use the resulting quotient which is the number of consumer billable hours per direct service staff hours which can be stated as "1 : result from step a." staff to consumer ratio, to find the appropriate staff to consumer ratio rate on the rate schedule.

2. Absences. Absences do not constitute a billable unit except as provided for above. An absence factor was built into the model rates. The Division will not compensate Qualified Vendors for any absences. For example, if a consumer stays in the day program for two (2) hours in the morning, then leaves for two (2) hours and then returns for three (3) hours and all activity takes place within the same program day, total hours for this consumer shall equal five (5).

3. If the consumer permanently stops attending the Qualified Vendor's program, the Qualified Vendor shall notify the Division's Program Administrator/Manager or designee. The Qualified Vendor shall not bill the Division for vacancies.

Note: The following statement in the service specification explains "on behalf of" for the purpose of direct care. For direct service staff, the Qualified Vendor must keep daily records of the number of hours each direct service staff spends providing direct services to consumers in the program. Only the time when consumers are present at the program shall be counted for direct service. Total time shall not include any time spent during transportation to/from the program. Staff time related to consumers who have intense behavioral or medical needs who have a specially authorized rate shall be recorded separately.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 92 **DATE: July 15, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Fiscal Intermediary

EFFECTIVE DATE: Upon Receipt

This Administrative Directive establishes the Fiscal Intermediary as an agent for persons with developmental disabilities and/or their families who use individual independent providers to provide home and community based services. These services are habilitation, attendant care, respite, and housekeeping.

Due to the responsibilities of tax payments and other employer obligations, the Division is requiring the use of a fiscal agent to manage tax responsibilities and other employer obligations for all individual independent providers. All individual independent providers will be considered and treated as employees of the person with developmental disabilities and /or the family, unless the individual independent provider supplies an Internal Revenue Service (IRS) ruling to the contrary. There are two (2) exceptions noted for individual independent providers that result in the classification as an independent contractor. These two (2) exceptions that result in independent contractor status are:

1. Those individual independent providers who have a formal Internal Revenue Service (IRS) determination as an independent contractor; or
2. Those who are the responsible person for an adult served by the Division and also provide services to this adult. In this case, the responsible person will be considered and treated as an independent contractor, unless they provide an Internal Revenue Service (IRS) ruling to the contrary.

In order to ensure continuity in services, all payments on behalf of consumers or legal representatives, where an individual independent provider and/or an independent contractor and/or vendor agency are used, shall be processed through the fiscal intermediary. When a consumer or legal representative uses only and exclusively a vendor agency, payments are not managed through the fiscal intermediary.

The Division of Developmental Disabilities shall through the Qualified Vendor process contract for one or more fiscal intermediaries to serve as the fiscal agents for consumers and families. The Fiscal Intermediary will provide for at least twice monthly payroll services, including the deduction of tax obligations for each individual independent provider. The Division shall ensure that the services of all contracted Fiscal Intermediaries are available statewide. Choice and change of the Fiscal Intermediary shall be managed per the Qualified Vendor rules.

Fiscal Intermediary Responsibilities:

The Fiscal Intermediary, as the agent for the consumer and family, shall do the following:

1. Work with the Division of Developmental Disabilities and Arizona Health Care Cost Containment System (AHCCCS) to develop appropriate informational materials to share with families to assist in choice making;
2. Work with the Division of Developmental Disabilities to successfully transfer funds and any necessary confidential consumer information;
3. Maintain this consumer and family information in a confidential manner and compliant with federal Health Insurance Portability and Accountability Act (HIPAA) regulations;
4. Provide direct easy access (such as toll free numbers, on-line computer access, etc.) to Customer Representatives who can assists consumers, families, and individual independent providers in answering questions and resolving concerns;
5. Pay claims submitted by individual independent providers promptly including all tax obligations meeting the terms specified in the contract;
6. Maintain a declining balance for each service for each consumer that is submitted to the consumer regularly;
7. Maintain a system that insures that the consumer/family have an available reserve of hours of support for each service before that service is provided; and
8. Work collaboratively and cooperatively with consumers, families, and the Division to resolve concerns.

Consumer and Family Responsibilities:

When a family chooses to use the services of an individual independent provider to provide supports authorized in the Individual Support Plan or Person Centered Plan or Individual Family Service Plan, the consumer and/or family must do the following things:

1. Utilize a fiscal intermediary to act as their agent for payroll and tax purposes;
2. Hire, orient and train each individual independent provider to provide the support authorized in the individual plan;
3. Review carefully each individual independent provider time sheet and sign if the time recorded is accurate;
4. Carefully and continuously track the hours used against the hours of service authorized for each service; and

5. Report any concerns with the Fiscal Intermediary to the Support Coordinator and work with the Fiscal Intermediary and Division staff to resolve those concerns.

Individual Independent Provider Responsibilities:

As the provider chosen by the person with developmental disabilities and/or family to provide the services outlined in the individual planning document, the individual independent provider shall:

1. Complete initially all certification requirements by service with the Arizona Health Care Cost Containment System (AHCCCS) by working with the Office of Licensure, Certification, and Regulation (OLCR) in the Department of Economic Security and to maintain certification for each service;
2. Contract with the Division;
3. Work cooperatively with the Fiscal Intermediary chosen by the consumer and/or family to complete all requirements;
4. Work cooperatively and collaboratively with the consumer/family, the Fiscal Intermediary, and the Division in providing supports and services including the development and on-going evaluation of the effectiveness of the Individual Support Plan or Person Centered Plan or Individual Family Service Plan; and
5. Work cooperatively with the consumer/family, the Fiscal Intermediary, and the Division to resolve any concerns.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 93 **DATE: July 30, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Minimum Documentation Requirements for a Review by the Program Review Committees

EFFECTIVE DATE: Upon Receipt

This Administrative Directive defines the minimum documentation requirements for submission of information to Program Review Committees. The purpose of this Directive is to standardize and simplify behavior plans and minimum documentation requirements.

In preparing to submit a packet for review by the Program Review Committee, the Support Coordinator or other designated Individual Support Plan Team member, must insure all required documentation is included in the packet. Some Districts may require additional information. Any other relevant information may also be included. The attached checklist must be completed and submitted with the review packet.

For further information, see Arizona Revised Statutes § 36-559, Arizona Administrative Code R6-6-901, et seq. and Chapter 1600 of the Division's Policy and Procedures Manual.

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MINIMUM REQUIREMENTS FOR PRC REVEW

MINIMUM REQUIRED COMPONENTS	POTENTIAL SOURCES			
A. Personal Information, i.e. Diagnosis, age, gender, height, weight, etc.	Personal Information Form ISP, BTP, PRC Packet			
B. Documentation of the existence and/or history of any inappropriate behavior.	BTP, FBA, ISP, PRC Packet			
C. A description of why the individual displays the behavior and include any environmental factors.	Behavior Treatment Plan Functional Behavioral Assessment			
D. Documentation of how any of the issues identified are addressed as part of the ISP.	ISP, PRC Packet, BTP			
E. A behavior treatment plan that uses the least restrictive methods available and includes, but is not limited to, the following elements: E.1. Baseline data;	Behavior Treatment Plan Functional Behavioral Assessment Data Sheets/Summaries			
E.2. An alternative/replacement behavior(s) to be increased;	Behavior Treatment Plan			
E.3. The teaching objective which is developed by the ISP team;	Behavior Treatment Plan			
E.4. The specific teaching strategies and reinforcement procedures;	Behavior Treatment Plan			
E.5. The specific behavior(s) to be decreased;	Behavior Treatment Plan			
E.6. A list of the antecedents and precursors to the behavior(s) and their strategies;	Behavior Treatment Plan			
E.7. The specific reactive strategies to be used for the behaviors to be decreased;	Behavior Treatment Plan			
E.8. Data recording schedules and methods;	BTP, Data Sheets/Summaries			
E.9. A method for monitoring the plan, including the appointment of a team member to actively monitor the plan (twice monthly onsite), prepare, sign and place in the individual's records a report of observations; and	BTP, PRC Packet, ISP			
E.10. A list of all medications prescribed to address health and mental health factors related to above behavior(s). Include: medication, dosage, times, expected benefit(s), and common side effects.	Behavior Treatment Plan Medication Checklist, PRC Packet, Med Reviews, Medication History			
F. If a restrictive plan is being proposed, documentation of how previously less restrictive methods have been used and the reasons why they have been unsuccessful. Include specific strategies used for the requested technique.	Behavior Treatment Plan, ISP Functional Behavioral Assessment, PRC Packet			
G. Author of the plan.	ISP, PRC Packet, BTP			
H. Documentation of ISP team approval for the final product with individual and/or responsible person consent.	ISP Signature Sheet, PRC Packet			
I. A description of how staff is trained in implementation of the behavior treatment plan.	BTP, ISP, PRC Packet			
J. Emergency Procedures/Crisis Plan (if applicable). Please note that such procedures should not be part of the behavior plan itself.	PRC Packet			
K. Residential and/*or* Day program behavior summarization data/graphs (at least one year) for target behaviors and positive behavior.	Data Sheets/Summaries/Graphs, PRC Packet			

* Providers preparing packets for PRC review: Please # all pages in the packet and complete the gray column **ONLY,** by noting specific page #s where the information can be found. The white columns are for the reviewers.

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ISP = Individual Support Plan; BTP = Behavior Treatment Plan; PRC = Program Review Committee; FBA = Functional Behavioral Assessment

Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 94 **DATE: August 4, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Transitional Waiver Program

EFFECTIVE DATE: Upon Receipt

This Directive revises Section 601, second paragraph, of the Division's Policy and Procedures Manual to "The Arizona Long Term Care System provides funding for certain services based upon assessed needs and medical necessity. The Arizona Long Term Care System does not provide day care or educational. Individuals who are no longer eligible for the Arizona Long Term Care System may be eligible for Transitional Waiver services. Transitional Waiver services include all Home and Community Based Services under the Arizona Long Term Care. The Transitional Waiver does not cover institutional services in excess of 90 days."

The Transitional Waiver is a program for individuals who were eligible for the Arizona Long Term Care System and have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility or Intermediate Care Facility for the Mentally Retarded level of care. These individuals continue to require some long-term care services, but at a lower level of care. The Transitional Waiver Program allows those individuals who meet the lower level of care, as determined by the Preadmission Screening, to continue to receive all Arizona Long Term Care System covered services that are medically necessary. Nursing facilities and Intermediate Care Facilities for the Mentally Retarded services are excluded, since reassessment has determined that nursing facilities services are not medically necessary.

Those individuals eligible for the Transitional Waiver Program must be transitioned from the regular Arizona Long Term Care System program. Initial applicants for Arizona Long Term Care System are not eligible to be placed in the Transitional Waiver. The Transitional Waiver Program provides all covered acute care, behavioral health services and long term care services except those at an institutional level in a nursing facility or Intermediate Care Facility for the Mentally Retarded. If the individual is a resident in a nursing facility or Intermediate Care Facility for the Mentally Retarded when determined

eligible for the Transitional Waiver Program, institutional services may continue to be provided for up to a maximum 90 days while the recipient is "transitioned" from an institutional placement to a home and community based services setting by the Division.

In addition to all other Arizona Long Term Care System standards identified in Chapter 1000 of the Division's Policy and Procedures Manual, the following standards also apply to individuals eligible for the Transitional Waiver Program:

1. The Support Coordinator, upon being notified of the change of an individual to the Transitional Waiver Program, must discuss the change in level of care with the individual or responsible person to ensure understanding of the change. A Support Coordinator must check the automated system roster daily. Those individuals who are eligible for the Transitional Waiver Program are identified with a "T".

2. Although they are no longer at risk of needing institutional care, individuals eligible for the Transitional Waiver Program will continue to be eligible to receive all medically necessary Arizona Long Term Care System covered home and community based services.

3. While institutional services are no longer considered medically necessary for individuals in the Transitional Waiver Program, a short-term stay in a nursing facility or Intermediate Care Facility for the Mentally Retarded is available. Individuals in the Transitional Waiver Program whose medical condition temporarily worsens to the extent that nursing facility services are medically necessary may receive up to a maximum of 90 continuous days of care at any one admission.

4. The Support Coordinator must ensure the individual or responsible person already residing in a nursing facility or Intermediate Care Facility for the Mentally Retarded who becomes eligible for the Transitional Waiver Program, understands that discharge from the nursing facility or Intermediate Care Facility for the Mentally Retarded is necessary within 90 days from the Transitional Waiver Program effective date. The Support Coordinator must work with the individual and responsible person towards moving out of the setting as soon as possible. The Division's Arizona Long Term Care System Administrator will notify the District Arizona Long Term Care System Specialist if an individual who is "Q" (institutional) placement is identified as being in the Transitional Waiver Program.

5. A Preadmission Screening reassessment must be requested from AHCCCS, via Member Change Report, within 45 days of nursing facility admission, for any individual in the Transitional Waiver Program who has had a deterioration of condition and who is expected to need nursing facility services for greater than 90 continuous days. A Preadmission Screening reassessment is not needed if the individual will not be admitted to a nursing facility.

The Support Coordinator may need to follow-up with the local Arizona Long Term Care System Office and notify the District Arizona Long Term Care System Specialist after the Preadmission Screening reassessment has been requested if there has been no response by the 60th day. Alternate placement options may need to be explored in case the member continues to meet the Transitional Waiver Program criteria.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 95 **DATE: August 31, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Maternal and Child Health

EFFECTIVE DATE: Upon Receipt

This Administrative Directive supercedes Section 604.10, Maternal and Child Health, of the Division's Policy and Procedures Manual.

