Supports for Community Living Waiver

Participant Directed Services

Provider Handbook

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Introduction

The Supports for Community Living (SCL) Waiver Participant Directed Services (PDS) allows participants who are eligible for services the ability to choose their own providers for non-medical waiver services. PDS gives participants flexibility in the delivery and type of services they receive by placing the participant in charge of directing services and managing a plan of care based on the authorized service care needs. PDS also allows participants to access other waiver services to purchase goods and services that are necessary to help them continue to live independently in their home and community. PDS is a Medicaid funded program; therefore, adherence to both federal and state program rules is required.

The regulatory language associated with the facilitation of PDS services for each waiver may be found in the following Kentucky Administrative Regulations (KAR):

907 KAR 12:010	New Supports for Community Living Waiver Services (SCL) and Coverage Policies; and
907 KAR 12:020	Reimbursement for New Supports for Community Living Waiver Services.

The language outlined in KAR supersedes the language outlined in the PDS Handbook. In order to ensure that the current version of the regulation is being followed, it is imperative that case management and financial management staff check the following Kentucky Legislative Research Commission (LRC) website (**http://www.lrc.ky.gov/kar/TITLE907.HTM**) and follow the current regulation language for each waiver program.

Principles

PDS differs from traditional waiver approaches in that the participant is in charge of determining available services, scheduling, employing, terminating, and evaluating the usefulness of the services, rather than a traditional agency or case manager. PDS is not for everyone, because not everyone is willing or able to manage all of the requirements or have a trusted representative to manage all the tasks for them. The goal of the PDS model is to offer participants the ability to direct services that most appropriately meet their needs, using person-centered planning principles, in order to remain living in the community. The following PDS and person-centered planning principles are essential to the model.

PDS Principles:

- Reflects the belief that individuals, when given the opportunity to choose the service(s) he/she will receive and direct some or all of them, will exercise his/her choice in ways that maximize their quality of life.
- Includes person-centered planning principles to ensure the participant is making personal choices for the spending of the Medicaid waiver allocation based on his/her needs and goals.
- Provides one option among several service delivery models, and must be available for all participants who choose the option.

- Provides a flexible, individualized budget based on unit authorization the participant decides regarding services that assist him/her meet their community support needs and enhance his/her ability to live in the community by -
  - ✓ Allowing the participant to use his/her individually designed plan of care to choose and directly hire employees to provide the services; and
  - ✓ Allowing the participant to use his/her individualized budget to purchase goods, supplies, or other items to meet community support needs.

- Allows the participant to designate a representative to help him/her with making decisions and managing his/her services.
- Provides a system of supports to assist the participant in developing and managing his/her plan of care; fulfill the responsibilities of an employer, which include managing units authorized for workers he/she hires; and obtain and pay for other services and goods.
- Obtains feedback from participants, representatives, and family members (when appropriate), as well as data from support service providers to continuously improve the program.

Person-Centered Planning Principles:

Person-centered planning principles are the cornerstone of quality service, and shall be used to guide interactions and supports for PDS participants.

Person-centered planning supports for individuals with disabilities will -

- Ensure dignity and respect for each person as a valued individual.
- Be entitled to the rights, privileges, opportunities, and responsibilities of community membership.
- Be supported and encouraged to develop personal relationships, learning opportunities, work and income options, and worship opportunities as full participants in community life.
- Be based on individually determined goals, choices, and priorities.
- Be easily accessed and provided regardless of the intensity of individual need.
- Be afforded the opportunity to direct the planning, selection, implementation, and evaluation of their services.
- Require that funding be flexible and cost effective and make use of natural, generic, and specialized resources.
- Be the primary decision makers in their own lives.
- Be evaluated based on outcomes for individuals.

The work we do and the way we work will -

- Ensure that all persons have dignity and value, and are worthy of respect.
- Provide safeguards to ensure personal security, safety, and protection of legal and human rights.
- Be coordinated on person-centered and family-centered principles, focusing on individual needs, strengths, and choices.
- Support that all people have strengths and abilities and are the primary decision-makers in their lives.
- Provide information and supports that promote informed decision-making.
- Be accessible and culturally responsible.

- Access informal and generic community resources whenever possible in the most integrated community setting appropriate to the person.
- Be based on best practice, and utilize state-of-the-art skills and information.
- Be directed toward the achievement of interdependence, contribution, and meaningful participation in the community.
- Distribute resources in an equitable manner according to the individual need and comply with requirements governing public funds administered by the system.

Organizational and Structural Administration

The Department for Medicaid Services (DMS) has authorized the Department for Aging and Independent Living (DAIL) to administer PDS, in conjunction with Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID). DAIL is responsible for the day-to-day operation of PDS at the state level, while additional roles associated with the model are fulfilled as follows:

A. **Area Development District (ADD).** DAIL has provider agreements with participating ADDs to provide the financial management components of the PDS service delivery system.

B. **Community Mental Health Center (CMHC).** DAIL has provider agreements with participating CMHCs to provide the financial management components of the PDS service delivery system.

A list of these agencies is provided in Appendix A.

C. A **Participant** is an individual who meets the Level of Care eligibility and financial requirements of the 1915c waiver (SCL). The individual shall become an employer of record, whereas the individual shall oversee recruiting, hiring, negotiating working hours, wages, and job duties, evaluating performance, and termination of employees. The individual shall also be responsible for communicating the status of PDS operations and providing appropriate documentation to the case manager. The individual must have the ability to self-direct his/her own care and understand the rights, responsibilities, roles, and risks of managing his/her own care, or if the individual is unable to make his/her decisions independently, he/she can designate a representative to do so for him/her.

D. A **Representative** is appointed if the participant is unable to make decisions independently. The participant, the case manager, or the participant's team may request a representative be named to provide PDS oversight of **all** services. A state guardianship worker may serve as a designated representative, but is not required to serve in this capacity.

The representative:

- Must be willing to serve in this capacity and understand the rights, responsibilities, roles, and risks of managing the care of the participant;
- Shall not be monetarily compensated for serving as a representative;
- Shall have no vested interest in any agency that may provide a waiver services;
- Shall not provide any PDS service to the participant appointed for;
- Be willing to comply with all criteria and responsibilities of the participant;

- Agree to assist the participant with managing the benefit total based on the participant's plan of care and support spending plan; and
- Obtain approval from the participant or team members to serve in this capacity.

The designation of a Representative is documented on the Rights, Risks, and Responsibilities form is provided in Appendix B.

