APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: Kentucky

B. Waiver Title:

Acquired Brain Injury
Acquired Brain Injury Long Term Care
Home and Community Based
Model II Waiver
Michelle P. Waiver
Supports for Community Living

C. Control Number:

KY.0333.R04.05
KY.0477.R02.05
KY.0144.R07.01
KY.40146.R07.01
KY.0475.R02.05
KY.0314.R04.06

D. Type of Emergency (The state may check more than one box):

O	**Pandemic or Epidemic**
X	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for

each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

1) On December 11, 2021, a deadly tornado outbreak hit the western region of Kentucky. Both the White House and the Federal Emergency Management Agency have declared a state of emergency in Kentucky due to this natural disaster.

2) As of December 13, 2021, at least 74 people had been killed and another 109 remain unaccounted for. Exact numbers are unavailable at this time, but it is estimated thousands more have been injured or left homeless. Among 1915(c) HCBS participants, the Department for Medicaid Services (the Department) has confirmed at least one death and several injuries. Additionally, multiple participants have lost their place of residences and multiple providers have damaged or destroyed facilities.

3) The Department along with its sister agencies, the Department for Behavioral Health, Developmental and Intellectual Disabilities and the Department for Aging and Independent Living, have been working together to contact affected providers and participants to assess their situation and provide assistance in accordance with guidance from Kentucky Emergency Management and the Kentucky National Guard.

4) Kentucky seeks temporary changes to the HCBS waivers to address staffing shortages, access to care issues and need for service provision beyond the terms of approved service descriptions to address participant health, safety and welfare in the wake of the natural disaster

5) Kentucky is making the changes to the waivers via Appendix K:

a. K2-b-iii: Expands services offerings to help address the effects of the natural disaster on waiver participants and providers
b. K2-b-iv: Expands the settings where Residential, Respite, Attendant Care, and Personal Assistance services can be provided
c. K2-b-v: Allows Residential services to be temporarily provided out-of-state
d. K2-d-i: Temporarily modify provider qualifications for Case Management, Respite, Personal Care, Attendant Care and Residential to assist providers with staffing shortages
e. K2-d-ii: Defines providers types for Individual Counseling services, which is being expanded to all waivers
f. K2-d-iii: Increases the number of individuals allowed in ABI and ABI LTC Residential settings and expands Technology Assisted Residential to ABI and ABI LTC participants

6. These flexibilities will be utilized with the necessary flexibilities noted in the COVID pandemic Appendix K's to respond to the tornados in Kentucky and the subsequent Presidential declaration of a major disaster for the Commonwealth of Kentucky (FEMA-4630-DR), dated 12/12/2021.

F. Proposed Effective Date: Start Date: 12/11/2021 **Anticipated End Date:** 6/30/2022

G. Description of Transition Plan.

Individuals will transition back to pre-emergency service status once the provider network and service availability has been restored to pre-natural disaster levels This transition will be implemented no sooner than forty-eight (48) hours after the public has been made aware of natural disaster containment and Medicaid providers have been notified of the intent to repeal emergency-based standards described herein. Providers will be given a period of sixty (60) days to transition all participants' plans of care back to normal limits and operations within the approval time period of the Appendix K.

In keeping with existing practices, individualized needs will be re-assessed on a case-by-case basis, as indicated, if any long-term changes are required to an individual's person-centered service plan once the Commonwealth resumes standard program rules and policies approved in the active 1915(c) HCBS waiver applications.

H. Geographic Areas Affected:

The following twenty-three (23) counties were impacted: Breckenridge, Boyle, Bullitt, Caldwell, Christian, Edmonson, Fulton, Graves, Green, Hart, Hickman, Hopkins, Logan, Lyon, Marion, Marshall, Monroe, Muhlenberg, Ohio, Shelby, Spencer, Taylor, and Warren.