There are several programs that support maternal and child health. These include Early, Periodic Screening, Diagnosis and Treatment, family planning, pregnant women's program and behavioral health. These programs are described below:

a. Early, Periodic Screening, Diagnosis and Treatment is the component of the Medicaid Program established in 1969 as the federally mandated screening and treatment program for children birth to age 21.

   The goal of Early, Periodic Screening, Diagnosis and Treatment is to provide health care through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems identified by well child checks and screens.

   An Early, Periodic Screening, Diagnosis and Treatment screening must include:

   1. a comprehensive health and developmental history (including both physical and behavioral health assessment);
   2. a comprehensive, unclothed physical examination;
   3. appropriate immunizations according to age and health history;
   4. laboratory tests (including blood lead levels);
   5. health education;
   6. appropriate dental screening;

7. appropriate vision screening and hearing testing; and

8. diagnostic services whenever a screening examination indicates the need to conduct a more in depth evaluation of the child's health status and to provide diagnostic studies.

As the Medicaid authority in Arizona, the Arizona Health Care Cost Containment System administers the Early, Periodic Screening, Diagnosis and Treatment program. Children who are eligible for Medicaid are eligible for Early, Periodic Screening, Diagnosis and Treatment services. Children who are eligible for the Arizona Long Term Care system are Medicaid eligible and, in turn, eligible for Early, Periodic Screening, Diagnosis and Treatment services.

The Arizona Health Care Cost Containment System contracts with health plans to provide all Early, Periodic Screening, Diagnosis and Treatment services to all Arizona children who are eligible for services through the Arizona Health Care Cost Containment System.

The Division ensures that the health plan providers are being monitored to ensure they are registered with, and coordinate with, the Arizona Department of Health Services' Vaccines for Children program.

The Division also contracts with health plans to provide Early, Periodic Screening, Diagnosis and Treatment services to children who are eligible for long term care. The Division provides habilitative services to children who are eligible for long term care. The health plans are under contract to provide rehabilitative services to children who are eligible for long term care.

Medicaid funds are available to pay for medically necessary services identified for a child with a disability in his/her Individualized Education Program, Individual Family Service Plan or Individual Support Plan.

All services authorized in the federal Medicaid law must be provided to children who are Early, Periodic Screening, Diagnosis and Treatment eligible. Services include:

1. screening;

2. evaluation;

3. clinic services;

4. rehabilitative services;

5. physical therapist services;

6. occupational therapist services;

7. speech pathology and audiology services;

8. licensed psychologist services;

9. social services;

10. inpatient psychiatric facility services; and

11. outpatient behavioral health services.

An authorization for services can only be denied for lack of a finding of medical necessity. It cannot be denied for any other reason, i.e., rehabilitative versus habilitative for children who are eligible for Medicaid through the Division.

Early, Periodic Screening, Diagnosis and Treatment means those procedures or professional services which are required to maintain, correct or ameliorate a physical, emotional or developmental problem which is discovered through screening, examination or evaluation or which is found to have worsened since a previous screening.

b. Family Planning - Medicaid policy requires education of clients on family planning services available to them. The goal of family planning is to enable an individual to make choices in both the timing and occurrence of pregnancies. This service is available through the individual's Primary Care Physician. Division health plans are required to educate their providers on the full scope of available family planning services and how members may obtain them.

c. Pregnant Women's Program - One step toward accomplishing the Pregnant Women's Program's goal is to ensure that pregnant women receive early and continuous prenatal care from a qualified obstetrical provider. Prenatal care is arranged through the individual's Primary Care Physician.

d. Behavioral Health Programs – Individuals eligible for long term care who need behavioral health services may be referred by their Support Coordinator, the Division's Behavioral Health Coordinator, their physician or by themselves to a Regional Behavioral Health Authority for evaluation and service planning. Covered services and procedures comply with the Arizona Health Care Cost Containment System behavioral health policies and procedures. Inpatient and outpatient services are covered as well as appropriate prescription drugs.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 96 **DATE: September 28, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Emergency Alert System

EFFECTIVE DATE: Upon Receipt

Service Description (Emergency Alert System)

An Emergency Alert System is a monitoring device/system for individuals who are unable to access assistance in an emergency situation and/or live alone.

Service Settings (Emergency Alert System)

Emergency Alert Systems are appropriate for use in all settings.

Service Requirements (Emergency Alert System)

The Individual Support Plan team must identify the need for an emergency alert system. In order to be approved to receive/use emergency alert system equipment, the member must meet the following five criteria:

a. Inability to access assistance should an emergency arise;

b. Does not have reliable/available emergency assistance on a 24-hour basis;

c. Lives alone or is alone for eight or more hours without contact with a service provider, family member or other support system;

d. The assessment of the individual's medical and/or functional level documents an acute or chronic medical condition which is not improving; and

e. The cost effectiveness study completed by the individual's Support Coordinator shows that the total cost of the emergency alert system equipment is within current guidelines.

The Support Coordinator must send supporting documentation to the Managed Care Operations Prior Authorizations Unit for prior authorization within 15 calendar days from the date the need was identified. This must include documentation of the five criteria noted above, the Individual Support Plan and the primary care physician's prescription. Managed Care will review the complete packet within 15 calendar days of receipt. If approved, Managed Care will contact the vendor with the lowest bid, authorize the service and notify the Support Coordinator.

Target Population (Emergency Alert System)

Individuals who are potentially eligible for an emergency alert system are those who live alone or are alone for 8 or more hours without contact with a service provider, family member or other support system and cannot call 911 by using a standard phone, portable phone or cell phone.

Exclusions (Emergency Alert System)

Emergency alert systems will not be provided to individuals capable of dialing 911 in an emergency or to those individuals living in group homes or child developmental homes.

There are no restrictions regarding home and community based services that may be provided in conjunction with emergency alert system services.

Service Provision Guidelines (Emergency Alert System)

The following service provision guidelines apply to emergency alert systems:

a. emergency alert systems will not be provided if not medically necessary and not prescribed by the primary care physician;

b. one emergency alert system and the medically necessary accessories for operation will be provided;

c. if an emergency alert system can be equipped with both voice and touch capabilities, only one option will be provided;

d. one system will be provided unless a second is medically necessary; and

e. replacement of equipment is covered in cases of loss or irreparable damage or wear not caused by carelessness or abuse.

Evaluation (Emergency Alert System)

The Support Coordinator must perform a review of the Individual Support Plan/Individual Family Service Plan as noted in Chapter 1000 of this Manual.

Service Closure (Emergency Alert System)

As determined by the Individual Support Plan/Individual Family Service Plan/Primary Care Physician team, all emergency alert systems will be returned to the Division when no longer medically necessary. If the individual is moving out of state, the emergency alert system and accessories must be returned to the Division. The Support Coordinator is responsible for picking up the device and accessories and returning them to the vendor and notifying Managed Care.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 97 **DATE: October 19, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Hospice

EFFECTIVE DATE: Upon Receipt

This Directive supercedes Section 602.7 of the Division of Developmental Disabilities' Policy and Procedures Manual.

Hospice is a service that provides health care and emotional support for terminally ill individuals and their families/caregivers during the final stages of life. This includes skilled nursing, respite and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care, home health aide services, and inpatient services available as necessary to meet the member's needs. The goal of the service is to provide palliative (designed to alleviate pain or discomfort) and supportive care to the individual and the individual's family members to meet the physical, emotional, spiritual and social stresses that are experienced during the final stages of illness and during dying and bereavement.

Target Population:

Individuals who have been diagnosed as terminally ill and have orders from the Primary Care Physician for Hospice may receive this service. The individual/responsible person must acknowledge that he/she recognizes Hospice Services are palliative, not curative.

Service Provision Guidelines:

The Division contracts with Health Plans to approve and provide Hospice Services to individuals of any age who are eligible for Long Term Care.

Hospice may be provided in the individual's home, a home and community based services approved alternative residential setting, a hospital or nursing facility with subcontracted hospice beds, or a free-standing hospice. The Health Plan and/or

Hospice provider will identify, with the family and Primary Care Physician, where the services will be provided and type of services.

AHCCCS requires the Primary Care Physician to certify that the member has a terminal illness prior to the delivery of Hospice Services. The Health Plan obtains this certification. The Health Plan will send the certification and supporting documentation to the Division's Managed Care Operations for the Division's Medical Director to review and make recommendations. The Medical Director will notify Managed Care Operations of any recommendations within five (5) working days. Managed Care Operations will notify the District Nurse and Support Coordinator of the service recommendations within 24 hours after approval from the Medical Director. The initial certification is effective for a 90-day period. A second 90-day period may be authorized if necessary. If services are needed beyond that time, certification must be obtained (by the Health Plan) every 30 days thereafter.

If Hospice is paid for by private insurance or Medicare, the Long Term Care Health Plan will pay the member's co-payment or deductible on behalf of the individual. If this payment ends, the Long Term Care Health Plan will pick up payment of the Hospice Service when it continues to be medically necessary.

Services identified on the Individual Support Plan will continue to be provided to a Long Term Care Member who is in a home or community based setting. These services will continue to be monitored according Chapter 1000 of this Policy manual.

The Support Coordinator will also review "Decisions About Your Health Care: Living Wills and Other Health Care Directives" (PAD-588) with the individual/responsible person and share with team members if appropriate, i.e. for someone living in a licensed setting.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 98 **DATE: November 24, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Ventilator Dependent Program

EFFECTIVE DATE: Upon Receipt

This Administrative Directive supercedes Sections 1402 and 1002.1.d. of the Division's Policy and Procedures Manual.

Overview

In accordance with the requirements of the Long Term Care Program, the Division will provide comprehensive, coordinated, cost-effective Long Term Care covered services which will further the goal of maintaining the individual who is ventilator dependent in the most natural and medically appropriate environment designed to maximize the individual's eventual weaning from both mechanical and intense medical dependence.

An individual who is ventilator dependent is one who is medically dependent upon a mechanical ventilator for life support at least six (6) hours per day and has been dependent on ventilator support for at least thirty (30) consecutive days. During the 30-day period, the individual may have been living in either a hospital, Nursing Facility, Intermediate Care Facility for the Mentally Retarded or a home and community based setting. Individuals intermittently dependent may not be classified as an individual who is ventilator dependent; however, they can receive long term care services if they are otherwise eligible as an individual who is non-ventilator dependent.

Service Description and Goals

The goal of service for an individual who is ventilator dependent is to provide medical, mechanical and support services in compliance with Long Term Care regulations to maintain the individual in the most medically appropriate

environment designed to maximize eventual weaning from mechanical dependence.

Goals for an individual who is ventilator dependent and their families include:

a. to provide services to persons with developmental disabilities who are ventilator dependent in the most natural and medically appropriate placement;

b. to assure that care is of high quality, cost effective and appropriate for the individual who is ventilator dependent and consistent with Long Term Care regulations;

c. to assist families, where feasible, in maintaining placement of their individual who is ventilator dependent at home;

d. to improve the informal and formal support network of individuals and/or families with an individual who is ventilator dependent;

e. to promote independence of individuals who are ventilator dependent from both mechanical devices and caregivers as much as possible;

f. to encourage development of further resources through community support; and

g. to assure that Individual Support Plans/Individualized Family Service Plans are developed and coordinated with the Primary Care Provider to assure appropriate utilization of acute and long term care services.

Service Settings

Services may be provided in the individual's own home, a child developmental foster home, adult developmental home or institution.

Service Requirements

Upon notification by ALTCS of the individual's date of determination or date of enrollment, the individual will be assigned a registered nurse by the Division who will become part of the Individual Support Plan Team/Individualized Family Service Plan Team. The Registered Nurse is employed in Central Office Health Care Services.

The Registered Nurse will:

a. open all new cases and coordinate initial discharge of the individual from hospital/institutional placement; initiate the Individual Support Plan/ Individualized Family Service Plan with the Support Coordinator, identifying all acute care providers and long term care service needs and the cost and scope of services to be provided;

b. notify emergency services and utilities initially and for changes of residence for the individual who is ventilator dependent;

c. assure the care for the individual who is ventilator dependent is appropriate and in compliance with Long Term Care regulations;

d. make on-site visits to the individual who is ventilator dependent at least every 90 days, and more often at the discretion of the Ventilator Dependent Program manager, to ensure the Individual Support Plan/Individualized Family Service Plan is being implemented and that services are necessary and cost effective;

e. make on-site visits when notified that there has been a change in the level of care of an individual who is ventilator dependent;

f. at the on-site visits, the Registered Nurse and Support Coordinator will jointly document the following:

    1. the health status of the individual who is ventilator dependent;

    2. visits to the physician and changes in the treatment plan;

    3. problems which have been identified which involve the health of the individual and recommendations for resolution; and

    4. continued eligibility as ventilator dependent.

    One copy of the Visit Report (Nursing Assessment) (DD-199-2) is filed in the individual's chart kept by the Registered Nurse; one copy is filed in the Support Coordination file;

g. coordinate covered services with the health plan;

h. assist families/caregivers to understand the procedure, through the Health Care Services Prior Authorization unit, to order approved medical equipment and supplies and adaptive aids using the Durable Medical Equipment Register form (DES-701)

i. submit a Cost Effectiveness Study (Appendix 600.D) on the individual's services on a quarterly basis to the Health Care

Services Medical Services Manager and the individual's file and review the Cost Effectiveness Study with the Medical Services Manager;

j. submit a Long Term Care Member Change Form (DE-701) for any changes in demographics, placement or eligibility of the individual for the ventilator program;

k. submit service authorization forms to the Support Coordinator or delegated data entry staff for data entry for nursing and respite services;

l. work with providers and individuals/families to resolve issues involving nursing/medical services;

m. attend Individual Support Plan/Individualized Family Service Plan, Individual Education Program meetings and foster care review boards when pressing issues need to be resolved;

n. submit notification of hospitalization to Business Operations to initiate potential reinsurance submission;

o. draft response for the Health Care Services Administrator to AHCCCS requests for corrective action resulting from bi-yearly audits or quality concerns;

p submit monthly status reports to Business Operations regarding hospitalizations, client count;

q submit, to the Health Care Services Administrator, an annual cost analysis of ventilator dependent program expenditures.