E. **Medicaid Agency Provider.** Agencies approved through an application process to provide Medicaid funded services. A list of Medicaid providers specific to the aforementioned waiver include:
   1. Adult Day Healthcare Centers
   2. Community Mental Health Centers
   3. Area Agencies on Agency and Independent Living
   4. SCL Approved Providers

F. **Quality Improvement Organization (QIO).** Medicaid contracts with a QIO to determine level of care, as well as approve and prior authorize services requested on the plan of care of the participant. This entity is also known as Carewise Health.

Relationship between Traditional Option and PDS

The traditional option for services within the SCL waiver consists of a participant in need of a service(s) consulting with a professional either from an agency who can provide a given service(s), his/her case manager, or a representative from one of the departments who administer the waiver, who has the authority to request the amount of units necessary to provide the participant for the agency selected to deliver that service at their discretion.

PDS allows the participant to have discretion, or management, over how, where, and when a service is delivered, and who will provide a service to the participant.

A waiver participant can also choose to use blended services. Blended services are defined as a non-duplicative combination of authorized waiver service(s) being provided pursuant to a participant's approved plan of care. When a participant chooses to use blended services, he/she receives some services from a traditional provider, while directing other services under PDS. Some services available under PDS may also be provided by a traditional agency; however, the services may not occur simultaneously, with exceptions to Community Guide and Community Access Group services. For example, a participant who has chosen and is approved to receive Day Training supports through the traditional provider may also hire a PDS employee to provide Day Training supports, however both providers cannot provide services at the same moment in time. In a Community Guide example, a Community Guide may be assisting the participant in learning how to oversee another employee who is providing Personal Assistance services.

Case Managers and Financial Managers

The state provides two distinct support services to assist participants in assuming their management responsibilities.

Case Manager

The case manager will help train, provide technical assistance, answer questions, coordinate services and community resources, monitor service(s), and assist in developing a person-centered plan of care (including safety plan and support spending plan). The training and technical assistance will help participants to be aware of any service limits, as well as provide guidance on recruiting, hiring, supervising, and firing employees. Case managers at a minimum, shall make a monthly face-to-face visit with the participant to assure service delivery is in accordance with the participant's plan of care and support spending plan, and is adequate to meet the participant's needs according to regulation. The face-to-face visit will also ensure the participant's health, safety, and welfare.

The case manager must also work closely with the financial management agency to ensure receipt of prior authorizations, forms necessary to initiate PDS monitor payment for service provisions and ensure they are within the scope of the plan of care, support spending plan, and prior authorization limits. Additionally, the case manager will complete or coordinate the review of a previously completed assessment/reassessment of participants for whom they are providing case management services. Any case management agency may be eligible to provide case management services for PDS participants.

Although all participating agency employees, including state level PDS staff, are available during most business hours to respond to participant inquiries, the case manager **shall** be the first level of contact with participants. The case manager must ensure the participant has appropriate contact information, for phone calls/emails when needed.

Prior to being offered employment or acting in a case manager role, a case manager must meet all requirements established in 907 KAR 12:010. Case managers may not provide any other direct service to a participant enrolled in PDS.

Financial Manager

The financial manager shall provide oversight with paying employer and unemployment compensation and any applicable local taxes, processing timesheets, reviewing records to ensure correctness, paying providers, and paying employees in accordance with the Fair Labor Standards Act, as well as any other local, state, and federal employment-related laws. Financial managers shall also provide case managers with employer and employee packets, which contain the necessary forms for operations within PDS. Financial managers must also provide case managers with accurate employer tax percentage rates in order to claim the appropriate dollars within billing parameters of a given service; this percentage rate shall be combined with wages for any employee providing a service to make a <u>gross billing</u> rate. *As an example*, a participant may negotiate a $12.00 per hour rate with an employee for Personal Assistance services. Next, the case manager would confirm with the FMA this rate is feasible with the billable maximums. The FMA will then apply the employer tax rate to the hourly wage, making it $13.41. Note: Employer tax rates vary by employer according to multiple circumstances, so not every percentage applied will be the same percentage across the state.

Financial managers shall not be a provider of services or supports other than financial management services to any participant enrolled in PDS. Financial managers cannot serve as the participant's designated representative. Financial managers must also adhere to Medicaid provider requirements established by DAIL, DMS, and DBHDID.

Assessments

Case managers shall compile information from multiple sources in order to lead conversations with the participant and the team in deciding how to best coordinate services; these include The Supports Intensity Scale (SIS), the Health Risk Screening Tool (HRST), Life Story, school records, diagnostic tools used by skilled professionals, and any other assessments or accounts of history of the participant. Once all needs, behaviors, and tendencies have been identified, the team can identify how to best meet the participant's needs in the plan of care, whether by supports designed through service definitions, or by those closest to the participant.

Plan of Care

As required for PDS by DAIL and DBHDID, it is the responsibility of the case manager to make sure a plan of care is completed for each participant within thirty (30) calendar days from the date of referral for PDS. A participant's plan of care is developed by the participant and their person centered team. It must be individualized to meet the participant's specific needs, identifying services and the objectives for those services needed to achieve the identified outcomes. All services or goods must reduce the need for personal care or enhance independence within a participant's home and community. The identified services will also include the total amount of hours (stated in units) needed, and all employees who will provide each service, with the highest paid employee at the top of each service listed. The wage listed for each employee must be stated at a gross billing rate. All services and supports whether or not funded through the Medicaid waiver must be reflected on the plan of care. The plan of care narrative should include details about natural supports used to meet the participant's needs. In order to be covered, a PDS service must be included in the plan of care using the SIS and/or other assessments as a guide. The hourly pay rate shall not exceed the fixed upper payment limits for PDS services in conjunction with the corresponding units of service unless approved through an Exceptional Rates Protocol request. The Exceptional Rates Protocol may be found in the 2012 Supports for Community Living Policy Manual, Appendix F. SCL reimbursement limits are found in 907 KAR 12:020, Section 3.

Safety Plan

The safety plan is also a required component of the participant's plan of care. It identifies who will be used to "back-up" the participant's employee(s) should an employee or other natural support become unavailable. It also should include directions on what the participant would like to be done when particular anticipated emergencies arise, such as what should occur if the participant has a seizure, falls, or has a behavior that might otherwise be harmful for the participant or other individual. The person who is responsible in the emergency event must be identified on the plan of care, and must be physically able to provide the needed services to the participant. This person can be paid or unpaid. Non-paid emergency back-up individuals are not required to meet any regulatory requirement of being an employee and, at a minimum, assure the health, safety, and welfare of the participant. Paid employees who only serve in a back-up

role must submit to and meet the regulatory requirements of an employee in order to serve as a back-up employee and must perform duties reflective of the service indicated on the timesheet.