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

Kentucky Emergency Management Procedures and Guidance

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii. _✓__Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. _✓__Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

Residential, Respite, Attendant Care and Personal Assistance services can be provided in shelters, hotels, churches, or state park resorts. This will include coverage of room and board for Respite Services as permissible in 42 CFR §440.182(c)(1) if necessary

v.__✓_ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

The impacted counties border Indiana and Tennessee. Our waivers currently allow for direct patient services to be provided outside the state with the exception of residential. Kentucky will temporarily expand services to include out-of-state residential services to provide expedited responses for emergency housing needs. Out of state providers must meet their state's provider qualifications and/or Kentucky's provider qualifications.

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d._ _✓__ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i._✓__ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

Case Management provider type qualifications will be modified to allow for Licensed Practical Nurses in all waivers and to modify the degree requirement from a Bachelor's degree to individuals who have an Associate's Degree or to allow for relevant experience to substitute for a degree in the provider qualifications. The age requirement for providers who provide respite, personal assistance, attendant care as well as residential staff will be decreased from twenty-one (21) to eighteen (18) when determined it is appropriate. This will allow for some of our health program vocational school students and college students to begin providing services and augment provider availability to provide additional services with the increase in staff.

ii.__✓_ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

The Department is expanding Individual Counseling services to all 1915(c) HCBS waivers. Providers of this service must meet the provider qualifications for Individual Counseling as outlined in our approved ABI and ABI LTC waivers.

iii.__✓_ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

The Department is increasing the number of participants allowed in a residential setting to up to five (5) in the ABI and ABI LTC waivers to ensure adequate capacity to serve individuals with emergency housing needs. The Department is also expanding Technology Assisted Residential service to the ABI and ABI LTC waiver, which will also allow up to five (5) participants in this setting.

e._✓__Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

The Department will allow level of care reevaluations for up to one year past the due date.

f.___ Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l.___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Pam
Last Name	Smith
Title:	Division Director
Agency:	Department for Medicaid Services
Address 1:	275 E. Main Street
Address 2:	Mail Stop 6W-B
City	Frankfort
State	Kentucky
Zip Code	40621
Telephone:	502-564-7540, ext. 2105
E-mail	pam.smith@ky.gov
Fax Number	502-564-0249

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

/S/ **Date:** 12/15/21

State Medicaid Director or Designee

First Name:	Lisa
Last Name	Lee
Title:	Commissioner
Agency:	Department for Medicaid Services
Address 1:	275 E. Main St.
Address 2:	6W-A
City	Frankfort
State	Kentucky
Zip Code	40621
Telephone:	502-564-4321
E-mail	lisa.lee@ky.gov
Fax Number	502-564-0509

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Home Delivered Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope):

Home Delivered Meal Service is defined as the provision of meals to a waiver participant who has a need for a home delivered meal based on a deficit in an activity of daily living or an instrumental activity of daily living identified during the assessment process. The service includes the preparation, packaging and delivery of safe and nutritious meals to a consumer at his or her home. A participant may be authorized to receive one home delivered meal per day. Also, for the purposes of this service, reheating a prepared home delivered meal is not the same as preparing a meal.

Home delivered meals:
1) Shall be provided to participants who are unable to prepare their own meals and for whom there are no other persons available to do so.
2) Shall take into consideration the participant's medical restrictions
4) Shall be individually packaged if they are heated meals.
5) May include frozen meals
5) May be individually packaged if they are unheated, shelf-stable meals, or may have components separately packaged.

The following highlighted text indicates the changes not already approved in our current Appendix K:
To ensure that all individuals continue to receive home-delivered meals, in addition to delivery to the participant's place of residence, meals may also be provided to a centralized location for providers to pick up for participant distribution and may include the delivery of bulk meals as not to exceed a total of what would constitute 2 meals a day.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Up to two (2) meals per day

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Certified Waiver Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Waiver Provider			

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Minor Home Adaptation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