The Support Coordinator will perform all Support Coordination duties as noted in the Division's Policy and Procedures Manual. Additionally, the Support Coordinator will:

a. make on-site visits with the Registered Nurse every 90 days or more frequently as determined by the team to ensure the Individual Support Plan/Individualized Family Service Plan is being implemented;

b. at the on-site visit, the Registered Nurse and Support Coordinator will jointly document the following:

1. services authorized and received and, if applicable, the reasons a service was not rendered;

2. the Individual Support Plan/Individualized Service Plan outcomes and the progress made toward meeting the outcomes and/or the barriers impeding outcome attainment; and

3. problems involving non-nursing issues and recommendations for resolution.

One copy of the Support Coordinator's Review of the Individual Support Plan (DD-500) is filed in the Support Coordination file; and one copy is filed in the Registered Nurse's case file.

c. obtain agreement from the Registered Nurse before requesting a change in non-nursing services. Submit paperwork necessary to institute and maintain all approved non-nursing services. Make all arrangements to secure non-nursing provider(s);

d. notify Registered Nurse when the individual who is ventilator dependent is hospitalized.

The Registered Nurse and Support Coordinator are responsible to:

a. assisting the individual and/or appropriate others in solving problems regarding the Individual Support Plan/Individualized Family Service Plan outcomes;

b. informing the individual and/or appropriate others regarding their appeals, hearing, and/or grievance rights; and

c. facilitating access to services and benefits as needed.

Individuals who are ventilator dependent are eligible to receive both acute and long term care covered services which will maximize their health and independence.

a. acute care services:

Acute care services are provided by the health plan (including Indian Health Services with which the individual who is ventilator dependant is enrolled according to Division policy. All individuals choose or are assigned a Primary Care Provider who is responsible for ordering all medical services.

The health plan is responsible for authorizing and managing all contracted acute care services provided to the individual on a 24-hour/7 days a week basis. The health plan notifies the Division's Health Care Services when individuals are hospitalized or utilize non-routine, high cost services. This notification is based on services authorized, not claims paid, and should be reported within two working days of the service (Indian Health Services follows

Division mandated policy/procedure for prior authorization of services provided by non-Indian Health Services facilities/providers). Charges for acute care services provided by the health plan are reimbursed by the Division upon submission of mandated claim forms by the health plan.

b. Long Term Care Services:

The Support Coordinator and Registered Nurse are responsible for assessment of service need and the coordination and monitoring of service provision. The Registered Nurse has final approval authority for all services (acute and long term care) provided to the individual who is ventilator dependent.

It is the Division's goal, to the extent possible, that primary caregivers develop as much independence as possible with respect to ongoing care of the individual who is ventilator dependent.

The Division assumes that in natural home settings, utilizing in-home supports, the primary responsibility for care resides with the family and that the family will play a significant ongoing role in the delivery of day-to-day care with the assistance of professional and non-professional support personnel.

Designated district personnel are responsible to reimburse claims for long-term care services using appropriate funding streams.

Target Population

An individual is eligible for ventilator dependent services if the individual is financially, medically and functionally eligible as determined by the Pre-Admission Screening and meets the definition of ventilator dependent as described in the Overview section of this Administrative Directive.

The Pre-Admission Screening determines the range and degree of the individual's medical condition and functional abilities and if the individual's level of care is Class 4 (ventilator dependent).

Exclusions

Individuals must meet eligibility as ventilator dependent as previously noted. Services must be covered by Long Term Care. Cost of services must not exceed 100% of the cost of institutionalization without a plan in place to reduce the cost of services to less than 100% of the cost of institutionalization within a six (6) month period.

The home and community based services included in the cost effectiveness study to determine costs as a percent (%) of institutionalization are:

a. adult day health;

b. attendant care;

c. home health nurse/aide;

d. homemaker;

e. respite (if provided on a regular basis, i.e., 4 hours. per week);

f. medically necessary transportation (if provided on a regular basis, i.e., 3 trips per week for dialysis); and

g. Durable Medical Equipment which is included in a Nursing Facility per diem and whose aggregate cost exceeds $200, regardless of purchase or rental, i.e., wheelchairs, walkers, hospital bed, etc.

Services NOT included in the cost effectiveness study include:

a. hospice services;

b. therapy services (physical, occupational, speech and respiratory);

c. medical supplies and drugs;

d. behavioral health services.

The Division is capitated by the AHCCCS for individuals who are ventilator dependent. If costs for all services, those included in the Cost Effectiveness Study and those not included in the Cost Effectiveness Study, exceed capitation all services will be reviewed by the Division's Health Care Services Medical Services Manager for potential change.

Service Provision Guidelines

A Support Coordinator will be assigned within two (2) working days of notification of enrollment in Long Term Care from AHCCCS. The Support Coordinator and the Registered Nurse must arrange for services begin as soon as possible.

a. telephone contact to the family must be initiated within five (5) working days of date of notification of enrollment or date of ventilator dependent status determination;

b. the onsite visit must be completed within seven (7) working days from notification of enrollment.

c. appropriate service delivery must begin within 10 working days of enrollment or notification of ventilator dependent status;

d. the Individual Support Plan/Individualized Family Service Plan must be entered into the Division's client database;

e. on-site visits must be made every 90 days or more frequently when the individual's medical status changes. If the visit cannot be made within 95 days, the reason(s) must be clearly documented in the Support Coordination file and the visit rescheduled as soon as possible;

f. updates of changes related to placement, level of care, or services on the Individual Support Plan must be submitted to the Long Term Care Ventilator Dependent Coordinator within five (5) working days of the change.

In addition to the requirements noted in Section 1808, documentation to be maintained by the Support Coordinator includes:

a. the authorized amount of services, in the client case notes;

b. the individual's progress toward established outcomes, and identification of barriers and/or achievements;

c. validation of services actually received as documented during the on-site visit;

d. validation that the client continues to meet minimum ventilator dependent criteria; and

e. all contacts by the Registered Nurse or Support Coordinator with caregivers, Primary Care Provider, providers, the individual, etc.

Provider Types and Requirements

Individuals who are ventilator dependent will be enrolled with the health plan of their choice as available in their residence zip code. The health plan is responsible to authorize and reimburse acute care services provided to members who are ventilator dependent through the health plan provider network and according to health plan policy and procedure for utilization management. Capitation will not be paid for members who are ventilator dependent to the health plan.

The Division is responsible to reimburse the health plan for these services at the lesser of the health plan's negotiated rate with the Division or the AHCCCS capped fee-for-service rate schedule.

Health plan responsibilities include:

a. accepting enrollees who are ventilator dependent by member's rate code and ventilator dependent plan number;

b. assigning each member to a Primary Care Provider, accepting member choice of Primary Care Provider when possible;

c. identifying a health plan staff member to work with the Division's Registered Nurse and Support Coordinator in coordinating services to individuals who are ventilator dependent;

d. educating health plan providers about provision of services to members;

e. notifying Heath Care Services Prior Authorization Nurse within one working day of utilization of hospitalization or non-routine high cost service, i.e., ambulance, prescription exceeding $100, etc.; and

f. working with the Support Coordinator, Registered Nurse and the Division to facilitate provision of services included in the comprehensive discharge plan. Although the health plan is not financially responsible for long term care services, many covered medical services may need to be authorized and provided by the health plan.

Division responsibilities include:

a. assigning a Support Coordinator and Registered Nurse to each member who is ventilator dependent. The Registered Nurse and Support Coordinator are responsible to coordinate all care provided to the member. They will work with the health plan identified staff person to coordinate health plan authorized services;

b. ensuring the District and the Individual Support Plan/Individualized Family Service Plan have a contingency plan for addressing the non-availability of trained care providers. The plan should address holiday shortages, emergency situations, and shortages due to highly specialized care. The plan must have a back-up system which assures that the necessary level of care can be maintained and that primary caregivers are aware of the back-up systems; and

c. if Third Party Liability exists to cover a ventilator dependent individual, services should be coordinated through the third party to avoid costs to the Division. Third Party Liability covered services shall be included on the Individual Support Plan/Individualized Family Service Plan.

   Additional Division covered services shall not exceed service need parameters established by the Individual Support Plan/ Individualized Family Service Plan Team. For example, if it is assessed that an individual needs six (6) hours per day of personal care and Third Party Liability is paying for twelve (12) hours per day of skilled nursing, the Division will provide no additional personal care services. If Third Party Liability terminates, the Division will

initiate 6 hours per day of personal care if the individual continues to need that level of service.

Service Evaluation

Monthly, Business Operations will prepare a ventilator dependent services cost report. This report will be used, with the Cost Effectiveness Study prepared by the Support Coordinator and Registered Nurse, in the overall management of the program.

As the Division is capitated for members who are ventilator dependent, it is critical to monitor costs of services in the aggregate, as well as on individual bases. Financial issues should not drive service provision except when aggregate expenses exceed total capitation.

Additionally:

a. providers must submit a monthly written progress report on Individual Support Plan/ Individualized Family Service Plan objectives to the Support Coordinator. The report must address the presence or absence of measurable progress toward the individual's goals and objectives; and

b. the Registered Nurse and Support Coordinator must perform a review of the Individual Support Plan/Individualized Family Service Plan as noted in the Service Requirements Section of this Administrative Directive.

Service Closure

Individuals may be terminated from the program if:

a. the individual no longer meets the definition of Ventilator Dependent;

b. the individual dies;

c. the individual, family or guardian requests disenrollment; or

d. the individual moves out of state.

When an individual is terminated from the program, the Individual Support Plan/Individualized Family Service Plan must:

a. identify and document reasons for closure;

b. identify and record the individual's status at close of services, including progress toward his/her outcomes;

c. provide the individual's records for review by the Primary Care Provider, and the Division's Medical Director;

d. as appropriate, provide referral information on optional services to meet the needs of individuals no longer eligible for Long Term Care; and

e. provide updated Support Coordination information, including service completion or change in level of care to AHCCCS within five working days. The AHCCCS Pre-Admission Screening Team will complete a Pre-Admission Screening reassessment and change the member enrollment consistent with AHCCCS policy.

A Notice of Intended Action must be sent in accordance with the processes defined in Section 2202 of this Manual.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 99 **DATE: December 14, 2004**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: The Diagnosis of Autism by Developmental Pediatricians

EFFECTIVE DATE: Upon Receipt

Purpose: To clarify the eligibility process for children and adolescents when a Developmental Pediatrician provides an evaluation that diagnoses autism.

Evaluations completed by Developmental Pediatricians that diagnose autism for children and adolescents may be used to assist in making eligibility determinations. Support Coordinator Supervisors will refer diagnostic evaluations to the Eligibility Review Committee for review by the Division's Medical Director who has the appropriate credentials to diagnose Autism.

The Medical Director will then determine if the evaluation contains the required DSM IV criteria for the diagnosis of autism and make a recommendation to the Eligibility Review Committee as to whether the evaluation may be used as part of the decision making process.

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Administrative Directive

NO. 100 **DATE: January 18, 2005**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Attendant Care Family

EFFECTIVE DATE: February 1, 2005

The intent of the funding for Attendant Care Family is to provide an option for Consumers who choose to live at home with their families. It is not an automatic payment at age 18, and it is not an entitlement benefit. Attendant Care Family should be based on assessed need, including the family's ability to provide natural supports.

The Division does not endorse lifelong residency in the family home, unless that is the choice of the Consumer and family and is in the Consumer's best interest. Therefore, to ensure all options have been considered, we are requiring effective with the date of this Directive, the facilitation of a person centered plan and personal, private interview of the Consumer by the Support Coordinator, if the use of Attendant Care Family service is proposed between the ages of 18-25. The intent of the interview is to ensure the individual has an opportunity to fully express their dreams and wishes.

Upon documentation of the plan and interview in the record, the Support Coordinator may authorize up to 40 hours per month of Attendant Care Family service. Because Attendant Care Family services should be based on assessed need, any amounts above this must be reviewed and approved by the District Manager/Administrator as an exception. Amounts over 300 units per month need to be reviewed under Centralized Utilization Review.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 101 **DATE: September 15, 2005**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Annual Individual Support Plan

EFFECTIVE DATE: Upon Receipt

This Directive supercedes Section 806.1 of the Division of Developmental Disabilities Policies and Procedures Manual.

Purpose

To clarify the annual Individual Support Plan date consistent with new rules for Qualified Vendors.

Frequency of Meetings

The Individual Support Plan team (Planning Team) must meet within 30 days of determination of eligibility for the Division to complete the initial Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (ISP). Unless waived as specified in section 808.2, the team will meet again within 30 days following assignment to a program, i.e. residential setting, day program or early intervention program, to review and modify the initial Plan. This plan shall be considered a review and not the Annual ISP date. The Planning Team must subsequently meet at least annually. If there are changes in the individual's circumstances (such as program, service needs, placement etc.) that require a significant modification in the plan prior to the Annual Plan due date, the Planning Team may choose to convene to revise the ISP. The date of this meeting is considered to be a "Review" date and not the Annual Plan date.