The safety plan is an important component when considering what constitutes an emergency event that warrants justified overtime for an employee. Should either paid or non-paid relief be unavailable to the employee on a shift, overtime may be granted. Please note that DMS will only reimburse at regular wages only, and any requested overtime pay must be sought by the employee directly to the employer.

Incident Reporting Requirements

The state has a viable system by which it receives, reviews, and acts upon critical events or incidents. Kentucky Revised Statutes (KRS) 209 requires staff or any other person who has reason to suspect or has actual knowledge that a vulnerable child or adult has been abused, neglected, or exploited to report immediately upon discovery to the Department for Community Based Services (DCBS) Protection and Permanency office.

Case managers must make a report within the timeframe designated by the classification of each incident to DBHDID and to the Guardian (as required by 907 KAR 12:010, Section 6). All incidents shall include a complete written report of the incident investigation and follow-up. All incidents must be filed in a secured centralized location within the case management agency and made available upon request to state and federal entities as appropriate.

Employee Requirements

PDS participants are responsible for recruiting employees to provide direct services. This can be done through any number of sources, including any media outlet, word of mouth, or other sources.

An employment application for a participant is located in Appendix C.

The case manager may assist the participant if the participant and/or team are having difficulty locating candidates for employment. Once a candidate is identified, the case manager shall inform the participant of the following requirements:

Prior to employment starting:

1. A Provider Contract: This contract indicates the amount of wages an employee shall make before employee taxes are deducted. <u>This wage shall be slightly less than the gross billing rate</u>. This contract shall also indicate the service(s) the employee shall provide to the participant.

A copy of the Provider Contract is located in Appendix D.

2. A Criminal Record Check from the Administrative Office of the Courts (AOC), or an out-of-state equivalent if the candidate has resided in any other state in the last year. The results of this criminal record check must comply with the standards set forth in 907 KAR 12:010, section 3 (aa) and (bb).
3. A Central Registry Check, or an out-of-state equivalent if the candidate has resided in any other state in the last year. The results must show no substantiation of allegations on file. Note: The Central Registry Check may be completed up to thirty (30) days after employment begins.
4. A Nurse Aide Abuse Registry Check, from the Kentucky Board of Nursing (KBN), or an out-of-state equivalent if the candidate has resided in any other state in the last year. For checks completed through the KBN, this can be completed via website or by mail submission. For website submission, the results must show the person is not found to be on the register. **Note**: Website submission results must also show that the person's name has been run properly, through any current married name, maiden name, or alias. Names submitted on this website may return several results; there will be an icon to "validate selected" names in order to complete the background check. Should a name show as being on the register with substantiation, contact the KBN for further instructions.
5. Tuberculosis (TB) screening; any positive screening must be reassessed annually by a physician.
6. Drug screening; this screening must be at least a five (5) panel screening.

Within six (6) months of start date*:*

1. College of Direct Supports Training; each case manager agency has a sub-administrator who can set up an account for the candidate to complete the courses. This web-based training can occur on most electronic devices that have access to the internet.
2. Certified Pulmonary Resuscitation (CPR)/First Aid (FA) training; this training may be provided by any accredited agency and must be renewed before resuming direct services according to expiration date.
3. A participant may request an employee to complete additional training to ensure proper procedures/protocol for specific situations.

The form to indicate verification of additional training is located in Appendix E.

Personal Service Agencies (PSA)

Participants may utilize a PSA to provide services instead of an individual employee. A PSA may employ multiple personnel to provide services for any number of participants. The main purpose of a PSA is to provide services to an individual with an employee base to ensure a participant's needs are met. A PSA must be qualified through the Office of Inspector General (OIG) with a certification. Each employee must have the following completed in order to comply with certification requirements:

1. Criminal record check through the AOC or out of state equivalent;
2. Nurse Aide Abuse Registry or out of state equivalent;
3. TB screening; and
4. Drug screening.

Any and all employees who provide a service to a participant must complete the following in order to be a qualified provider of PDS:

1. Central Registry Check, within thirty (30) days of first shift completed with participant;
2. College of Direct Supports training, within six (6) months of first shift completed with participant;
3. Verification of CPR/FA training, within six (6) months of first shift completed with participant; and
4. Any additional training that the participant requires.

For existing employees during the transition, each employee shall have up to one (1) year to complete the College of Direct Supports and CPR/FA trainings.

Once an employee completes these requirements by the required timeframe, the case manager shall notify the financial management agency with an Eligible Employee Form, provided in Appendix F.

Services

SCL services promote personal choice and control over the delivery of waiver services by affording opportunities for participant direction. PDS *direct* services are specific non-residential, non-medical services and shall incorporate activities similar to those provided in the traditional waiver option such as adult day training, supported employment, personal assistance, respite, community access, and community guide. Other PDS services include goods and services, environmental accessibility adaptation, natural supports training, shared living, transportation, vehicle adaptation, case management, and financial management services.

Services and supports that facilitate independence shall be provided in the participant's home or in the community. To be covered, a PDS service shall be specified in a participant's plan of care. Reimbursement shall not exceed Medicaid's allowed reimbursement specified in the SCL payment regulation, 907 KAR 12:020.

Each service has a unique billing code under the waiver, and for a service that has been selected to be provided through PDS, the case manager and financial manager would denote an **HI** modifier after each billing code for PDS designation.

Community Access (Individual [97535 HI]) – Community Access provides the participant with an opportunity to connect with clubs, associations, and any other groups in the community at large, and become involved with a group's organization, function, and events/activities. The participant or the participant's team would identify what groups may be considered for this service, and the participant's employees for this service shall assist the participant in developing relationships with a group's members, along with seeking involvement from the group's members in assisting the participant to be a member of the group. Once these relationships have been forged, the case manager shall phase the service out of the plan of care, creating a lesser need on formal supports and a development of natural supports. Community Access Individual is to be provided on a one (1) to one (1) ratio, and shall not exceed forty (40) hours per week alone or in combination to community access group. Community Access services

shall not exceed sixteen (16) hours per day alone or in combination with Personal Assistance, employment hours worked in the community, and Day Training.

Community Access (Group [97537 HI]) – Community Access Group is designed to provide the same service as Community Access Individual, with the only service exception being that a participant may bring along another participant; services may be provided on a two (2) participants to one (1) employee ratio.

