

SCL Participant Directed Services

Department for Aging and Independent Living
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What Will Be Our Focus

- Piecing together the concept
- Describing roles
 - Participants/Employers
 - Employees
 - Financial Management Agents
 - Representatives
- Services
- Timesheets

What will be our focus

- Plan of Care
- Case Management and Contacts
- Corrective Action Plans
- Fraud
- Incident Reports

Nailing Down The Self-Directed Concept:

- Why choose self-direction?
 - To assist the participant in gaining and exercising control over his/her services;
 - Affording each participant the opportunity to determine what is in his/her best interests; and
 - To become more invested and more knowledgeable of how services are available and maximize utilization.

Principles of PDS

Gives the participant:

- **Freedom:** Live a meaningful life in the community;
- **Authority:** Direct the services needed for support;
- **Support:** Organize resources in ways that are life enhancing and meaningful;
- **Responsibility:** Wise use of public funds; and
- **Confirmation:** Leadership of self-advocates.

PDS Gives Participants The Power of Choosing:

- **WHO** will provide services;
- **WHAT** services are needed or desired;
- **HOW** services will be provided;
- **WHEN** services will be provided; and
- **WHERE** services will be provided.

Who Can Participate?

- Individuals who meet the financial and medical requirements for the SCL waiver; and
- Individuals who can:
 - Understand the rights, risks, and responsibilities of managing their own care; and
 - Understand how to utilize what services are available to best fit any unmet needs.

What Else is Involved?

- Recruiting & Hiring – the participant needs to start looking at who could potentially be an employee to provide services;
- Forming schedules – knowing when the participant wants services delivered;
- Developing job descriptions – ability to inform employees what duties may be required to perform;
- Authorizing work – utilizing a standardized timesheet with service documentation as justification for paying employees;
- Disciplinary action and termination – the participant should establish guidelines in order to maintain appropriate use of the self-directed model;

What Else is Involved?

- Natural Supports – This is not a program for everyone, as it does not have the capacity for around-the-clock care on an everyday basis; and
- The employer/employee relationship
 - Participants must know he/she is the employer, not you, or your agency; and
 - Employees must know the participant is the employer, not you, or your agency.

Employees



Who Can Provide Services?

- The individual and/or representative will recruit, hire, and supervise employees to provide services as approved in the Participant's Person Centered Service Plan.
- Employees may include:
 - Family
 - Friends
 - Relatives
 - Neighbors
 - Employees recruited by the participant
 - Personal Service agencies employed by the participant

Note that any a MAP 532 (Exemption form) must be submitted to DAIL for those are an immediate family member or guardian. An immediate family member is defined by KRS 205.8451 (3).

MAP 532 Exemption Process

- The Case Manager is responsible for providing assistance in understanding and illustrating the questions posed in the Exemption form.
- Each question should be discussed in detail on **how** the applicant(s) meets the needs of the participant in ways that would be otherwise detrimental should other employees or agencies provide the requested service(s).

Participant Information:

Name Last:	First:	MI:	Medicaid ID:
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Paid Service Provider Information:

Name Last:	First:	MI:
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Current Case Manager:

Last Name:	First Name:
Email:	
CM Provider Name:	CM Provider #:

Relation <i>(Please mark appropriate box in table below)</i>	Clear
"Legally responsible individual" means an individual who has a duty under state law to care for another person and includes: a) A <u>Parent</u> (biological, adoptive, or foster) of a minor child who provides care to the child; b) The <u>guardian of a minor child</u> who provides care to the child; or c) A <u>spouse</u> of a participant.	<input type="checkbox"/>
"Guardian" is defined by KRS 387.010(3) for a minor (means any person who has not reached the age of eighteen (18)) and in KRS 387.812(3) for an adult (means an individual who has attained eighteen (18) years of age.)	<input type="checkbox"/>
"Immediate family member" is defined by KRS 205.8431(3). (Means a parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, or grandchild.)	<input type="checkbox"/>

What services are you providing?
What duties will you be performing that exceed the range of activities you normally provide as a family member/legally responsible person?
How will these duties be cost-effective?
What unique abilities and qualifications do you possess that may not be found with other potential employees?

Participant Name: , MAID #: _____

What anticipated time of day/week will these duties be performed?

--

How is the participant limited in independence and how will you be able to increase this with your employment?

--

How is the participant limited in community access and how will you be able to increase this with your employment?

--

What other sources for these services has your team pursued? Why were these sources unsuccessful?

--

I have tried to find a qualified provider but am unable to do so for the following reasons: (Check all that apply)

- No qualified provider is located within thirty miles from my residence.
 No qualified provider will provide services at the necessary times and places. Please explain:

--

Date: _____

Signature of Requesting Immediate Family Member, Guardian or Legally Responsible Individual

Date: _____

Participant/Guardian Signature: (Guardian if above not signed by Guardian)

Date: _____

Case Manager Signature:

By electronically signing and dating this document, the Case Manager verifies that the Participant/Guardian and the Immediate Family Member, Guardian or Legally Responsible Individual requesting to be a paid service provider agree with the information contained in this form and has electronically signed this document or if not, has signed a paper copy which is kept with the participant's service records.

MAP 532 Exemption Process

- A candidate may apply for up to 5 services:
 - Personal Assistance;
 - Day Training;
 - Community Access;
 - Transportation; and
 - Respite.
- Case Managers may provide a copy of the Helpful Hints within the Participant Manual to the team members to further assist in this process.
- DAIL will respond and provide determinations within 14 business days.

MAP 532 Exemption process (cont.)

- Candidates are not considered eligible for a proposed service(s) unless approved by the department or through the hearing process.
- Participant may request appeals or reconsiderations of any denials; instructions will be provided with the determination statement issued via postal mail and email to the case manager.
- Once approved, the employee does not have to apply again to the same service so long as:
 - The service remains under PDS; and
 - There is no separation of employment (quitting or being terminated).

Employee Requirements:

Employees must meet qualifications similar to an employee of a traditional direct service. This includes:

Application;

I-9 verification form (completed by the employer);

W-4 and K-4 tax forms;

PDS Contract illustrating services provided and agreed wages;

- Drug screening (5 panel minimum);
- TB screening/test;

Employee Requirements (cont.)

- College of Direct Supports training requirements;
- CPR/First Aid training by American Red Cross or American Heart Association;
- Background check requirements; and
- Valid driver's license with minimum liability insurance if transporting the participant.

Participants are responsible for the costs associated with these requirements.



Commonwealth of Kentucky
 Cabinet for Health and Family Services
 Department for Aging and Independent Living

**Kentucky Participant Directed Services
 Employee/Provider Contract**

I (employee name) _____, have agreed to work under the employment of
 (employer name) _____.

Services under this contract will consist of the following:

<u>SERVICE PROVIDED</u>	<u>RATE PER HOUR</u>

Services Available Through the Participant Directed Services:

- | | |
|---------------------------|-----------------------------------|
| (SCL) Community Access | (HCB and SCL) Respite |
| (SCL) Community Guide | (HCB) Home and Community Supports |
| (SCL) Day Training | (SCL) Supported Employment |
| (SCL) Personal Assistance | (SCL) Transportation |

As an employee:

I agree to provide the above listed services as required by my employer at the rate stated above per hour.

I understand there may be civil or criminal penalties if I intentionally defraud the Department for Medicaid Services.

I understand that I shall not be approved as a Participant Directed Services (PDS) provider if results from my background check reveal that I have pled guilty to or been convicted of committing an offense as outlined in (SCL) 907 KAR 12:010, Section 3(3), or (HCB) 907 KAR 7:010, Section 2.

I understand that I shall not be approved as a PDS provider if I am registered on the Kentucky Nurse Aide abuse registry.

I understand that I shall not be approved as a PDS provider if results from the Central Registry Check reveal that I have been substantiated for abuse.



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

I understand that under KRS 205.5607 (Kentucky Independence Plus Through Consumer Directed Services Program) Workers Compensation (KRS Chapter 342) shall not apply to my employment as a Participant Directed Services provider. This means that neither the state, nor any state agency, nor political subdivision, nor any fiscal intermediary, nor representative, nor service advisor can be held liable for any injuries or losses I may incur while providing services.