<u>Annual Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (ISP) Review Dates:</u>

In addition to required timeframes for meetings, the Annual ISP must be developed within 30 days of determination of eligibility with the Division. The meeting date to develop the plan becomes the annual due date. The ISP may be held up to five (5) working days before the Annual Plan due date every

subsequent year. If an individual/family member delays, cancels or reschedules the review, this must be documented in the progress notes. Routine reviews will be completed within the timelines established in policy (90 or 180 days).

When a person is placed into a new program or setting, the Planning Team will meet within 30 days to make appropriate adjustments to the plan. Any adjustments to the plan must be documented on the "Support Coordinator's Review of the ISP" form (DD-500). This meeting will constitute one of the routine reviews required but cannot replace or change the Annual Plan due date for the ISP.

If the person has been in the program prior to the implementation of these guidelines, the Planning Team must agree on the Annual Plan due date. The Planning Team's agreement regarding the annual date must be documented on both the DD-500 form and the progress notes.

If there is disagreement on the annual due date, the District Program Manager will review any historical information provided and make a final determination as to what will be the annual due date.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 102 **DATE: September 15, 2005**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Coordination of Care with Schools

EFFECTIVE DATE: Upon Receipt

This Directive further clarifies Section 912.4 of the Division of Developmental Disabilities Policies and Procedures Manual.

Coordination of Care between the Division and the School System

In addition to the review and annual due dates for the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (ISP), the Support Coordinator is responsible to ensure the overall provision of care in coordination with other agencies for each individual, including educational services. It is important that Support Coordinators and Support Coordinator Supervisors understand the appropriate ways to coordinate care with a local school system.

It is important to develop working relationships with the various school districts within the proximity of the Support Coordinators assigned Division office. This includes identifying the appropriate teachers and the school hierarchy for addressing any issues that may arise. The development of these relationships before serious concerns occur will assist in resolving issues in a more collaborative and timely manner.

The Support Coordinator should work with the family to identify the dates and times for meeting with the school(s) and participating in the development of the Individual Education Plan (IEP). Coordinating the efforts of the IEP with the Division's plan (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan) can ensure these plans complement each other and assist in providing better care for the individual receiving services. If the family doesn't remember to invite the Division staff to the IEP meeting, the school representative may be invited to the Individual Support Plan/Individualized Family Plan/Person Centered Plan (ISP) meeting.

If the Support Coordinator identifies an educational need, the following steps should be taken:

a. At the request of the family, contact the local schoolteacher and/or principle within five (5) working days to inquire about the status or process for meeting the identified need.

b. Contact the Division's Central Office within two (2) working days to request support with their counterpart in the local school district if the teacher and/or principle have not responded.

c. Contact the District Program Administration/District Program Manager within two (2) weeks to request support in coordinating with the Special Education Division of the Arizona Department of Education when there has not been a response from the local school district.

d. As appropriate, raise the general issue(s) regarding the Arizona Department of Education through Central Office.

e. Follow up with the individual or the representative regarding whether or not the need was met.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 103 **DATE: September 15, 2005**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Coordination of Care with Health Plans

EFFECTIVE DATE: Upon Receipt

This Directive further clarifies 908.1 in the Division of Developmental Disabilities Policy and Procedures Manual.

Purpose

This Directive specifies the Support Coordinator's responsibilities for working with Health Plans to facilitate consumer care.

Coordination of Care between the Division and Health Plans

The Support Coordinator is responsible to ensure the overall coordination of care for each individual, including acute care and long term care services. It is important that the Support Coordinators and Support Coordinator Supervisors understand the basic acute care services and appropriate ways to coordinate care with the contracted health plans.

Each Health Plan has an identified Division Liaison to assist with the coordination of care for individuals enrolled through the Arizona Long Term Care System (ALTCS) program. The Division's Health Care Services provides the primary oversight of the contract with the Health Plans. If staff has any issues that cannot be resolved directly with the Health Plan Liaison, Health Care Services should be contacted immediately.

Division Policy 908.1 outlines the open enrollment information, including the option for individuals to select Indian Health Services if eligible. Each Health Plan provides a Member Handbook explaining the member services and procedures for accessing those services. The Support Coordinator can obtain a copy of the handbook directly from the Internet website for Arizona Physicians IPA, Mercy Care Plan, and Care 1st. Contact Capstone Health Plan directly to obtain a copy of their handbook.

The Division's contract with each Health Plan requires a quarterly meeting with local Support Coordinators. The purpose of these quarterly meetings is to discuss, negotiate, problem-solve, communicate and facilitate the delivery of consumer care. Factors for consideration regarding consumer care include the delivery of services in a timely, cost effective manner. The delivery of consumer care should also promote quality for Division of Developmental Disabilities (Division)/Arizona Long Term Care System (ALTCS) members.

If the Support Coordinator identifies an acute care service need, the following steps should be taken:

1. Contact the Health Plan Division-Liaison within 5 (five) working days to inquire the status or process for meeting the identified need.
2. Contact the Division's Health Care Services within 5 (five) working days to request support in coordinating with the appropriate Health Plan if there is a delay in response.
3. As appropriate, raise the general issue(s) at the next quarterly meeting with the Health Plan.
4. Follow up with the individual or the representative regarding whether or not the need was met and identify any additional actions if the need has not been met.

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P O L I C Y D I R E C T I V E

NO. 104 **DATE: April 20, 2006**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia
Assistant Director
Division of Developmental Disabilities

SUBJECT: Service Plans

EFFECTIVE DATE: Upon Receipt

Purpose

This Directive supercedes Section 807.4.2 of the Division of Developmental Disabilities Policies and Procedures Manual.

Service Plan

Following development of the functional statements of need, the long-term goal(s), and the outcomes, the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan team (Planning Team) will identify the resources/supports necessary to accomplish the goal(s) and outcomes. The team shall first consider and document those resources, services, and supports that are available within the family, neighborhood and community. This information should be used to identify the necessary and appropriate recommended services to be provided by the Division.

The "Service Plan/Supports and Services" section of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) must include the:

- Name of the service
- Number of units of service to be provided and the frequency with which it is to be provided
- Name of the provider(s) who will deliver the service
- Projected start date of the service

The Planning Document section, "Plan/Supports and Services" must also list indirect services. Indirect services are provided by another entity or through private pay. For example: When physical therapy is provided by the public school, physical therapy must be listed as an indirect service). If it is a

behavioral health service, the appropriate behavioral health information must be listed.

For those consumers using an Independent Provider, the fiscal intermediary will manage the authorization and the individual/family will select the provider and schedule the service.

On-demand services are those services, such as respite, which are provided on an irregular schedule when the consumer has an intermittent need. Indirect services are provided by another agency. For example, physical therapy is provided by the public school.

The number of units of service will be determined according to the specific needs to be addressed by the service. The numbers of units of services is also dependent on the time it takes to complete each task.

The "Service Plan/Supports and Services" section of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Document) must reflect whether or not the consumer is dependent on Attendant Care, Housekeeping, Respite, or Habilitation that is received in an Individually Designed Living Arrangement.

Risk Assessment Plan

If a consumer receives "critical services" (bathing, toileting, dressing, feeding, transferring to and from bed or wheelchair and assistance with similar daily activities) a "back-up plan" must be developed to address the potential risk in the event the provider is a "no show". The Risk Assessment will direct the Planning Team to the "Back-up Plan Contact Sheet".

Back-up Plans

Back-up plans are required to ensure the health and safety of the individual and must be documented in the "Back-up Plan Contact Sheet". Copies of the back-up plan must be provided to all Planning Team members and the district representative. A copy of the back-up plan must also be maintained in the consumer's file.

Services provided routinely to a consumer must have a person identified as a "back-up" when an individual staff/provider is unable to perform the supports as documented in the Individual Support Plan "Back-up Plan Contact Sheet". The plan for back up should include how the back up person is identified and a reasonable option for alternative supports.

In some cases, the responsible agency is the resource for providing substitute staff. For those cases where only individual independent providers are engaged to provide supports, the Planning Team may want to consider an agency as a backup.

The "Back-up Plan Contact Sheet" must reflect the identified back up method and ensure the consumer and responsible party clearly understand the necessary steps to ensure support is provided. The back-up plan requires a member services preference level that can be changed by the consumer/responsible person at any time.

The levels include:
Level 1: Gap must be filled within 2 hours
Level 2: Gap must be filled, services needed today
Level 3: Gap must be filled within 48 hours
Level 4: Gap must be filled by next scheduled visit

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 105 **DATE: January 30, 2006**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Guidelines for Paper Review by the Program Review Committee

EFFECTIVE DATE: Upon Receipt

Purpose:

The following guidelines have been designed to provide an option to both the Planning Team (Individual Support Plan/Individualized Family Services Plan/Person Centered team) and the Program Review Committee (PRC) to meet the minimum requirement for annual review of an established behavior plan through a paper review process. This option is limited solely to situations where the consumer is on psychotropic medications and during the annual review by the PRC, the presented information and data clearly demonstrates that the consumer has been stable for one year.

Applicability:

Consumers whose behavior plan involves the use of psychotropic medications, including the use of over-the-counter and herbal medications when used to modify behavior, but do not involve the utilization of other more restrictive approaches and/or strategies listed below.

Note: The use of psychotropic medications is prohibited if:

- They are administered on an "as needed" or "PRN" basis.
- They are in dosages which interfere with the consumers daily living activities (as determined by the Planning Team).
- They are used in the absence of a behavior plan.

If the consumer's behavior plan includes any of the following techniques and/or strategies, the plan is not eligible for consideration by the Program Review Committee for subsequent annual review through the "paper review" process:

- Techniques that require the use of force.
- Programs involving the use of response cost.
- Programs that might infringe upon the rights of the consumers pursuant to applicable federal and state laws, including A.R.S.§ 36-551.01.
- Protective devices used to prevent a consumer from sustaining injury as a result of the person's self-injurious behavior.

Exception:
For consumers living in an Intermediate Care Facility for the Mentally Retarded rules and regulations will take precedence over the "Guidelines for Paper Review".

Eligibility:

The following criteria must be met for a consumer's behavior plan to be monitored by Program Review Committee through the annual paper review process:

1. The consumer participated in their program, activities of daily living and chosen leisure/community activities without any significant behavioral disturbances for the past year.

   Note: "Significant behavioral disturbance" is defined as any physical aggression, or pattern of verbal aggression or other actions that are not typical for the individual (such as significant deterioration in personal hygiene or social withdrawal).

2. There were no behavioral incidents requiring the use of emergency measures* during the past year.

   Note: Emergency Measures are defined as the use of physical management techniques (Client Intervention Techniques – Level II physical intervention techniques) or psychotropic medications in an emergency to manage a sudden, intense or out of control behavior.

3. During the past year, there were no changes and/or increases in the consumer's prescribed psychotropic medications.

Note: The only exception to this criterion is if the consumer required an increase in an antidepressant medication and it was in the absence of any behavioral disturbances.

4. Through a review of all Incident/Serious Incident reports for the consumer during the last year, there were no noted situations where the consumer's behavior has resulted in police involvement, psychiatric hospitalization, or crisis intervention through the behavioral health system.

Required Information for Initial Consideration for Annual "Paper Review" Process:

In order for a Program Review Committee to consider subsequent annual reviews conducted through the paper review process, the Planning Team needs to provide the following:

- Copy of the consumer's current Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document).
- Copy of the consumer's current behavior plan, with data and information that meets the criteria set forth in the above "Eligibility" section.
- Documentation that indicates that there will be on going medical monitoring, quarterly medication reviews and laboratory testing as needed.
- Copies of the Service Plan Review Form (DD-500) for the last year.

Minimum Required Information for Subsequent Annual "Paper Review" Process:

In order for a Program Review Committee to complete a subsequent annual review of a consumer's behavior plan through the paper review process, the Planning Team must minimally submit the following:

- Copy of the consumer's current Planning Document (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan).
- Copy of the consumer's current behavior plan, with information or data that indicates that the consumer continues to be stable.
- Copies of reports of on going medical monitoring, quarterly medication reviews and any required laboratory testing, for the past year.
- Copies of the Service Plan Review Form (DD-500) for the last year.
- Any other information requested by the Program Review Committee.

Responsibilities of the Program Review Committee (PRC):

Upon receipt of the above minimum required information from the Planning Team the Program Review Committee Chairperson will:

- Schedule a review of the submitted information by the entire membership of the Program Review Committee.

- Request further information and/or schedule a subsequent formal face-to-face review, if during the paper review process it is determined that further information is needed.

- Forward a disposition report to the Planning Team upon the Program Review Committee's review and approval of the submitted behavior plan. The disposition report will indicate approval, any recommendations made and the date of the next scheduled review.

Loss of Eligibility for Paper Review Process:

If any of the following situations occur, the Planning Team must notify the Program Review Committee (PRC) Chairperson in writing within 30 days of the occurrence. The Planning Team must also reconvene and forward a copy of the consumer's behavior plan to the PRC within 90 days. This includes situations where:

- The consumer cannot participate in their program, activities of daily living and/or leisure activities of their choice, due to any significant behavioral disturbance.
- An emergency measure intervention was utilized (physical and/or chemical restraint).
- Any change or increase in the consumer's psychotropic medications was made.

  Note: The only exception to this criterion is if the consumer required an increase in an antidepressant medication and it is in the absence of any behavioral disturbances
  .
- The consumer's negative behavior results in law enforcement involvement, psychiatric hospitalization, crisis intervention by the behavioral health system, or injury to oneself or others.

Upon receipt of the consumer's behavior plan from the Planning Team, the PRC will schedule a formal review of the plan. Subsequent PRC reviews of the consumer's behavior plan will be conducted "face-to face" until such time as the individual has been stable on his/her psychotropic medications for one year.