Community Guide (H2015 HI) – Community Guide services provide the participant with a mentor to assist with understanding the services available under the waiver and making decisions in how those services are delivered, knowing the responsibilities of being an employer, and developing the ability to manage an employee candidate through the employment process. Community Guide services should only be considered **if** the participant/team decides that the participant could benefit from the service and may be able to complete the tasks associated with this service independently. Community guide is limited to five hundred seventy six (576) fifteen (15) minute units per year. An employee providing Community Guide to a participant is not eligible to provide any other service to that same participant.

Day Training (DT) (T2021 HI) - DT services are intended to support the participation of participants in daily, meaningful, and valued routines of the community, which for adults may include work-like settings that do not meet the definition of supported employment. DT services include an emphasis of developing skills necessary for the transition from school to adult responsibilities; self-advocacy; adaptive and social skills; pre-vocation development; and community integration. The nature of these activities and outcomes should be age and culturally appropriate. The service expectation is to achieve the outcomes (goals) defined by each participant, as well as to attain and support participation in less restrictive settings. The training, activities, and routines established shall be meaningful to the participant and provide an appropriate level of variation and interest. The objectives are individualized and developed under the direction of the participant through the person-centered planning process, and is provided in accordance with the approved plan of care.

DT services are typically provided on a regularly scheduled basis, for no more than five days per week and exclude weekends. The hours must be spent in training and outcome related activities. DT services may be provided as an adjunct to other services included on a participant's plan of care. For example, a participant may receive Supported Employment or other services for part of a day or week and DT services at a different time of the day or week. DT services will only be billable for the time that the participant actually received a service.

Services provided in a variety of community settings that assist the individual in meeting the personal outcomes reflected in their approved plan of care may be included. The supports are an opportunity to access community-based activities that cannot be provided by natural or other unpaid supports, and are defined as activities designed to result in increased ability to access community resources. Any participant receiving DT services that are performing productive work that benefits an organization, or would be performed by someone else if not performed by the participant, must be compensated. Participants who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

Personal Assistance (T1019 HI) – Personal Assistance services are designed around the needs of the participant for personal hygiene tasks, household routine tasks, and/or community outings tasks, including medical appointments, which may involve observing, reminding, training, and/or hands-on assistance of these tasks. Personal Assistance is limited to sixteen (16) hours per day, alone or in combination with employment hours worked in the community, Day Training, and Community Access.

Respite (T1005 HI) - Respite care services shall be short term care that is provided in the absence of *or* to give relief to any individual providing care to the participant. Respite may be provided in the home or community. Respite is limited to 830 hours per calendar year, and not available to a participant receiving residential services.

Supported Employment (T2019 HI) – Supported Employment shall be services that enable a participant to engage in paid work which occurs in an integrated community setting with competitive wages and benefits commensurate to the job responsibilities. Long term support and follow-up is provided to maintain the job and continued success after the participant is fully integrated into the workplace and the Supported Employment Specialist is no longer needed on a regular basis. Supported Employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. Supported Employment is limited to forty (40) hours per week, and shall be provided on a one (1) to one (1) basis.

The following provides a brief summary of other services that may be participant directed:

Environmental Accessibility Adaptation (T2028 HI) – This service is available to participants who may be able to utilize equipment or adaptations to their home environment to lessen the need for physical assistance from others. A case manager shall ensure a vendor is in good standing with the Office of the Secretary of the Commonwealth of Kentucky pursuant to 30 KAR 1:010 and 30 KAR 1:020, and that all adaptations are provided within applicable state and local building codes. Examples of this service include the widening of a doorway, installation of a ramp or grab-bar, bathroom or other room modifications to accommodate needs, and electrical or plumbing installation that accommodates equipment necessary for the participant. Environmental Accessibility Adaptation is limited to $8,000 dollars per participant per lifetime.

Adaptations shall not be provided by an immediate family member, guardian, or legally responsible individual, not include any modification that has no direct medical or remedial benefit to the participant, not provide additional total square footage to a home unless necessary to complete the modification, and shall not be provided to a property owned by a provider.

Goods and Services (T1999 HI) – A participant may require certain items, services, or supplies that will promote inclusion into the community, reduce the need for other Medicaid services, increase the participant's safety in the home environment, and the participant does not have the funds to cover the costs of those goods or services. The good or service may not be considered experimental in nature. A participant may purchase goods and services within their budget that directly relate to the needs of the participant, interventions, and expected outcomes the participant has helped outline in their individualized plan of care. In order to be covered, any service or goods must be included in the plan of care and support spending plan, and be

approved by Medicaid. Examples may include assistive technology or assistive-type goods and services, incontinent supplies, and nutritional supplements. Goods and Services is limited to $1,800 dollars per plan of care year, and is not eligible for Exceptional Supports Protocols; any additional supplies necessary may be obtained through Specialized Medical Equipment.
It is the case manager's responsibility to ensure goods and services are purchased within the regulatory guidelines. The case manager should seek consultation from their supervisor who may also consult with state employees, if any questionable goods or services are requested or purchased by a participant.

Natural Supports Training (T2025 HI) – Natural supports training is a service to provide those who are currently providing unpaid supports to a participant, or those who wish to provide unpaid supports, with more information, instruction, and insight to a participant's particular routines, interests, coping mechanisms, and any other traits to someone in a caregiving role.

Natural supports training may not duplicate or occur simultaneously with any education or training provided through Occupational, Speech, or Physical Therapy services, Consultative or Clinical Therapy services, or Positive Behavior Supports services. This service shall also not include costs associated with travelling, meals, lodging, or attendance to training events or conferences shall not include paid caregivers, nor services or training events or conferences that are not related to the needs of the participant. An immediate family member, guardian, or legally responsible individual may not be a provider of training for natural supports. Natural Supports Training is limited to $1,000 per plan of care year.

Shared Living (T2032 HI) – Shared Living is considered an alternative to residential in which the participant may live with a caregiver, who provides unpaid supports to the participant in exchange for costs associated with room and board of the participant. The plan of care shall outline what needs the caregiver would provide to the participant, that may include assisting with the acquisition, retention, or improvement of skills associated with activities of daily living, or supervision required for safety or the social and adaptive skills necessary to enable the participant to reside safely in the home. These duties shall be outlined in the plan of care, specified in a contractual agreement between the participant and the caregiver, and complement other services the participant receives to enhance independence. Shared Living is limited to $600 dollars per month. A Shared Living caregiver shall meet the direct supports professional qualifications outlined in 907 KAR 12:010, Section 1. A caregiver may provide supports for up to two (2) participants in the same residence.