1. Designed to enable participants to interact more independently with their environment thereby enhancing their quality of life and reducing their dependence on physical support from others; and
2. A physical adaptation to a participant's or family's home, which shall be necessary to:
    a. Ensure the health, welfare, and safety of the participant; or
    b. Enable the participant to function with greater independence in the home and without which the participant would require institutionalization;
3. May include the following if necessary for the welfare of a participant:
    a. Installation of a ramp or grab-bar;
    b. Widening of a doorway;
    c. Modification of a bathroom facility; or
    d. Installation of a specialized electric and plumbing system, which shall be necessary to accommodate the medical equipment or supplies necessary for the welfare of the participant;
4. Shall not include:
    a. An adaptation or improvement to a home that is not of direct medical or remedial benefit to a participant;
    b. An adaptation that adds to the total square footage of a home except if necessary to complete an adaptation; and
    c. An adaptation to a provider-owned residence;
5. Shall be provided:
    a. In accordance with applicable state and local building codes; and
    b. By a vendor who shall be in good standing with the Office of the Secretary of State of the Commonwealth of Kentucky pursuant to 30 KAR 1:010 and 30 KAR 1:020; and
6. Shall be coordinated and documented in the MWMA by a case manager by:
    a. A description of each adaptation purchased;

b. A receipt for every adaptation made, which shall include the:
   1. Date of purchase;
   2. Description of the item;
   3. Quantity and per unit price; and
   4. Total amount of the purchase;
   5. The signature and title of the case manager; and
   6. The date the entry was made in the record.

An immediate family member, guardian, or legally responsible individual of a participant shall not be eligible to be a vendor or provider of an environmental accessibility adaptation service for the participant.

A home accessibility modification shall not be furnished to a participant who receives residential habilitation services except if the services are furnished in the participant's own home.

A request shall be documented in a participant's person-centered service plan and include cost of adaptations

The above information applies with the following changes:
Services may be covered under the waiver in accordance with all the requirements when other sources are not available or the service is not covered under any other resource.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Certified Waiver Provider

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Goods and Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	

Goods and services shall:

1. Be services, equipment, or supplies that are not otherwise provided through this waiver or through the Medicaid state plan individualized to a participant who chooses to use participant-directed services;

2. Be utilized to reduce the need for personal care or to enhance independence within a participant's home or community;

3. Not be a good or service available to a recipient outside of the department's waiver program;

4. Meet the following requirements:
a. The good or service shall decrease the need for other Medicaid services;
b. The good or service shall promote participant inclusion in the community;
c. The good or service shall increase a participant's safety in the home environment; and
d. The participant shall not have the funds to purchase the good or service, or the item or service is not available through another source;

5. If participant directed and purchased from a participant-directed budget, be prior authorized;

6. Not include experimental or prohibited treatments;

7. Be clearly linked to a participant need that has been documented in the participant's person-centered service plan;

8. Be coordinated and documented in the MWMA by a case manager by:
a. Description or itemized line item of purchase and cost;
b. Receipts for procurements that include the date of purchase;
c. The signature and title of the case manager; and
d. The date the entry was made in the record; and

9. Not exceed $1,800 per one (1) year authorized person-centered service plan period.

A purchase of a good or service shall not circumvent other restrictions on waiver services:
1. Established in this administrative regulation; and
2. Including the prohibition against claiming for the costs of room and board.

An immediate family member, guardian, or legally responsible individual of a participant shall not be a provider of participant-directed goods and services to the participant.

A case manager shall submit reimbursement documentation to the financial management agency. Equipment purchased as a good shall become the property of the participant.

Changes to the above description:
Expand to include this option in all waivers for both individuals participant directing services or receiving traditional waiver services
Remove the $1,800 financial limit and approve higher amounts with a prior authorization up to $5,000

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Certified Waiver Provider

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Specialized Medical Equipment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope):

Include a device, control, or appliance specified in a participant's person-centered service plan that shall:
a. Be necessary to ensure the health, welfare, and safety of the participant; or
b. Enable the participant to function with greater independence in the home;

2. Include assessment or training needed to assist a participant with mobility, seating, bathing, transferring, security, or other skills including operating a wheelchair, a lock, a door opener, or a side lyre;

3. Include a computer necessary for operating communication devices, a scanning communicator, a speech amplifier, a control switch, an electronic control unit, a wheelchair, a lock, a door opener, or a side lyre;

4. Include customizing a device to meet a participant's needs;

5. Include partial nutrition supplements, special clothing, an enuresis protective chuck, or another authorized supply that is specified in the participant's person-centered service plan;