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 106 **DATE: January 30, 2006**

TO: Policies and Procedures Manual Holders

FROM: Ric Zaharia, Ph.D.
Assistant Director
Division of Developmental Disabilities

SUBJECT: Program Review Committee (PRC) Statewide "Sun Setting" Guidelines

EFFECTIVE DATE: Upon Receipt

Purpose: To provide guidelines under which an established behavior plan may be exited from annual review by the Program Review Committee.

Exit Criteria for Annual Review of Behavior Plans by Program Review Committee (PRC)

The following criteria must be met for a consumer's behavior plan to exit from the required annual review by the Program Review Committee (PRC):

- Discontinuation of psychotropic medications as part of the behavior plan treatment strategy.

- Psychotropic medication is clearly prescribed for a non-behavior modifying purpose.

  - Rationale for the medication is clearly documented by the prescribing physician as being "medical in nature" (i.e. migraine, seizures, etc.), with no associated behavioral disturbance or issues.

  - The Program Review Committee must be satisfied that use of the psychotropic medication will continue to be monitored by the prescribing physician and that there is clearly not a need for a behavior plan to be developed by the Planning Team (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team).

- Unless otherwise indicated, use of psychotropic medication, prescribed for a non-behavior modifying reason and without the need for a formal behavior plan, will only require a one (1) time review and approval by the Program Review Committee (PRC).

- And elimination of the use of other more restrictive approaches/strategies within the behavior plan that require PRC review and approval and/or annual review, per R6-6-903.A.

  - Techniques that require the use of force.
  - Programs involving the use of response cost.
  - Programs, which might infringe upon the rights of the consumer pursuant to applicable federal and state laws, including A.R.S. 36-551.01.
  - Protective devices used to prevent a consumer from sustaining injury as a result of their self-injurious behavior.

- Or the consumer is discharged from services through the Division of Developmental Disabilities.

EXCEPTION*:* For consumers living in an Intermediate Care Facility for the Mentally Retarded facility, rules and regulations will take precedence over the above "Sun-setting Guidelines".

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A D M I N I S T R A T I V E D I R E C T I V E

NO. 107 **DATE: June 30, 2006**

TO: Policies and Procedures Manual Holders

FROM: Barbara Brent
Acting Assistant Director
Division of Developmental Disabilities

SUBJECT: National Voter Registration Act

EFFECTIVE DATE: July 1, 2006

This Directive rescinds Section 508, Voter Registration, of the Division's Policy and Procedures Manual. All support coordination staff must comply with DES 1-01-24 (attached).

Staff will accept the verification of U.S. citizenship that the consumer presents, but are NOT required to verify that it is an acceptable U.S. citizenship document (see Section E.10).

Staff will sign the attached acknowledgement form to indicate they have reviewed and understand the policy. The acknowledgement must be signed by August 30, 2006 for current employees or, for new employees, within 60 days of hire. This form will be maintained in the Supervisor's file.

DES 1-01-24
Voter Registration

PURPOSE DES 1-01-24.A

AUTHORITY DES 1-01-24.B

DEFINITIONS DES 1-01-24.C

POLICY DES 1-01-24.D

PROCEDURE DES 1-01-24.E

EXHIBITS
- *Offer of Voter Registration* (NVRA-5) Exhibit A
- Arizona Voter Registration Form Exhibit B
- Guidelines for Completing the Arizona Voter Registration Form Exhibit C
- *Batch Report* (NVRA-6) Exhibit D
- County Elections Contacts Exhibit E

DES 1-01-24
Voter Registration

A. PURPOSE

The purpose of this policy is to ensure that the Department complies with the requirements of the National Voter Registration Act of 1993 and applicable Arizona statutes by offering individuals the opportunity to register to vote at offices that provide public assistance or services for individuals with disabilities.

B. AUTHORITY

42 U.S.C. Chapter 20, Subchapter 1-H	National Voter Registration
A.R.S. § 16-140	Voter registration assistance agencies
A.R.S. § 16-152	Registration form
A.R.S. § 16-166	Verification of registration
Executive Order 2004-30	Definitions

C. DEFINITIONS

Public assistance: Any money payments made by the Department that are paid to or for the benefit of any dependent child as provided in A.R.S. Title 46, Chapter 2, Article 5.

D. POLICY

1. Department offices that provide public assistance or state-funded services for individuals with disabilities shall offer each applicant or participant of benefits or services the opportunity to register to vote.

2. Department staff shall advise each applicant or participant of their right to register to vote and offer the opportunity to register:

   a. With each application for benefits or services,

   b. With each renewal or redetermination of benefits or services, and

   c. When the applicant or participant appears at a Department office to report a change of address.

3. Department staff may assist an applicant or participant to re-register to vote when an applicant:

   a. Has a name change,

b. Requests a party affiliation change, or

c. Has moved.

4. An applicant or participant may register to vote at any site where applicants or participants are interviewed for benefits or services. This includes local offices, itinerant sites, and home visits. Each site shall provide the same assistance for voter registration that it provides for benefits or services, including bilingual services.

5. Staff providing voter registration assistance shall not:

   a. Seek to influence an applicant's political preference or party registration,

   b. Wear or display any material that:

      i. Identifies past, present, or future seekers of partisan elective office,

      ii. Contains logos or other graphics that may be identified with a political party or preference, or

      iii. Would reasonably be associated with a political party or preference or that identifies a political issue or ballot measure.

   c. Make any statement to an applicant or take any action the purpose of which is to discourage the applicant from registering to vote, or

   d. Make any statement to an applicant or take any action the purpose of which is to lead the applicant to believe that a decision to register or not register has any bearing on the availability of benefits or services.

6. Staff shall advise applicants and participants that:

   a. The voter registration process is separate from the program eligibility process, and

   b. An interview is not necessary to register to vote.

7. Proof of citizenship is needed in order to register to vote in Arizona for the first time or if the individual has moved to another county in Arizona. Proof of citizenship is not required to re-register because of a move within the same county, change of name, or change of political party.

8. The Department shall accept all voter registration applications and forward the applications to the appropriate County Recorder's office. The Department screens applications for completeness as a service to the client submitting the application and forwards all applications received to the appropriate County Recorder.

9. Voter registration information is confidential. Staff shall not use the information for any purpose other than voter registration.

E. PROCEDURES

1. Staff shall advise applicants or participants of their right to register to vote at each application for benefits or services, redetermination of eligibility, or when a participant appears at a Department office to report a change of address, and may assist an applicant or participant to re-register to vote when there is a name change or change in party affiliation.

2. Staff shall provide applicants or participants with an *Offer of Voter Registration* (NVRA-5) form and encourage the individual to mark on the form whether they request or decline the opportunity to register to vote. See Exhibit A.

   a. The applicant or participant should be encouraged to sign and date the form.

   b. If the applicant or participant does not sign the NVRA-5, staff shall circle "No" and initial the form indicating the individual declined the opportunity to register to vote.

   c. Staff shall give the bottom portion below the dotted line of the NVRA-5 to the applicant or participant whether or not the individual chooses to register to vote.

3. If an applicant or participant wishes to register to vote, staff shall provide the individual an *Arizona Voter Registration Form* to complete. See Exhibit B.

4. Staff shall assist the applicant or participant in completing the registration form when requested. The staff member shall sign the *Arizona Voter Registration Form* indicating that the staff member assisted the applicant in its completion when staff fill out the form.

5. Staff shall encourage the applicant or participant to complete the *Arizona Voter Registration Form* during the interview or before leaving the local office.

6. If an applicant or participant does not want assistance in completing the *Arizona Voter Registration Form* at the office, the individual may take the form and complete it at his or her discretion. At this point, the Department has no further responsibility for voter registration.

7. If an applicant or participant is already registered or does not want to register to vote, staff shall ask the individual to sign the NVRA-5. If the individual refuses to complete the NVRA-5, staff shall initial the form and date it.

8. Individuals registering to vote must fill out **in black ink** the boxes on the *Arizona Voter Registration Form* except those marked optional. See Exhibit C. Staff shall review the form before the individual leaves the office to ensure that it is completed accurately and legibly. The Department shall accept and forward to the appropriate County Recorder all voter registration forms submitted regardless of their completeness and the applicant's citizenship information.

9. A completed *Arizona Voter Registration Form* shall contain the number of the applicant's Arizona driver license, or nonoperating identification license. If the applicant does not have either of these licenses, the applicant must include the last four digits of his or her Social Security Number. If the applicant does not have a driver license or nonoperating identification license or a Social Security Number, staff shall leave it blank and a unique identifying number will be assigned by the Secretary of State. If the applicant's Arizona

driver license or nonoperating identification license was issued before October 1, 1996, additional verification is required to prove citizenship.

10. A complete *Arizona Voter Registration Form* must also contain proof of citizenship or the form will be rejected by the County Recorder's office. If the applicant has an Arizona driver license or nonoperating identification license issued after October 1, 1996, this will serve as proof of citizenship. If not, proof of citizenship must be included with the *Arizona Voter Registration Form*. The following documents are acceptable to establish citizenship:

    a. A legible photocopy of a birth certificate that verifies citizenship and supporting legal documentation (i.e., marriage certificate) if the name on the birth certificate is not the same as the applicant's current legal name.

    b. A legible photocopy of pertinent pages of a United States passport identifying the applicant.

    c. Presentation to the County Recorder of United States naturalization documents or the number of the Certificate of Naturalization in box 20 on the front of the form..

    d. The applicant's Bureau of Indian Affairs Card Number, Tribal Treaty Card Number, or Tribal Enrollment Number in box 16 on the front of the form.

    e. A legible photocopy of a driver license or nonoperating license from another state within the United States if the license indicates that the applicant has provided satisfactory proof of citizenship.

    f. A legible photocopy of a Tribal Certificate of Indian Blood or Tribal or Bureau of Indian Affairs Affidavit of Birth.

11. If the applicant needs to include a photocopy of proof of citizenship, place the proof of citizenship in an envelope along with the *Arizona Voter Registration Form* and mail the documents to the appropriate County Recorder's office. **Send legible photocopies and not the originals. Documents will not be returned.**

12. If the applicant is registered to vote in Arizona and uses the registration form because of a move within the same county, change of name, or change of political party affiliation, photocopies of proof of citizenship is not required.

13. If the applicant has moved to a different Arizona county, proof of citizenship must be provided.

14. A designated person at each office shall mail the *Arizona Voter Registration Form* to the appropriate County Recorder's office listed on the form. Forward the *Arizona Voter Registration Forms* to the County Recorder's office within five calendar days of receipt of the form. This same process applies if an applicant or participant leaves an *Arizona Voter Registration Form* at the local office.

15. Staff shall not destroy *Arizona Voter Registration Forms* or *Offer of Voter Registration* (NVRA-5) forms.

16. Each local office shall designate staff to:

    a. Ensure the confidentiality of the voter registration process.

b. Ensure that forms are sent to the appropriate County Recorder's office within five calendar days.

c. Retain the upper portion of the *Offer of Voter Registration* (NVRA-5) form. These forms will be forwarded to the Arizona State Library, Archives, and Public Records.

d. Use the *Batch Report* (NVRA-6) form as a routing cover sheet to include with the daily Offer of Voter Registration forms. See Exhibit D.

e. Send the upper portion of the NVRA-5 forms and a copy of the NVRA-6 to the Arizona State Library, Archives, and Public Records when a standard 12 inch x 15 inch x 10 inch records storage box is full. Arizona State Library, Archives and Public Records retains the records for a two-year period after which time the forms are destroyed.

f. Ensure that the office has an adequate supply of the following voter registration forms:

i. *Arizona Voter Registration Form*. Each local office shall order these forms from the County Recorder's office of the county in which the office is located. See Exhibit E. When requested, the County Recorder's office provides envelopes to local offices to mail the *Arizona Voter Registration Forms* back to the County Recorder's office.

ii. *Offer of Voter Registration* (NVRA-5). This form is available electronically in English or Spanish in Outlook Public Folders, or in hard copy format from the DES Supply Center. Each local office shall maintain its own supply of the form.

iii. *Batch Report* (NVRA-6). This form is available electronically in Outlook Public Folders, or in hard copy format from the DES Supply Center. Each local office shall maintain its own supply of the form.

g. Collect all completed and incomplete *Arizona Voter Registration Form*s and *Offer of Voter Registration* forms at the end of each work day.

17. Designated staff shall enter the information onto the *Batch Report* (NVRA-6) form at least once each month.

a. At least once each month a completed copy of the *Batch Report* (NVRA-6) form shall be forwarded to:

Secretary of State
Election Services Division
1700 W. Washington Street, 7th Floor
Phoenix, AZ 85007.

b. When a records storage box is full, a copy of the *Batch Report* (NVRA-6) form and all *Offer of Voter Registration* (NVRA-5) forms shall be forwarded to:

Arizona State Library, Archives and Public Records
Records Management Division
1919 W. Jefferson Street
Phoenix, AZ 85009

18. Individuals with a disability that have difficulties or questions regarding voter registration may call the Recorder in the county he or she resides.

NVRA-5

OFFER OF VOTER REGISTRATION

Applying to register to vote or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote today? ____Yes ____No

IF YOU DO NOT MARK EITHER LINE, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like hel
we will help you. Th
You may fill out the a
with you and mail it to the county recorder yourself or you may complete the registration here and deposit it in the box provided.

If you choose to register to vote here, the information regarding the agency where the registration took place will remain confidential and will be used only for voter registration purposes. If you choose not to register to vote at this time, that information will remain confidential and will be used only for voter registration purposes.