Transportation (T2003 HI) – Transportation service is designed for participants who would not otherwise access transportation through other formal services, or for whom services are not customarily available through natural supports. In residential services, Personal Assistance, Respite, and Community Access, transportation is a duty that may be associated with any objective that appropriately applies to fulfill an objective in the plan of care. Transportation is available to those who may not have access to agencies or employees for services. Participants shall utilize the Mileage Log to verify the delivery of the transportation service. Reimbursement for miles travelled shall not exceed two thirds (2/3) of the reimbursement rate established in 200 KAR 2:006, Section 8 (2) (d), if provided by an individual. The rate shall be adjusted quarterly in accordance with 200 KAR 2:006, Section 8 (2) (d). If the service is provided by a public transportation provider, a receipt would be attached to the mileage log for each trip. Reimbursement for transportation shall not exceed $265 dollars per month per participant. A person who provides transportation must be at least eighteen (18) years of age,

have a valid driver's license, and the vehicle used for transportation must have, at minimum, valid liability insurance.

Transportation shall not be utilized when involving school attendance, receives transportation through another covered service, has access to transportation under the Individuals with Disabilities Education Act, or customarily receives transportation from a relative. A participant shall not utilize a person for transportation with a conviction of driving under the influence within the last twelve (12) months.

The form used for reimbursement is located in Appendix G.

Vehicle Adaptation Services (T2039 HI) – Vehicle Adaptation services allows modifications to vehicles in order to enable participants to be more mobile in the community, whether being a passenger or a driver. Examples of modifications are a hydraulic lift, a ramp for entry/exit of the vehicle, a modified or special seat, or any interior alteration that enhances safety while the vehicle is in motion. Vehicle adaptations must be performed on vehicles that are owned either by the participant or the participant's family. Vendors who provide estimates for modifications must be approved by the Office of Vocational Rehabilitation, and shall be in good standing with the Office of the Secretary of the State of the Commonwealth of Kentucky pursuant to 30 KAR 1:010 and 30 KAR 1:020. Vehicle Adaptations shall not exceed $6,000 per five (5) year period.

Vehicle Adaptations shall not be provided by an immediate family member, guardian, or legally responsible individual of the participant.

Exceptional Supports Protocol

In extraordinary circumstances related to the assessed needs of the participant, exceptional supports funding may be requested to provide extraordinary services to a participant experiencing challenging medical, behavioral health, or maladaptive behavioral issues. Please refer the Supports for Community Living Policy Manual 2012, Appendix F for further details. Note: Exceptional supports request packets may request a service(s) exceed the upper limit for a service unit rate, or to exceed the amount of units allowed in a given time span (week, month, and/or year), but the request may not exceed both unit and rate limitations.

Immediate Family Member, Guardian, or Legally Responsible Individual as a paid service provider

Multiple services within the SCL waiver have a statement in the regulation that allows immediate family members, guardians, or legally responsible individuals to provide the requested services, if the individual qualifies based on the requirements found in 907 KAR 12:010, Section 5 (4). If a participant wishes to have one or more of these individuals as an employee, the case manager may provide a MAP 532 for completion. The form is to be completed by the potential employee. Each question should provide appropriate detail demonstrating the viability of the potential employee. The case manager may consult with DAIL for guidance if individuals have

questions completing the form. Once submitted, DAIL shall determine eligibility within fourteen (14) business days of receiving the MAP 532. DAIL may request additional information from the case manager in order to make a determination.

A copy of the MAP 532 and a helpful hints guide are provided in Appendix H.

Prior Authorization (PA) of Services

The case manager is required to obtain a PA for any waiver service including goods and services, prior to the date of service or expenditure. QIO reviews the PA request and issues an authorization or a denial for each service. If approved, a PA letter will be issued. The PA is also available to the case manager agency and financial management agency via the Kentucky Health Network System. If denied, a letter will be sent to the case manager and participant outlining the appeal process. The case manager will be responsible for ensuring prior authorization, while the financial manager will be responsible for paying for goods and services, billing Medicaid, and tracking reimbursements. The case manager will be responsible for ensuring the participant is kept up-to-date on the monthly expenditures and the remaining units balance for each service during the monthly face-to-face contact.

Should services need to be altered in any way, whether a new service is needed, more or less hours of an existing service is needed, any change in employees or their wages, or a change in traditional providers, the case manager would submit an updated plan of care to QIO for approval. An example would be a change in diagnosis, or a decrease in a physical condition that causes the participant to need more hands-on assistance.

Timesheets

Employees who provide services to a participant must record time and service documentation on timesheets. Employees must utilize the timesheet approved by DAIL for case managers and financial managers to process properly. The participant/representative shall be responsible for the content of the timesheet (dates, times, services provided, and service documentation that justifies services provided). The case manager shall be responsible for ensuring the timesheet reflects the times that appear appropriate for the service provided according to regulation, hours and services utilized are within PA limits, the content of the service documentation appears to reflect the duties and objectives identified in the plan of care, and the document is legible. Should the timesheet not meet any of these standards, the case manager may consider the timesheet incomplete and submit the timesheet back to the participant/representative and discuss revisions.

Once reviewed and approved, the case manager shall submit only the first page of the timesheet to the financial manager for processing; the case manager shall retain a copy of the first page and the corresponding service documentation. The financial manager shall review the timesheet to ensure legibility and Prior Authorization limits to ensure proper processing. Should the financial manager discover any discrepancies, the financial manager shall consider the timesheet incomplete and submit the timesheet back to the case manager for review.

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

1 Participant /ID # _____ 3 Pay Period _____ to _____

2 Employee /ID # _____ 4 Employee Address/Zip _____

Date Service Provided (MM/DD/YY) 5	Service Provided 6		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	7 Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
SubTotals Wk 1			0.00			0.00			0.00			0.00
SubTotals Wk 2			0.00			0.00			0.00			0.00
Total Hours			0.00			0.00			0.00			0.00

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
	8		$0.00
			$0.00
			$0.00
			$0.00
		TOTAL	$0.00

This is the approved timesheet for PDS. One timesheet shall be used for each employee. The participant/representative/employer is responsible for accurate accounting and reporting of time. The amount referenced does not represent amount paid after taxes withheld. By signing, the participant/ representative/ employer and employee certify that all information is true and correct.