6. Include an ancillary supply necessary for the proper functioning of an approved device;

7. Be identified in a participant's person-centered service plan;

8. Be recommended by a person whose signature shall verify the type of specialized equipment or supply that is necessary to meet the participant's need; and who:
a. Meets the personnel and training requirements established in Section 3 of this administrative regulation; and is:
(i) An occupational therapist;
(ii) A physical therapist; or
(iii) A speech-language pathologist; or

b. Is a certified or licensed practitioner whose scope of practice includes the evaluation and recommendation of specialized equipment or supplies;

9. Not include equipment, a supply, an orthotic, prosthetic, service, or item covered under the department's: a. Durable medical equipment program pursuant to 907 KAR 1:479; b. Hearing services program pursuant to 907 KAR 1:038 or 907 KAR 1:039; or c. EPSDT program pursuant to 907 KAR 11:034 or 907 KAR 11:035; and

10. Be coordinated and documented in the MWMA by a case manager by:
a. A description or itemized line item of purchase and cost;
b. Receipts for procurements that include the date of purchase;
c. The signature and title of the case manager;
d. The date the entry was made in the record; and
e. The signature, title, and date of the documentation review by the case manager supervisor providing supervision to the case manager.

Equipment purchased pursuant to this subsection for a participant shall become the property of the participant.

When the waiver serves individuals under age 21, medical equipment and supplies must be covered under the state plan and furnished as services required under EPSDT.
For individuals over age 21, services are available under the waiver as necessary when not available under the state plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Certified Waiver Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
agency		907 KAR 7:005 (regulations for certification)	All standards identified in program regulations and services manual.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	**DBHDID**	**Initially and at least every 2 years**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

1. Enable a participant who chooses to use participant-directed services to gain access to integrated waiver and other community services, activities, resources, and organizations typically utilized by the general population;

2. Only be provided when transportation is not:
a. Otherwise and customarily available through natural supports including family, friends, neighbors, or community agencies; or
b. Included as an element of another waiver service;

3. Include nonemergency travel;
4. Be clearly described in a participant's person-centered service plan, which shall include information regarding the unavailability of other transportation services or resources;

5. Be reimbursable based upon the assessed needs of a participant as specified in the participant's person-centered service plan;
6. Be provided by a driver who:
a. Is at least eighteen (18) years of age and legally licensed to operate the transporting vehicle to which the individual is assigned or owns;
b. Has proof of current liability insurance for the vehicle in which the participant will be transported;
c. Is an individual or other public transit resource including a local cab or bus service; and

7. Not:
a. Include transporting a participant to school (through the twelfth grade);
b. Be available to a participant who:
(i) Receives transportation as an element of another covered service;
(ii) Is receiving a residential service via the waiver program;
(iii) Has access to transportation under the Individuals with Disabilities Education Act; or
(iv) Customarily receives transportation from a relative.

A participant shall not contract with an individual to provide transportation if the individual has a driving under the influence conviction within the past twelve (12) months.

A transportation service may be provided by an immediate family member, guardian, or legally responsible individual of the participant in accordance with Section 10 of this administrative regulation.

Changes to requirements:
Expanding service option to all waivers
Expanding the service to also be provided by traditional service providers not just participant directed

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
				Certified Waiver Providers

Specify whether the service may be provided by *(check each that applies):*	✓	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Individual Counseling

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Counseling services, which:

1. Shall be designed to help a participant resolve personal issues or interpersonal problems resulting from his or her ABI;
2. Shall assist a family member in implementing an approved person-centered service plan;
3. In a severe case, shall be provided as an adjunct to behavioral programming;
4. Shall include substance abuse or chemical dependency treatment, if needed;
5. Shall include building and maintaining healthy relationships;
6. Shall develop social skills or the skills to cope with and adjust to the brain injury;
7. Shall increase knowledge and awareness of the effects of an ABI;

Changes Applicable to All Waiver Participants:
Provide counseling for Post Traumatic Stress or other issues stemming from the natural disaster

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Certified Waiver Provider

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.