_____

Signature of Client *(or initials of staff person)* Date

- -

If you believe that someone has interfered with your right to register to vote or to decline to register to vote, your right to privacy in deciding whether to register to vote or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

State Election Director
Secretary of State's Office
1700 West Washington
Phoenix, Arizona 85007
(602) 542-8683

EXHIBIT A

Copies of this form may be obtained in an electronic format by accessing the following Outlook public folder: Public Folders/All Public Folders/ADES Forms

AMIENTO

eer no será afectada por
su decisión de empadronarse para votar o de no empadronarse para votar.

Si usted no esta empadronado para votar donde usted actualmente vive, ¿le conviniera solicitar empadronamiento para votar hoy día aquí mismo?
____ Si ____ No

SI USTED NO MARCA NINGUNA DE LAS RESPUESTAS, SE CONSIDERARÁ QUE USTED HIZO LA DECISIÓN DE NO EMPADRONARSE PARA VOTAR HOY DÍA.

Si usted necesita ayuda para completar el formulario de solictud de empadronamiento, nosotros estamos dispuestos a ayudarle. La decisión de procurar o aceptar ayuda es suya. Se le permite completar el formulario de solicitud en privado. Usted tiene la opción de llevarse el formulario consigo y regresarlo por correo al registrador del condado o usted puede completar su empadronamiento aquí y depositarlo en el depósito que se proporciona.

Si usted se decide a empadronarse para votar, la información tocante la oficina donde se efectuó el empadronamiento permanecerá confidencial y

se usará únicamente para los propósitos de empadronamiento de votantes.

_____

_____
Firma del Cliente *(o iniciales del miembro del personal)* Fecha

- - - -

ARIZONA VOTER REGISTRATION FORM
FORMULARIO DE INSCRIPCIÓN DE VOTANTE EN ARIZONA
INSTRUCCIONES EN ESPAÑOL SE ENCUENTRAN AL REVERSO

Questions? For questions regarding voter registration, call your County Recorder listed on the back of the form

You Can Use This Form To:
- Register to vote in the state of Arizona
- Let us know that your name, address or party affiliation has changed

To Register To Vote In Arizona You Must (Qualifications):

NEW REGISTRATION REQUIREMENTS

- Your completed voter registration form must contain the number of your Arizona driver license, or nonoperating identification license.

If you do not have either of these

Copies of this form may be obtained in an electronic format by accessing the following web site: http://www.azsos.gov/election/Forms/voterregistrationform.pdf."

How To Register To Vote:
- You can mail or hand deliver your completed form to your County Recorder's office
- Your County Recorder's office will mail you a proof of registration within 4 – 6 weeks
- Your decision to register to vote or not, and where you submitted your registration, will remain confidential

Registrations Received By Mail:
- In the case of registration by mail, a voter registration is valid if it complies with either of the following:

1. The registration is dated 29 days or more before an election and is received by the County Recorder within 5 days after the last day to register to vote in that election.
2. The form is postmarked 29 days or more before an election and is received by the County Recorder by 7 p.m. on the day of that election.

also contain proof of citizenship or the form will be rejected.

If you have an Arizona driver license or nonoperating identification license issued after October 1, 1996, this will serve as proof of citizenship. If not, you must enclose proof of citizenship with the form.

The back of the form contains a list of acceptable documents to establish your citizenship and instructions on how to attach copies of the documents to the voter registration form.

Citizens With Disabilities Can:
- Contact the County Recorder/Elections Department for information about polling place access, early voting, assistance at the polling place and all other election related procedures

If you are not a citizen of the United States or will not be 18 by the next General Election, do not complete this form.

<Fold Line----------Fold Line>

*USE BLACK PEN – COMPLETELY FILL OUT FORM *USE PLUMA DE TINTA NEGRA – LLENE EL FORMULARIO COMPLETAMENTE

[1] Are you registered to vote at another address? Yes☐ No☐ Not Sure☐
List the former address, including county and state

BOX FOR OFFICE USE ONLY
S

[2] Last Name | First Name | Middle Name | Jr./Sr./III

[3] Address where you live – If no street address, describe residence location using mileage, cross streets, or landmarks. Do not use post office box or business address. Draw a map below if located in rural area. | [4] Apt./Unit/Space No.

[5] City | [6] County | [7] Zip | [8] Address where you get your mail, *if mail is not delivered to your home*

[9] Birth Date (Month/Day/Year) | [10] State or Country of Birth | [11] Telephone number | [12] Father's name or mother's maiden name

[13] AZ Driver license number or AZ Nonoperating license number | [14] AZ Driver license number or AZ nonoperating license number issue date | [15] Last four digits of social security number | [16] *Optional - Check ID type and write number in box*
☐ Indian census number, ☐ Bureau of Indian Affairs card number,
☐ Tribal treaty card number, or ☐ Tribal enrollment number
No.

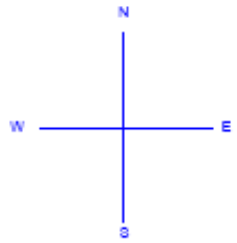
[17] Specify Party Preference | [18] Occupation | [19] If your name was different the last time you registered, list former name | [20] Certificate of Naturalization number

[21] ➢ Are you a citizen of the United States of America? Yes☐ No☐
➢ Will you be 18 years of age on or before election day? Yes☐ No☐
If you checked "No" to either one of these questions, do not submit this form.

VOTER DECLARATION – By signing below, I swear or affirm that the above information is true, that I am a RESIDENT of Arizona, I am NOT a convicted FELON or my civil rights are restored, and I have NOT been adjudicated INCOMPETENT

X _____ _____
SIGN HERE DATE

[22] If no street address draw a map here:



[23] If you are unable to sign the form, the form can be completed at your direction. The person who assisted you must sign here.
SIGNATURE OF PERSON ASSISTING_____ DATE_____

[24] Will you be willing to work at a polling place on election day? Yes☐ No☐

<Remove tape and fold to mail ----------Remove tape and fold to mail>

ARIZONA VOTER REGISTRATION FORM (Translation)
FORMULARIO DE INSCRIPCIÓN DE VOTANTE EN ARIZONA

¿Preguntas? Para preguntas con respecto a la inscripción de votante, llame a su Registrador del Condado indicado al reverso del formulario

Usted puede usar este formulario para:
- Inscribirse para votar en Arizona
- Informarnos que su nombre, dirección o afiliación de partido ha cambiado

Para inscribirse para votar en Arizona, usted tiene que (Requisitos):
- Ser ciudadano de los Estados Unidos (vea los requisitos de la prueba de ciudadanía al revés)
- Ser residente de Arizona y del condado indicado en su inscripción
- Tener 18 años o más en o antes del día de la próxima Elección General normal

ADVERTENCIA: El ejecutar una inscripción falsa es un delito grave de clase 6

Usted no puede inscribirse para votar en Arizona si:
- Usted ha sido condenado de un delito grave y todavía no se le han restituido sus derechos civiles
- Usted ha sido juzgado incompetente

Cómo inscribirse para votar:
- Usted puede enviar por correo su formulario llenado a la oficina de su Registrador del Condado o entregarlo personalmente
- La oficina de su Registrador del Condado le enviará por correo una prueba de inscripción dentro de 4 a 6 semanas
- Su decisión de inscribirse para votar o no inscribirse, y donde usted presentó su inscripción, se quedará confidencial

Inscripciones recibidas por correo:
- En caso de inscripción por correo, una inscripción de votante es válida si cumple con cualquiera de los siguientes:
  1. El formulario está fechado 29 días o más antes de una elección y es recibido por el Registrador del Condado dentro de 5 días después del último día para inscribirse para votar en esa elección.
  2. El formulario tiene la fecha de matasellos de 29 días o más antes de una elección y es recibido por el Registrador del Condado para las 7 p.m. del día de esa elección.

NUEVOS REQUISITOS DE INSCRIPCIÓN

- Su formulario llenado de inscripción de votante tiene que contener el número de su licencia de manejar, o el número de su licencia de identificación no de manejar.
  Si no tiene ninguna de estas licencias, tiene que incluir las últimas cuatro cifras de su número de seguro social.
  Si no tiene una licencia de manejar ni una licencia de identificación no de manejar ni un número de seguro social, se le asignará un número único de identificación por la Secretaría de Estado.

- Un formulario llenado de inscripción de votante también tiene que contener prueba de ciudadanía o se rechazará el formulario.
  Si usted tiene una licencia de manejar o una licencia de identificación no de manejar expedida después del 1 de octubre de 1996, ésta servirá como prueba de ciudadanía. Si no, tiene que adjuntar prueba de ciudadanía con el formulario.
  El reverso del formulario contiene una lista de los documentos aceptables para establecer su ciudadanía e instrucciones sobre cómo adjuntar copias de los documentos al formulario de inscripción de votante.

Los ciudadanos con discapacidades pueden:
- Comunicarse con el Registrador del Condado o el Departamento de Elecciones del Condado acerca del acceso al lugar de votación, votación temprana, ayuda en el lugar de votación y todos los otros procedimientos relacionados con elecciones

Si usted no es ciudadano de los Estados Unidos o no tendrá 18 años para la próxima Elección General, no llene este formulario.

Copies of this form may be obtained in an electronic format by accessing the following web site: http://www.azsos.gov/election/Forms/voterregistrationform.pdf."

<Línea de doble----------Línea de doble>

– USE ESTA SECCIÓN COMO EJEMPLO, LLENE LA CARA DEL FORMULARIO –

[1] ¿Está usted inscrito para votar en otra dirección? Sí☐ No☐ No sé☐
Escriba la dirección anterior, incluyendo el condado y el estado

CASILLA SÓLO PARA EL USO DE LA OFICINA
S

[2] Apellido | Nombre de pila | Segundo nombre | Jr./Sr./III

[3] Dirección en donde Ud. vive – si no hay dirección de calle, describa la ubicación de su residencia usando el millaje, cruces de calles o puntos de referencia. No use un apartado postal ni dirección de negocio. Dibuje un mapa abajo si está ubicado en una zona rural.

[4] Dpto./Unidad/No.de espacio

[6] Ciudad | [5] Condado | [7] Código postal | [8] Dirección en la cual Ud. recibe su correspondencia, *si no se entrega la correspondencia a su casa*

[9] Fecha de nacimiento (Mes/Día/Año) | [10] Estado o país de nacimiento | [11] Número de telefono | [12] Nombre de su padre o nombre de soltera de su madre

[13] Número de su licencia de manejar | [14] Fecha de expedición | [15] Las últimas cuatro | [16] Opcional - *Marque el tipo de identificación y escriba el número en la casilla*

Copies of this form may be obtained in an electronic format by accessing the following web site: http://www.azsos.gov/election/Forms/voterregistrationform.pdf."

no presente el formulario.

DECLARACIÓN DE VOTANTE – Al firmar abajo, juro o afirmo que la información más arriba es verdad, que soy RESIDENTE de Arizona, que NO soy un CRIMINAL convicto, o mis derechos civiles están restituidos y no se me ha juzgado INCOMPETENTE

X _____ _____
FIRME AQUÍ FECHA

[23] Si usted no puede firmar el formulario, se puede llenar bajo su dirección. La persona que le ayudó tiene que firmar aquí.
FIRMA DE LA PERSONA QUE AYUDA _____ FECHA _____

[24] ¿Estará usted dispuesto a trabajar en un lugar de votación el día de la elección? Sí☐ No☐

N
O E
S

<DESPEGUE LA CINTA ADHESIVA Y DOBLE PARA ENVIAR POR CORREO ---------- DESPEGUE LA CINTA ADHESIVA Y DOBLE PARA ENVIAR POR CORREO>
<Fold Line----------Fold Line>

*USE BLACK PEN – COMPLETELY FILL OUT FORM *USE PLUMA DE TINTA NEGRA – LLENE EL FORMULARIO COMPLETAMENTE

[1] Are you registered to vote at another address? Yes☐ No☐ Not Sure☐
List the former address, including county and state

BOX FOR OFFICE USE ONLY
S

[2] Last Name | First Name | Middle Name | Jr./Sr./III

[3] Address where you live – If no street address, describe residence location using mileage, cross streets, or landmarks. Do not use post office box or business address. Draw a map below if located in rural area.

[4] Apt./Unit/Space No.

[6] City | [5] County | [7] Zip | [8] Address where you get your mail, *if mail is not delivered to your home*

[9] Birth Date (Month/Day/Year) | [10] State or Country of Birth | [11] Telephone number | [12] Father's name or mother's maiden name

[13] AZ Driver license number or AZ Nonoperating license number | [14] AZ Driver license number or AZ nonoperating license number issue date | [15] Last four digits of social security number | [16] *Optional - Check ID type and write number in box*
☐ Indian census number, ☐ Bureau of Indian Affairs card number,
☐ Tribal treaty card number, or ☐ Tribal enrollment number
No.

[17] Specify Party Preference | [18] Occupation | [19] If your name was different the last time you registered, list former name | [20] Certificate of Naturalization number

[21] ➢ Are you a citizen of the United States of America? Yes☐ No☐
➢ Will you be 18 years of age on or before election day? Yes☐ No☐
If you checked "No" to either one of these questions, do not submit this form.

VOTER DECLARATION – By signing below, I swear or affirm that the above information is true, that I am a RESIDENT of Arizona, I am NOT a convicted FELON or my civil rights are restored, and I have NOT been adjudicated INCOMPETENT

X _____ _____
SIGN HERE DATE

[23] If you are unable to sign the form, the form can be completed at your direction. The person who assisted you must sign here.
SIGNATURE OF PERSON ASSISTING_____ DATE_____

[24] Will you be willing to work at a polling place on election day? Yes☐ No☐

[22] If no street address draw a map here:
N
W E
S

Voter Receipt
Recibo del Votante

<Remove tape and fold to mail ----------Remove tape and fold to mail>

VOTER REGISTRATION FORM - FORMULARIO DE INSCRIPCIÓN DE VOTANTE

VOTER REGISTRATION INFORMATION

If you meet the qualifications listed on the front of this form, complete, sign and return the attached registration form. This form may be used to register in any county in Arizona.