9 _____ Employee Signature _____ Date

10 _____ Participant/Representative/Employer Signature _____ Date

11 _____ Reviewed by: Case Manager Signature _____ Date

R. 2013
DAIL & BHDID

12 _____ Reviewed by: Financial Manager signature _____ Date

Instructions for filling out the timesheet are as follows:

1. Participant - The person's name for whom the services are being rendered*
2. Employee - The person's name who is conducting the service(s)*
3. Pay Period – The dates for the pay period for the time entered. The case manager will provide pay period dates*
4. Employee Address/Zip – The mailing address of the employee*
5. Date Service Provided – Enter the day the employee worked in the format MM/DD/YY
6. Service Provided – List services that are being provided*
7. Time IN/OUT – Enter the time when services started and ended, to specifying AM or PM. Total the amount of time worked at the end of the column.
8. Gross Total Amount – Enter the service(s) and the total hours worked for that pay period in the appropriate boxes along with the pay rate. Add the totals.
9. Employee signature – The employee will sign and date the timesheet, making sure all the information is correct.
10. Participant/Representative signature – The participant or representative will sign and date the timesheet verifying all the information is correct before submitting to the Case Manager.
11. Case Manger signature – the Case Manger will sign and date the timesheet verifying the information is correct before submitting to the Financial Manager

12. Financial Manager signature – the Financial Manager will sign and date the timesheet verifying the information is correct.

Note: *The case manager may provide timesheets with the numbers 1, 2, 3, 4, and 6 prefilled.

The case manager shall sign and date the front page to acknowledge review of the timesheet for legibility and appropriate detail consistent with the plan of care and PA limits.

The financial manager shall sign and date the front page to acknowledge review of the timesheet for legibility, payroll processing, and appropriate detail consistent with the PA limits.

Service Documentation: The service documentation sheet is the second page of the timesheet. For each day worked, the employee must give a full description of the service provided and evidence of training or service that supports the Plan of Care.

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

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

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service 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)	

R. 2013 DAIL & BHDID

Monthly Summary: For each month an employee works, the employee must complete a monthly summary, which is a description of progression towards the participant's goals, if something prevents the participant from achieving the goal, and the plan for the next steps to achieve goal(s).

PARTICIPANT DIRECTED SERVICES MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each service provided in the month, please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.	
Month Services Provided (MM/DD/YY):	

Identify the Issue: The case manager should state who is involved in the issue, when the issue occurred, where it occurred, what occurred, and any conversations/correspondence that occurred prior to the development of the CAP.
Stating the Regulation/Policy: The case manager quotes the regulation language and/or policy language the issue directly impacts.
Agreed Upon Resolution: The case manager meets with the team and all parties involved agree upon a way to minimize or eliminate the issue. This resolution should be between thirty (30) to ninety (90) days.
Potential Consequences: State what action(s) would be taken should the above stated issue be repeated. This should include during the stated timeline of the resolution or after the stated timeline.
Prevention: State how, if applicable, mechanisms and/or ideals could be used to assist in preventing the above issue from being repeated.
Signatures: The participant/representative, case manager, and any other parties involved shall sign the plan to show acknowledgement and agreement of the terms. A failure for any involved parties to sign may result in termination from PDS.

A copy of this form is provided in Appendix J.

Termination

A participant may be terminated from PDS if it is determined that the participant's health, safety, and welfare are at risk and the terms of the CAP have been violated. Termination of any one (1) service or all services from PDS cannot occur until a traditional provider is ready to provide the service(s) impacted. The case manager may consult with a BDHDID Quality Administrator (QA) when searching for a provider. A provider must be secured for a given service before any PDS service is removed; this applies to voluntary and involuntary termination.

APPENDIX A

Participating Financial Management Agencies

Contact Information, Location, and Counties Served

Adanta
(606)679-4782 259 Parkers Mill Road, Somerset, KY 42501
Barren River ADD
(270)781-2381 177 Graham Avenue, Bowling Green, KY 4201
Bluegrass ADD
(859)269-8021 699 Perimeter Drive, Lexington, KY 40517
Buffalo Trace ADD
(606)564-6894 201 Government Street, Suite 300, Maysville KY 41056
Communicare
(270)737-0311 617 North Mulberry Street, Elizabethtown, KY 42701
Cumberland River CMHC
(606)528-7010 1203 American Greeting Card Road, Corbin, KY 40702
Four Rivers Behavioral Health
(270)442-5088 425 Broadway, Suite 201, Paducah, KY 42001
Gateway ADD
(606) 780-0090 100 Lake Park Drive, Morehead, KY 40351
Green River ADD
(270)926-4433 300 GRADD Way, Owensboro, KY 42301
KIPDA
(502)266-6084 11520 Commonwealth Drive, Louisville, KY 40299
Lifeskills
(270)901-5000 380 Suwannee Trail Street, Bowling Green, KY 42103
Kentucky River Community Care
(606)436-5761 115 Rockwood Lane, Hazard, KY 41701
Mountain Comprehensive Care
(606)886-8572 108 South Front Avenue, Prestonsburg, KY 41653
Northern Kentucky ADD
(859)282-2700 22 Spiral Drive, Florence, KY 41042
NorthKey
(859)331-3292 503 Farrell Drive Covington, KY 41011
Pathways
(606)329-8588 1212 Bath Avenue, Ashland, KY 41105
Pennyrile ADD
(270)886-9484 300 Hammond Drive, Hopkinsville, KY 42240
Pennyroyal CMHC
(270)886-7171 3999 Fort Campbell Boulevard, Hopkinsville, KY 42240
River Valley Behavioral Health
(27)689-6500 1100 Walnut Street, Owensboro, KY 42302
Seven Counties
(502)459-5292 3717 Taylorsville Road, Louisville, KY 40220

Counties Served By Region

Barren River ADD & Lifeskills
Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, Warren

Bluegrass ADD
Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, Woodford

Communicare
Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson, Washington

Buffalo Trace ADD
Bracken, Fleming, Lewis, Mason, Robertson

Cumberland River CMHC
Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, Whitley

Four Rivers Behavioral Health
Ballard, Calloway, Carlisle, Fulton, Hickman, Graves, Marshall, McCracken

Gateway ADD
Bath, Menifee, Montgomery, Morgan, Rowan

Green River ADD & River Valley Behavioral Health
Daviess, Hancock, Henderson, McLean, Ohio, Union, Webster

KIPDA & Seven Counties
Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble

Kentucky River Community Care
Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe

Mountain Comprehensive Care
Floyd, Johnson, Magoffin, Martin, Pike

Northern Kentucky ADD & NorthKey
Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, Pendleton

Pathways
Boyd, Carter, Elliott, Greenup, Lawrence

Pennyrile ADD & Penny Royal CMHC
Caldwell, Christian, Crittenden, Hopkins, Livingston, Lyon, Muhlenberg, Todd, Trigg

APPENDIX B

Rights, Risks, and Responsibilities Form

PARTICIPANT DIRECTED SERVICES
RIGHTS, RESPONSIBILITIES AND RISKS STATEMENTS

I understand that I have the **RIGHT** to:

- Choose whether an authorized service will be provided by a traditional waiver provider or through Participant Directed Services;
- Work with my case manager in developing my plan of care;
- Have a monthly face-to-face visit with my case manager; and
- Contact my case manager twenty-four (24) hours per day and seven (7) days per week if a question arises.