I understand that I shall not be approved as a PDS provider if results from my drug screening reveal a positive drug test as outlined in 907 KAR 12:010.

I understand that if I do not complete all training that is required with the specified timelines, I will no longer be eligible as a PDS provider for the participant.

I understand that I must maintain employee/employer confidentiality.

I understand this is an at-will contract and either party may terminate this agreement at any time.

I understand that I must notify my employer of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.

I agree to follow all relevant state and federal statutes and regulations.

I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer and myself.

As an employer:

I understand that I may be responsible for costs associated for employment requirements, including employee training.

I understand that I may be responsible for wages for my employee should my employee or I not provide employee qualifications by the respective deadlines.

I understand that I can only require my employee to assist with duties that are relevant to my needs and outcomes that are specified on the Person Centered Service Plan for Medicaid payment.

I understand that I may be responsible for payment for any hours I may require my employee to work beyond any prior authorization limits or waiver regulation guidelines.

Employee/Provider Date

Employer/Participant Date

Employee Requirements (cont.)

- Employees must be at 18 years old;
- Be a citizen of the United States with a valid Social Security Number, or possess a valid work permit if not a U.S. citizen;
- Be able to understand and carry out instructions;
- Be able to communicate effectively with the participant, representative, participant's guardian, or family of the participant; and
- Be able to keep records as required by the participant.

Drug screening

- Drug screening must be completed prior to beginning employment;
- DAIL recommends a 5 panel minimum for screening;
- Applicants cannot show positive results for prohibited or illicit drugs;
- Prescription orders must be retained for controlled substances reflected in results; and
- Results shall not transfer from a previous employer.

TB Screening

- TB assessment/test must be completed within the first 30 days of services provided and annually thereafter;
- Applicants must provide proof of following protocols dictated by medical professionals to ensure no active TB disease is present; and
- Results may transfer from a previous employer.

Employee Training

College of Direct Supports training include at a minimum:

- Maltreatment of Vulnerable Adults & Children;
- Individual Rights and Choices;
- Safety at home and in the community;
- Supporting Healthy lives;
- Person Centered Planning; and
- Any other training required by the participant.

These would be obtained online through a sub administrator at the Case Management Agency.

Employee Training

- CPR/FA must be acquired through the American Heart Association or the American Red Cross;
- Training must be completed within 6 months of beginning employment;
- May transfer from previous employer; and
- Must be renewed upon expiration.

Additional Trainings

- Supported Employment Specialist
 - Must complete KY Supported Employment Training Project curriculum from the Human Development Institute through UK within 6 months of beginning employment.
- Community Guide
 - Must complete curriculum within CDS within 6 months of beginning employment.
- Trainings completed through the CDS and HDI may transfer from the previous employer.

Additional Trainings

- Participants may wish to have employees trained on specific topics, such as how to handle conditions associated with a diagnosis, or request they attend seminars related to a disability.
- The participant can dictate how these specific requested trainings are completed.
- These and other requested trainings can be documented on the Additional Training form.



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living &
Department for Behavioral Health, Developmental and Intellectual Disabilities

**PARTICIPANT DIRECTED SERVICES
EMPLOYEE TRAINING VERIFICATION**

As a chosen employee, I certify that I have completed the following topics, which exceed what is required by the College of Direct Supports, required by my case management agency, DAIL, BHDID or employer:

_____	_____
	Date
_____	_____
	Date
_____	_____
	Date
_____	_____
	Date

Employee Signature

Date

Consumer/Representative/Employer Signature

Date

Case Manager Signature (if applicable)

Date

Employee Background Checks

Each employee upon hire shall have the results of the following background checks:

- Administrative Office of the Courts (AOC), or out-of-state equivalent if residing outside Kentucky in the last year;
 - Central Registry Check (CAN), or out-of-state equivalent if resided outside Kentucky in the last year; and
 - Kentucky Board of Nursing nurse abuse registry check, or out-of-state equivalent if resided outside Kentucky in the last year.
- The AOC and Nurse Abuse Registry Check must be done prior to employment. The CAN must be obtain within thirty (30) days from the start of employment; and
 - These checks shall not transfer from a previous employer.

Employee Background Checks

- For the **AOC** or Out-of-state equivalent, an employee may not be convicted of:
 - Violent crime or sex crime as defined in KRS 17.165 (1) to (3);
 - Any drug related conviction within the last 5 years;
 - If transporting participants, any DUI conviction within the last year;
 - Any felony plea bargain, diversion, or conviction that has not been completed; or
 - Has a conviction of abuse, neglect, or exploitation.

Employee Background Checks

- Scenarios that qualify for '*plea bargain, diversion, or conviction that has not been completed*' include:
 - Parole;
 - Probation; and
 - Halfway house placement.
- Eligibility for employment is time sensitive for these 3 scenarios, depending on the jurisdiction of the court; a general rule is to use the sentencing date as a starting point for the statement on the AOC.

Employee Background Checks

- The **Nurse Aide Registry** may be completed online with the KY Board of Nursing Website:
<https://secure.kentucky.gov/kbn/bulkvalidation/basic.aspx>
- Be sure to enter all known names of the employee (The I-9, application, or AOC request form can provide these).
- Print all known name results with a date stamp at the bottom of the page.
- 'Validate Selected' for all names in search results.
- Should results reveal an employee's name is on the registry, follow up with KY Board of Nursing to ensure it is the same person as the applicant.

Employee Requirements

- Case Managers shall maintain results of employee qualifications within participant files.
- Case Managers shall complete the Eligible Employee form to provide the FMA with verification of the employee's qualification.
- Employees who do not complete the qualifications in the designated timeframes shall not be considered eligible for payment under the waiver until qualifications are completed; should employers continue to request employees to work, the employer shall be responsible for wages of those employees.

**Participant Directed Services (PDS)
Eligible Employee Form**

Participant Name: _____ Participant MAID: _____
 PDS Employee Name: _____ Employee SSN: _____
 Employee Address: _____
 Employee Telephone/Email: _____ PDS Employee Date of Birth: _____
 CM Name/Email: _____ CMS Name/Email: _____

 Copy of the Signed POS Member Contract (please attach)

Pre-hire Checks and Screening (Must be completed prior to employment) - CM agency responsible for maintaining documentation of completion

Background Checks and Screenings	Date Approved/Completed	Renewal/Due Date
AOC check Date		
Nurse Aide Abuse Registry Check		
Drug Screening		
Pre-hire If Applicable forms	Date Approved/Completed	Renewal/Due Date
MAP 532 (If applicable)		
Valid Driver's License (If transporting a participant only)		
Liability Insurance (If transporting a participant only)		

By providing this document to the designated Financial Management Agency, I have reviewed and determined the PDS employee has met and completed the requirements as stated in KAR 12:010 and 12:020.

 Case Manager Signature Date

30 day Checks and Screening-CM agency responsible for documentation of completion

30 Day requirements	Date Approved/Completed	Renewal/Due Date
Central Registry check		
TB Screening		

By providing this document to the designated Financial Management Agency, I have reviewed and determined the PDS employee has met and completed the requirements as stated in KAR 12:010 and 12:020.

 Case Manager Signature Date

Training Requirements (Must be completed within six (6) months after employment for new hires)

Training Title	Date Approved/Completed	Renewal/Due Date
First Aid and CPR		
KY CDS Maltreatment of vulnerable adults & children		
KY CDS Individual Rights and Choices		
KY CDS Safety at home and in the Community		
KY CDS Supporting Healthy Lives		
KY CDS Person centered planning		
Other (if applicable):		

By providing this document to the designated Financial Management Agency, I have reviewed and determined the PDS employee has met and completed the requirements as stated in KAR 12:010 and 12:020.