The form may be mailed or given to a person designated to receive voter registration forms. Call your County Recorder as listed below for more information.

INFORMACIÓN PARA LA INSCRIPCIÓN DE VOTANTE

Si usted satisface los requisitos indicados en la cara de este formulario, llene, firme y regrese el formulario de inscripción adjunto. Se puede usar este formulario para inscribirse en cualquier condado en Arizona.

Se puede enviar por correo el formulario o se puede darlo a una persona designada para recibir los formularios de inscripción de votante. Para más información, llame a su Registrador del Condado como se indica en la lista abajo.

NEW REGISTRATION REQUIREMENTS

If this is your first time registering to vote in Arizona or you have moved to another county in Arizona, your voter registration form must also include proof of citizenship or the form will be rejected. If you have an Arizona driver license or nonoperating identification license issued after October 1, 1996, write the number in box 13 on the front of this form. This will serve as proof of citizenship and no additional documents are needed. If not, you must attach proof of citizenship to the form. Only

REQUISITOS DE UNA NUEVA INSCRIPCIÓN

Si esto es su primera vez de inscribirse para votar en Arizona, o si se ha mudado a otro condado, su formulario de inscripción de votante también tiene que incluir prueba de ciudadanía o se rechazará el formulario. Si usted tiene una licencia de manejar de Arizona, o una licencia de identificación no de manejar de Arizona, expedida después del 1 de octubre de 1996, escriba el número en la casilla 13 en la cara de este formulario. Esto servirá como prueba de ciudadanía y no se necesitan

Copies of this form may be obtained in an electronic format by accessing the following web site: http://www.azsos.gov/election/Forms/voterregistrationform.pdf."

- Presentation to the County Recorder of United States naturalization documents or the number of the certificate of naturalization in box 20 on the front of this form
- The applicant's Bureau of Indian Affairs Card Number, Tribal Treaty Card Number, or Tribal Enrollment Number in box 16 on the front of this form
- A legible photocopy of a driver license or nonoperating license from another state within the United States if the license indicates that the applicant has provided satisfactory proof of citizenship
- A legible photocopy of a Tribal Certificate of Indian Blood or Tribal or Bureau of Indian Affairs Affidavit of Birth.

If you need to include a photocopy of proof of citizenship, please fold the proof along with the voter registration form and place both items in an envelope and mail them to your County recorder listed below. **Send legible photocopies and not the originals. Photocopies will not be returned to you.**

If you are registered in Arizona and use this registration form because you move within a county, change your name, or change your political party affiliation, you do not need to provide photocopies of proof of citizenship. If you move to a different Arizona county, you will need to provide proof of citizenship.

nombre legal actual

- Una fotocopia legible de las páginas pertinentes de un pasaporte de los Estados Unidos que identifican al solicitante
- La presentación al Registrador del Condado de documentos de naturalización de los Estados Unidos o el número del certificado de naturalización en la casilla 20 en la cara de este formulario
- El Número de la Tarjeta del Departamento de Asuntos Indios, el Número de la Tarjeta de Tratado Tribal, o el Número de Inscripción Tribal en la casilla 16 en la cara de este formulario
- Una fotocopia legible de una licencia de manejar o licencia no de manejar de otro estado dentro de los Estados Unidos, si la licencia indica que el solicitante ha proporcionando prueba satisfactoria de ciudadanía
- Una fotocopia legible de un Certificado Tribal de Sangre India o Tribal o una Declaración Jurada de Nacimiento del Departamento de Asuntos Indios.

Si usted necesita adjuntar una fotocopia de prueba de ciudadanía, favor de doblar la prueba junto con el formulario de inscripción de votante y ponga los dos en un sobre y envíelos por correo a su Registrador del Condado indicado en la lista abajo. **Envíe fotocopias legibles y no los originales. No se regresarán las fotocopias a usted.**

Si usted es inscrito en Arizona y usa este formulario de inscripción porque se muda dentro de un condado, se cambia su nombre, o cambia su afiliación de partido político, no tiene que proporcionar fotocopias de prueba de ciudadanía. Si se muda a otro condado en Arizona, tendrá que proporcionar prueba de ciudadanía.

ACCOMMODATIONS FOR INDIVIDUALS WITH DISABILITIES

Alternative format materials, sign language interpretation, and assistive listening devices are available upon 72 hours advance notice to your County Recorder.

To the extent possible, additional reasonable accommodations will be made available within the time constraints of the request.

PARA ACOMODAR A LAS NECESIDADES DE LAS PERSONAS CON DISCAPACIDADES

Los materiales en formatos alternativos, interpretación por señas y dispositivos de audición asistida están disponibles al dar aviso previo de 72 horas a su Registrador del Condado.

Al punto posible, se harán disponibles más acomodamientos razonables dentro de las limitaciones de tiempo de la solicitud.

GENERAL INFORMATION

1. You must re-register whenever you:
   - **Move**
   - **Change your name**
   - **Change your political party affiliation**
2. Early ballots may be requested from the County Recorder of your county of residence.
3. Keep this copy as your receipt. After the County Recorder receives your registration and places it in the county general register, a notice will be sent to you within 4–6 weeks indicating that your name appears on the register. If you do not receive your notice contact your County Recorder.

INFORMACIÓN GENERAL

1. Usted tiene que volver a inscribirse siempre que:
   - **Se mude**
   - **Se cambie su nombre**
   - **Cambie su afiliación de partido político**
2. Se puede solicitar boletas electorales tempranas del Registrador del Condado del condado de su residencia.
3. Conserve esta copia como su recibo. Después de que el Registrador del Condado reciba su inscripción y la anote en el registro general del condado, se le enviará un aviso dentro de 4 a 6 semanas que indica que su nombre aparece en el registro. Si usted no recibe su aviso, póngase en contacto con su Registrador del Condado.

Apache County Recorder St. Johns, AZ 85936 (928) 337-7516 (TDD# 337-4402)	Graham County Recorder Safford, AZ 85546 (928) 428-3560 (TDD# 428-3562)	Mohave County Recorder Kingman, AZ 86402 (928) 753-0767 (TDD# 753-0769)	Santa Cruz County Recorder Nogales, AZ 85621 (520) 375-7990 (TDD# 761-7816)
Cochise County Recorder Bisbee, AZ 85603 (520) 432-8354 (TDD# 432-8360)	Greenlee County Recorder Clifton, AZ 85533 (928) 865-2632 (TDD# 865-2632)	Navajo County Recorder Holbrook, AZ 86025 (928) 524-4192 (TDD# 524-4294)	Yavapai County Recorder Prescott, AZ 86305 (928) 771-3248 (TDD# 771-3530)
Coconino County Recorder/ Elections Department Flagstaff, AZ 86001 (928) 779-6589 (TDD# 226-6073)	La Paz County Recorder Parker, AZ 85344 (928) 669-6136 (TDD# 669-8400)	Pima County Recorder Tucson, AZ 85701 (520) 740-4330 (TDD# 740-4320)	Yuma County Recorder Yuma, AZ 85364 (928) 373-6034 (TDD# 373-6033)
Gila County Recorder Globe, AZ 85501 (928) 425-3231 (TDD# 425-0839)	Maricopa County Recorder/ Elections Department Phoenix, AZ 85003 (602) 506-1511 (TDD# 506-2348)	Pinal County Recorder Florence, AZ 85232 (520) 866-6850 (TDD# 866-6851)	*State of Arizona* *Secretary of State* *Form Rev. 3/06*

GUIDELINES FOR COMPLETING THE ARIZONA VOTER REGISTRATION FORM

When completing the voter registration application, please use black ink only.

Box Name	Instructions for Completing the Voter Registration Application
(1) Additional or Former Address	Check "Yes" or "No" or "Not sure". If you mark other than "No", list the former address, including county and state.
(2) Name	Complete last name, first name, middle name, and suffix (Jr/Sr/III).
(3) Address where you live	Address where you live, including complete house number, street name, and house . If you do not have a street address, describe nearest residence location using mileage, major cross streets, or landmarks. **Do not use post office box or business addresses.** Draw a map of the location, if necessary, in the box provided at bottom of form.
(4) Apt./Unit/Space	If applicable, enter the apartment, unit or space number of residence address.
(5) City	Enter city of primary residence address.
(6) County	Enter county of primary residence address.
(7) Zip	Enter zip code of primary residence address.
(8) Mailing Address	If you do not receive your mail at your home address, enter the address where you get your mail, including street address or post office box, unit number, city, state, and zip code.
(9) Birth Date	Enter month, day, and year. (*i.e., January 1, 2005*).
(10) State or Country of Birth	Enter the state in which you were born <u>or</u> the country) (Mexico, Canada, etc.) in which you were born.
(11) Telephone Number	It is included to assist county recorders in contacting voters who may not have filled out their form completely or legibly. Enter a daytime telephone number (*including area code*) or an alternative number where you can be reached or where a message can be left for you.
(12) Father's Name or Mother's Maiden Name	Enter your father's full name or your mother's maiden name (*mother's family name prior to marriage*).
(13) AZ Driver License or Nonoperating Number	Enter your driver license number or nonoperating identification license number. If you do not have a driver license or a nonoperating identification license number, enter the last four digits of your social security number. If you do not have a current and valid driver license or nonoperating identification license or a social security number, a

	unique identifying number will be assigned by the Secretary of State.
(14) AZ Driver License or Nonoperating Number Issue Date	Enter the issue date of your driver license or nonoperating identification license.
(15) Last Four Digits of Social Security Number	Enter the last four digits of your social security number if you do not have a current and valid driver license or nonoperating identification license.
(16) Native American Identification Type	This box is **optional**. Check the appropriate form of identification if applicable, and enter the number from the identification in the box.
(17) Specify Party Preference	Individuals may choose to leave it blank or write "unaffiliated." If the voter registers as independent, or no party preference, or as a member of a political party that is not entitled to representation on the ballot, the voter may vote the ballot of only one of the political parties that is entitled to representation on the ballot at the Primary Election.
(18) Occupation	Type of work you are currently performing or are trained to do.
(19) Former Name	If your name was different the last time you registered, list your former name.
(20) Certificate of Naturalization Number	If you are a naturalized U.S. citizen, enter the number of your certificate of naturalization, if needed for citizenship purposes.
Box Name	**Instructions for Completing the Voter Registration Application**
(21) Are You A Citizen/Will You be 18 **Voter Declaration**	Check “Yes” or “No” indicating you are a citizen of the United States or eligible to vote in the United States. Check “Yes” or “No” indicating you will be 18 years of age on or before election day. The form cannot be processed by the County Recorder unless both questions are answered “Yes”.. By signing this form you swear or affirm that the information listed on the form is true. Individuals must sign the form verifying that they meet the qualifications listed in the voter registration form.
(22) Directional Map	If no street address from Box 3, describe residence location by drawing a map using mileage, cross streets, or landmarks as identifiers.
(23) Receiving Assistance With Form	If you are unable to sign the form, you may receive assistance to complete the form at your direction. The person who assisted you must sign indicating they have provided assistance to you at your request. Enter the current date the form was completed.
(24) Work At Polling Place	Check “Yes” or “No” that you would be willing to work at a polling place on election day.

NVRA-6

BATCH REPORT
TRANSMITTAL FORM FOR
VOTER REGISTRATION DECLINATIONS

Records
Records
Management
Division
1919 W. Jefferson
Phoenix, AZ
85009

Agency _____

_____

Location

Copies of this form may be obtained in an electronic format by accessing the following Outlook public folder: Public Folders/All Public Folders/ADES Forms

Beginning Date _____

Ending Date _____

Number of Agency Applications (optional) _____

Number of Voter Registration Declinations _____

Send Copy to:

Secretary of State
Elections
1700 W. Washington St., 7th Floor
Phoenix, AZ
85007

Send Copy and Forms to:

Arizona State
Library, Archives
and Public

BATCH REPORT
TRANSMITTAL FORM FOR
VOTER REGISTRATION DECLINATIONS

Agency _____

_____

Location _____

Beginning Date _____

Ending Date _____

Number of Agency Applications (optional) _____

Number of Voter Registration Declinations _____

Send Copy to:	Secretary of State Elections 1700 W. Washington St., 7th Floor Phoenix, AZ 85007
Send Copy and Forms to:	Arizona State Library, Archives and Public Records Records Management Division 1919 W. Jefferson Phoenix, AZ 85009

EXHIBIT E

County Election Contacts

Apache County
County Recorder, St. Johns, 928-337-7514, TDD 928-337-4402
Elections Director, St. Johns, 928-337-7537.
Online access at www.co.apache.az.us/recorder/

Cochise County
County Recorder, Bisbee, 520-432-8356. TDD 520-432-8360
Elections Officer, Bisbee, 520-432-9236
Online access at www.co.cochise.az.us/elections

Coconino County
County Recorder, Flagstaff, 928-779-6585, TDD 928-226-6073
Elections Administrator, Flagstaff, 928-779-6589
Online access at www.coconino.az.gov/recorder.aspx?id=1028

Gila County
County Recorder, Globe, 928-425-3231 ext. 8735, TDD 928-425-0829
Elections Director, Globe, 928-425-3231 ext. 8708
Online access at http://recorder.gilacountyaz.gov/

Graham County
County Recorder, Safford, 928-428-3560, TDD 928-428-3562
Elections Officer, Safford, 928-428-3250
Online access at www.graham.az.gov/recorder.htm

Greenlee County
County Recorder, Clifton, 928-865-2632, TDD 928-865-2632
Elections Director, Clifton, 928-865-2072
Online access at www.co.greenlee.az.us/Recorder/RecorderHomePage.aspx

La Paz County
County Recorder, Parker, 928-669-6136, TDD 928-669-8400
Clerk, Parker, 928-669-6115
Online access mailto: at www.co.la-paz.us/recorder.htm

Maricopa County
County Recorder, Phoenix, 602-506-1511, TDD 602-506-2348
Director, Phoenix, 602-506-1511
Online access at http://recorder.maricopa.gov

Mohave County
County Recorder, Kingman, 928-753-0701, TDD 520-753-0769
Director, Kingman, 928-753-0733
Online access at http://www.co.mohave.az.us/depts/recorder/voterreg_default.asp

Navajo County
County Recorder, Holbrook, 928-524-4190, TDD 928-524-4294
Elections Coordinator, Holbrook, 928-524-4062
Online access at http://www.co.navajo.az.us/

Pima County
County Recorder, Tucson, 520-740-4330, TDD 520-740-4320
Elections Director, Tucson, 520-740-4260
Online access at www.recorder.pima.gov/

Pinal County
County Recorder, Florence, 520-866-7100, TDD 520-866-7166
Director, Florence, 520-866-6237
Online access at http:/www.co.pinal.az.us/Recorder/

Santa Cruz County
County Recorder, Nogales, 520-375-7990, TDD 520-761-7816
Clerk, Nogales, 520-375-7808
Online access mailto:at www.santa-cruz.az.us/recorder/index.html

Yavapai County
County Recorder, Prescott, 928-771-3248, TDD 928-771-3530
Director, Prescott, 928-771-3250
Online access at http://www.co.yavapai.az.us/departments/Rec/RecHome.asp

Yuma County
County Recorder, Yuma, 928-373-6020, TDD 928-373-6033
Elections Officer, Yuma, 928-373-1014
Online access at www.co.yuma.az.us/recorder/index.htm
Note: Yuma sends ALL voters an early ballot request.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
DIVISION OF DEVELOPMENTAL DISABILITIES

POLICY/DIRECTIVE ACKNOWLEDGEMENT

My signature, below, indicates that I have read and understand Administrative Directive 107, National Voter Registration Act. This acknowledgement will be kept by my supervisor.

_____ _____
NAME (print) SIGNATURE

_____
DATE

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 108 **DATE: July 12, 2006**

TO: Policies and Procedures Manual Holders

FROM: Barbara Brent
Acting Assistant Director
Division of Developmental Disabilities

SUBJECT: Incontinence Briefs

EFFECTIVE DATE: Upon Receipt

Purpose

This Directive gives guidelines for the provision of incontinence briefs to Division of Developmental Disabilities consumers. Incontinence briefs will not be covered by Children's Rehabilitative Services (CRS).

1. **The Division's acute care contracted health plans shall provide incontinence briefs for children eligible for the ALTCS program and are under the age of 21 who:**
   - ✓ Have a disability resulting in incontinence
   - ✓ Have a physician prescription for incontinence briefs
   - ✓ Are age 3 years or older

2. **The Division shall provide incontinence briefs for children 3 to 21 who are:**
   - ✓ Group home residents that do not qualify for Medicaid (ALTCS or targeted).
   - ✓ Dependent wards in care with the Division that do not qualify for Medicaid (ALTCS or targeted).

3. **The Division shall:**
   - ✓ Limit the benefit to 240 briefs per month, even if the member has medical necessity for more.
   - ✓ Apply appropriate Prior Authorization requirements.

4. **Any exceptions to this Directive must have District Program Manager approval.**

BB:LC:PLW:ch

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. 109 **DATE: July 18, 2006**

TO: Policies and Procedures Manual Holders

FROM: Barbara Brent
Acting Assistant Director
Division of Developmental Disabilities

SUBJECT: Administrative Leave for Investigative Purposes

EFFECTIVE DATE: Upon Receipt

Purpose

For purposes of directing administrative leave to investigate 'alleged employee wrongdoing', pursuant to DES Policy 1-26-05, authority for granting of administrative leave is delegated to District Managers/Administrators for a 72 hour period. Subsequent authorization authority for administrative leave while an investigation or fact finding continues rests with the Assistant Director or designee. The Division Personnel Director will prepare letters for administrative leave beyond 72 hours for the Assistant Director's signature.

Generally, extended administrative leave is discouraged for purposes of what might be a protracted internal or external investigation. An employee is considered innocent of any charges or allegations until an investigation or fact finding suggests otherwise. Extended administrative leave may be perceived as punishment.

In making a recommendation to the Assistant Director as to the disposition of an employee under investigation, the responsible manager or administrator should take into account the following factors based on the nature of the allegation:

- *the seriousness of the allegation*: cursing between employees is less serious than cursing a consumer or family member;

- *the influence the Division has over the length of an investigation*: an internal fact finding can be expedited if an employee is on administrative leave; an external fact finding cannot always be expedited, so extended leave may be less appropriate;

- *the impact of an extended leave on review:* in an appeal process there may be less sympathy for the State's position if a protracted investigation and extended leave suggest the matter was not a high priority;

- *Imminent jeopardy or risk of harm to consumers, families or employees:* an employee who threatens to bring a gun to the workplace will present managers with a more serious threat to safety than an employee who calls a consumer an inappropriate name;

The following matrix may be useful in considering a recommendation as to the disposition of an employee undergoing an investigation.

	Allegations of misconduct not on the current job	Allegations of misconduct	Serious allegations of misconduct	Allegations of misconduct of serious harm to consumers, families or Department
High Supervision/ No authority	←Typical			
Job re-assignment at work station or other work station		←Typical		
Assignments at home			←Typical	
Extended Administrative Leave				←Typical

Administrators who request DES Internal Affairs investigations should highlight in the request those rare occasions when the subject employee has been placed on administrative leave.

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Arizona Department of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

ADMINISTRATIVE D I R E C T I V E

NO. **110** **DATE: August 11, 2006**

TO: Policies and Procedures Manual Holders

FROM: Barbara Brent
Acting Assistant Director
Division of Developmental Disabilities

SUBJECT: Qualified Vendor Approval Process

EFFECTIVE DATE: Upon Receipt

Purpose:

The Qualified Vendor application and approval process as outlined in Administrative Rule 6-6-2100 et seq. requires that the Division of Developmental Disabilities review and verify the ability of applicants to meet minimum contract requirements and to effectively deliver services to consumers. To ensure that applicants meet contract requirements and service specifications as described in the application and vendor program plan, the Division will review and approve Qualified Vendors as described in this directive.

I. Application and Contract Review:

A. The Division of Developmental Disabilities is required to review and verify the readiness of all Qualified Vendor applicants to perform its contractual responsibilities to deliver community developmental disability services to consumers. Prior to approval of an application, the Division will review and verify the Qualified Vendor Application against evaluation criteria, which include recruitment and training policies, incident reporting procedures, complaint and grievance processes, program feedback processes, consumer involvement information and internal quality management plans.

B. In addition to the regulatory and insurance requirements stipulated in R6-6-2104, the Division contract unit shall review the following information:
- Criminal and financial background information.
- Documentation of financial stability.
- Program plan or description.
- Organizational chart and executive resumes.
- Direct care staff job description and qualifications.
- Corporate structure.

- Licensure.

C. The Contract Unit shall forward to the Assistant Director its recommendation for approval or denial of the application based on satisfactory compliance all qualified vendor application requirements. The timeframe for completion of this review shall be sixty days from the time of acknowledged receipt of a completed qualified vendor application.

II. District Readiness Review

A. Subsequent to approval by the Assistant Director, the Contract Unit shall forward documentation of its review to each relevant District Program Manager. Prior to any authorization of services to new Qualified Vendors or new service for an existing Qualified Vendor, each District in which the Vendor has indicated it wishes to initiate services, will conduct a readiness review to ensure that the vendor is prepared to meet the needs of consumers as articulated in the vendor's program plan and application. The District "readiness review team" will receive documentation provided by the Contract Unit and assure the Qualified Vendor's ability to provide services.

B. The District "readiness review team" will meet with the Qualified Vendor to:
- Introduce key personnel.
- Review vendor plans for service provision and locations.
- Offer technical assistance and answer questions.
- Review policies, procedures, training and quality management plans.

C. For Vendors applying for services other than group homes or day programs, the District will determine that the Vendor is ready to begin service provision by adding the Vendor to its district service directory and listing for vendor calls. The Vendor will be notified that they are approved to deliver services. No post-contract review shall exceed 60 days. If a review exceeds 60 days, the Vendor contract may be terminated. Qualified Vendors subject to professional licensure shall be exempt from this review (nurses, therapists, etc).

D. If the Vendor is applying to provide group home or day program services, the District will hold its final determination until the Vendor is approved per the program monitoring process described at Section III.

E. No post-contract review shall exceed 60 days. If a review exceeds 60 days, the Vendor's contract may be terminated.

III. Program Monitoring Review

A. New Qualified Vendor applicants of group home or day program services shall undergo a concurrent review by Program Monitoring staff. This review may

be coordinated with the District Readiness Review and shall begin on the date of contract award.

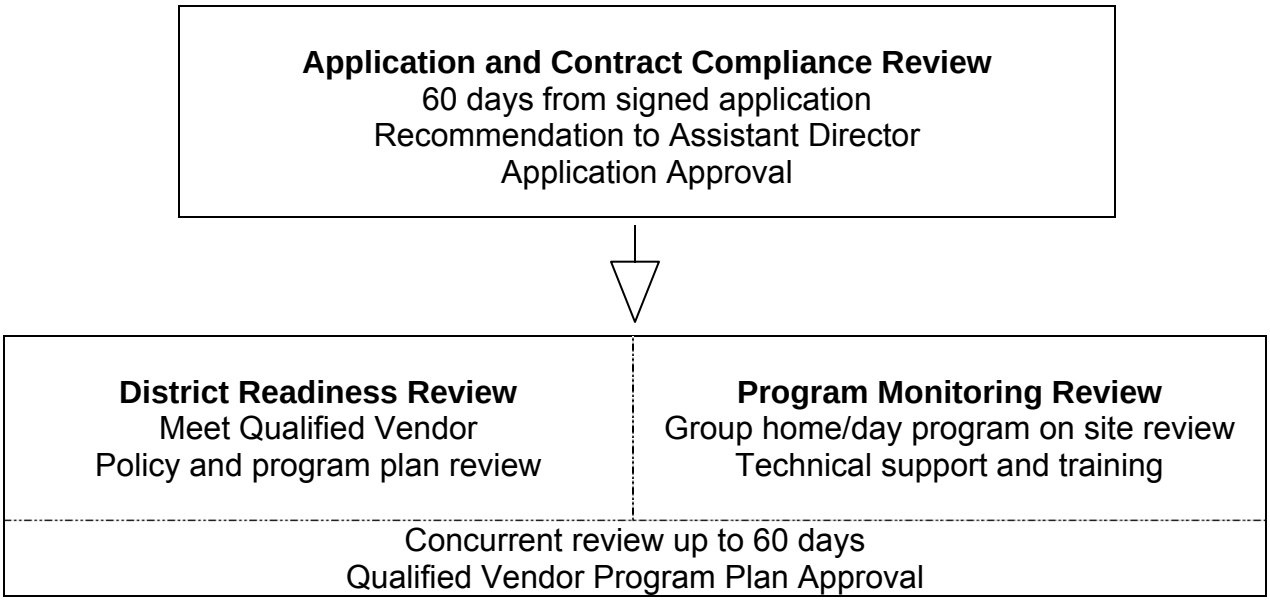
B. **All** Qualified Vendors, prior to opening a **new** home(s) or a program facility, shall provide documents as required in Section 6.8.2.8 of the Qualified Vendor agreement (Contract Compliance Checklist) to the assigned program monitor. The program monitor will complete a New Home/Program Report and forward the New Home/Program Report to the appropriate District Program Manager for the readiness review team and approval.

C. No post-contract review shall exceed sixty days. If a review exceeds sixty days, the Vendor's contract may be terminated.

D. At any time during the qualified vendor application or review process, the vendor may request or be referred for assistance in meeting application requirements or meeting District and program monitoring readiness approval.

E. Division staff will visit the group home or day program every thirty days for the first six months and provide a monthly status to the District Program Manager or designee.

Qualified Vendor Approval Process



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Arizona Department Of Economic Security
DIVISION OF DEVELOPMENTAL DISABILITIES

A D M I N I S T R A T I V E D I R E C T I V E

NO. **111** **DATE: September 21, 2006**

TO: Policy and Procedures Manual Holders

FROM: Barbara Brent
Assistant Director (Acting)
Division of Developmental Disabilities

SUBJECT: **Cognitive Disability**

EFFECTIVE DATE: September 21, 2006

Purpose

This Administrative Directive describes amendments to Arizona Revised Statutes § § 36-551 and 36-581, that prescribe a change in terms and definitions for the Division of Developmental Disabilities. Effective September 21, 2006, the term "cognitive disability" shall replace the words" mental retardation".

Change in Terms

Pursuant to A.R.S. § 36-551, "Cognitive disability" means a condition that involves sub average general intellectual functioning, that exists concurrently with deficits in adaptive behavior manifested before age eighteen and that is sometimes referred to as intellectual disability or mental retardation.

Pursuant to A.R.S §36-581, "Developmental disability" means autism, cerebral palsy, epilepsy or cognitive disability.

These changes do not affect the federally defined term "Intermediate Care Facility for the Mentally Retarded" (ICF/MR).

Eligibility Requirements

This change in terms and definitions shall not affect in any way the statutory requirements for eligibility.

BB:KS:PLW

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