I understand that I have the **RESPONSIBILITY** to:

- Be trained to coordinate my care prior to beginning Participant Directed Services services;
- Participate in monthly face-to-face visits with my case manager;
- Work with my case manager to determine my natural supports (family and friends) who can assist me when my Participant Directed Services are not being provided;
- Hire and train employees who I trust to perform the services outlined on my plan of care;
- Work with my case manager to ensure my employees have completed pre-employment checks;
- Keep up with my employees' time and the services provided, and ensure timesheets and service notes are documented correctly before being submitted to my case manager; and
- Pay my monthly patient liability on time, if applicable while maintaining my Medicaid eligibility.

I understand that I have the **RISK** of being terminated from Participant Directed Services:

- If I fail to pay my monthly patient liability;
- If I do not use my Participant Directed Services within sixty (60) consecutive days;
- If I do not make appropriate decisions concerning my Participant Directed Services and place my health, safety and welfare in jeopardy; and
- If I am non-compliant with my plan of care;

Member Name:_____ **Medicaid ID:**_____

I appoint_____ as my representative to manage my services for the Participant Directed Services Waiver.

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

As the participant or designated representative choosing Participant Directed Services, I have read the above Rights, Responsibilities and Risks statements. I have had all my questions answered by my case manager, and I have received a copy of these statements from my case manager. I understand that I must be at least 21 years of age, must not be paid for the role of representative, be responsible in managing care for the participant and participate in training as directed by the case manager. I further understand that if I submit any false information to the SCL waiver provider and Department that I am subject to criminal prosecution, jeopardize my Participant Directed Services eligibility, and will be required to return any benefits received.

_____ _____
Participant/Representative Signature **Relationship to Participant** **Date**

_____ _____
Case Manger Signature **Date**

APPENDIX C

Employee Application

PARTICIPANT DIRECTED SERVICES
EMPLOYMENT APPLICATION

Participant/Employer Name: _____

Applicant Instructions

1. *Please print answers to all questions;*
2. *A resume will not be accepted in lieu of this application;*
3. *Proof of eligibility to work in the United States must be submitted prior to employment;*
4. *Registry and/or background checks must be completed prior to employment; and*
5. *Any false statements and/or omissions may result in a rejection of this application and/or removal from employment after hire.*

Personal Information

_____
Last Name First Name Middle Name

_____
Date of Birth SSN # Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

If you have not lived in Kentucky within the past year, please provide a previous address:

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

If required to transport, can you provide proof
of valid Liability Vehicle insurance? ☐Yes ☐No
Can you lift more than 50lbs while standing? ☐Yes ☐No
Are you legally eligible for employment in the United States? ☐Yes ☐No
Have you ever been arrested or convicted of a criminal offense? ☐Yes ☐No

_____
If yes, please describe. *Please note that an affirmative answer will not automatically disqualify you from being considered as a candidate for employment.*

What is your relationship to the participant/employer? _____

Certification/Education

Are you currently certified in CPR/ First Aid? ☐Yes ☐No
If yes, please provide case management agency with documentation.

Please list any other certifications relevant to the position: _____
_____

Please list highest level of education completed: _____

Work Experience

Do you have experience as a caregiver? ☐Yes ☐No

_____

If yes, please describe.

Are you currently employed? ☐Yes ☐No

_____

Company Name Supervisor Name Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____

Start Date Schedule (Days & Hours Working)

Please list any job history relative to the position, beginning with the most recent.

1) _____

Company Name Supervisor Name Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____

Start Date (Month/Year) End Date (Month/Year) Reason(s) for Leaving

2) _____

Company Name Supervisor Name Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____

Start Date (Month/Year) End Date (Month/Year) Reason(s) for Leaving

3) _____

Company Name Supervisor Name Telephone #

_____

Street Address (Including Apt. # or P.O. Box #) City State Zip Code

_____

Start Date (Month/Year) End Date (Month/Year) Reason(s) for Leaving

References

1) _____
Full Name Occupation Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

2) _____
Full Name Occupation Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

3) _____
Full Name Occupation Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

Emergency Contacts

1) _____
Full Name Relationship Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

2) _____
Full Name Relationship Telephone #

_____
Street Address (Including Apt. # or P.O. Box #) City State Zip Code

I certify that the information provided within this employment application is true and correct to the best of my knowledge.

_____ _____
Signature **Date**

APPENDIX D

Provider Contract

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:

SERVICE PROVIDED	**RATE PER HOUR**

Services Available Through the Participant Directed Services:

Community Access
Community Guide
Day Training
Personal Assistance
Respite
Shared Living
Supported Employment
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 907 KAR 12:010, Section 3 (3).

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.

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 for employment with 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 payments associated for employment requirements, including employee training.

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 Plan of Care.

I understand that I may be responsible for payment for any hours I may require my employee to work beyond the authorized amount in the Plan of Care.

_____	_____
Employee/Provider Date	Employer/Participant Date

APPENDIX E

Employee Additional Training Verification 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**

APPENDIX F

Eligible Employee 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 (PDS)
Eligible Employee Form

Participant Name: _____ Participant MAID: _____

PDS Employee Name: _____ PDS Employee SSN: _____

PDS Employee Address: _____

PDS Telephone: _____ PDS Employee Date of Birth: _____

CM Name: _____

_____Copy of the Signed PDS Member Contract (please attach)

MAP 532 (if applicable) Date Approved: _____

Background check **(Must be completed prior to employment)**

AOC check Date Completed: _____
Nurse Aide Abuse Registry Check Date Completed: _____
Drug Screening Date Completed: _____
TB Screening Date Completed: _____

(Must be completed within thirty (30) days after employment)

Central Registry check Date Completed: _____

Training Requirements **(Must be completed within six (6) months after employment)**

First Aid and CPR Date Completed: _____
Kentucky College of Direct Supports Date Completed: _____
- Maltreatment of vulnerable adults & children Date Completed: _____
- Individual Rights and Choices Date Completed: _____
- Safety at home and in the Community Date Completed: _____
- Supporting Healthy Lives Date Completed: _____
- Person centered planning Date Completed: _____
- Other _____ (if applicable) Date Completed: _____

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**

APPENDIX G

Transportation Mileage Log

[1]Kentucky Participant Directed Services
Mileage Log

Participant:

Driver: _____

Date	Start Time	End Time	Starting Odometer	Ending Odometer	Purpose	Mileage

NOTE: If transportation was purchased for use, please attach all receipts.