 Case Manager Signature Date

Personal Service Agencies (PSA)

- A listing for PSAs can be found here:
<http://chfs.ky.gov/os/oig/directories.htm>
- Case managers will need to obtain a copy of the agency's current OIG certification; this certification covers the criminal record check, Nurse Aide Registry check, drug screening, and TB assessment.
- Case managers will need to review the agency's Policies and Procedures to determine if the Central Abuse Registry check and CPR/FA training is provided to each employee; each of these will be required within the specified time frame if not covered by the PSA.
- Once an employee has provided care, he/she will be required to complete CDS and any participant required training within 6 months.

Financial Management Agents

A decorative graphic consisting of a solid red horizontal bar that spans the width of the slide. Below this bar, on the right side, there are several horizontal lines of varying lengths and colors (white and light red) that create a stepped, architectural effect.

FMA choice

- The DAIL website houses a list of available FMAs across the state; a participant or case manager may contact any agency to determine which FMA provides the preferred methods of processing FMA duties.
- Once contacted, an FMA will provide the case manager with forms and resources for completing information regarding the participant, the employee(s), and the case management agency.

Relationship between the FMA and CM

- The Case Management Agency and FMA shall enter into an MOU; this MOU illustrates the general timeframe and necessary forms for processing for participants.
- FMAs will disclose to the case manager:
 - Pay period deadlines;
 - Method of timesheet delivery;
 - Method of issuing payment; and
 - Employer/Employee tax exemption scenarios.

The Financial Management Agency (FMA):

- The FMA is an agency designated to handle financial processes for a participant.
- Primary duties include:
 - Paying federal, state, and local applicable taxes on behalf of the employer;
 - Processing payroll on behalf of participants;
 - Providing employer tax percentage to case managers for employees' wages (expressed in dollars);
 - Processing invoices for Goods & Services and Environmental & Minor Home Modification; and
 - Submitting billing claims for reimbursement against the Prior Authorization.

Being designated as an Employer

- The participant is afforded control through becoming an Employer of Record; this will allow the participant to manage providers as hired employees that provide selected services.
- Participants will need to complete forms to acquire an FEIN (Federal Employment Identification Number) and KEIN (Kentucky Employment Identification Number). The FMA may provide online resources for these steps.
- The participant must complete a form called the 2678, designating the FMA to pay these taxes on behalf of the participant.

Form **2678** Employer/Payer Appointment of Agent

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0048

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

For IRS use:

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

Part 1: Why you are filing this form...

(Check one)

- You want to appoint an agent for tax reporting, depositing, and paying.
- You want to revoke an existing appointment.

Part 2: Employer or Payer Information. Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) -

2 Employer's or payer's name (not your trade name)

3 Trade name (if any)

4 Address

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (Check all that apply.)	For ALL employees/payees/payments	For SOME employees/payees/payments
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

- Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X Sign your name here

Date

Print your name here

Print your title here

Best daytime phone

Now give this form to the agent to complete.

Role of Financial Management Agency

- As an employer of record, the participant must be assessed employer taxes; these taxes shall be handled by the Financial Management Agent (FMA).
- Employees shall complete W-4 and K-4 forms upon hire for submission to the FMA.

Role of Financial Management Agency

- Once a wage has been determined by the participant, the FMA shall inform the Case Manager of the tax rate that applies to the service provided; this combined rate cannot exceed the billable maximum unless exceptional supports has been authorized.
- Parents, children ages 18-21, and non-family live in caregivers who have been authorized for employment may be eligible for tax exemption from FICA (Federal Insurance Contributions Act) taxes, and participants are exempt from FUTA (Federal Unemployment Tax Act), SUTA (State Unemployment Tax Act) and FICA; the FMAs vary across the state in implementing these laws.

Understanding how the money works

- Once a wage has been determined by the participant, the Financial Management Agent (FMA) shall inform the Case Manager of the tax rate that applies to the service provided, translated to a dollar figure.
 - **Example:** Employee works at \$12.00/hour, the FMA informs you the tax rate is 12.65%; 12.65% of \$12.00 is \$1.51, so the gross billable rate \$13.51.
- You will need to be aware of four terms when speaking to the Person Centered team:
 - Maximum billable rate
 - Gross billable rate
 - Gross pay rate
 - Net pay

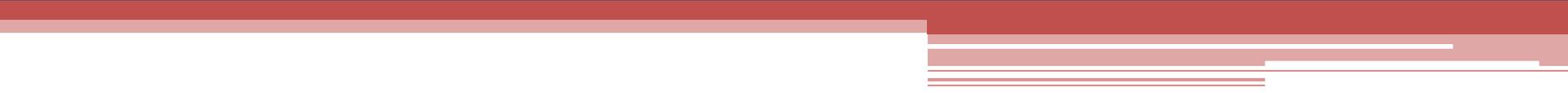
Relationship between the FMA and CM

- Case Manager shall be the contact person for the FMA regarding employees, timesheets, and taxes regarding the participant
- Case Manager shall submit all pertinent employee and participant information for proper processing. This includes:
 - Plan of Care services, wages, and employees authorized;
 - Participant's demographic information;
 - Participant's tax forms (SS-4, 2678, any other necessary forms);
 - Employees' demographic information;
 - Employees' tax forms (W-4, K-4, Direct Deposit form, Exemption status form); and
 - Employee Provider Contract.

Claims processing and paying employees

- The FMA may contact the case manager when scenarios arise regarding claims and payroll. These can include but not be limited to:
 - Wage and tax rates exceeding unit rates stated on the plan of care;
 - Too many units submitted by employee(s) in a given week/month that cannot be covered by the PA;
 - A service on a timesheet is not authorized;
 - Incomplete information regarding an employee; and
 - Prior Authorizations misalign.

Representatives



What if a participant needs assistance to self-direct?

- A participant may appoint a **Representative**. The following applies to a representative role:
 - Cannot provide a paid service to same participant;
 - DAIL recommends the representative be available to attend Level of Care Assessments, Person Centered Service Plan meetings, and Face to Face meetings as well as be available via phone for any indirect contacts.

Role of Representative

- Ensure Person Centered Principles are applied to all decision-making regarding services and employees;
- Authorize and direct all employee functions and processes; and
- Provide key input and insight on participant's Person Centered Service Plan.
- If a representative is appointed, the participant remains the Employer of Record and should have their name on all Employer related forms.

Role of Representative

- You can be the difference – Case Managers can empower or undermine representatives; stand firm when speaking to these individuals and also to participants/guardians when it comes to the operations of PDS.
- Clearly identifying who is to perform what duties helps reduce confusion and misuse of PDS.

Role of Representative

- Guardians who work for participants may struggle with allowing participants/representatives to perform their employer related duties; it is strongly recommended these guardians be asked to make difficult decisions regarding these roles and duties, and stand by those decisions.
- Speaking with employees or other members of the participant's team can cause the representative to lose interest/investment in assisting the participant.

Services



What services can employees provide?

- Personal Assistance
- Respite
- Community Access
- Supported Employment
- Day Training
- Community Guide

Personal Assistance

- Billable rate maximum: \$5.54/unit or \$22.16/hour.
- Maximum hour use: 16 hours/day; this equals 64 units/day, and 448 units/week.
- Replaced CLS; may include needs pertaining to ADL, IADLs, general community outings/event attendance, transportation to and from medical appointments.
- May not include academic instruction/assistance while attending school through the 12th grade.
- Not available to those receiving residential services.
- Considering weekly request vs. monthly request.

Respite

- Billable rate maximum: \$2.77/unit or \$11.08/hour.
- Maximum hour use: 830 hours per level of care year or 3320 units.
- Not necessary to address any need during provision of service; only requirement is to relieve a caregiver.
- Participants may wish to participate in stated goals, enjoy general leisure time, or sleep.
- Case Managers should discuss with participant and team the possibility of requesting respite as a 'one time request' and receive the full 3320 units so participant may spend more freely.

Community Access

- Billable rate maximum: \$8.00/unit or \$32.00/hour.
- Maximum hour use: 40 hours/week, or 160 units
- Provided by a Community Access Specialist who has:
 - A bachelor's degree in the human services field;
 - A bachelor's degree with at least 1 year of experience in the IDD field; or
 - Relevant credentialing or experience that will substitute on a year for year basis.
- The specialist educates members of clubs to understand and assist with participant's independent skills, group and community interactions.

Community Access

- For use **only** if participant wishes to pursue membership in a specific clubs, groups, or organizations.
- Considered a 'phase out' service; as participant develops natural supports base from members of the club, the specialist and service is removed.
- Strategies for a couple scenarios.

Supported Employment

- Billable rate maximum: \$10.25/unit, \$41.00 per hour
- Maximum hour use: 40 hours/week, or 160 units
- Provided by a Supported Employment Specialist, who has:
 - A bachelor's degree with at least 1 year of experience in the IDD field; or
 - Relevant experience or credentialing on a year for year basis.
- Provides support throughout the employment process; interests, skillset, interaction coaching, employee conduct, job description/expectation training, and career development.

Supported Employment

- Not eligible for guardians, immediate family members, or legally responsible individuals.
- Specialists must complete a Supported Employment Long Term Support Plan and a Person Centered Employment Plan.
- Supported Employment, Day Training, Personal Assistance, Community Access, and Community Employment shall be limited to 64 units per day.
- Must pursue OVR or IDEA funding before accessing.

Day Training

- Billable rate maximum: \$2.20/unit, or \$8.80/hour
- Maximum hour use: 40 hours per week, or 160 units
- Can be used to provide training for transition from school to vocation and adult responsibilities.
- Provide activities that promote positive decision making, developing interpersonal skills, or developing vocational interest(s) and/or skills.
- Supported Employment, Day Training, Personal Assistance, Community Access, and Community Employment shall be limited to 64 units per day.

Community Guide

A participant or team members may utilize a Community Guide service to assist with Participant Directed responsibilities:

- Recruiting, interviewing, developing job descriptions and evaluating employees;
- Providing guidance and information on duties and functions of being an employer;
- Assisting in understanding the needs of a participant as well as how to best address those needs through available services within the waiver; and
- Assist with coordinating processes for qualifying employees.

A Community Guide shall meet the personnel and training requirements as defined in Sections **1, 3, and 5** of the 907 KAR 12:010.

- Limited to 144 hours per POC year, and billable at no higher than \$32.00 per hour.

Community Guide

- Should a Community Guide be selected, a Representative must be appointed, as a Community Guide cannot serve as an employee and provide employer responsibilities dually to the same participant.
- A Representative would need to retain, at a minimum, the responsibilities of maintaining employees.
- A person providing Community Guide is not eligible to provide another type of service to any other participant.
- Not eligible for immediate family members, guardians, or legally responsible individuals.

Service Parameters

- Any combination of Personal Assistance, Supported Employment, Adult Day training, Regular employment and Community Access is limited to 16 hours per day.
- No employee can work more than 40 hours per calendar work week for a participant unless authorized by the case manager.
- All PDS services are considered **1:1**, with exclusions to Shared Living, Community Guide, and Community Access Group.
- If an employee works for 3 or more participants, the employee would need to complete **all** employee training requirements as stated in Section 3 of the 907 KAR 12:010.

Service Parameters

- A service can be divided between traditional and PDS in order to receive the service at optimal.
- Wages and units must remain under regulation limits unless an exceptional rate protocol has been granted.
- Exceptional Supports can increase units or rate, but not both.
- The process for Exceptional Supports is illustrated in Appendix F of the SCL II manual.

Service Parameters

- Should a participant require more ongoing care than the Plan of Care can provide, then the Case Manager submits a Plan of Care modification to the Carewise Health for review.
- Any other adjustments to the Plan of Care (units, services, wages, employees) would also require submission to Carewise Health.
- This may include an adjustment of hours (expressed in units), wages (expressed as the gross billable rate per unit), and/or the addition of employees.
- Requests for Prior Authorization modifications must remain with service definition and billable limits unless otherwise authorized through Exceptional Supports Protocol.

Routine Treatment

- “Routine treatment” is a term that is used to illustrate unique medical conditions requiring other forms of administration. Employees can perform duties that relate to:
 - Medication Administration;
 - Stage one and Stage two wound care;
 - catheter care;
 - G-Tube and J-Tube feeding;
 - Oxygen or Nebulizer use;
 - Glucose monitoring;
 - Ostomy care;
 - Tracheotomy care (excluding the cannula);
 - Insulin injections; and/or
 - Digital stimulation.

What other services are available?

- Shared Living
- Environmental Accessibility Adaptation
- Goods and Services
- Natural Supports Training
- Transportation
- Vehicle Adaptation Services

Shared Living

- May be provided to 2 participants in the same home.
- Invoices shall cover costs associated to food and rent, including property taxes, insurance, utilities, and maintenance, power, water/sewer, and natural gas.
- A shared living caregiver may provide assistance to a participant's needs for ADLs, social activities, and/or IADLs.
- The caregiver shall have a contract with the participant to show the estimated cost per month of room and board, along with duties/activities anticipated to be performed with the participant.

Shared Living (continued)

- The selected caregiver must meet the employee requirements illustrated in Section 3 of KAR 12:010.
- Reimbursement shall not exceed \$600 per month.
- Reimbursement dollars shall be issued to the participant; any dollar issued beyond the equal sharing cost may impact other benefits received.
- The Shared living caregiver cannot be an immediate family member, extended family member, guardian, or legally responsible individual, nor an extended family member.
- The caregiver shall be responsible for completing service documentation page of timesheet for each day assistance is provided.

PARTICIPANT DIRECTED SERVICES SHARED LIVING VOUCHER FOR PAYMENT

Copies of all bills associated with shared living reimbursement must accompany voucher

Participant/ID: _____

Pay Period: _____ to _____

Participant Address: _____

Month/Year: _____

Date of Expense (MM/DD/YY):	Service Provided	Bill Amount	Amount Due	Comments/Details
	Rent (per lease agreement)			
	Electricity			
	Natural Gas			
	Food			
	Water/Sewage			
	Insurance			
	Property Taxes			
	Maintenance Fees			
	Total Expenses	\$ -	\$ -	Service Billing Code: 2032 HI

Instructions: Please fill in participant's name, address, pay period, and month/year. For Date of Expense, please provide date of payment. For electronic completion, as Bill Amount is entered, total expenses field will calculate a total. **The amount due depends on the number of individuals in the household. This amount must be evenly divided by the number of individuals in the household.** Any dollar figure reimbursed over the even share shall impact the participant's other benefit plans. Multiple vouchers may be sent in within a given month.

This is an approved voucher for Shared Living Services under Participant Directed Services. This voucher shall only contain items related to the Services Provided Column. The participant or appointed representative shall be responsible for accurate reporting of expenses. By signing, the participant/representative certifies that all expenses reported are accurate and correct. By signing, the shared living caregiver certifies that the expenses reported directly relate to their portion of cost for living at the above stated address.

Participant signature and date: _____

Case manager signature and date: _____

Caregiver signature and date: _____

Financial manager signature and date: _____

Environmental Accessibility Adaptation

- The ability to have home modifications covered that demonstrate an ability to interact more independently with environment. Examples include:
 - Doorway widening;
 - Ramp or grab-bar installation; or
 - Shower or bathroom modification.
- The adaptation must be provided by a vendor who has a good standing status with the Office of the Secretary.
- <https://app.sos.ky.gov/ftsearch/>
- Limited to \$8,000 lifetime per participant.
- Not eligible to be completed by an immediate family member, guardian, or legally responsible individual.

Goods and Services

Goods and Services provides coverage for supplies, commonly consumables, to assist with the health, safety, and welfare of the participant, as well as assist with level of independence.

- There must be a direct link to the needs of the participant and the product requested for coverage.
- Requested amount cannot exceed \$1,800 per Prior Authorization.
- Service is not eligible for exceptional supports; any additional requirements must be obtained through Specialized Medical Equipment from traditional providers.

Natural Supports training

Training provided to enhance those who may be involved with providing natural supports in areas associated with needs based on the participant's Plan of Care. This could be:

- Members of groups, clubs, or organizations
- Extended family members
- Friends
- Other community members

Natural Supports Training

- A member of the participant's team can coordinate with someone in the field with expertise associated with disabilities to conduct a training or seminar that's geared toward:
 - Education and heightened awareness about more appropriate interactions with the participant; and
 - Strategies to foster a more enriching and supporting lifestyle in the home and community.

Natural Supports Training

- Covered costs are only in relation to the speaker's ability to provide the training;
- Reimbursement is limited to \$1,000 per participant per year;
- Participants may 'pool' together should additional funding be required;
- Case manager shall retain documentation of the date, location, time, audience attendance, and a copy of any certification if issued by the speaker.

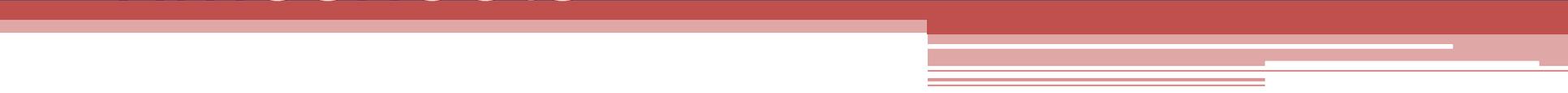
Transportation

- Shall only be utilized when a participant does not ordinarily have access to transportation through another service or through family, friends, neighbors, or community agencies.
- Be provided by a driver who is at least 18 years old and possesses current liability insurance and driver's license.
- May be provided through access to mass transit or taxi service; these may be reimbursed through a cost per trip method instead of mileage base.
- Shall not exceed \$265 per month.
- Reimbursed by mileage report through invoice at 2/3 the state rate, which can be found at:
<http://finance.ky.gov/services/statewideacct/Pages/travel.aspx>

Vehicle Adaptation

- Allows modifications to a participant or participant's family member's vehicle.
- Limited to \$6,000 per 5 year period.
- Vendors who submit estimates must complete modifications approved by the Office of Vocational Rehabilitation (OVR).
- Documentation must be obtained to show that the participant is not eligible to receive the modification from the OVR.

Timesheets

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Timesheets

- Participants are responsible for the content of timesheets, including:
 - Hours, wages, service documentation, identifying information.
- Information must be legible, or it is considered an incomplete timesheet.
- Timesheets must be received by the case manager within 30 days of the last date of service provided on the timesheet in order to monitor health, safety, and welfare.

Timesheets (continued)

Service documentation must include:

- A full description of the service rendered;
- Evidence of training or service to support outcomes designated in the Plan of Care; and
- Date, location, signature, and time of the service.

Once reviewed, a copy or the original timesheet shall be submitted to the FMA for processing; a copy of the timesheet and service documentation shall be maintained by the case manager. This may be negotiated with the chosen FMA.

Timesheets (continued)

- Once received, the case manager shall review for discrepancies, including:
 - Duplicating time between employees or participants;
 - Unwarranted overtime;
 - Illegible or incomplete information;
 - Submission beyond prior authorization limits; and
 - Service documentation that does not match the time worked or information on the Person Centered Service Plan;

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

Documentation/Information Must Be Printed & Employees Are Responsible For Completing Service Documentation

Participant Name/ID #: _____

Employee Name & ID #: _____

For each date of service please outline: 1) A full description of the activities provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

Documentation/Information Must Be Printed & Employees Are Responsible For Completing Service Documentation

Participant Name/ID #: _____

Employee Name & ID #: _____

For each date of service please outline: 1) A full description of the activities provided that covers the entire shift; and 2) Evidence of training or service that supports the outcomes in the Plan of Care.

Date Service Provided (MM/DD/YY)	
11/04/15	<p>We started with a shower. Steve required multiple prompts, but did not have his usual verbal outbursts. Once he was done, we decided on what he wanted to do. He pointed at some candy, but I asked him if he wanted some breakfast and he said yes, so we cooked, he ate, and we cleaned up. After finishing he heard the animals outside and wanted to pet them, so we went and I showed him how to feed the animals with the cup. He got a little carried away petting and the amount of food, but we talked about how to feed and pet properly with each animal and I did some model behavior with him. He seemed to catch on to what I was saying.</p>
11/04/15	<p>I asked Steve if he wanted to help with dinner and he said yes. He was willing to mix ingredients and pour into the pan, but he's still scared of the oven. I showed him how to check for heat before touching but he is too afraid to try. We ate and he did well to put dishes in the dishwasher, no prompts. This part seems easy for him now.</p>
11/06/15	<p>We started with a shower. Must have been bad timing because he had his outbursts. He took his shower after about 45 minutes. I tried distractions, planning for the day, and importance of hygiene repeatedly but he didn't respond well. Once finished he went back to his room and watched tv. For lunch he wanted a burger from Hardee's but I was able to convince him to choose Subway. He didn't show any negative actions with changing his decision.</p>
11/07/15	<p>Came in for Respite. Steve was pretty grouchy. May not have been happy his brother wasn't there. I tried to distract him with the animals outside, and it worked for a while. He was willing to take a walk to mailbox and back, then he wanted to pick up twigs in the yard. Once he finished he went through his baseball cards and ate a snack.</p>
11/08/15	<p>I took Steve to church to meet with the members of the adopt-a-highway program. He was happy to see the folks again and ready to hit the road. He's got the steps down for getting prepared and how to ask for help when things are too big to pick up. I talked more about Steve with 3 members today. We talked about triggers for behaviors again; they seem to be warming up to Steve and feel like Steve understands some of the more simple conversations. He was worn out when he got back.</p>

More about timesheet submissions

- As discrepancies may be discovered and identified with the participant/representative, employees may dispute hours submitted with their employer; should this occur, the parties may need to seek the assistance of the state Department of Labor for resolution.
- Should submissions be received that the case manager cannot verify, then the employer may be responsible for payment of those employees.

The Plan of Care



On the MAP 530

- When requesting a service for PDS, select the service that has a code with the **HI** modifier;
- As the service is created, employees may be added underneath the service intended to provide;
- The employee with the highest wage should be listed first, as this helps cue what the highest rate should be requested;

On the MAP 530

- Configure your unit rate with the highest wage plus employer taxes to ensure total coverage; and
- The service requested should list the total units of all employees projected to work in a given service.
- The Participant Summary is utilized to generate Emergency Back Up plan information, along with all other gathered pertinent knowledge to the participant.

Create Draft Plan Section

Create Draft	Create Draft Plan *=-Required field
View Plan Details	
Goals	Waiver Program: Supports for Community Living
Service Details	Category Of Plan: Initial
Non-Waiver Program	* Proposed Start Date (MM/DD/YYYY): <input type="text"/>
Service Summary	Level Of Care End Date (MM/DD/YYYY): 07/07/2016
Upload Documents	* Select the Route: <input type="text" value="--Select--"/> <input type="button" value="v"/>
Submit Plan	<input type="button" value="Cancel"/> <input type="button" value="Create Draft"/>

View Plan Details Section

- Create Draft
- View Plan Details**
- Goals
- Service Details
- Non-Waiver Program
- Service Summary
- Upload Documents
- Submit Plan

View Plan Details

Plan: **Supports for Community Living**

Plan Status: **Draft**

Proposed Start Date (MM/DD/YYYY): 07/08/2015
Level Of Care End Date (MM/DD/YYYY): 07/07/2016

Plan Components	Last Changed Date	Last Changed User	Last Changed User Title
Goals			
Service Details			
Non-Waiver Program			

Overall Comments

Reset Save Next ▶

Note: Use the Quick Launch - Accompanying Data and Document menu link to add information such as Individual Narrative, Functional Information, Medical Information and Health and Safety Information.

Goals Section

Create Draft

View Plan Details

Goals

Service Details

Non-Waiver Program

Service Summary

Upload Documents

Submit Plan

Goals *-=Required field

Plan: **Supports for Community Living**

Plan Status: **Draft**

Select	Goals	Objectives	Last Update

[View/Edit](#) [Add](#) [Delete](#)

[◀ Back](#)[Next ▶](#)

Service Details Section

Create Draft

View Plan Details

Goals

Service Details

Non-Waiver Program

Service Summary

Upload Documents

Submit Plan

Service Details *=-Required field

Plan: **Supports for Community Living**

Plan Status: **Draft**

Select	Service Name	Setting	Service Start Date	Service End Date	Total Prior Authorized Units/Frequency	Provider Number	Status	Prior Authorized Date
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< >

[View/Edit](#) [Delete](#) [Associate Provider](#) [Add](#) [Current PA Information](#)

Total Plan Of Care Cost Requested: \$0

Total Participant Directed Service Cost: \$0

Total Traditional Services Cost: \$0

[◀ Back](#) [Next ▶](#)

Non-Waiver Program Section

Create Draft	Non-Waiver Program *=-Required field
View Plan Details	
Goals	Plan: Supports for Community Living
Service Details	Plan Status: Draft
Non-Waiver Program	<p>* Does the Individual Receive Non-Waiver Services?: <input type="radio"/> Yes <input type="radio"/> No</p>
Service Summary	◀ Back Next ▶
Upload Documents	
Submit Plan	

Service Summary Section

Create Draft	<h2>Service Summary</h2> <p>Plan: Supports for Community Living</p> <p>Plan Status: Draft</p> <p>Total Cost</p> <p>Total Plan Of Care Cost Requested: \$0</p> <p>Total Participant Directed Service Cost: \$0</p> <p>Total Traditional Services Cost: \$0</p> <p>Non-Waiver Services</p> <table border="1"><thead><tr><th>Non-Waiver Program</th><th>Service</th></tr></thead><tbody><tr><td colspan="2">No Non-Waiver services are added.</td></tr></tbody></table>	Non-Waiver Program	Service	No Non-Waiver services are added.	
Non-Waiver Program		Service			
No Non-Waiver services are added.					
View Plan Details					
Goals					
Service Details					
Non-Waiver Program					
Service Summary					
Upload Documents					
Submit Plan					

◀ Back **Next ▶**

Upload Documents Section

Create Draft

View Plan Details

Goals

Service Details

Non-Waiver Program

Service Summary

Upload Documents

Submit Plan

Upload Documents *=-Required field

Plan: **Supports for Community Living**

Plan Status: **Draft**

What is Needed	Types of Document Accepted
*POC Documents Verification	OTHER, Person Centered Employment Plan, Long Term Support Plan, Positive Behavior Plan, Therapy Treatment Plan, MAP-350, Life Story, Family Friendly Support Profile Form, MAP-530, MAP-531, POC Sign In Sheet, SCL Exceptional Supports Fax Form, SCL Exceptional Supports Approval, MAP-532 Approval, Participant Summary

Document Summary

Document Type	Date	Comments	Action
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Document Upload Section

Document Type

--Select--

File

[Browse](#)

Supported file Types: *.PDF, *.TIFF and *.TIF
only Maximum File size must not exceed 2 MB

Comments

[Attach Another Document](#)

Submit Plan Section

Create Draft	<h2>Submit Plan * = Required field</h2> <div style="border: 1px solid gray; padding: 5px; margin-bottom: 10px;"> <p>Plan: Supports for Community Living</p> <p>Plan Status: Draft</p> </div> <p>Waiver Program: SCL</p> <p>Category of Plan: Initial</p> <p>Proposed Start Date (MM/DD/YYYY): 07/08/2015</p> <p>Level Of Care End Date (MM/DD/YYYY): 07/07/2016</p> <p>* Individual has given approval to share plan: <input type="radio"/> Yes <input type="radio"/> No</p> <p>* Individual, Authorized Representative, and/or Legal Guardian has signed the Plan signature sheet <input type="radio"/> Yes <input type="radio"/> No</p> <p>* The Case Manager has signed the Plan Signature Sheet: <input type="radio"/> Yes <input type="radio"/> No</p> <p>* This is to certify that the Individual/Legal Representative have been informed of waiver services. Consideration for waiver program as an alternative to institutional placement is requested: <input type="radio"/> Yes <input type="radio"/> No</p> <p>* The Individual understands that under the waiver programs, they may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services: <input type="radio"/> Yes <input type="radio"/> No</p> <p>* Please indicate if you would like the Case Supervisor to review the Plan: <input type="radio"/> Yes <input type="radio"/> No</p> <p>E-Signature</p> <p>Provide an electronic signature to certify responses are accurate and correct.</p> <p><input type="checkbox"/> * I certify that I have made an informed choice when selecting the providers/employees to provide each service.</p> <p>* Case Manager First Name <input type="text"/> Case Manager Middle Initial <input type="text"/> * Case Manager Last Name <input type="text"/> Suffix <input type="text" value="--Select--"/></p> <p>* Individual's First Name <input type="text"/> Individual's Middle Initial <input type="text"/> * Individual's Last Name <input type="text"/> Suffix <input type="text" value="--Select--"/></p> <p style="text-align: center;"> <input type="button" value="Back"/> <input type="button" value="Submit Plan"/> </p> <p><small>Note: Use the Quick Launch - Accompanying Data and Document menu link to add information such as Individual Narrative, Functional Information, Medical Information and Health and Safety Information.</small></p>
View Plan Details	
Goals	
Service Details	
Non-Waiver Program	
Service Summary	
Upload Documents	
Submit Plan	

Tips for goals and objectives

- In drafting, the case manager should focus more on the frequency of need vs. the frequency of provision; the latter lends more toward joint employment status.
- Consider designing agreed upon person centered goals that do more than just 'provide care'; the 'how' of fulfilling needs can go much further into justifying longer shifts.

Tips for goals and objectives

- While the SIS reveals needs for the participant, the Narrative and Life Story are to be utilized first in structuring goals.
- Needs identified through the SIS may be relayed into the ‘What others need to know or do to support me and help me to stay healthy and safe’ section.
- ‘Important to’, ‘Important for’, and What others need to know or do to support me and help me to stay healthy and safe’ should be the primary source for goal development.

Case Management and Contacts

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Case Management Role

- Case Managers shall initiate, coordinate, implement, and monitor processes/services;
- Identify arrange, and facilitate team meetings;
- Develop, update and monitor the plan of care;
- Assist and promote choices;
- Conduct monthly face to face meetings;
- Ensure the overall health, safety, and welfare of the participant;
- Gather information to compile monthly summaries; and
- Serve as liaison for the participant and Financial Management Agency service provider (FMA).

Case Management Role (continued)

- Upon introduction to PDS, a Case Manager would provide the participant with an overview of the participant's role of being an employer of record; this shall include:
 - Determining potential employees;
 - Developing and maintaining employment scheduling;
 - Negotiating wages;
 - Providing job descriptions for employees;
 - Evaluation of employee performance;
 - Outlining disciplinary actions, and;
 - Termination of employment as necessary.
- The Case Manager shall provide the participant with option to choose from available FMA serving their region.
- Participant needs to complete employer tax forms associated with this responsibility; these will be provided by your FMA.

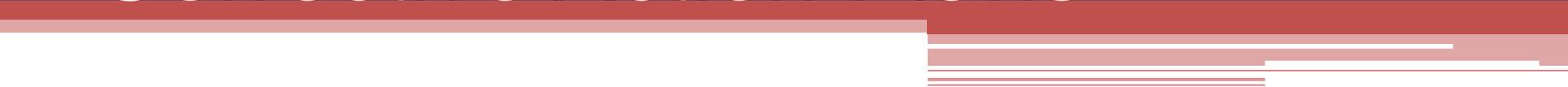
Case Management Role (continued)

- The Case Manager shall provide and explain the employee packet to the participant. The packet contains:
 - Required background checks;
 - Provider contract;
 - Policies and procedures of the FMA;
 - Payroll processes;
 - Timesheet, and;
 - Process for meeting employee training and screening requirements.
- As employees are chosen, the case manager shall submit each employee on the Plan of Care with negotiated wages and anticipated total units utilized for Prior Authorization.
- Once results are obtained from the screenings and background checks results, the Case Manager will ensure that each employee has met the regulation requirements.

Case Management Monthly Contacts

- When visiting a participant, a Case Manager would need to review program utilization with the participant (and representative if applicable) to ensure the Plan of Care and services are appropriate.
- This visit can occur at any site where other services are conducted.
- Documentation of the visit must be provided on the Focus Tool provided by DDID.

Corrective Action Plans

A decorative graphic consisting of a thick red horizontal bar that spans the width of the slide. Below this bar, on the right side, there are several thin, parallel horizontal lines in a lighter red or pinkish color, creating a stepped or layered effect.

Non-Compliance

- Participants, team members, or employees may be considered a focal point when developing a Corrective Action Plan (CAP).
- Anytime a participant's health, safety, or welfare is jeopardized, a CAP should be initiated to provide a formal attempt to address any significant issue(s).
- This must be completed before proceeding to remove a service, employee, or participant from PDS.

What to Include in CAPs

Complete DAIL CAP form:

- Identify the problem/state the issue: Who, What, Where, When, How Often;
- Identify which administrative regulation and/or agency, DAIL, DBHDID, or other policy violated;
- Establish an agreed upon resolution allowing consumer at least thirty (30) but no more than ninety (90) days to resolve problem;

What to Include in CAPS (continued)

- Identify potential consequence(s) for repeated offense(s);
- Establish prevention mechanisms; and
- Dates and signatures of consumer/representative, any other parties involved, and case manager.

Participant Directed Services Corrective Action Plan

Participant:

Guardian:

Case Manager:

State Issue:

Regulation/Policy Violation:

Agreed Upon Resolution:

Potential Consequences:

Prevention:

If Issue stated in Corrective Action Plan is not resolved within _____ days from the date of signature, possible termination from Participant Directed Services may be pursued. Failure to reach an agreed upon resolution may result in request for termination from Participant Directed Services.

Participant Signature:

Date:

Guardian signature:

Date:

Representative Signature:

Date:

Case Manager Signature:

Date:

Fraud and Exploitation

A decorative graphic consisting of a solid red horizontal bar that spans the width of the slide. Below this bar, on the right side, there are several horizontal lines of varying lengths and colors, including red and white, creating a stepped or layered effect.

Keeping Your Eyes and Ears Open...

- While pretty seldom in comparison, instances where employees trying to take advantage of the participant in this program can occur. Signs of fraudulent or exploitive behavior can include but not be limited to:
 - Other team members looking to dictate how, where, when, or who are carrying out services;
 - Submitting questionable times when realizing the participant's routine;
 - Handwriting for signatures looking different;

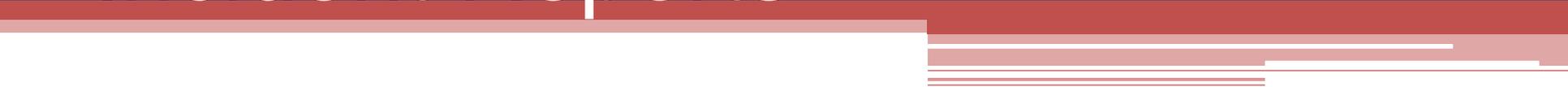
Keeping Your Eyes and Ears Open...

- Noticing subtle differences in how certain team members interact with each other;
- Being unusually persistent for the number of hours and wages assigned to an employee;
- Conversation revealing spending habits with the participant; and
- Repeated disregard for regulation and program parameters.

Getting to Investigative Processes

- Always feel free to report any alleged activities to the Office of Inspector General (OIG);
- Consult with DAIL so dynamics of the situation can be explored, as DAIL has worked closely with OIG on multiple cases; and
- Being advised of what to submit for investigation.

Incident Reports



Incident Reports

- Any Incident Reports may be initiated by the Case Manager or by the employee; this depends on who discovers the incident.
- As an incident is reported to the Case Manager, this shall be considered the discovery of the incident.
- Submission for Incident Reports to DDID shall follow the same format as an incident occurring through a traditional service.
- DAIL does not require a copy of the report.

Upon Release 5 for MWMA

- Incident reports may be generated by employees, providers, or case managers.
- While housed within MWMA, only employees or providers who have created incident reports may view what he/she has created; case managers and case manager supervisors may view all incidents generated on a participant.
- Case managers must complete follow up reports for any incident reports generated through PDS.

Name: GRAPE, EVGENI MAID: N/A Enrolled Program: HCB Case #: 100022743 [Quick Launch](#)

Incident ID: 1047 Report: Incident Report Report Status: In Progress Incident Status: In Progress Classification:

[Individual Information](#)[Provider Information](#)[Incident Details](#)[Incident Categories](#)[Incident SubCategories](#)[Sub Category Questions](#)[Document Upload](#)

Reporting Provider Information

***=Required field**

Reporting Provider Details

Provider Number : 9 Reporter : David McQueary
Traditional/PDS : Traditional Provider Name : Hearts of Kentucky, LLC
Physical Address: 00 CPMU QYNMD HFDR Mailing Address: N/A
OQCWYTYST KY 40601
Phone Number : 9999999999
Fax Number : 9999999999
Email Address : STERY@gmail.com
Provider Staff Name (s) Involved :

* Did you witness this incident: YES NO

Responsible Provider Information

*Provider:

[◀ Back](#)[Next ▶](#)

Name: GRAPE, EVGENI MAID: N/A Enrolled Program: HCB Case #: 100022743 Quick Launch

Incident ID: 1047 Report: Incident Report Report Status: In Progress Incident Status: In Progress Classification:

- Individual Information
- Provider Information
- Incident Details**
- Incident Categories
- Incident SubCategories
- Sub Category Questions
- Document Upload

Incident Details

***=Required field**

* Location :

If Other, Specify:

Address Line 1

Address Line 2

City State Zip Code Zip +4 County

Incident Details

* What happened immediately before incident :

* Describe the incident that took place :

* What happened immediately after the incident :

Was another peer involved :

YES

NO

Date and Time Guardian was notified :

 --Select--

Date and time Physician was notified :

 --Select--

Date and time Case Manager was notified :

 --Select--

Date and time DCBS was notified :

 --Select--

Comments :

◀ Back

Save & Exit

Next ▶

Name: **GRAPE, EVGENI**

MAID: N/A

Enrolled Program: HCB

Case #: 100022743

[Quick Launch](#)

Incident ID: 1047
 Report: Incident Report
 Report Status: In Progress
 Incident Status: In Progress
 Classification:

[Individual Information](#)
[Provider Information](#)
[Incident Details](#)
[Incident Categories](#)
[Incident SubCategories](#)
[Sub Category Questions](#)
[Document Upload](#)

Incident Categories

 *=**Required field**

* Date and Time of Discovery : 08/18/2015 09:00 PM

* Level of Supervision at time of incident : 1:1 Staffing

Select	Incident	Date and Time Occurred
<input type="checkbox"/>	Behavior	
<input type="checkbox"/>	Confidentially Breach	
<input checked="" type="checkbox"/>	Death	08/18/2015 09:00 PM
<input type="checkbox"/>	Elopement	
<input type="checkbox"/>	Environmental	
<input type="checkbox"/>	Fall	
<input type="checkbox"/>	Illness/Injury	
<input type="checkbox"/>	Medication	
<input type="checkbox"/>	Public Health Concerns	

<input type="checkbox"/>	Restraint	
<input type="checkbox"/>	Seizure	
<input type="checkbox"/>	Suicide	
<input type="checkbox"/>	Suspected Abuse	
<input type="checkbox"/>	Suspected Exploitation	
<input type="checkbox"/>	Suspected Neglect	

[◀ Back](#)

[Save & Exit](#)

[Next ▶](#)

Name: GRAPE, EVGENI MAID: N/A Enrolled Program: HCB Case #: 100022743 [Quick Launch](#)

Incident ID: 1047 Report: Incident Report Report Status: In Progress Incident Status: In Progress Classification:

Individual Information

Provider Information

Incident Details

Incident Categories

Incident SubCategories

Sub Category Questions

Document Upload

Incident Sub Categories *=**Required field**

Death

Death was: Unexpected Expected

[◀ Back](#)

[Save & Exit](#)

[Next ▶](#)

Name: **GRAPE, EVGENI**

MAID: N/A

Enrolled Program: HCB

Case #: 100022743

[Quick Launch](#) ▼

Incident ID: 1047

Report: Incident Report

Report Status:

In Progress

Incident Status:

In Progress

Classification:

Individual Information

Provider Information

Incident Details

Incident Categories

Incident SubCategories

Sub Category Questions

Document Upload

Incident Sub Category Questions

* = Required field

Death

Suspected Cause Of Death :

Autopsy Performed :

 YES NO

Existing DNR(Do Not Resuscitate) :

 YES NO

If No, was CPR/Heimlich Performed :

 YES NO

If No, why was CPR/Heimlich not performed :

Was 911 Called :

 YES NO

Death - Unexpected

Recent Illness :

 Yes No Unknown

Type Of Illness :

[◀ Back](#)[Save & Exit](#)[Next ▶](#)

Name: GRAPE, EVGENI MAID: N/A Enrolled Program: HCB Case #: 100022743 [Quick Launch](#)

Incident ID: 1047 Report: Incident Report Report Status: In Progress Incident Status: In Progress Classification:

- Individual Information
- Provider Information
- Incident Details
- Incident Categories
- Incident SubCategories
- Sub Category Questions
- Document Upload**

Document Upload

What is Needed	Types of Document Accepted
Supporting Incident Documentation	List of Current Medications, MAR (Medication Administration Record), Staff Notes, Coroners Report, Incident Supporting Document

Document Summary

Document Type	Date	Comments	Action
---------------	------	----------	--------

Document Upload Section

Document Type

File
 [Browse](#)
Supported file Types: *.PDF, *.TIFF and *.TIF
only Maximum File size must not exceed 2 MB

Comments

[Attach](#)

[Attach Another Document](#)

[← Back](#)

[Save & Exit](#)

[Submit](#)

Incident Follow Up Screenshots

DRAFT

Name: [GRAPE, EVGENI](#)

MAID: N/A

Enrolled Program: HCB

Case #: 100022743

[Quick Launch](#)

Incident ID: 1047 **Report:** Follow-Up Report (Case Manager) **Report Status:** In Progress **Incident Status:** In Progress **Classification:** 3

Incident Details[Provider Actions Taken](#)[Incident Categories](#)[Incident Sub Categories](#)[Sub Category Questions](#)[Document Upload](#)**Incident Details**

What happened immediately before incident :

test

Describe the incident that took place :

test

What happened immediately after the incident :

test

Comments about Incident:

[◀ Back](#)[Save & Exit](#)[Next ▶](#)

Name: [GRAPE, EVGENI](#) MAID: N/A Enrolled Program: HCB Case #: 100022743[Quick Launch](#)

Incident ID: 1047 Report: Follow-Up Report (Case Manager) Report Status: In Progress Incident Status: In Progress Classification: 3

[Incident Details](#)[Provider Actions Taken](#)[Incident Categories](#)[Incident Sub Categories](#)[Sub Category Questions](#)[Document Upload](#)

Actions Taken

*Required field

Date and Time of Discovery : 08/18/2015 12:00 PM

Date and Time Guardian was notified : Not Applicable

Date and time Case Manager was notified : Not Applicable

Date and time Physician was notified : Not Applicable

Date and time DCBS was notified : Not Applicable

* Was everyone notified by required deadlines? YES NO

Follow-Up Findings

* What is the person's current status? (Choose one) :

- Stable with no serious changes noted
- Seen by professional and returned home
- Seen by professional and admitted to facility
- Other. Briefly describe

* Why did the critical incident occur? (Choose one) :

- Failure to follow crisis support plan and/or behavior support plan
- Unable to determine
- Other. Briefly describe

* Could this critical incident have been prevented? YES NO

* Were staff training needs identified? YES NO

* Identify needed changes to prevent similar critical incidents. (Choose one):

- Watch more for advance signs of and triggers for the incident
- Team meeting
- Improve communication within the agency and between agencies
- Agency process/procedures improvements
- Other. Briefly describe

Comments:

◀ Back

Save & Exit

Next ▶

Name: **GRAPE, EVGENI**

MAID: N/A

Enrolled Program: HCB

Case #: 100022743

[Quick Launch](#)

Incident ID: 1047

Report: Follow-Up Report
(Case Manager)Report
Status:

In Progress

Incident
Status:

In Progress

Classification: 3

[Incident Details](#)[Provider Actions Taken](#)[Incident Categories](#)[Incident Sub Categories](#)[Sub Category Questions](#)[Document Upload](#)

Incident Categories

*=**Required field**

* Date and Time of Discovery : 08/18/2015 09:00 PM

* Level of Supervision at time of incident : 1:1 Staffing

* Incident

Select	Incident	Date and Time Occurred
<input type="checkbox"/>	Behavior	
<input type="checkbox"/>	Confidentially Breach	
<input checked="" type="checkbox"/>	Death	08/18/2015 09:00 PM
<input type="checkbox"/>	Elopement	
<input type="checkbox"/>	Environmental	
<input type="checkbox"/>	Fall	
<input type="checkbox"/>	Illness/Injury	
<input type="checkbox"/>	Medication	
<input type="checkbox"/>	Public Health Concerns	

<input type="checkbox"/>	Restraint	
<input type="checkbox"/>	Seizure	
<input type="checkbox"/>	Suicide	
<input type="checkbox"/>	Suspected Abuse	
<input type="checkbox"/>	Suspected Exploitation	
<input type="checkbox"/>	Suspected Neglect	

Comments :

◀ Back

Save & Exit

Next ▶

Name: [GRAPE, EVGENI](#)

MAID: N/A

Enrolled Program: HCB

Case #: 100022743

[Quick Launch](#) ▾

Incident ID: 1047 **Report:** Follow-Up Report (Case Manager) **Report Status:** In Progress **Incident Status:** In Progress **Classification:** 3

[Incident Details](#)[Provider Actions Taken](#)[Incident Categories](#)[Incident Sub Categories](#)[Sub Category Questions](#)[Document Upload](#)

Incident Sub Categories

*=**Required field**Death was: Expected Unexpected[◀ Back](#)[Save & Exit](#)[Next ▶](#)

Name: GRAPE, EVGENI

MAID: N/A

Enrolled Program: HCB

Case #: 100022743

[Quick Launch](#)

Incident ID: 1047 Report: Follow-Up Report (Case Manager) Report Status: In Progress Incident Status: In Progress Classification: 3

[Incident Details](#)[Provider Actions Taken](#)[Incident Categories](#)[Incident Sub Categories](#)[Sub Category Questions](#)[Document Upload](#)

Incident Sub Category Questions

*Required field

Suspected Cause Of Death :

Autopsy Performed :

 YES NO

Existing DNR(Do Not Resuscitate) :

 YES NO

Was 911 Called :

 YES NO

Recent Illness :

 Yes No Unknown

Type Of Illness :

[◀ Back](#)[Save & Exit](#)[Next ▶](#)

Name: **GRAPE, EVGENI** MAID: N/A Enrolled Program: HCB Case #: 100022743 Quick Launch

Incident ID: 1047 Report: Follow-Up Report (Case Manager) Report Status: In Progress Incident Status: In Progress Classification: 3

- Incident Details
- Provider Actions Taken
- Incident Categories
- Incident Sub Categories
- Sub Category Questions
- Document Upload**

Document Upload is mandatory for Death category.

Document Upload

What is Needed	Types of Document Accepted
*Supporting Incident Documentation	List of Current Medications, MAR (Medication Administration Record), Staff Notes, Coroners Report, Incident Supporting Document

Document Summary

Document Type	Date	Comments	Action

Document Upload Section

Document Type

--Select--

File

Browse

Supported file Types: *.PDF, *.TIFF and *.TIF only Maximum File size must not exceed 2 MB

Comments

Text input field for comments

Attach

Attach Another Document

Back

Save & Exit

Submit

- <http://www.lexingtonfamily.com/resources/exceptional-family/>

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