Participant's signature: _____ Date: _____ Driver's signature: _____ Date: _____

Case Mngt signature:_____ Date: _____ Fin. Mngt signature: _____ Date: _____

_____

Please note that any miles submitted shall be calculated at two-thirds (2/3) the reimbursement rate established quarterly per 907 KAR 12:020, Section 3 (19), and 200 KAR 2:006, Section 8(2)(d)

APPENDIX H

Helpful Hints Guide

MAP 532, Application for Immediate Family Member, Guardian, or Legally Responsible Individual

Helpful Hints for Completing the MAP 532

Question 1: What services are you providing?

List the services the employee is projected to work under the new waiver, whether it be Personal Assistance, Community Access, Supported Employment, Day Training, and/or Respite. CLS is not part of SCL 2. Additionally, provide brief detail of the duties to be performed under each service.

Question 2: What duties will you be performing that *exceed the range of activities you normally provide* as a family member/legally responsible person?

Does this person ever provide any natural supports to the participant outside of time submitted on a timesheet? If so, then this may NOT be considered beyond their range of activity.

It is possible the employee provides natural supports, but the duties to be performed will not relate back to what is normally completed through natural supports.

The answer has to tie back to the question, which is, if you as an employee are approved for a service(s), what will you be doing that is different from what you normally do? The form must detail specific duties to be completed, not just stating personal hygiene, homemaking, community inclusion, or other broad terms.

Question 3: How will these duties be cost-effective?

Compare the service(s) this employee would provide to what has been provided in the past for the participant.

If applicable, compare the proposed wages of this employee to other employees who are currently working, previously worked, or have interviewed and declined based on wage expectation, and if Personal Service Agencies (PSAs) has requested upper limits of payment.

Question 4: What unique abilities and qualifications do you possess that may not be found with other potential employees?

Questions to consider when answering Question 4 include:

- Does the employee currently work, or have work history with an agency associated with a vulnerable population, such as a nursing home, hospital, other care facility, whether it is medical or non-medical?
- Has the employee attended any post-secondary school that targets the human services field in some manner?
- Has the employee ever attended any seminars/events/trainings that provided education to the employee?

- Has the employee received specific training from an institution that is directly related to the needs of the participant, such as catheter care, G-tube/J-tube care, etc.?
- Is the employee a member of any groups/networks that focus on a vulnerable population?

Question 5: What anticipated time of the day/week will these duties be performed?

Are the services requested at targeted times when providers or other employees would not be available to provide support to the participant? Please be specific.

Question 6: How is the participant limited in independence and how will you be able to increase this with your employment?

Is the employment of this person the primary, and possibly only, means to which the participant will receive support for independence? Are other employees/providers unwilling/unable/restricted to provide support for the independence requested in the plan of care?

Note: If the family member already provides a certain level of support that promotes independence without payment or outside of time submitted on timesheets, it may be difficult for the family member to prove that the employment would increase independence.

Question 7: How is the participant limited in community access and how will you be able to increase this with your employment?

Questions to consider in answering Question 7:

- How will the employment of this family member increase community access for the participant?
- What will the family member be doing differently than what is normally provided?
- Are other employees/providers unwilling/unable/restricted from providing the requested community access?

Question 8: What other resources for these services has your team pursued? Why were these services unsuccessful?

List examples of how employees have not been willing to work with the participant or candidates for employment cannot be located in the area?

Provide specific examples of providers who have refused to provide support to the participant, and the circumstances of that refusal?

MAP 532
(12/2013)

PDS Request Form for
Immediate Family Member, Guardian, or Legally Responsible Individual as Paid Service Provider

Participant Information:

Name Last:		First:		MI:		Medicaid ID:	

Paid Service Provider Information:

Name Last:		First:		MI:	

Current Case Manager:

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

Relation *(Please mark appropriate box in table below)*	Clear
"Legally responsible individual" means an individual who has a duty under state law to care for another person and includes: (a) A Parent (biological, adoptive, or foster) of a minor child who provides care to the child; (b) The guardian of a minor child who provides care to the child; or (c) A spouse of a participant.	☐
"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.)	☐
"Immediate family member" is defined by KRS 205.8451(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.)	☐

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.

APPENDIX I

PDS Timesheet

PARTICIPANT DIRECTED SERVICES EMPLOYER/EMPLOYEE TIMESHEET

Documentation/Information Must Be Printed & Service Documentation Must Accompany Timesheet

Participant /ID # _____ Pay Period _____ to _____

Employee /ID # _____ Employee Address/Zip _____

Date Service Provided (MM/DD/YY)	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time	Service Provided		Total Time
	Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)		Time IN (AM/PM)	Time OUT (AM/PM)	
SubTotals Wk 1			0.00			0.00			0.00			0.00
SubTotals Wk 2			0.00			0.00			0.00			0.00
Total Hours			0.00			0.00			0.00			0.00

GROSS TOTAL AMOUNT FOR PAY PERIOD

Service & Billing Code	Hours	Rate	Total
			$0.00
			$0.00
			$0.00
			$0.00
		TOTAL	$0.00

This is the approved timesheet for PDS. One timesheet shall be used for each employee. The participant/representative/employer is responsible for accurate accounting and reporting of time. The amount referenced does not represent amount paid after taxes withheld. By signing, the participant/ representative/ employer and employee certify that all information is true and correct.

Employee Signature **Date**

Participant/Representative/Employer Signature **Date**

Reviewed by: Case Manager Signature **Date**

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DAIL & BHDID

Reviewed by: Financial Manager signature **Date**

PARTICIPANT DIRECTED SERVICES SERVICE DOCUMENTATION

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

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please outline: 1) A full desciption of the service 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 MONTHLY SUMMARY

*Documentation/Information Must Be **Legibile** & Employees Are Responsible For Completing Monthly Summaries*

Participant Name & ID #: _____ Employee Name & ID #: _____

For each date of service please detail on: 1) Analysis of progression toward the participant's outcomes on the plan of care; 2) What keeps the participant from achieving outcomes; and 3) What is planned for the next step to achieve outcomes.

Month Services Provided (MM/DD/YY):	

APPENDIX J

Corrective Action Plan Form

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

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: