SUPPORT BROKER MANUAL

Consumer-Directed Community Supports

Self-Directed Services (adults)
Family-Directed Services (children)

Version: November 2014

IDAHO DEPARTMENT OF HEALTH & WELFARE

www.selfdirection.idaho.gov

www.familydirected.dhw.idaho.gov

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INTRODUCTION

Consumer-Directed Community Supports is a flexible program option for participants eligible for the: Adult and Children's Developmental Disabilities waivers, and the Children's Home and Community Based Services - State Plan Option (HCBS-DD).

The Consumer-Directed Supports option includes Self-Directed Community Supports and Family-Directed Community Supports. Self-Directed Community Supports is a program option for adults eligible for the Adult Developmental Disabilities Waiver described in Idaho Administrative Rules (IDAPA) 16.03.10, "Medicaid Enhanced Plan Benefits". Family-Directed Community Supports is a program option for children eligible for the Developmental Disabilities Waiver and the Home and Community Based Services - State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits". CDCS is not a covered option for participants enrolled in the Children's Act Early Waiver.

The CDCS option allows eligible participant to choose the type and frequency of supports they want, within parameters, negotiate the rate of payment, and hire the person or agency they prefer to provide those supports. The program is supported by IDAPA Rule 16.03.13.

My Voice, My Choice

The Consumer-Directed Services model is based on the principles of self-determination, including the participant-driven supports philosophy called *My Voice, My Choice*. The Idaho Consumer-Directed program is called *My Voice, My Choice*.

The guiding principles of *My Voice, My Choice* are that participants have:

- Freedom to plan their own lives.
- Control over the Medicaid dollars to get the services and supports they need, within parameters.
- Support to be involved in their community, as much as they choose.
- Responsibility for the choices and decisions they make.

This manual is written for the potential or working Support Broker and has several goals:

- Ensure that Support Brokers understand, agree with, and can state the philosophy that is the foundation of *My Voice, My Choice.*
- Provide complete and detailed step-by-step information describing the:
    - Support Broker qualifying process.
    - Function of the Circle of Support.
    - Person-centered planning process.
    - Business model of the Consumer-Directed Services model.
- Ensure that Support Brokers know their required and optional job duties.
- Provide the tools necessary to do the Support Broker job.
- Provide guidelines on how to work with employers and the Circles of Support to complete a *Support and Spending Plan.*
- Clarify the procedures, processes and rules that govern the Support Broker role.

Decision-Making Authority

The participant, or legal guardian if one exists, is responsible for decisions made on behalf of an adult participant. A parent, or legal guardian, is responsible for decisions made on behalf of a minor child participant. For the purpose of this manual "*employer*" refers to either an adult participant in the Self-Directed Services Program or to the parents, or legal guardian if one exists, of a minor child that is enrolled in the Family-Directed Services Program.

CHAPTER ONE: GETTING STARTED

Support Broker Job Description

Support Brokers are employed directly by participants with a developmental disability. For participants that are minor children, the employer is the parent, or legal guardian if one exists, of that child. Support Brokers help their employer develop and manage their services and supports, providing support in a way that is flexible and responsive to the needs and abilities of their employer. Support Brokers also help their employers develop a *Support and Spending Plan* (*SSP*), monitor their annual budget and develop back-up plans to mitigate potential risks to the health and safety of the participant. Additionally, Support Brokers assist their employers in the process of managing employees, including recruiting, hiring, and monitoring as necessary. Support Broker services are defined by IDAPA 06.03.13.10.16 as *assistance to the participant in the areas of planning, budgeting and negotiating their services.*

Support Brokers are committed to a value system that supports each participant's fundamental right to live a life of dignity, self-determination, community inclusion. Support Brokers assure the participant's health and welfare are supported – assuring safety through a network of family members, friends and paid supports. Support Brokers help provide leadership, resources, ideas and coordination for their employers. A Support Broker has a clear focus on helping an employer identify individualized goals to increase independence and quality of life.

For information about the Idaho Administrative Rules Act (IDAPA), visit:
http://adminrules.idaho.gov/rules/current/16/0313.pdf

The *Idaho Administrative Procedures Act (IDAPA)* rules are the legal foundation for the Department of Health and Welfare (DHW) to ensure that Support Brokers adhere to the rules and standards of care for their employer.

Responsibilities

According to *IDAPA 16.03.13 - Consumer-Directed Services,* at a minimum, the Support Broker must:

- Participate in the person-centered planning process.
- Develop a written *SSP* with the participant that includes the services and supports that the participant needs and wants, and addresses related risks that could accompany the participant's needs and wants. The *SSP* must include a comprehensive plan for each potential risk with three back-up plans for every risk identified. This plan must be authorized by DHW before executed.
- Assist the participant to monitor and review his Medicaid individualized budget.
- Submit documentation regarding the participant's satisfaction with identified supports as requested by the DHW.

- Participate with DHW's quality assurance measures, as requested
- Assist the participant to complete the annual re-determination process as needed, including updating the *SSP* and submitting it to DHW for authorization.
- Assist the participant, as needed, to meet his participant responsibilities outlined in Section 120 of these rules and assist the participant, as needed, to protect his own health and safety.
- Complete the Department - approved *Criminal History Check Waiver Form* when a participant chooses to waive the criminal history check requirement for a Community Support Worker. Completion of this form requires that the Support Broker provide education and counseling to the participant and his Circle of Support regarding the risks of waiving a criminal history check and assist with detailing the rationale for waiving the criminal history check and how health and safety will be protected.
- Assist children enrolled in the Family-Directed Community Supports (FDCS) Option as they transition to adult DD services.

In addition to the rules stated above, IDAPA rule requires that each Support Broker must be able to provide the following services when requested by the participant:

- Assist the participant to develop and maintain a Circle of Support.
- Help the participant learn and implement the skills needed to recruit, hire and monitor community supports.
- Assist the participant to negotiate rates for paid Community Support Workers (CSW).
- Maintain documentation of supports provided by each CSW and participant's satisfaction with these supports.
- Assist the participant to monitor community supports.
- Assist the participant to resolve employment-related problems.
- Assist the participant to identify and develop community resources to meet specific needs.

Limitations

Support Brokers cannot provide or be employed by an agency that provides paid community supports as defined by the *Paid Community Support Broker Worker Duties and Responsibilities* section of IDAPA 16.03.13.135.150.

The Qualification Process

The Support Broker job description, application and application instructions are on the Self-Direction and Family-Direction website: www.selfdirection.idaho.gov and www.familydirected.dhw.idaho.gov. Individuals interested in becoming a Support Broker must complete the Department application to document that they meet all the criteria below:

- Are 18 years of age, or older.
- Have skills and knowledge typically gained by completing college courses, community classes or workshops that count toward a degree in the human services field.
- Have at least two years of verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field.
- Pass DHW's criminal history background check.

The following are not eligible to become a Support Broker for a participant:

- An adult participant's parents
- The adult participant's guardian, payee or conservator.
- The participant's spouse.
- An employee of an agency that provides paid community supports to the participant.

Exception: Under the Family-Directed Services option, a qualified parent or legal guardian of a minor child may act as the child's unpaid Support Broker.

Criminal History Check

According to IDAPA 16.05.06.100.26, DHW has the responsibility to ensure criminal history checks are conducted for Support Brokers. The intent of these rules is to facilitate the protection of children and vulnerable adults by requiring criminal history checks of persons providing services for these participants. DHW will ensure that applicants meet criminal history check requirements prior to qualifying an applicant to become a Support Broker and approving service provisions.

A DHW Criminal History Background Clearance does not mean an individual has no criminal record.

People who have felony convictions or been a party to a valid child or adult protection complaint cannot work or provide service to Consumer-Directed Services participants unless an exemption is granted by the DHW Criminal History Unit. Individuals convicted of other crimes will be evaluated on a case-by-case basis and may be granted an exemption. No exemptions will be granted for the "disqualifying offenses" listed below:

Disqualifying Offenses

A disqualifying offense is an offense that precludes an applicant from providing services or receiving a background check "clearance". If an applicant is found to have a disqualifying offense listed below, they will be issued an "unconditional denial" and will not be allowed to provide services or receive licensure or certification.

An "Unconditional Denial" will be issued for the following offenses:

Disqualifying Offenses – Permanent

If a person, as an adult or juvenile, has a conviction or withheld judgment of any crimes on the disqualifying offenses list or has any of the findings below, regardless how long ago it occurred, (s)(s)he will be excluded from being a Medicaid provider and will not pass the background check.

- Abuse, neglect, or exploitation of a vulnerable adult;
- Aggravated, first degree and second-degree arson
- Child Abuse Registry listing Level 1 or 2
- Crimes against nature
- Forcible sexual penetration by use of a foreign object
- Incest
- Injury to a child, felony or misdemeanor
- Possession of sexually exploitative material
- Sexual abuse or exploitation of a child
- Negative finding on Nurse Aide Registry
- Any felony punishable by death or life imprisonment
- Poisoning
- Rape; in any degree
- Robbery
- Felony or first degree stalking
- Sale or barter of a child
- Video voyeurism
- Enticing of children
- Kidnapping
- Lewd conduct with a minor
- Mayhem
- Inducing individuals under 18 years of age into prostitution or to patronize a prostitute
- Manslaughter: Voluntary, Involuntary or Felony Vehicular Manslaughter
- Murder in any degree; or, assault with intent to commit Murder
- Attempt, conspiracy, accessory after the fact or aiding and abetting to commit any of the Disqualifying offenses.

Disqualifying Five-Year Offenses

If a person, as an adult or juvenile, has a conviction or withheld judgment of any crimes on the disqualifying five-year offenses list, and the conviction date is within five years of his or her background check, (s)he will be excluded and will not pass the background check.

- Any felony not described on the permanent disqualifying offenses list
- Misdemeanor forgery of and fraudulent use of a financial transaction card
- Misdemeanor forgery and counterfeiting
- Misdemeanor identify theft
- Misdemeanor insurance fraud
- Misdemeanor public assistance fraud
- Stalking in the second degree
- Misdemeanor Vehicular Manslaughter (effective 7/1/2012)
- Attempt, conspiracy, accessory after the fact or aiding and abetting to commit any of the Disqualifying Five Year offenses.

Support Brokers must report if they are charged with any criminal activity that might impact their ability to work with vulnerable adults or children. According to IDAPA 16.03.13, Support Brokers are required to report this charge immediately to their employer, the employer then is required to report it to DHW immediately. A substantiated charge of abuse, neglect, exploitation, or a criminal conviction of any crime which would disallow a person from being a provider to DHW participants must be reported to their employer immediately**.**

Training

Training tools and courses are available to Support Broker applicants on the DHW Consumer-Directed Community Supports public websites.

The *Support Broker Training Curriculum*, available on the Self-Direction website, focuses on providing services to adults. Additional software may be needed to fully utilize the training curriculum; directions for additional software are available on the web site.

Once the application is approved, an applicant is eligible to participate in DHW sponsored Support Broker training. DHW sponsored training is available through local Regional Medicaid Services or Family and Community Services (FACS) offices. DHW led Support Broker training is optional for Support Brokers who choose to serve adult participants only, but mandatory for all Support Brokers that serve children. Contact the local regional staff for specific information on dates, times and course availability. For local regional staff names and phone numbers, call the toll-free number at 1-866-702-5212. If serving children only, a contact list of FDS Case Coordinators is available on the Family-Direction Program website. (See front of manual)

> Q: What kind of training do I need to be a Support Broker?
>
> A: A Support Broker must pass an exam prior to providing any paid services to the participant. Taking the training courses provided by the Department will help you pass the exam, and is mandatory to serve children.

The Support Broker Qualification Examination

The qualification exam is based on the Consumer-Direction philosophy, rules, guidelines and procedures. The exam incorporates information from the on-line curriculum, the Support Broker Training and the *Support Broker Manual*, with questions regarding the Self-Direction and the Family-Direction programs. There is no charge for the examination.

The exam is completed in two sections. The first portion of the exam is taken at a Department office and is a closed-book exam. Once this part is completed, the applicant can take the second part, which is a take-home case study. The take-home portion requires that the applicant develop a *Support and Spending Plan (SSP)* that will meet criteria for authorization.

The following applies when completing both parts of the exam:

- The first part, a proctored exam, is a "closed-book exam". Books or other written material, cell phones, backpacks, purse or hand-held electronic devices are not allowed in the exam room for the closed-book part of the exam.
- The date and time must be scheduled in advance with the regional trainer. Walk-ins will not be accepted.
- The test is offered during regular business hours and takes up to 90 minutes to complete.
- A photo identification must be presented at the time of the exam.
- The exam will be taken in a private room and must be completed in ink.
- The trainer will be available to provide assistance during the exam, but does not need to remain in the same room.
- Once the applicant has completed the closed-book part of the exam, the trainer will provide a case study and *Work Book from which the applicant is* responsible for completing a *SSP.*
- The applicant can use any resources to complete the *SSP*.
- The SSP must be complete**d** and submitted within 5 working days.
- Once the plan meets approval criteria and is completed to your satisfaction scan and email to: CDSO@dhw.idaho.gov.
- Both the closed-book exam and the case study will be graded by DHW staff.
- A passing score is 70% or better on both parts of the exam.
- The applicant will receive a written notice stating exam results.
- If the exam is failed, it can be taken up to 3 times in a 12-month period.
- A consultation with the regional trainer can be requested to determine what areas of the test were problem areas that resulted in score of less than 70%.
- If the applicant fails the exam 3 times, (s)he must wait 12 months from the last failed exam date to re-take it.

Public Support Broker List

If the Support Broker indicates such, the qualified Support Broker's name will be placed on a public register of approved Support Brokers maintained by the Department on the Self-Direction and Family-Direction web sites. Support Brokers who do are not currently taking new participants should contact the Department to be taken off the list.

Receiving Your Notice of Qualification

To become a qualified Support Broker you must:

- Submit a complete application (Refer to the document *How to Become A Support Broker*.)
- Pass the Department criminal history check per the Support Broker protocol
- Pass the qualification examination
- Receive a *Notice of Qualification*, which notifies the individual is now a qualified Support Broker. This letter is sent to the FEA as well.

Upon receiving the *Notice of Qualification*, a Support Broker will be qualified to work for adult participants and for parents or legal guardians of minor children. This letter will serve as proof of

qualification, a Support Broker will present it to an employer and to the Fiscal Employer Agent (FEA) when (s)he completes the *Employment Packet*.

Annual Re-Qualification

The anniversary date for the annual re-qualification is one year from the date on the original *Notice of Support Broker Qualification*. In order to be re-qualified as a Support Broker, the following must be submitted 45 days prior to your current certification expiration:

- An application for re-qualification, located on the Self and Family-Direction web site.
  - o Documentation that you have completed a minimum of 12 hours of training in subjects specific to Support Broker job duties and responsibilities. Documentation can be provided by signed:
    - Certificates of completion
    - Continuing education units (CEUs)
    - Signed verification of course completion
    - Report cards from an educational institution
  - o Training may be taken through:
    - DHW
    - Agencies contracted with DHW
    - Community education classes
    - Seminars
    - Conventions
    - On-line training
    - Teleconferences
    - Workshops
    - Private trainers
    - College courses
    - Self-study
  - o Training subjects can include, but are not limited to:
    - Person-centered planning and related topics
    - Budget development and budget monitoring
    - Employment issues
    - IDAPA rules and/or Medicaid policies
    - Conflict resolution
    - Maintaining a Circle of Support
    - Community resource identification
    - Integration

A Support Broker may complete a maximum of 6 hours a year (of the required 12 hours) through self-study. Self-study can take the form of reading and/or on-line courses; the Support Broker needs to submit a brief synopsis of the course, including a written description of the material, its location and specifics of how it applies to Support Broker job duties.

Unfortunately, the Department does not have an automated system designed to remind Support Brokers their re-qualification material is due – Support Brokers are responsible for remembering this responsibility. If this material is not submitted, the Support Broker qualification will expire on its anniversary date.

Q: How soon do I need to submit an application for re-qualification?

A: 45 days prior to the expiration date of the current Support Broker Qualification Notice.

Approval of Application for Re-Qualification

If the re-qualification application is approved, a notification letter will be sent prior to the expiration of the current qualification.

Denial of Application

If the re-qualification application does not clearly demonstrate at least 12 hours of on-going training related to Support Broker responsibilities, a notice will be sent that further documentation or additional training is necessary before a person continues to act or work as a Support Broker. This letter will contain specific information to the case. A Support Brokers' current qualification will lapse on the annual renewal date and they cannot bill or be paid for Support Broker services until they receive a notice of continuing qualification.

A person will not be able to continue to act or work as a qualified Support Broker if (s)he has been convicted of a criminal charge which disqualifies him or her from providing Medicaid services or if there is a substantiated report in which they have been found to be the perpetrator in a case of abuse or neglect against a child or vulnerable adult.

Quality Assurance

Support Broker functions are integral to the success of individuals in Consumer-Directed Community Supports. Support Brokers must be experienced in working with individuals with developmental disabilities and knowledgeable of resources and practices in the field. They must perform the functions required by IDAPA rule and additional functions as needed by their employer.

Support and Spending Plans (SSP) are reviewed by the Department to assure that the participant's needs are met and significant risks are addressed. A monitoring review/survey of Support Brokers and their participant files is completed to assure compliance with rules, procedures and policy. Participants and their families will be surveyed to collect information regarding satisfaction. When issues of concern are identified in the participant and family satisfaction surveys, review of complaints and/or *SSP* reviews, the participant may be selected for an enhanced quality assurance review.

Terminating a Support Broker Employment Agreement

The Department of Health and Welfare, Division of Medicaid, may terminate a Support Broker *Employment Agreement* at any time. In most cases, remediation will be attempted prior to revocation. Termination may occur in the event that a Support Broker fails to perform his or her job duties adequately despite a plan of correction.

NOTES:

CHAPTER TWO: STARTING THE JOB

The Employer

Medicaid rules state that the Support Broker's employer is a Medicaid participant (or the parent or legal guardian of a minor child) who has a developmental disability and is in need of active treatment.

Participants can choose the Consumer-Directed Services option or the Traditional Model option in order to receive services for individuals with developmental disabilities. Consumer-Directed Services allow participants to have greater freedom to manage their own care within defined parameters. Participants must hire a Support Broker to act as an ongoing link between DHW, Community Support Workers, vendors, the FEA and other persons as necessary.

Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a Qualified Intellectual Disabilities Professional directed toward the:

- Acquisition of the behaviors necessary for the resident to function with as much self- determination and independence as possible; or
- Prevention or deceleration of regression or loss of current functional status.

Active treatment **does not** include:

- Interventions that address age-appropriate limitations; or
- Physical assistance for persons who are unable to physically perform tasks but who understand the process needed to do them.

Submitting the Enrollment Packets

Once a Support Broker is hired, (s)he will complete an *Employment Agreement* with his or her employer. Prior to being able to bill for services, the Support Broker needs to enroll with a Fiscal Employer Agent (FEA). Payment cannot be made for any services until the *Enrollment Packet* is complete and accepted and an *Employment Agreement* that is supported by the authorized *Support and Spending Plan* is signed.

The FEA *Enrollment Packet* is given to employers when they attend the *Guide to Self-Directed Life* (adult) or *Guide to a Family-Directed Life* (minor child) training. The packet is also available on the FEA website. All information is to be completed and submitted to the FEA. Employers will receive training from the FEA on how to complete forms for enrollment and forms for their employees. Support Brokers must ensure their employer has enrolled with the FEA before they complete their *Support Broker Employment Agreement* and FEA enrollment. Below is a step-by-step guide to the enrollment process:

FEA Enrollment Process for the Employer

The Participant:

- Gets the FEA enrollment packets.
- Completes training with the FEA.
- Completes the FEA enrollment packet.
- Sends the enrollment packet back to the FEA.

The FEA:

- Reviews the packet. If there are errors or the packet is incomplete, the FEA will return the forms for correction and resubmission. Errors and incomplete forms will delay the process significantly; accuracy is critical.
- Notifies the participant and Medicaid of successful enrollment.
- Mails the participant their *Employer Identification Number* (*EIN*). This number is used on all time sheets for the Community Support Workers (CSWs) hired by the employer, including the Support Broker.

It is the Support Brokers responsibility to ensure all paperwork they submit to the FEA is accurate and complete. Errors will delay processing.

FEA Enrollment Process for Employees

Employers will receive an *Employer Identification Number* (*EIN*) when they enroll with the FEA. The Support Broker and other CSWs can now enroll. Employers can submit their own enrollment packets simultaneously with the packets of their employees. Support Brokers and other CSWs receive enrollment and related forms directly from their employer.

Support Broker or other employee will complete the forms as needed. These forms include state and federal tax withholding information and information regarding timesheets and payment. The employee may submit the completed forms to the participant or Support Broker who submits the completed forms to the FEA, or the employee may submit their completed forms directly to the FEA

The FEA will review all of the forms.

If there are errors or the forms are incomplete, the FEA will return the forms for correction and resubmission. Errors and incomplete forms will delay the process significantly; accuracy is critical.

The FEA will notify employees of successful enrollment by mailing the employee an *EIN*. This *EIN* is used on all time sheets.

The Support Broker will sign two *Employment Agreements*:

1. The Medicaid Support Broker Agreement.
2. The Participant Support Broker Employment Agreement.

Employment Agreement templates have been authorized by the Department. Templates of these agreements can be found on the Consumer Direct website. Templates of agreements are also on the FEA website. The *Medicaid Support Broker Agreement* will be part of the employment packet from the FEA once the Support Broker has been hired by a participant. The *Participant-Support Broker Employment Agreement* is filled out with the employer when they reach an agreement regarding job duties. The maximum wage is $18.72 per hour. An employer can pay different hourly rates for different services performed. A Support Broker cannot provide any other paid services to an

employer outside of the Support Broker duties listed on the *Employment Agreement* and *SSP.* The budget for Support Broker duties should not jeopardize the budget needed for other support services.

Items that must be in the *Participant - Support Broker Employment Agreement* include:

- How often a task will be performed and the approximate time each task will take.
- How often the Support Broker will meet with their employer and the Circle of Support.
- Required and requested employment duties, according to IDAPA 16.03.13 (listed in Ch. 1).
- Signature of their employer and their legal guardian, if applicable.

Suggestions for drafting an *Employment Agreement*:

- Identify and list what services will be accomplished and coordinated for the employer.
- Specify how often the Support Broker will meet with his or her employer, how often they will have phone contact and how many hours a month the Support Broker expected to spend in direct contact with the employer.
- List the required job duties and how much time these duties are expected to take.
- List and prioritize discretionary tasks as agreed upon by the Support Broker and the employer.
- Approximate how many hours a week/month will be needed to complete the discretionary tasks.
- Determine if the amount of total time a week/month for required and discretionary tasks fall within the employer's expectation of what Support Broker services will cost. If it doesn't fall within the employer's expectations, make adjustments.
- List the current negotiated wage (maximum wage amount is $18.72 per hour before taxes).

Note: Under the Family-Directed Services program, parents may act as unpaid Support Brokers for their minor child only if they qualify for and obtain a Support Broker qualification.

Q: What if more than one participant wants to use my services?
A: You may have more than one employer, however, regardless of how many you serve, you must maintain high quality services. You must fulfill all requirements with each employer thoroughly and timely and maintain the privacy of each participant.

The Fiscal Employer Agent

Employers must purchase financial management services from a Fiscal Employer Agent (FEA) to participate in the Consumer-Direction option. The FEA provides financial support to participants by:

- Tracking individual expenditures.
- Monitoring overall budgets.
- Performing payroll services.
- Completing employment related documentation and tax responsibilities.

Getting Paid Through the Fiscal Employer Agent

The FEA issues paychecks on behalf of an employer. Contact the FEA directly for assistance filling out the forms or for questions regarding your paycheck.

In order to be paid, a Support Broker must have completed the following steps:
Support Brokers cannot bill, and will not be paid for Support Broker services until they have:

- Passed the exam and received a written notice that they have qualified.
- Submit required, accurate documents with the FEA, including a signed *Employment Agreement*.
- Received their Employee Identification Number (EIN) from the FEA.

- Be enrolled with the FEA.
- Have an EIN issued by the FEA.
- Their employer has reviewed and signed the Support Broker time sheets.
- Have submitted a complete and signed time sheet to the FEA.

Support Brokers are paid according to the time schedule provided by the FEA, pay can only be for actual hours worked. Support Brokers must have their time sheet signed and submitted by specified, predefined dates to ensure payment at the next payroll day. Submitting time sheets electronically via the FEA web site portal is the quickest and preferred method of submission. Support Brokers can only provide one service, that of a Support Broker, which is coded as SBS. A Support Broker can get paid different hourly wages for different Support Broker services, using a qualifying sub-code.

The Good News

"When do I get my first pay check?" is a natural question most people ask when they start a new job. The first paycheck a Support Broker will receive includes all the hours put into developing the *Support and Spending Plan*. Your *Employment Agreement* details the hours including:

- Meeting with the employer and the Circle of Support.
- Helping the employer fill out the *My Voice, My Choice Workbook*.
- Researching and calculating rates for services and prices of goods that need to be purchased.

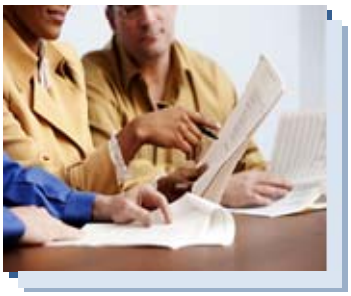
A Support Broker will need to track all the time (s)he spends on support broker duties prior to the authorization of the *Support and Spending Plan.*

The Not-So-Good News

Support Brokers cannot be paid until the *Support and Spending Plan* (*SSP*) is authorized; therefore, they will be doing work initially for payment at a later date. After the SSP is authorized, Support Brokers may submit their first time sheet with the total number of hours they worked to that point. The first time sheet has to be dated after the date the *SSP* was approved, as Medicaid can't pay for services that occurred prior to authorization. The first paycheck to a Support Broker will reflect the hours authorized to meet with the Circle of Support and develop the *SSP.* A Support Broker cannot be paid more than 40 hours of work per week or for duties out of the scope of a Support Broker (e.g., transportation).

In the adult program, if an employer has a current *Individual Service Plan* (*ISP*), and is receiving services through the traditional waiver option, the *ISP* will remain active until the *SSP* goes into effect. The Service Coordinator will continue to provide and bill for services. The Support Broker will need to work with the Service Coordinator during crucial transition months - the Service Coordinator can provide valuable information and ensure that contact is maintained with current services and Medicaid. Service Coordinators will be expected to continue with their normal job duties until the current *ISP* expires and are responsible for handling service needs and any problems that arise during this time.

In the children's program, your Case Manager will continue to work with you and your Family-Direction Case Coordinator to ensure a smooth transition. The traditional model *Plan of Service* will never overlap with the *SSP*; when the *Plan of Service* ends, the *SSP* will begin.



CHAPTER THREE: THE SUPPORT AND SPENDING PLAN

Steps to Develop a *Support and Spending Plan*

The *Support and Spending Plan (SSP)* is the key to an employer's ability to manage services. The intent of the *SSP* is to ensure the participant gets the help they need to become as independent as possible. The *SSP* must include goals that the participant wants to achieve within the next year that support increased independence. The plan also includes information about what can be done to reach goals without paid supports and services (i.e., through natural supports).

The Circle of Support

The first step in building a *SSP* is to identify a Circle of Support. According to IDAPA 16.03.13, the Circle of Support consists of people who encourage and care about the participant and are willing to help develop the *SSP*. Work the Circle performs on behalf of an employer is not paid.

The participant's Circle of Support should be built and operated with the primary goal of working in the interest of the participant. The group's role is to give and get support for the participant and to develop a plan of action, along with, and on behalf, of the participant to help the participant accomplish his personal goals.

A Circle of Support may include family members, friends, neighbors, co-workers and other community members. In the adult program, when a participant's legal guardian is selected as a Community Support Worker, the Circle must include at least one non-family member that is not the Support Broker. Members of the Circle of Support will be chosen by the participant and commit to:

- Helping promote independence and improve the life of the participant in accordance with the participant's choices; and
- Meeting on a regular basis to assist the participant to accomplish expressed goals.

Additional information on the Circle of Support for adult participants can be found in Module 'C' of the Support Broker training curriculum on the Self-Direction website.

Natural Supports

A natural support may perform any duty of the Support Broker as long as the Support Broker still completes the responsibilities required in rule. A natural support may also perform any task for the participant as long as they are qualified and possesses the necessary training or certification. Supports provided by a natural support must be identified on the participant's *SSP*, but time worked does not need to be recorded or reported to the Fiscal Employer Agent (FEA), as they are unpaid.

Use the Guide Manuals

The *Guide to a Self-Directed Life* is the consumer handbook that has been developed for adult participants in the Self-Directed Services Option. The *Guide to Family-Direction* is the handbook for families and legal guardians with a minor child participant in the Family-Directed Services Option. The *Guide Manual* is given to each participant during the Guide Training. These *Guide Manuals* give specific directions and instructions for participants and suggest that they use their Support Broker to help identify members of their Circle of Support.

It is important that participants use natural (unpaid) supports as much as possible as each participant has a limited budget. The Support Broker fee must comprise only one small part of that budget.

The Person-Centered Planning Process and the *My Voice, My Choice Workbook*

Person-centered planning is the foundation of consumer-driven support planning. Person-centered planning means that a participant's needs and goals define the *Support and Spending Plan (SSP)*. The *My Voice, My Choice Workbook (Workbook)* prompts the Circle of Support to focus on the participant.

The *Workbook* helps employers identify how they want to spend their individualized budget. An employer may ask for help when filling out the *Workbook*. Each participant will be given a copy of the *Workbook* during training. The *Workbook*:

- Can be downloaded from the self-direction or family- direction web site.
- Should be used to help an employer identify long-term goals and needs.
- Should contain both long and short-term goals.
- Will assist an employer break down long-term goals into short-term tasks that can be accomplished within the one-year time span of their *SSP*.
- Will become the foundation of the *SSP*.
- Must be returned with the completed *SSP* to the Regional Care Manager for adult participants or the FACS Case Coordinator for minor child participants. Make sure you or your employer makes a copy of the *Workbook* and the *SSP* before turning them in to the Department.

Support Brokers need to be mindful of how much time they spend with their employer helping with the *Workbook*. Identify how many hours it will take to complete the person-centered planning meetings and help with the *SSP*. These duties and hours must be included in the *Employment Agreement*.

Your employer may need the help of other professionals to complete portions of the *Workbook*. The *Workbook* includes information on health and safety risks and needs. Health professionals and therapeutic care providers may need to be consulted. While reviewing the *Workbook*, please note how much time is needed in gathering health and safety information from others. Make sure this time is included in the *Support Broker - Employment Agreement*.

The Individualized Budget

The individualized budget is the amount of Medicaid money that each individual can spend annually to purchase allowable supports and services. The individualized budget is set through a specific process based on each participant's assessed and identified needs. Participants are advised of their budgets in the eligibility approval letter.

Support Brokers need to know the individualized annual budget amount for each employer and ensure the services and supports don't exceed that amount prior to submitting a *SSP*. Participants cannot exceed their annual budget. If their employers cannot budget their expenses to fit within their individualized budgets, their Support Broker will need to help them review their options.

Calculate Allowable Expenses

The individualized budget will be used to purchase an employer's authorized supports and services. The budget must also pay for the FEA, Support Broker services, Community Support Worker services, and necessary equipment and supplies. The *SSP* provides worksheets to help with necessary budgeting. The Community Support Worker (CSW) provides identified supports to the participant. If the identified support requires specific licensing or certification within the State of Idaho, the CSW must have the applicable licensing or certification.

Support Brokers should help their employers figure out the costs of each service they want to use. The Support Broker is responsible to make sure each service is allowable, according to IDAPA 16.03.13 and guidelines distributed by the DHW. See *Appendix A* for guidelines for allowable goods and services for each type of support category. The adult and children's program have separate guidelines as allowable expenses for adults and children are different. The FDS Allowable Expense sheet also includes information on the process to obtain goods, including Durable Medical Equipment.

Identified supports include activities that address the participant's preferences and needs for:

- **Job support** to help secure and maintain employment or attain job advancement;
- **Personal support** to help maintain health, safety and basic quality of life;
- **Relationship support** to help establish and maintain positive relationships with family members, friends, spouse or others in order to build a natural support network and community;
- **Emotional support** to help learn and practice behaviors consistent with goals and wishes while minimizing interfering behaviors;
- **Learning support** to help learn or improve skills that relate to identified goals;
- **Transportation support** to help accomplish identified goals, participants can pay a Community Support Worker for miles that they drive or pay them by the hour while transporting them to and from services and activities approved on the *SSP*;
- **Adaptive equipment** identified in the participant's *SSP* that meets a medical or accessibility need and promotes increased independence; and
- **Skilled nursing support** identified in the participant's *SSP* that is within the scope of the Nurse Practice Act and is provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

Support Brokers are responsible for knowing which expenses are, and which are not, allowed by the Department and the Consumer-Directed Program. There is a significant difference between allowable expenses of the Self-Direction and Family-Direction Programs.

Review Rates and Budgeting

Support Brokers can help their employer negotiate wages and rates. Participants are not bound by previously negotiated Medicaid rates, but cannot pay over fair-market rates for their supports and services. As long as those services are allowable under the Medicaid rules and guidelines, the cost is negotiable. The Idaho Department of Labor is a good resource in determining a fair-market rate.

In the children's program, Family-Direction, the annual maximum rate of pay per hour for each employee and contractor must be listed on the *SSP* under the appropriate support category. The employer will likely start the CSW out at a lower wage and give raises through the year to reach the maximum listed on the *SSP*. If an employer wishes to go above the rate on the SSP, he or she must submit a *Plan Change Form* to the Case Manager/Coordinator. If approved, the employer will need to submit a new *Employment Agreement* to their FEA. The new rate of pay is now considered the annual maximum and cannot be exceeded.

In Self-Direction, the starting wage can be on the plan, and raises can be given by submitting a new Employment Agreement.

The *SSP* includes specific worksheets for budgeting. These worksheets should be used to help an employer calculate the cost of each paid service/support. Instructions on how to use the budgeting

sheets are included in the *SSP*. Support Brokers should help their employer by remaining knowledgeable about community resources.

Employer's Taxes

When an employer hires a CSW to provide hourly services, the employer is responsible for paying payroll "withholding" taxes, which are computed as a percentage of the negotiated hourly wage. This additional cost is the employer's share of Social Security, Medicare, and federal and state unemployment taxes. This additional amount needs to be included in the hourly wage on the *SSP Authorization* pages, and represents the total cost for each hour worked by a CSW. The rate of the employer taxes is subject to change annually, and typically ranges between 11-13%. The FEA will include a chart in the enrollment packet which will help calculate employer taxes based on an hourly rate of pay. Employers can use this chart when filling out their *SSP* budget amounts. For example, if an employer is paying a CSW $10.00 per hour, and the employer taxes are 12%, the total amount budgeted on the *SSP*, is $11.20.

$10.00 x .12 = 1.20 ⇨ $10.00 + 1.20 = $11.20

Employers don't pay payroll taxes for independent contractors, vendors or agencies as they are all types of contractors. The IRS and federal and state labor laws prohibits paying employees, such as a CSW, as independent contractors. Misclassified employees will not receive protections to which they are entitled, such as family and medical leave and unemployment insurance. Additionally, they will be responsible for a larger tax burden. Under Idaho law, an independent contractor is free from direction and the employer does not control how the work is performed. An example of a contractor could be an established hippotherapy provider, a service in which the employer purchase services, but does not create a detailed job description telling staff when, where and how to their job. Rather the participant will receive the service as created and controlled by the hippotherapist.

Some Idaho laws also require that independent contractors be established businesses, which may include having business expenses and income. IRS *Publication 1779* gives guidelines to employers in determining whether a specific individual is a contractor or an employee. If an Employer is unsure whether an individual is an employee or an independent contractor, (s)he may contact a local Idaho Department of Labor tax representative for guidance.

Calculating Sales Tax

Employers will need to pay sales tax on goods purchased from a vendor. The only exception may be in the case of some items prescribed by a professional health practitioner.

An employer may need to purchase specific goods to help remain as independent as possible in the community. For example, an adult participant may need to purchase a microwave because (s)he is unable to use a stove safely and need a microwave to safely cook hot meals independently. This would be an allowable expense for an adult participant as it will help the participant remain in the least restrictive and most normal setting.

The employer needs to include the price of the microwave and sales tax on the *SSP*. So, if the microwave costs $50.00, your employer must put the total amount needed, including sales tax, on their plan: The total cost would be $53.00, given a 6 percent sales tax.

50 x .06 = 3.00 ⇨ 50.00 + 3.00 = 53.00

Tax Exempt Items

Some items prescribed by a physician, podiatrist, chiropractor, dentist, optometrist, psychologist, ophthalmologist, nurse practitioner, denturist, orthodontist, audiologist or hearing aid dealer/fitter may be tax exempt when purchased through certain vendors specializing in medical or habilitative goods and supplies. This could include durable medical equipment, such as prosthetic devices and medical supplies such as catheters. If your employer routinely uses the above items, please check to see that a prescription has been written for the good by the employer's physician.

Home Alone Time Requests in a Certified Family Home

Requests for "home alone time" are submitted to the Regional Care Manager on the *Support and Spending Plan* (*SSP*) or may be requested any time during the plan year using the *Support and Spending Plan Change Form* (*SSPC*). The *SSP* or *SSPC* must identify a goal for "home alone time" and identify in the 'Activities' section of a *My Support Plan* page what activities the person is able to do on their own that allows them to safely stay home alone (i.e., call 911, call CFH provider on cell phone, exit home without assistance in the event of a fire, go to neighbor's house for assistance, not answer the telephone or door while alone, able to get a snack to eat on their own, etc.).

A back-up plan must be developed that identifies those person(s) the participant can contact for assistance when using 'alone time'.

When evaluating the participant for 'home alone time', the Support Broker/Circle of Support may use the following questions to guide the discussion. This list is just an example and is not considered to be all-inclusive of what should be considered to ensure each participant's health and safety.

- How has the participant demonstrated an ability to successfully respond to a variety of emergency situations? The Circle of Support should be able to verify the following:
    - Can the participant independently evacuate the residence in the event of a fire?
    - Can the Circle of Support provide reasonable details that support the participant is able to demonstrate an ability to appropriately respond to a variety of situations that may present when they are home alone (e.g., telephone rings, a knock at the door, problems when using household appliances, sustains a minor or major injury, etc.).
    - Are back-up supports available to a participant while using 'alone time'?
    - Does the participant have the ability to recognize the need for and seek emergency help?
    - Does this request for 'home alone' time include the participant being able to go out into the community while on 'home alone time'?
        - If 'no', does the participant have a history of compliance when it comes to following directions (e.g. not leaving the home by themselves)?
        - If 'yes', Support Broker/Circle of Support should be able to provide reasonable details to support the participant is able to demonstrate an ability to navigate the community in a safe and effective manner (e.g. does the participant understand 'stranger danger', how and who would they contact in an emergency situation while in the community, are they at risk for exploitation, do they have a history of behaviors that would put them or the community at risk if they are out and about on their own, etc.).
        - If the participant wishes to increase the number of hours of "home alone time" approved on the annual *SSP* or *SSPC* form, the increased number of hours must be requested and approved through an updated *SSPC* form prior to increasing the number of hours a participant spends in 'alone time'. This change form would not go to the FEA.

Goods and Supplies for Children

To be considered for funding under the Family-Directed Services program, goods and services require written recommendation from a licensed medical practitioner, occupational therapist, physical therapist, speech language pathologist or psychologist stating that the purchase meets the criteria below:

- Safe and effective treatment that meets acceptable standards of medical practice.
- Needed to optimize the health, safety and welfare of the child.
- Least costly alternative that reasonably meets the child's need.
- For the sole benefit of the child.

Goods and services must also meet the criteria below. The good or service must:

- Maintain the ability of the child to remain in the community.
- Enhance community inclusion and family involvement.
- Decrease dependency on formal support services and thus increase independence of the child.

All services must be required to meet the child's needs directly related to their developmental disability as identified on their annual *Support and Spending Plan (SSP*).

The SSP must not include a request for goods and services as a substitute for human assistance and request the same type of assistance from a person. Additionally, a *SSP* should not include request for human assistance when there is a previous approval for goods and services as a substitute for human assistance unless justified.

In the Family-Direction Program, all durable medical equipment and supplies over $100.00 must first be requested through a Medicaid vendor according to Medicaid's Durable Medical Equipment (DME) policy. See *Appendix K* for detailed instructions for this process. If the good is not eligible for funding through the DME program, funding can be considered through the FDS program.

If the item is not typically funded through Durable Medical Equipment, it is not necessary to request funding through a Medicaid vendor.

> In FDS, If an item is not typically funded through Durable Medical Equipment as shown in Appendix K, it is not necessary to request funding through a Medicaid vendor.

Vendor Payments for Ongoing Services or Goods

Vendors can be paid up to 3 months in advance for ongoing goods or services. The Case Coordinator/Care Manager will authorize 12 months of services on the *SSP*, but the employer/Support Brokers will only be able to submit *Vendor Requests Forms,* which request payment for services and goods in up to 3-month increments. Prepayments should not be made unless necessary.

Developing the *Support and Spending Plan*: What Must Be Included?

According to IDAPA 16.03.13, participants, with the help of their Support Broker, must develop a comprehensive *Support and Spending Plan* (*SSP*) based on the information gathered during the person-centered planning meeting. The *SSP* is not valid until authorized by the Department.

The *SSP* must include the following:

- Active treatment goals: Goals must support the participant in his or her choice to live as independently as possible in the community. Goals must be concrete, realistic and meet the

definition of active treatment. The program must support the acquisition of behaviors necessary for the participant to function with as much self-determination and independence as possible. This must include services for prevention or deceleration of regression or loss of current optimal functioning. (See page 13 for the definition of *active treatment*)

- Details on tasks or parts of tasks that the participant can perform independently, without a paid support.
- All natural supports available for assistance.
- Paid supports must be:
  - A safe and effective treatment that meets acceptable standards of medical practice.
  - Needed to optimize the health, safety and welfare of the participant.
  - The least costly alternative that reasonably meets the participant's need.
  - For the sole benefit of the participant.
- Goods and services must:
  - Maintain the ability of the participant to remain in the community.
  - Enhance community inclusion and family involvement.
  - Decrease dependency on formal support services and thus increase independence of the participant.
  - Paid or non-paid Community-Direction program supports must focus on the participant's wants, needs and goals in the following areas:
    - Personal health and safety including quality of life preferences.
    - Securing and maintaining employment.
    - Establishing and maintaining relationships with family, friends and others to build the participant's Circle of Supports.
    - Learning and practicing ways to recognize and minimize interfering behaviors.
    - Learning new skills or improving existing ones to accomplish set goals.
- Support needs such as:
  - Medical care and medicine (necessary for adult plans only).
  - Skilled care including therapies or nursing needs.
  - Community involvement.
  - Preferred living arrangements, including possible roommate(s).
  - Responses to emergencies, including access to emergency assistance and care.

Person-Centered Planning

Following the principals of person-centered planning, the *SSP* must reflect the wants, preferences and needs of the participant.

In the Family-Direction Program, the planning process is facilitated by the participant's parents, or legal guardian. Unlike the adult program, all supports and services the child receives related to his or her developmental disability do <u>not</u> have to be on the *SSP*. These services can be still purchased with the child's Medicaid card and do not decrement the child's budget. For example, goods purchased through the DHW Durable Medical Equipment Unit, transportation, physical therapy, occupational therapy and speech language therapy services all must be on the *SSP*, however, they don't have to be carried over to the authorization page be deducted from the *SSP* budget. Through these supports and services, the *SSP* must clearly demonstrate how:

- The child's assessed needs are being met, and
- Services and supports, paid and unpaid, are ensuring the child's health and safety.

Plans that do not include supports and services to address health and safety concerns will not be approved. It's the Support Broker's role to ensure that these needs are being addressed.

All health and safety needs must be addressed in the SSP for both children and adults.

Documentation of goods and services must address the following:

- How goods and services "*increase independence or provide a substitute for human assistance; and decrease the need for other Medicaid services.*"
- Ensure the *SSP* does not include both a request to purchase individual goods and services as a substitute for human assistance and a request for the same assistance from a person.

If goods and services have previously been approved and purchased as a substitute for human assistance, the participant should not request the assistance of a person for that same support without appropriate documentation to justify the additional personal support.

In certain circumstances, a *SSP* may identify the need for two Community Support Workers (CSWs) to complete the same task at the same time during any part of the support schedule. A Care Manager or Case Coordinator may authorize this request when there is documentation attached regarding:

- A detailed description of why the participant's health and safety cannot be assured without a second CSW.
- A notation that the *SSP* costs are within the participant's assigned budget.
- The use of the second CSW provides for the participant's needs without using a more costly support. The *Two CSWs Form* must be completed when two CSWs bill at the same time for the same task and must be attached to the *SSP*. The use of two CSWs must also be noted within the *Support Plan* sections of the *SSP* and on the *Employment Agreements* for each CSW.
- Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three backup plans for each identified risk to implement in case the need arises;
- Sources of payment for the listed supports and services, including the frequency, duration and main task of the listed supports and services; and
- The budgeted amounts planned in relation to the participant's needed supports. Community Support Worker *Employment Agreements* submitted to the FEA must identify the negotiated rates agreed upon with each Community Support Worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment. The FEA will compare and match the *Employment Agreements* to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment.

Care Mangers and Case Coordinators will approve these types of requests on a case-by-case basis. If approved, they will submit the *Two CSWs Form* along with the *SSP Authorization* to the FEA. The FEA will use the *Two CSWs Form* as a trigger to by-pass their security protocol. In these instances, paper time sheets must be submitted and a manual review of all the time sheets being submitted for that participant is required.

Identifying Related Risks

As Support Brokers help their employers fill out the *My Voice, My Choice Workbook*, they will notice that there are many prompts to help identify risks. When completing the *Workbook*, all risks need to

be identified on the *Health and Safety Plan Worksheet.* A risk is a hazard that could endanger the participant's health or safety. The prompts include questions about health and safety to help identify possible risks. Below are examples of prompts regarding health and safety:

- "Who knows about your health and safety needs?"
- "Are there any behavior that may put your child or others at risk?"
- "Are there any relationships you are uncomfortable with?"
- "What help do you need at home to make sure things get done that are important to you and your well- being?" (Self-Direction example)

For example, in the Self-Direction program, if an employer needs a CSW to supervise him or her to ensure the participant takes prescribed medication and help the participant prepare a meal every morning. This participant may be at risk if the CSW does not come to work unexpectedly. This example would not pertain to Family-Direction as a child would not be left alone if a CSW does not come to work, it would be the parent's role to step in and supervise their child when necessary, or make alternative arrangements.

In the Family-Direction program, perhaps a child has medication that he must take immediately when he shows warning signs of an upcoming seizure. Not having the medication promptly could put his health at risk. The CSW should be trained on administering the medication, but what if the CSW is temporarily unavailable? Other adults in the immediate environment could be trained as a back-up plan.

Safety and Back-up Plans

If a risk identified is an issue of "immediate jeopardy" to the participant's health and safety, three realistic back-up plans must be developed and included in the *SSP*. The back-up plans should be based on the participant's need for services to avoid a risk to health or safety.

In the previous example, the adult participant may be in immediate jeopardy if a scheduled CSW doesn't show up to work., therefore, the *SSP* must include three back up plans on how this situation will be dealt with to assure the health and safety of the participant. For example, in this situation, the back-up plans could include:

- Phone a back-up CSW with whom an "emergency service" arrangement has been made
- Contact a next-door neighbor who has agreed to act as back-up in an emergency situation
- Phone his or her guardian, if applicable, who has agreed to handle these situations

If a child exhibits any behaviors that put him or others at risk, there has to be a detailed safety and back-up on the *SSP*.

The Risk Identification Tool

The safety and back-up plans are risks identified on the *Health and Safety Plan Worksheet*. There is a checklist available in *Attachment D* to help identify risks. As covered in the last section, all risks identified involving immediate jeopardy to the participant's health and safety must have a corresponding *SSP Back-Up Plan* that addresses the risk. However, depending on the nature of the support provided to lower the risk, there may not be an issue of "immediate jeopardy".

A back-up plan must be developed for situations that place the participant's health and safety in "immediate jeopardy".

Participants may have health conditions or be more susceptible to medical emergencies that endanger their health and safety and place them in immediate jeopardy. These types of risks, such as the ones listed below, need to have back-up plans on the *SSP*.

- Seizures
- Dehydration
- Constipation
- Choking

Be sure to consult with the participant's physician, when appropriate, prior to writing a back-up plan.

Support and Spending Plan **Limitations**

According to IDAPA 16.03.13.160, the *SSP* limitations include:

- Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and consumer-directed services at the same time, the participant, the Support Broker, and the Department must all work together to assure that there is no interruption of required services when moving between traditional services and the CDCS option;
- Services may be purchased from a developmental disability agency (DDA) that also provides services in the traditional model. The cost and service would be negotiated by the employer. If a employer wishes to enter into this type of agreement, it is mandatory to identify specific Community Support Workers (CSW) who will be supplying services under this agreement. The CSW remains the employee of the agency, but will provide individual services as directed, controlled and approved by the participant. The agency/CSW would have to agree to enter into a vendor agreement with a Fiscal Employer Agency (FEA), submit an invoice to the FEA and receive payment from the FEA. You can review the *Participant-Agency/Community Support Worker Employment Agreement* and instructions at http://www.consumerdirectonline.net/idaho/# (under Idaho FEA forms on right side)
- All paid community supports must fit into one or more types of supports described IDAPA 16.03.13.
- Community supports must be:
  - A safe and effective treatment that meets acceptable standards of medical practice.
  - Needed to optimize the health, safety and welfare of the participant.
  - The least costly alternative that reasonably meets the participant's need.
  - For the sole benefit of the participant.
- Supports must:
  - Maintain the ability of the participant to remain in the community.
  - Enhance community inclusion and family involvement.
  - Decrease dependency on formal supports and thus increase independence of the participant.
- Additionally, the *SSP* must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others.
- Community supports for minor children must not supplant the role and responsibility of a parent or legal guardian.
- Community supports must not be provided in a group setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services.
  - This limitation does not preclude a participant who has selected the Self-Directed option from choosing to live with recipients of traditional Medicaid services.
  - This limitation does not preclude participants from participating in community social or other events with their peers.

- CSW services can only be provided on a one-on-one basis, providing services in a group format is not allowed.
- *SSPs* that exceed the approved budget amount will not be authorized.
- The FEA will not pay a CSW for services that exceed the agreed upon amount authorized on the *SSP*. Time sheets or invoices submitted in excess of the *SSP* agreement will not be paid.

Writing the *Support and Spending Plan*

The following list may help in writing the plan:

- Know what must be included in the *SSP*.
- Make a list of the participant's goals and needs for the plan year, as identified in the *Workbook.*
- Have the employer identify who is in the Circle of Support.
- The Circle of Support is involved with developing and creating the plan.
- Review the *Guide to a Self-Directed Life* or *Guide to a Family-Directed Life.*
- Review the *Workbook* to ensure that it is completely and thoroughly filled out.
- Know the amount of the annual individualized budget.
- Know what services and supports (allowable expenses) can be purchased with Medicaid funds and the usual rates for allowable services.
- Know all services the participant is receiving, both paid and unpaid. All services that are related to the participant's developmental disability need to be on the plan even if they are not included in the budget. For example, physical therapy services obtained at an outpatient clinic.
- Explore and identify natural supports, community resources and low-cost alternatives.
- Identify the risks and back-up plans.
- Have your employer and the Circle of Support identify how to access community resources.
- Identify what times and days the participant may need or want supports and services.
- Ask questions about how often extra help is needed.
- Find out if paid support during vacations is needed.
- Identify what the participant can do independently.
- Ensure the employer is in agreement with the information in the *Workbook*. If they do not agree, keep working with him or her and their Circle of Support until they do agree with what has been created.

Once you have completed all the steps and located the above information, the *Workbook* will be used to transfer information to the *SSP*. The plan has instructions for completing each step. Once the budget pages are complete, the *Workbook* and *SSP* is submitted to the Medicaid Care Manager if the participant is an adult, or Family and Community Services (FACS) Case Coordinator if the participant is a minor child.

More Tips for filling out the *SSP*:

- Read all the instructions.
- Make sure all pages are complete and correct.
- Identify specific, concrete goals that can be accomplished within the one-year plan timeframe.
- Type the *SSP.*
- On the *SSP's Authorization* sheet, place zeros in the support sections that will not be used.
- The FEA cost must be included in the budget.
- The total costs of all employees and goods must be included on the plan's *Authorization* sheet, including the employer and sales taxes.

In the Meantime: Your Employer's Service Needs

The completed *SSP* is submitted for authorization to the Medicaid Care Manager if the participant is an adult, or to FACS Case Coordinator if the participant is a minor child. While they are going through this process, the participant will continue with their usual services. If the participant is transitioning from the traditional model and this is the first time (s)he is accessing the Consumer-Directed Services Option, there may be an *Individual Service Plan* or a *Plan of Service* still active. The current Plan Manager or Service Coordinator will need to be actively involved in ensuring that the participant's services continue. The current Plan Manager or Service Coordinator is responsible for requesting an extension, if necessary.

Note: The Consumer-Directed Service option does not have the ability to extend service plans. The participant will receive a notice regarding eligibility re-determination 120 days prior to the end of the plan year. After eligibility for the program is re-established, the Support Broker and an employer have 90 days to complete a new *SSP*. It is important that a new plan is completed and submitted to the plan reviewer for review 45 days prior to the end of the current plan year.

Re-determination ⇨	**Write new plan** ⇨	**Submit to DHW for review**
120 – 90 days before the end of the SSP.	90 - 45 days 45 days to write SSP	45 prior to end of SSP

The Idaho Council on Developmental Disabilities has information on current events and other topics. Contact them at:

700 W Sate St., Boise, Idaho 83702-5868
(208) 334-2178 or 1-800-544-2433

Email: **icdd@icdd.idaho.gov** Web: **www.icdd.idaho.gov**

NOTES:

CHAPTER FOUR: GETTING THE PLAN AUTHORIZED

Make sure the *Support and Spending Plan (SSP*) reflects the participant's goals and includes supports to help him or her become who they want to be. Use the Medicaid Care Manager or Family and Community Services (FACS) Case Coordinator as a sounding board or reference as needed. Remember, the *SSP* must reflect the concepts of active treatment, both Self-Direction and Family-Direction plans must reflect a person/family centered planning process.

Presenting the Plan to the Plan Reviewer

The participant and the Support Broker will submit a *SSP* to the Medicaid Care Manager via the Information Coordinator, Kristy Swinford either by fax at (208) 332-7297 or by email at BDDACM@dhw.idaho.gov if the participant is an adult, or to the FACS Case Coordinator if the participant is a minor child. The *SSP* should be submitted for review 45 days prior to the start date of the plan. The Department reviewer has 10 business days to review the plan and respond. Support Brokers and employers should always make a copy of all documents that are submitted.

The plan reviewer reviews the plan using the following criteria:

- Services and supports meet the guidelines for allowable expenses.
- Services and supports do not exceed the approved budget amount.
- The *My Voice, My Choice Workbook* is included with the *SSP*.
- The completed *Health and Safety Plan* form is included in the *Workbook*. Any risks identified on the form or on the *Risk Identification Tool* have a corresponding support plan.
- Each service or support includes the annual cost, source of payment, frequency, duration, and an associated goal.
- The *SSP* is typed.
- Each field on the *SSP* is completed, even if only with N/A (not applicable) or zeros.
- *Informed Consent and Choice Statement* on the demographic page is signed and dated.

If a Community Support Worker (CSW) resides in the same home as the participant and is providing care within the home, the residence must be certified as a Certified Family Home by the Department and the home must follow all the Rules governing Certified Family Homes. These rules are found in *IDAPA 16.03.19 Rules Governing Certified Family Homes* and include:

- Supervision: Appropriate, adequate supervision for 24 hours each day unless the participant's plan of service provides for alone time.
- Daily activities and recreation: Daily activities, recreational activities, maintenance of self-help skills, assistance with activities of daily living (i.e., The performance of basic self-care activities in meeting a participant's needs to be sustained in a daily living environment, including bathing, washing, dressing, toileting, grooming, eating, communicating, continence, managing money, mobility and associated tasks) and provisions for trips to social functions, special diets, and arrangements for payments.

- Medical: Arrangements for medical and dental services and monitoring of medications. If the resident is unable to give medical consent, the provider will give the name and contact information of the person holding guardianship or power of attorney for health care to any health care provider upon request.
- Furnishings and equipment: Linens, towels, wash cloths, a reasonable supply of soap, shampoo, toilet paper, sanitary napkins or tampons, first aid supplies, shaving supplies, laundering of linens, housekeeping service, maintenance, and basic television in common area. Additionally, the following will apply:
    - Resident living rooms must contain reading lamps, tables, and comfortable chairs or sofas;
    - The resident must be provided with his own bed which must be at least thirty-six (36) inches wide, substantially constructed, and in good repair. Roll-away type beds, cots, folding beds, or double bunks must not be used. The bed must be provided with springs which are in good repair, a clean and comfortable mattress which is standard for the bed, and a pillow;
    - The resident sleeping room must be equipped with a chair and dresser, substantially constructed and in good repair;
    - On request, each sleeping room must be equipped with a lockable storage cabinet for personal items for each resident, in addition to the required storage in resident sleeping rooms;
    - Adequate and satisfactory equipment and supplies must be provided to serve the residents. The amount and kind will vary according to the size of the home and type of resident; and
    - A monitoring or communication system must be provided when necessary due to the size or design of the home.
- Plan of service: Development and implementation of the plan of service for private-pay residents and implementation of the plan of service for state-funded residents.
- Activity supplies: Activity supplies in reasonable amounts that reflect the interests of the resident.
- Transportation: Arrangement of transportation in reasonable amounts to community, recreational and religious activities within 25 miles of the home. The home must also arrange for emergency transportation.
- Room, utilities and meals: The home must provide room, utilities and 3 daily meals to the resident. The charge for room, utilities and 3 meals must be established in the admission agreement.

A copy of the current Certified Family Home certificate must be submitted along with the *SSP* when care is being provided to the participant in the home of the Community Support Worker. If the participant will receive less than 24 hour paid supports the *SSP* must include back-up plans addressing how the participant's health and safety needs will be met during that time (e.g., natural supports, job supervision, alone time). Any alone time requested should include a back-up plan indicating how much time alone the participant will receive per day or per week, when the alone time is likely to occur and where the alone time will occur.

Take the Next Step:

After reviewing the *Support and Spending Plan,* the Plan Reviewer can either approve the plan, recommend changes needed to approve the plan, or deny the plan. Make sure you and your employer are ready for any outcome.

Approval of the Plan

If the *SSP* is approved, the DHW plan reviewer will:

1) Send the employer, FEA and Support Broker a copy of the *SSP and SSP Authorization Notice.*
2) Pre-authorize the budget associated with the approved *SSP*.
3) Deactivate any outstanding prior authorizations for any traditional services.

Recommended Changes

If the *SSP* is not approved as submitted, the plan reviewer will call or email the Support Broker (or parent, if submitted by a parent) with the following information:

- Reasons why the *SSP* was not approved.
- Instructions for re-submitting the plan if modifications are to be made.
- Instructions to request a Hearing, should the participant decide not to modify and re-submit the *SSP*.

If the re-submitted plan is approved, the plan reviewer follows the approval process.

When the Plan is Denied

If a participant disagrees with the budget amount and/or eligibility determination, (s)he has the right to appeal the Department's decision and request due process. Appeals will follow the Department's standard administrative process found at IDAPA 16.05.03 "Rules Governing Contested Case Proceedings and Declaratory Rulings".

The Fair Hearing Appeal

If the participant does not appeal the denial within 28 days, their Consumer-Directed Community Supports file will be closed. The participant can elect to use traditional services if this is an initial plan, or remain with their traditional participant service plan if they were transitioning to the Consumer-Directed Option from the traditional ~~s~~services.

If the participant does appeal within 28 days, the "*Rules Governing Case Proceedings and Declaratory Rulings"* (IDAPA 16.05.03) will be followed. The appeal rights and how to access the process is included in the Denial Notice that the participant receives when their *SSP* is denied.

Q: What happens if the current plan expires before a new plan is authorized?

A: Make sure to get the new plan to the plan reviewer 45 days prior to expiration of the current plan, to give ample time for review and time for changes as needed. If the participant's plan isn't authorized by the expiration date, the participant has the choice to return to traditional Medicaid DD services while continuing to negotiate a new SSP.

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CHAPTER FIVE: THE ROLE OF THE FISCAL EMPLOYER AGENT

What Does the Fiscal Employer Agent Do?

The Fiscal Employer Agent (FEA) will:

- Provide enrollment packets to participants, including employment forms for employees.
- Provide training on the enrollment process and employment forms.
- Check to ensure that employees are not on the *Medicaid Exclusion List*.
- Provide payment for all authorized services and goods that the employer receives through the Consumer-Directed Services Option, including taxes to state and federal taxing bodies on behalf of the employer.
- Provide monthly expenditure reports to the employer.
- Handle complaints and issues related to payroll and purchase problems.
- Provide other reports that the Department needs to monitor the quality of the service.

The FEA will give each participant an enrollment packet at the Guide Training. The enrollment packet includes forms to authorize the FEA to act as a payroll agent for the employer and to pay employees. The packet includes all the necessary tax forms for employees, *Employment Agreements* and waiver forms.

What Does the FEA Need to Do Their Job?

The FEA needs the following in order to process payroll and requests for vendor payments:

- A copy of the authorized *SSP* from the Medicaid Care Manager or FACS Case Coordinator.
- Notification from the Department that prior authorization for specific service codes have been entered into the Medicaid payment system.
- Complete and correct *Employment Agreements* for each employee.
- Current certification or licensure for each employee as required.
- Current Criminal History Background Check clearance for each employee as required, or *Waiver of Criminal History Check* form.
- Complete and correct tax forms, including the W-4 and the I-9.
- An accurate and signed timesheet for each employee.
- A voided receipt and *Request for Vendor Payment* for each purchase of goods (see next section).
- An agreement between the insurance company and the employer regarding Worker's Compensation Insurance, if requested.
- If an employee submits a time sheet and does not have proper authorization for billing, or the time sheet exceeds the amount authorized, the FEA will not pay the employee. The FEA will contact the employer to notify him or her of the situation.

How Does the FEA Pay for Purchased Goods?

When your employer needs to purchase an item that is authorized on the SSP and covered under their individualized budget, the FEA pays the bill for the item. An employer must take the following steps to ensure payment for goods and services:

- Obtain a voided receipt for the item the employer wants to purchase from the vendor.
- Fill out the *Request for Vendor Payment* form (this form is in the enrollment packet).
- Mail the voided receipt with the *Request for Vendor Payment* form to the FEA.
- The FEA will send the employer a check for the exact amount on the voided receipt, made out to the vendor. The stub attachment will state specifically what can be purchased with the check.
- The FEA will not reimburse an employer for a purchase they have already made.
- The FEA will not send a check for an item that is not specified and authorized on the plan.
- The check it can be taken to the vendor to purchase the item(s).
- The employer must save the receipt for the item and attach it to the stub attachment. The receipt will be checked by Medicaid to ensure it matches the attachment for the specific item that was authorized.

Goods other than the specified item cannot be purchased with the check disbursed by the FEA.

If for some reason the good costs less than the amount on the check, the extra funds must be returned to the FEA.

An *Employment Agreement* is submitted whenever the vendor is also an independent contractor or an agency. The appropriate *Employment Agreement must be used* to specify the number of hours, job tasks and wage. The *Employment Agreement* should be submitted with the *Request for Vendor Payment* to the FEA.

The Support Broker is responsible for submitting neat, organized and accurate paper work to the FEA. Inaccurate or unorganized paper work could delay the process significantly. Be sure to use the same form of the participant's name on all paperwork with all submissions (e.g., Bob vs. Robert).

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CHAPTER SIX: COMMUNITY SUPPORT WORKERS

What is a Community Support Worker?

IDAPA Rule 16.03.13, defines a Community Support Worker (CSW) as "an individual, agency or vendor selected and paid by the participant to provide community support worker services." Services are defined as:

- **Job support** to help the participant secure and maintain employment or attain job advancement;
- **Personal support** to help the participant maintain health, safety, and basic quality of life;
- **Relationship support** to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community;
- **Emotional support** to help the participant learn and practice behaviors consistent with plan goals while minimizing interfering behaviors;
- **Learning support** to help the participant learn new skills or improve existing skills that relate to his identified goals;
- **Transportation support** to help the participant accomplish his identified goals; transportation support can be paid for through reimbursement for miles driven and/or through hourly wage;
- **Adaptive equipment** identified in the participant's plan that meets a medical or accessibility need and promotes his increased independence; and
- **Skilled nursing support** identified in the participant's plan that is within the scope of the Nurse Practice Act and is provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

In addition, IDAPA rule states if the identified support requires specific licensing or certification within the State of Idaho, the identified CSW must obtain the applicable license or certification (e.g., Nurse, Speech Language Pathologist).

In Self-Directed Services program (SDS), a legal guardian can be a paid CSW, but must not be paid from the individualized budget for the following:

- To perform or to assist the participant in meeting the participant responsibilities outlined in Section 120 of IDAPA 16.03.13.
- To fulfill any obligations he is legally responsible to fulfill as outlined in the guardianship or conservator order from the court.

A paid CSW cannot be the spouse of the participant and must not have direct control over the participant's choices, must avoid any conflict of interest, and cannot receive undue financial benefit from the participant's choices.

In Family-Directed Community Services program (FDS), a parent or legal guardian cannot be a paid CSW. A paid CSW:

- Must not supplant the role of the parent or legal guardian; and
- Cannot be paid to fulfill any obligations that the parent or legal guardian is legally responsible to fulfill for their child.

CSW duties and responsibilities include:

- Prior to providing goods and services to the participant, the CSW must complete and return the packet of information provided by the FEA. When The CSW will be providing services, this packet must include documentation of:
- Complete the DHW criminal history check process, including clearance in accordance with IDAPA 16.05.06, "*Rules Governing Mandatory Criminal History Checks*" or documentation that this requirement has been waived by the participant on a Department approved form. The employer must include the rationale for waiving the criminal history check and describe how health and safety will be assured in lieu of a completed criminal history check. Individuals listed on a state or federal provider exclusion list must not provide paid supports. The fee for the criminal history check cannot be paid for by Medicaid funds.
    - A completed *Employment Agreement* with the employer that specifically defines the type of support being purchased, the negotiated rate and the frequency and duration of the support.
    - Current state licensure or certification if identified support requires certification or licensure;
    - If required, a statement of qualifications to provide supports identified in the *Employment Agreement* and *SSP*.
- The CSW must track and document the time required to perform the identified supports and accurately report the time on the time sheet provided by the participant's FEA or complete an invoice that reflects the type of support provided, the date the support was provided, and the negotiated rate for the support provided. This documentation must also be maintained for Quality Assurance purposes.

By filling out his or her timesheet, the CSW is indicating that (s)he fulfilled all duties and obligations identified on the *Employment Agreement*. By signing and submitting the timesheet, the employer is verifying that the CSW fulfilled those obligations. Signing and submitting an incorrect or falsified time sheet constitutes Medicaid fraud.

Hiring CSWs

Helping Employer Find Workers

An employer may ask the Support Broker to help them find a CSW. This can involve helping the employer learn and implement the skills necessary to recruit, hire and train a CSW. These steps should be taken during this process:

- Review Ch. 2 regarding the Support Broker *Employment Agreement*: Make sure the scope of the task has been defined with your employer and that it has been written it into the *Employment Agreement* and agree on the amount of hours that the employer will pay to have you help with the recruitment and hiring of CSW(s).
- Define the specific tasks the Support Broker will need to perform. Tasks may include helping the employer develop a job description, placing an ad, contacting the local Job Service, interviewing and writing an *Employment Agreement*.

Define the Scope of the Community Support Worker Job

- Specify exactly what your participant's needs are: What will the CSW do for the participant.

- Define the skills needed for a CSW to meet those needs. Do they need training, education, licensing or certification in special areas?
- Identify any desired education, experience or specific physical abilities necessary for the job (e.g., if the job involves heavy lifting, specify how much and how often).
- Specify whether or not the CSW will need to have a vehicle.
- Decide whether a criminal history check is warranted for the particular position (refer to *Appendix E*: Waiver of Criminal History Check.).
- Help the employer write a draft of the *Employment Agreement* to serve as a guide.
    - Identify the frequency and duration of the service for each day, week or month.
    - Help your employer decide on a pay range that is within his or her budget (remember to add in additional employer tax expenses). The pay range must not exceed the prevailing market rate, according to IDAPA 16.03.13.120.03.

Writing a Job Description

It is important to define job specifics and requirements as well as how many hours and what type of support is needed so that the ad will attract the right person, for the right job.

- State the name of the job first (e.g., "driver", "personal care attendant", "home and yard light maintenance").
- Identify specific duties, hours and days of the week the service is needed (e.g., "driver needed to transport person with disabilities Monday – Friday to and from job site; pick up at 9:00 am and 3:00 p.m., two hours a day").
- State the location of the job if this is relevant (e.g., "Employer and job are in in Garden City").
- Identify any necessary requirements (e.g., "Must have driver's license, insurance, reliable vehicle, and telephone", "Must be at least 21 years of age, and be able to pass a criminal history check").
- State the hourly wage (e.g., "$9.75 per hour").
- List contact name and phone number.

Job Application

It's recommended that each employer have a job application that applicants can complete and sign. Several examples can be found in *Appendix H* The employer may want to ask potential employees if they have ever been convicted of a crime, as this individual, if hired, may be put in situations which require a high degree of trust. Is the employer comfortable with a CSW who has been convicted of theft multiple times around his or her personal possessions? This is a decision each employer must make.

Finding Staff

There are many ways to find a good CSW for your employer; below are a few suggestions:

- The employer might already have someone in mind.
- The employer might have some ideas about where to find CSW(s).
- Ask the employer's Circle of Support for ideas, help and referrals.
- Advertise at the local Job Service.
- Advertise in the local newspaper.
- Advertise on the internet.
- Ask other families, participants and support brokers

Hiring CSW's to Work in a Certified Family Home: Substitute Care

- Community Support Workers (CSWs) coming into the home are considered "Substitute Care" providers when the person identified on the CFH certificate as the CFH provider is not in the

CFH and the CSW is responsible for providing care and supervision to a resident while in the CFH. CSWs that meet the definition of a Substitute Care provider must be CPR certified, complete the Assistance with Medications course if they are assisting the participant to take medication, and complete a Criminal History Background Check. *IDAPA 16.03.19.300. SHORT-TERM CARE AND SUPERVISION.*

- It is also considered to be Substitute Care when someone residing in the CFH home not identified on the CFH certificate is responsible for providing care and supervision to a resident in the CFH when the certified person is absent from the home.
- CSWs will not be considered Substitute care providers when they go into the home and the certified person is present in the home and is available to provide regular care and supervision.
- CSWs will not be considered Substitute care providers if the supports they are providing occur in the community.
- Substitute care providers may provide care and supervision to a resident in a CFH for up to thirty (30) consecutive days. This rule is specific to those situations when the CFH provider is away from the home 24/7 for up to 30 days. CSW's coming into the home for only parts of the day will not fall under this rule.
- CSWs who provide four (4) hours per week or less of *supervision only* to a resident of the CFH, in the CFH, do not need to meet the CPR, Assistance with Medications course and Criminal History Background Check requirements.

Negotiating Duties and Wages

Once the employer has located a person who wants to work as a CSW, the next step is to complete an *Employment Agreement*. There may be some negotiation involved regarding the duties, hours and wages. The Support Broker needs to help the employer to complete a draft *Employment Agreement* to serve as a guide. Review 'Negotiation' in Module D, Section 3, of the *Support Broker Training Curriculum*. The end result of whatever negotiation takes place will be written into the *Employment Agreement* contract.

Medicaid dollars can only be used for services that are provided. The Consumer-Directed Services Option does not allow employers to pay for sick time, vacation, over-time, holidays or for services that weren't provided.

It is a good idea to offer a starting wage below the authorized amount on the SSP, so that the employer can give a merit and/or longevity raise in the future!

Waiving the Criminal History Background Check

An employer has the option to waive the criminal history background check for a CSW. This means an employer can choose not to have a criminal history background checked on a particular worker. However, if the employer chooses this option, (s)he will have to submit a written statement explaining why. This statement is attached to the *Employment Agreement* template. The statement must explain how the participant's health and safety will be protected if the criminal history background check is waived. The Support Broker is responsible for discussing the risks of waiving a criminal history background check with the employer.

Appendix E: has information about the Medicaid policy regarding criminal history background checks and waiving them. A Support Broker will sign the waiver form with an employer indicating that the Support Broker has addressed the issue with your employer. CSWs listed on a state or federal provider exclusion list cannot provide paid supports even if the criminal history background check has been waived by the employer.

A Criminal History Background Check "clearance" does not mean a person has never been arrested and convicted of a crime(s).

Listed below are some reasons that an employer might get a criminal history background check completed on a person before hiring them as a CSW:

- The CSW will be working in the home or directly with the participant when no one else is around.
- The participant may be vulnerable to suggestions and may have been taken advantage of by people in the past.
- The CSW is not well known to the participant or their Circle of Support.

Below are some reasons that an employer might want to waive a criminal history background check:

- The CSW is employed for a short time to do a specific task and will not interact directly with the participant in the participant's home.
- The CSW will never be in direct contact with the participant without someone else also being present at all times.
- The CSW is very well known to the participant and the Circle of Support and there are no concerns.

Helping Your Employer Get the Most from Their Employees

Review the *Guide to a Self-Directed Life* or *Guide to a Family-Directed Life* with your employer. The guide will help your employer find and keep the right worker.

Process to hire

Now that the employer has identified a CSW and completed the *Employment Agreement*, the new employee needs to submit the entire employee packet, including either the criminal history check or the waiver of criminal history background check, to the FEA. Once this is done and the FEA has issued an Employee ID Number (EIN) to the CSW, the CSW can begin working for the participant.

Teaching the Participant to be a Good Employer

The Support Broker may be asked to help supervise and monitor CSWs, as employers vary in ability to manage employees. What can be done to help maximize an employer's ability to manage? Below are ways to help an employer become more independent in this role:

- Develop a written list of rules and expectations of the employee.
- Reiterate that the CSW is an 'at will' employee and explain what that means.
- Review the terms and conditions of the *Employment Agreement* with the employer.
- Update job requirements as needed. A new *Employment Agreement* needs to be completed if there is a change in job duties, support category or the hourly wage.
- Set up a regular time to discuss issues and concerns between the CSW and employer.
- Keep written records of all meetings between the employer and CSW for a minimum of 5 years.
- Establish review periods and decide what, and how, tasks will be reviewed. Remind the employer to keep records of the reviews for a minimum of 5 years.
- Make sure that regular documentation is kept of hours worked and what services were provided for a minimum of 5 years.
- Encourage consistency regarding expectations of the CSW.

- Actively discourage any abuse or exploitation of the CSW, intentional or accidental, by the employer, and help the employer to keep personal boundaries.
- Encourage proactive problem solving.
- Set up regular times and methods to reinforce positive work habits and attitudes.
- Identify training opportunities for the CSW that are free or to which the employer can contribute.
- Set a good example; encourage the employer by modeling positive and pro-active communication with the CSW.

Monitor Your Employer's Satisfaction

Support Brokers are expected to talk to their employer on a regular basis about his or her satisfaction with all services. A Support Broker should build this into his or her routine visits and handle problems immediately. IDAPA rules state that the Support Broker will, '*submit documentation regarding the participant's satisfaction with identified supports as requested by the Department*.' If a CSW is doing the job well, the Support Broker and employer should be able to document it. Use the *Service Satisfaction Survey* to record the employer's concerns and feelings. A template of the survey can be found in *Appendix C.* Listed below are some suggestions for using the *Service Satisfaction Survey*: A Support Broker must:

- Save the results of the survey; you may be asked to provide the results to the Department's Quality Assurance Team.
- Help the employer review the results with the CSW.
- Use results of the survey to discuss problems, concerns, or to justify raises.
- Use the results and the discussion to modify the employment agreement or specific tasks and plans, as needed.

> Review your employer's satisfaction with their Community Support Workers at least 3 times a year. Schedule reviews every 3 – 4 months.

Annual individual participant reviews are conducted by the Department. This process ensures that participants continue to receive the right services for them and identifies any areas of concern. A Support Broker's work will also be monitored. The employer will be asked to participate in a satisfaction survey conducted by the Department. Problems or issues regarding performance as a Support Broker will be addressed by the Medicaid Bureau of Developmental Disabilities Services.

Reviewing the Community Support Worker's Timesheet

An employer may ask for help reviewing CSW time sheets, as the employer has to sign each time sheet before the CSW can be paid. The employer has the responsibility to make sure the timesheet accurately reflects dates, hours and category of service actually provided. If the participant has trouble understanding the timesheet, the Support Broker should help him or her with this task (be sure to include this task on the *Employment Agreement*). Also, the Support Broker should find out if there are *natural supports* that can help the employer or provide training or aids which will allow them to become more independent. The timesheet includes date of service, times of service and a service code. The codes are 3 digits and match the codes used on the *Employment Agreement*. Timesheets and instructions are provided by the FEA.

Advise all employers and employees to submit bills and timesheets to their FEA timely. There is no mechanism to fund bills and timesheets that are submitted late – submissions past the plan end dates may not be paid.

At worst case scenario, leave a minimum of a six week time period prior to the end of the plan year for your timesheet or bill to be processed by the FEA in case there is an issue with the request.

Leaving billing to the last minute won't leave time to resolve any discrepancies between the employer and employee/vendor. The FEA, as the Medicaid provider, has a year to bill, the Support Broker and CSWs do not.

Help the employer keep a file with copies of important documents including, but not limited to:

- The *Workbook*.
- The complete *Support and Spending Plan*
- All workers' *Employment Agreements*.
- Completed time sheets
- All other program, tax and employment related documents

The Support Broker needs to make sure that the time sheet matches the *Employment Agreements* and *Support and Spending Plan* for category and code of service. For example, If Bill Jones's *Employment Agreement* states he will perform chore services under the category of Personal Supports, the code is PSS. This is the code that needs to be on the time sheet. If Bill uses JSS, he will not get paid.

The Support Broker needs to check the date(s) of service for accuracy. Did Bill clean the medical equipment on the date that is stated on the timesheet? If the employer is unsure, the Support Broker can help create a calendar or some other method to track when CSWs come to work. The Support Broker can ask questions like "*is Bill supposed to come once a week?"* and *"When did he last come*?" and make observations to judge the situation. For example, does the equipment look like it has been cleaned in the last week?

The Support Broker needs to also check that the amount of hours for the service is a reasonable match for the annual amount that has been allotted on the *SSP Authorization Sheet*. If the *Authorization Sheet* states that chore services will cost $1,300 a year, and the employer states that Bill is supposed to come once a week and that he pays Bill $7.25 per hour, the Support Broker can use a calculator to determine if the information is reflected accurately. In this example, Bill should be working about 3 hours a week. The timesheet should reflect that.

If something doesn't look right, the Support Broker should ask the employer, what (s)he would like done about it. The Support Broker should encourage the employer to talk to the Circle of Supports and help the employer and the Circle look at options and resolve any problems. The Support Broker should not take immediate responsibility or control of the situation unless:

- It may possibly result in immediate threat to the health or safety of the employer.
- It constitutes Medicaid fraud.

In either of these cases, a Support Broker is mandated to immediately report abuse, neglect, exploitation and Medicaid fraud. Call Adult or Child Protection or law enforcement in the case of abuse, neglect or exploitation. Additionally, call the Medicaid Care Manager or the FACS Case Coordinator if Medicaid fraud is suspected.

Immediate Risk to Health and Safety

A Support Broker must report situations immediately in which a CSW's actions could result in an immediate risk to the health and safety of the participant. A worker may be endangering the participant through specific behaviors or omission of services. The CSW may not have sufficient training or may be purposefully exploiting the participant. An employer might feel bad for reporting problems and found out through the review of time sheets. The Support Broker should report the problem immediately if there is an immediate danger.

Nursing and other health related services may be essential to the participant's health and safety. If services are not being provided that should be, concerns need to be reported immediately to the employer, the Circle of Support and the Medicaid Care Manager or FACS Case Coordinator.

Brain Ticklers

Here are some scenarios that might occur:

- The Support Broker receives a call from a CSW. The CSW has been stopped by police while driving a participant to an activity and may be arrested. The CSW forgot to tell his employer that there was a warrant out for his arrest for an old problem he "forgot" to go to court about.
- A participant calls the Support Broker to tell them a CSW never showed up for work today.
- A CSW dropped the participant off at home and didn't check to make sure anyone else was there… and there wasn't.
- A CSW tells the Support Broker that a few weeks ago (s)he thought another CSW did something unethical with the participant.
- A CSW is doing personal errands, activities or chores while "on the clock", instead of providing services to the participant. For example, a CSW is frequently texting at work rather than completing agreed upon duties for the participant.
- The Support Broker suspects a CSW is engaging in inappropriate behaviors with the participant.
- A participant tells the Support Broker that (s)he thinks a CSW stole money from him or her.
- The Support Broker finds out that the CSW doesn't have any insurance on the car (s)he is using to transport the participant to and from activities.
- The Support Broker suspects a CSW is abusing, neglecting or exploiting the participant.

Preparing For the Worst

The Support Broker should take preventive measures. Remember, each identified risk must have three back-up plans which should be used as needed. Below are preventative measures Support Broker can take:

- Have a list of natural supports and phone numbers handy; use natural supports if possible when the workforce is not fully staffed. If the employer doesn't have any natural supports, make a goal to develop some.
- Discuss possible crises with the employer, the Circle of Support, and the CSWs ahead of time. Prepare them to cope with emergencies, role-play and identify hypothetical solutions.
- Create a list of community resources, such as neighborhood resource police officers, non-emergency police dispatch, food banks, churches, senior centers, low cost health/medical centers, etc.
- Keep a file on substitute CSWs and other people who have passed the criminal history check and who want part-time work.
- Ensure the employer has an accessible method to get hold of the Support Broker or a natural support as needed.
- Network with other Support Brokers to share resources.
- Call the local Council on Developmental Disabilities Self-Advocates at: Toll free: 1 (800) 544-2433 or Boise area: (208) 334-2178. They can provide helpful advice and resources.
- Maintain a working relationship with the Medicaid quality assurance staff and FACS Case Coordinators; they may be able to help with additional resources.

You Have a Back-Up Plan, But Things Still Go Wrong - Now What?

If it's an emergency or life threatening, the Support Broker should call 9-1-1 immediately and don't try to handle the situation alone. The Support Broker should:

- Take the time to consult with the employer and the Circle of Support to identify a solution together if the situation doesn't place an employer's health and safety in immediate danger.

- Consider submitting a *SSP Change Form* if the crises is recurring. Frequent crises may indicate a need to change services, increase specific services, change a category of service or transition to the traditional pathway of services.
- Abuse, neglect, exploitation and abandonment issues must be reported immediately to either law enforcement or adult or child protection.
- Identify root causes and look for solutions.
- Respond positively to a crisis situation.
- Consider all pieces of the puzzle and be creative in your solutions.
- Ask questions.

Dismissing Staff

A Support Broker may have to help an employer dismiss a CSW, which can be a difficult and embarrassing task. A Support Broker needs to:

- Document
  - Keep copies of the S*ervice Satisfaction Surveys*. If there are on-going problems with minor issues such as lateness, inappropriate behaviors or language, record them. If an employer gives an employee a verbal warning or asks the Support Broker to do it for them, they need to put it in writing and ask the employer or the legal guardian to sign and date it.
- Get the employer or their guardian involved
  - Except in cases which present a threat to health or safety, the employer makes the final decision. If (s)he is uncomfortable with an attitude or behavior displayed by a CSW, talk about it to help identify the issue and encourage him or her to talk to the CSW about it.
  - Ask the employer to get feedback from the Circle of Support about the issues of concern.
- Attempt correction first
  - If the issue is an ongoing minor annoyance which is not immediately threatening to safety or health, attempt a plan of correction first.
  - Encourage the employer to identify what action might resolve the problem and discuss it with the CSW.
  - Set a specific, measurable and objective benchmark (e.g., “Within the next month, you will not be more than 10 minutes late to work and you will call ahead of time if you are going to be late”).
  - Write down the plan of correction and have everyone sign it.
- Be direct and calm
  - Stay calm. If the Support Broker feels (s)he is getting angry or defensive, stop the discussion.
  - Help the employer stay calm by being a good role model. End the conversation if the employer gets emotional or upset.
  - Stay objective while facilitating and assisting the employer.
  - If the employer wants help making a decision, remain objective and help explore options.
- Put it in writing
  - If the employer decides that a CSW needs to be dismissed, help him or her put it in writing. It can be very simple and the employer does not need to give a reason if (s)he does not want to. Date and have the employer sign the memo.
- Have a back-up plan
  - Make sure there is a back-up plan. When a CSW is dismissed, it may leave a gap in needed services. A back-up plan must be put into place immediately.
- Report the termination of employment to the FEA
  - The FEA will provide a form to the Support Broker on which to report the termination.

Reporting Abuse, Neglect, or Exploitation

Idaho Statutes; *Title 39; Health and Safety Chapter 53; Adult Abuse, Neglect and Exploitation Act; 39-5303. Duty to Report Cases of Abuse, Neglect or exploitation of Vulnerable Adults.*

(1) Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, ombudsman for the elderly, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission. Provided however, that nursing facilities defined in section 39-1301(b), Idaho Code, and employees of such facilities shall make reports required under this chapter to the department. When there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency.

(2) Failure to report as provided under this section is a misdemeanor subject to punishment as provided in section 18-113, Idaho Code. If an employee at a state licensed or certified residential facility fails to report abuse or sexual assault that has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult as provided under this section, the department shall also have the authority to:

(a) Revoke the facility's license and/or contract with the state to provide services;
(b) Deny payment;
(c) Assess and collect a civil monetary penalty with interest from the facility owner and/or facility administrator;
(d) Appoint temporary management;
(e) Close the facility and/or transfer residents to another certified facility;
(f) Direct a plan of correction;
(g) Ban admission of persons with certain diagnoses or requiring specialized care;
(h) Ban all admissions to the facility;
(i) Assign monitors to the facility; or
(j) Reduce the licensed bed capacity.

Any action taken by the department pursuant to this subsection shall be appealable as provided in chapter 52, title 67, Idaho Code.

(3) Any person, including any officer or employee of a financial institution, who has reasonable cause to believe that a vulnerable adult is being abused, neglected or exploited may report such information to the commission or its contractors.

(4) The commission and its contractors shall make training available to officers and employees of financial institutions in identifying and reporting instances of abuse, neglect or exploitation involving vulnerable adults.

(5) Any person who makes any report pursuant to this chapter, or who testifies in any administrative or judicial proceeding arising from such report, or who is authorized to provide supportive or emergency services pursuant to the provisions of this chapter, shall be immune from any civil or criminal liability on account of such report, testimony or services provided in good faith, except that such immunity shall not extend to perjury, reports made in bad faith or with malicious purpose nor, in the case of provision of services, in the presence of gross negligence under the existing circumstances.

(6) Any person who makes a report or allegation in bad faith, with malice or knowing it to be false, shall be liable to the party against whom the report was made for the amount of actual damages sustained or statutory damages in the amount of five hundred dollars ($500), whichever is greater, plus attorney's fees and costs of suit. If the court finds that the defendant acted with malice or oppression, the court may award treble actual damages or treble statutory damages, whichever is greater.

Warning Signs of Abuse, Neglect, or Exploitation

These ‘warning signs’ are not proof that abuse, neglect or exploitation is occurring, rather, they are indicators that a problem may exist and further investigation or discussion with the participant’s Circle of Support is needed. Any injury or condition that will impact the health and safety of the participant

needs to be attended to immediately, regardless of whether the cause is known. Below are examples of common indicators of abuse.

Physical Indications

- An injury that has not received medical attention or that has not been properly cared for.
- An injury that is inconsistent with the explanation for its cause.
- An indication of pain or discomfort at being touched.
- Cuts, burns, puncture wounds, scratches, bruises or welts anywhere on the body.
- An appearance of dehydration or malnutrition when there is no known cause of such condition.
- A sallow complexion or otherwise abnormal skin coloration.
- Dark circles around eyes, sunken eyes or cheeks.
- Misuse of medication or inappropriate administration of medication by a caregiver.
- Soiled clothing or bed linens.
- "Doctor shopping" (i.e., frequent use of hospital emergency rooms or different doctors).
- Frequent changes in staff (e.g., CSWs or vendors).
- Chronic lack of necessities such as food, running water, heat or electricity.
- Chronic lack of personal items such as a comb, soap, and clean clothes.
- Imposed isolation (i.e., the participant is discouraged or prevented from attending community events, church, the senior center or from seeing friends and neighbors).

Behavioral indications

- Fear
- Anxiety, agitation
- Anger
- Withdrawal
- Depression
- Non-responsiveness, resignation, ambivalence
- Excuses or implausible explanations, contradictory statements
- Reluctance or hesitation to discuss certain subjects or to talk about a caregiver, family member or other person to whom the participant is dependent
- Confusion disorientation

Suspect Caregiver Behavior

- Prevents the participant from speaking to or seeing visitors
- Displays anger, indifference, aggression or sexually suggestive behavior toward the participant.
- History of substance abuse, sexual predation, mental illness, criminal behavior or family violence
- 'Cold' demeanor (i.e., shows no affection or is openly disrespectful of the participant)
- Flirts or uses sexual innuendo to communicate with the participant
- Makes conflicting statements or offers implausible explanations regarding injuries or condition
- Describes the participant as a burden or nuisance

Indications of Exploitation

- Frequent expensive gifts to the caregiver from the participant
- Personal papers, credit cards, checks, or savings account paperwork are missing
- Caregiver's name has been added to the participant's bank account, deed or title to property
- The participant has numerous unpaid bills
- There is a new or recently revised will, but the participant is physically or cognitively incapable of writing or revising such a document.
- The participant has no concept of how much monthly income he or she receives
- The participant's signature appears on a loan application
- There are frequent checks for cash drawn on the participant's account

- There are irregularities on the participant's tax return
- The caregiver refuses to allow the participant to spend his or her own money.
- Signatures on checks or other documents which are allegedly those of the participant do not resemble that participant's known signature or are otherwise suspicious in appearance

To Report Suspected Abuse, Neglect, Self Neglect or Exploitation

Adult Protection: State-wide: 1-800-859-0321 Boise area: 208-322-7033
FAX: 208-322-3569 TDD/TTDY: 1-800-377-3529 www.sageidaho.com

Child protection: During business hours, call the Idaho CareLine by dialing 2-1-1 or 1-800-926-2588 (TDD 208-332-7205), for number in your nearest town.

NOTES:

CHAPTER SEVEN: CONTINUING DUTIES FOR THE SUPPORT BROKER

Maintain Regular Contact

Support Brokers needs to make sure their employers can easily contact them in case of an emergency and have a back-up plan in case they are unavailable.

Documentation

IDAPA 16.03.10.704.02. states that Support Brokers are required to maintain the certain documentation.

> Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: Direct Service Provider Information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information:
>
> 1. Date and time of visit; and
> 2. Services provided during the visit; and
> 3. A statement of the participant's response to the service, if appropriate to the service provided,
> 4. including any changes in the participant's condition; and
> 5. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by his or her signature on the service record.
> 6. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services.

Written Documentation should always include, but is not limited to:

- Services the Support Broker provides to help the employer self/family-direct.
- Contacts with an employer by phone, mail, email, or in person. It is recommended that the Support Broker meet with employers at least quarterly to review their satisfaction with services.
- Note in documentation what took place during the contact, how long it lasted, and if there were any issues or concerns.
- Contacts with the Participant's Circle of Support.
- Meetings with CSWs.
- Any complaints and what follow-up was conducted.

Your written record should include the following information:

- Date
- Purpose or reason
- Brief summary of discussion
- Who was present
- Time spent
- Outcome
- Appropriate signature(s)

Plan Changes

A *Plan Change Form* is required when there is a change in:

- Support type (e.g., moving money from Relationship Support to Learning Support)
- The service being provided
- A service is added or deleted from the plan
- A good is added or deleted from the plan

A *Plan Change Form* is not necessary when the only change is a change in an employee, vendor or agency providing a service already on the plan. In these cases, paperwork will need to be completed with the FEA, such as an employment packet or contractor enrollment packet, when there are changes in provider. Any plan change that results in a change in an employee's hourly wage or the service category from which that employee is paid must be accompanied by a new *Employment Agreement*, sent to the FEA.

Additionally, if there needs to be a change in the rate of pay of a CSW beyond what is budgeted on the *Support and Spending Plan*, a new *Plan Change Form* must be submitted.

The *Plan Change Form* can be found on each program's web site. An example of a *Plan Change Form* for the Family-Direction Program is in the *Appendix J* of this manual.

What Happens When a Plan Change Is Submitted?

- The Medicaid Care Manager/FACS Case Coordinator receives a plan change request.
- The Care Manager/Case Coordinator reviews the plan change request within 5 business days of its receipt.
- The Care Manager/Case Coordinator determines whether the support, good, and/or service meets the criteria for allowable expenses and falls within the individualized budget.
- The Care Manager/Case Coordinator ensures that risk factors are adequately identified and safety plans are provided for each risk.
- An *Authorization Sheet* must be submitted listing the new service, task, or good requested.

Q: When is a plan change necessary?

A: Any shift in money from one category to another requires a plan change. Adding a new service, task, or good, or deletion of a service which has a safety plan attached to it, requires a plan change.

Request for New Budget Allocation

Participants can request a new budget allocation if they have had a significant change in condition which requires an increase in supports that cannot be met by the existing budget allocation. If an employer and Support Broker believe this is the case, the Support Broker needs to contact the regional Medicaid Care Manager or FACS Case Coordinator. They will instruct you on the process to be followed when there has been a significant change of condition. The Support Broker should be prepared to submit information and supporting documentation which verifies a significant change in condition has occurred to the regional Medicaid Care Manager or FACS Case Coordinator. The Independent Assessment Provider will assess the change in condition and follow established protocols for determining if a budget increase is supported.

Budget Oversight

An important duty of the Support Broker is to help employers monitor and review their Consumer-Direction budget. Employers can lose the right to participate in Consumer-Direction if they cannot stay within the budget assigned.

Employers will get a monthly statement from the FEA. The statement will include an account of what has been spent each month and how much money is left in the budget. The statement will include specific amounts for each bill that has been paid on his or her behalf. The employment and vendor agreements state the details of how much money can be spent on each specific support and service. The FEA will match the bills they pay to those agreements. If bills don't match, are over the authorized amount, or the amount of money for a specific service has been exhausted, the bill will not be paid.

Support Brokers need to review each monthly statement with their employer and match it to the amount that has been budgeted for each specific support and service. It is the Support Brokers' job to help their employer resolve any difficulties. They should find a good way to visually show an employer how much money is being spent and how much is remaining each month. There are many types of budgeting tools on the market and they should use what works best for each employer.

Annual Re-Determination

Employers will be evaluated annually to determine if they still meets the criteria for Adult Developmental Disabilities Waiver, the Children's Developmental Disabilities Waiver or the Children's Home and Community Based Services State Plan Option. Support Brokers need to assist their employers with this process. Approximately 120 days before the end of the annual plan, employers get a letter from the Independent Assessment Provider. This letter will inform them of what is needed in order to continue services for another year.

Employers will need to schedule an appointment with the Independent Assessment Provider to review the past year and update medical and social information. A new evaluation of their functional abilities may be conducted. The evaluation tool that is used for this purpose is called the Scales of Independent Behavior- Revised (SIB-R). The SIB-R is used to determine if a participant meets waiver level of care criteria, according to IDAPA Rule.

An employer may find out that (s)he is no longer eligible for Adult Developmental Disabilities Waiver, the Children's Developmental Disabilities Waiver or the Children's Home and Community Based Services State Plan Option. If this happens, the participant will no longer be eligible for the Consumer-Directed Option. If a participant chooses to appeal this decision, the current plan will be extended until the hearing is finalized. If the denial is upheld, recoupment of funds from the date of the denial is a possibility. Support Brokers are responsible for helping their employers prepare to transition out of the level of services they are getting.

For adult participants, if they remain eligible for Developmental Disability Waiver Services, they may choose to return to the traditional path. They may want to get residential habilitation or community supported employment through an agency. They may want to have an agency hire and train his or her workers. If participants and their Circle of Support want to choose this option, they may choose a Plan Developer to work with them instead of a Support Broker. Please review the next chapter, *Transitioning from the Consumer-Directed Services Option,* for more information.

If a participant remains eligible for the Consumer-Directed Services option and wants to continue with this service delivery model, (s)he will continue to need a Support Broker. Each participant will need to develop a new *Support and Spending Plan* for the upcoming year with services and supports within the new annual budget determined and allocated by the Independent Assessment Provider.

Employer Responsibilities

Another continuing duty of a Support Broker is to help employers meet their responsibilities on the Consumer-Directed Services Option.

Each participant agrees to the following:

- Accept the guiding principles of the Consumer-Directed Program.
- Participate in person-centered planning meetings.
- Negotiate payment rates for paid community supports and services.
- Complete *Employment Agreements* for the FEA, the Support Broker and CSW services. Submit those agreements to the FEA on Department approved forms.
- Ensure that *Employment Agreements* contain sufficient detail for the type of support/services that are being purchased.
- Develop a comprehensive *Support and Spending Plan*.
- Review and verify time sheets and bills.
- Participate in the quality assurance process.

Health and Safety

Another important responsibility of Support Brokers is to help their employers protect the participant's health and safety. They need to identify risk factors, develop safety plans, develop backup plans, and mitigate risks whenever possible. Support Brokers are responsible for communicating with the appropriate authorities if they believe the participant's health or safety is being threatened.

This responsibility includes reporting if a participant is threatening his or her own health or safety in any way. Perhaps a participant is refusing to take medication or living in an unsafe environment. An adult participant may have given all his or her food to a friend and have no money left to buy more. The participant may be acting disoriented or confused and refuse to go to the doctor. In a non-life threatening situation, a Support Broker would need to call on a legal guardian (or parent for children), another natural support, or contact a DHW staff member. In a life-threatening situation emergency services or law enforcement should be contacted immediately.

Complaints and Critical Incident Report

A complaint is a statement of dissatisfaction with services. A critical incident is a serious situation which results in an immediate threat to a participant's health, safety, or well-being. A complaint about Medicaid services or services related to the Self-Directed Program should be made directly to the provider of the service and the local regional Quality Assurance Specialist. The Quality Assurance Specialist will record the complaint and make sure it is investigated appropriately. Complaints related to the Family-Directed Program should be directed to Darcy Neser at (208) 334-0603.

All critical incidents need to be reported to the participant's Circle of Support, the regional Quality Assurance Specialist, and emergency services, such as law enforcement, or Adult or Child Protection immediately. Some examples of critical incidents are death, attempted suicide, substantiated abuse and neglect, unusual restraint, fiscal fraud, break-in and burglary, over-dose of medication or similar events.

An accident is a mishap or mistake which did not occur as a result of any purpose or intent. If an accident occurs that has physical, emotional, or legal ramifications for a participant, the Support Broker must report it immediately to the legal guardian (or parent if the participant is a child). If an adult participant is his or her own guardian, the Support Broker needs to talk with him or her to determine whether family members need to be notified.

Maintain the Circle of Support

An ongoing part of a Support Broker's job is to maintain and develop a participant's Circle of Support. Support Brokers the Circle of Support should exchange contact information. A Support Broker needs to schedule regular contact times to talk with family members, friends, community members, advocates and others who form the natural support system. An employer may want to have regular meetings, phone calls, email or choose a more informal method of continuing contact. The Support Broker should meet with the Circle of Support several times a year to work on the *Support and Spending Plan*, update the budget information, discuss changes in services or needs and discuss future needs and goals.

The Support Broker should look for opportunities to expand the Circle. Community activities are opportunities to meet new people, develop relationships and build natural supports. If the participant doesn't engage in any community activities, try to find some that the participant would like to attend. There are low-cost and free activities in all communities. Call local churches, community centers, non-profits, libraries and adult education centers for events and activities.

CHAPTER EIGHT: TRANSITIONING FROM CONSUMER-DIRECTED SERVICES

Voluntary Transition for Adults on Self-Direction

Return to a Traditional Waiver Program - Adults

Adult participants can return to traditional waiver services by contacting the Medicaid Care Manager and stating they wish to discontinue their participation in the Self-Direction option. If a participant wants to return to the traditional pathway, the regional Medicaid Care Manager will complete intake and presumptive eligibility. Please see *Appendix* for the transition process from the Family Directed Program back to the traditional model

An employer will need to designate a plan developer, either paid or unpaid, to help with the planning process. The plan developer will help the participant complete a *120-day Transition Plan* using the standard traditional service's *Individual Support Plan*.

The Medicaid Care Manager will complete the following processes based on the needs of the participant:

- Prior authorize community crisis supports if there is an immediate crisis. The *Crisis Resolution Plan* must identify ways to prevent ongoing crisis.
- Approve the *120-day Transition Plan.*
- Prior authorize services identified on the costing page. Services identified on the plan will be prior authorized from the date the *120-day Transition Plan* was approved once the *Individual Support Plan* has been submitted to the Care Manager.
- The Care Manager will contact the Independent Assessor to begin the formal eligibility process.
- The Care Manager will send a letter to the participant notifying them that the *120-day Transition Plan* has been approved.

The Independent Assessment Provider Will Follow Their Usual Process

- The Independent Assessment Provider verifies a participant's eligibility for adult developmental disability services using the traditional business model for Annual Re-Determination of Program Eligibility.
- If the participant is determined to have a developmental disability and is waiver eligible, letter(s) approving eligibility are sent to the participant.
- Once eligibility has been determined, the process for obtaining traditional services after the *120-day Transition Plan* has expired will occur according to the existing business model.

Q: What qualifies as a crisis transition?
A: Crisis transitions happen when an event or process occurs which jeopardizes the participant's health or safety.

Involuntary Transition from the My Voice, My Choice Option

The Department may choose to remove a participant from the Self-Direction option if (s)he refuses to utilize or abide by required supports or if the participant's choices directly endanger his or her own health, welfare or safety or that of others. A participant may not be able to continue in Self-Direction option if (s)he is not:

- Willing to work with the Support Broker, FEA or Circle of Support
- Following the *Support and Spending Plan*
- Following the risk and safety *Back-up Plans*
- Following the procedures of the program

Transitioning Out Of The Self-Directed Community Supports Program

No Immediate Jeopardy to Health and Safety

If there is no immediate jeopardy to the health or safety of a participant, DHW will send a letter by certified mail notifying the participant of the concerns. The letter will:

- State that the participant will be removed from the Self-Directed option if specific identified concerns are remedied.
- List the specific concerns and the date by which a plan of correction needs to be submitted.
- Allow the participant 10 business days to submit a plan of correction.

After receiving the letter, the participant can pursue one of the following options:

Option 1: Participant submits a Plan of Correction to the Medicaid Care Manager within 10 days.

Option 2: Participant does not submit a Plan of Correction to the Care Manager within 10 days.

Option 1: Participant Submits a Plan of Correction Within 10 Days

The Medicaid Care Manager reviews the plan to determine whether the noted concerns have been addressed. The Care Manager will either approve or deny the Plan of Correction.

Approved Plan of Correction

- The Medicaid Care Manager will send a letter to the participant and Support Broker notifying him or her that the Plan of Correction has been approved.
- The Care Manager will monitor implementation of the Plan of Correction through the quality assurance processes.

Denied Plan of Correction

- The Medicaid Care Manager will send a letter to the participant and the Support Broker stating the Plan of Correction has been denied and the participant is being removed from the Consumer-Directed Community Supports Option. The letter will include the date the removal will be effective and the appeals process.
- Adult participants will need to have eligibility re-determined. The Medicaid Care Manager will determine presumptive eligibility on the participant. The adult participant is presumed eligible when there is documentation that validates developmental disability and Intermediate Care Facility – Intellectually Disabled (ICF-ID) level of care waiver eligibility. Information to verify eligibility may be obtained from old Department records, Developmental Disabilities Agency records and the Idaho Center for Disabilities Evaluation (ICDE).
- If the adult participant meets presumptive eligibility, the regional Medicaid Care Manager will complete the following processes based on the specific needs of the participant:
    - Prior authorize community crisis supports.
    - Coordinate with the participant and the Circle of Support to develop a 120-day transition plan. The current participant *Individual Support Plan* format is used for the 120-day plan.

This plan must contain those services and supports that will allow the participant to live safely in the community.

- The regional Medicaid Care Manager will review the transition plan, and if modifications are required prior to approval, will communicate with the plan developer about the needed changes.
- The Medicaid Care Manager will prior authorize services identified on the 120-day transition plan authorization page. Services identified on the plan will be prior authorized back to the date the 120-day transition plan was approved, once a complete traditional plan (*Individual Support Plan* or *Plan of Service)* has been submitted to the Medicaid Care Manager.
- Idaho Center for Disabilities Evaluation will verify participant's Developmental Disability and waiver eligibility using the traditional business model for Annual Re-determination of Program Eligibility.
- If a participant is determined to be developmentally disabled and waiver eligible, the Idaho Center for Disabilities Evaluation will send a letter to the participant approving eligibility.

Option 2: Participant Doesn't Submit a Plan of Correction Within 10 Days

- The Medicaid Care Manager will send a letter to the participant and the Support Broker stating that a Plan of Correction has not been submitted and the participant is being removed from the Self-Direction Option. The letter will include the date the removal will be effective and information on the appeal process.
- If the participant, or the legal guardian, requests continuation of services for an adult with a developmental disability, the Medicaid Care Manager will complete the intake process and presumptive eligibility.
- The participant will be presumed eligible when there is documentation that validates developmental disability eligibility and Intermediate Care Facility - Intellectual Disability (ICF-ID) level of care waiver eligibility. Information to verify eligibility may be obtained from old Department records, developmental disabilities agency records, and the Idaho Center for Disabilities Evaluation.
- If the participant meets presumptive eligibility, the Medicaid Care Manager will complete the following processes based on the specific needs of the participant:
  - Prior authorize community crisis supports.
  - Coordinate with participant and Circle of Support to develop a 120-day transition plan.
  - The participant must develop a plan of service, with or without the help of a paid or unpaid plan developer. The *Individual Support Plan* is used for the 120-day plan. This plan must contain those services and supports that will allow the participant to live safely in the community.
- The Medicaid Care Manager will review the plan and if modifications are required prior to approval, will communicate with the participant about needed changes.
- The Medicaid Care Manager will prior authorize services identified on the 120-day Plan Authorization page. Services identified on the plan will be prior authorized when a complete *Individual Supports Plan* has been received and approved.
- Within the next 120-day period, Idaho Center for Disabilities Evaluation will verify the participant's eligibility using the traditional business model for annual re-determination of program eligibility.
- If a participant is determined to have a developmental disability and is waiver eligible, the Idaho Center for Disabilities Evaluation will send a letter to the participant approving eligibility.
- The participant will submit an annual *Individual Support Plan* for authorization.

Immediate Jeopardy to Health and/or Safety

If DHW determines there is reason to immediately remove a participant from the Consumer- Directed Supports Option, the regional Medicaid Care Manager sends a letter to the participant and the Support Broker indicating that the participant is being removed from the Consumer- Directed Supports Option with the date the removal will become effective. The Care Manager will initiate the transition process to traditional services. If the adult participant is found to be eligible for waiver services, the Care Manager will initiate a 120 day transition plan with the participant and his or her Circle of Support.

Termination of Support Broker Services

According to IDAPA 16.03.13, if a Support Broker decides to end services with a participant, (s)he must give the participant at least a 30 day written notice prior to terminating services. The Support Broker must also assist the participant to identify a new Support Broker and provide the participant and new Support Broker with a written service transition plan by the date of termination.

The transition plan must include an updated *Support and Spending Plan* that reflects current supports being received, details about the existing Community Support Workers and unmet needs.

Transitioning Out Of The Family-Directed Community Supports Program

Voluntary Transition

Voluntary transition occurs when a family or legal guardian communicates to their FACS Case Coordinator they want to discontinue participation in the Family-Directed Supports (FDS) Program.

FACS will follow the following Transition Process:

1. FACS will appoint a Case Manager from the “Traditional pathway” based on the Case Management determination guideline.
2. The Case Manager will consult with the Case Coordinator to determine if the transition is urgent or if there is time to execute the Traditional pathway case management process.
    - If the transition is not urgent, the Case Manager will begin the standard case management process to create a full-year Plan of Service (POS).
    - If the transition is urgent, The Case Manager will create a 90-day Transition Plan with the family or legal guardian on the POS using family-centered planning principles with services and supports that will allow the child to live safely in the community. The purpose of the 90-day Transition Plan is to act as a bridge of service until the full annual plan can be written using the case management process.
3. The FDS Case Coordinator will complete the FDS Program Exit Interview with family/legal guardian for program improvement purposes.
4. The FDS Case Coordinator will review the 90-day Transition Plan or POS. If modifications are required prior to approval, FDS Case Coordinator communicates with the Case Manager about needed changes.
5. The FDS Case Coordinator will prior authorize services identified on the 90-day Transition Plan or POS back to the date the 90-day Transition Plan or POS was approved once all of the following documents have been submitted to FACS Case Manager:
    - 90-day Transition Plan or POS;
    - POS Signature Page;
    - POS Supports and Services Authorization Page; and
    - History and Physical (if applicable).
6. The FDS Case Coordinator will cancel the prior authorization for Family-Directed Supports effective the date the 90-day Transition Plan or POS is approved.

Involuntary Transition

The Department may choose to not to allow the individual to continue in the Family-Directed Supports program if the parents or legal guardian is:

- Not willing to work with a Support Broker.
- Not willing to work with a Fiscal Employer Agent.
- Not following their child's Support Plans and the child's health and safety is being compromised.
- Making choices that directly endanger the child's health, welfare or safety or endangering or harming others.
- Not following the rules and procedures of the program.

Immediate Jeopardy To Health and/or Safety

If the FDS Case Coordinator determines a child's health or safety is in immediate jeopardy (s)he will:

- Send an *Immediate Removal from FDS Option Notice* by Certified Mail-return receipt requested to the individual and their Support Broker stating the individual is being removed from Family-Directed Community Supports Option. The *Notice* will include the date on which removal is effective and appeal rights.
- Prior authorize community crisis supports using the standard business procedure for prior authorization (if applicable).
- The Transition Process above will be implemented using a 90-day Transition Plan format. (under voluntary transition).

No Immediate Jeopardy To Health and/or Safety

- FDS Case Coordinator will send a Plan of Correction Notice by Certified Mail—Return Receipt Requested to the family or legal guardian and their Support Broker which states the child will be removed from the Family-Directed Supports Option unless non-compliance with identified program requirements is remedied.
- The *Notice* will list the specific concerns that need to be addressed and the date by which a plan of correction needs to be submitted to the FDS Case Coordinator.
- The *Notice* will allow the family or legal guardian ten business days to submit a plan of correction relevant to the identified concerns. After receiving the Notice, the family or legal guardian can pursue one of the two following options:

Option 1: Submit *Plan of Correction* to FDS Case Coordinator within 10 business days; or

Option 2: Do not submit a *Plan of Correction* to FDS Case Coordinator within 10 business days.

Option 1: Family Or Legal Guardian Submits A Plan Of Correction

FDS Case Coordinator will review the Plan of Correction to determine whether non-compliance with program requirements has been remedied. FDS Case Coordinator will approve, remediate, or deny *Plan of Correction*.

Approve Plan Of Correction

- Send a *Plan of Correction Approval Notice* to family or legal guardian and Support Broker notifying them that *Plan of Correction* has been approved.
- FACS Case Coordinator monitors implementation of *Plan of Correction* through quality assurance processes.

Deny Plan Of Correction

- The FDS Case Coordinator will send *a Plan of Correction Denial Notice* by Certified Mail - return receipt requested to the family or legal guardian and their Support Broker stating the *Plan of*

Correction has been denied and that the participant is being removed from the FDS Program. The notice includes the date on which removal is effective and appeal rights.

- Prior authorize community crisis supports using the standard business procedure for prior authorization (if applicable).
- The Transition Process above will be implemented using the *90-day Transition Plan* format. (listed under voluntary transition)

Option 2. Individual Doesn't Submit A Plan Of Correction

- FACS Case Coordinator sends a *Removal for No Plan of Correction* Notice by Certified Mail-Return Receipt Requested to the family or legal guardian and their Support Broker stating a Plan of Correction has not been received and child is being removed from the Family-Directed Program. The *Notice* includes the date on which removal is effective and appeal rights.
- Prior authorize community crisis supports using the standard business procedure for prior authorization (if applicable).
- The Transition Process above will be implemented using 90-day Transition Plan format. (listed under voluntary transition)

Participant Wants to Access the Consumer-Directed Option Mid-Plan Year

Participants that want to access the Consumer-Directed Option before the usual annual re-determination date need to contact the regional Care Manager or Case Coordinator and request information about the program. The regional staff will give them the date and time to attend an orientation meeting and Guide Training.

NOTES:

Chapter Nine: Transitioning from Children's to Adult Services

The Family-Direction Program ends upon the child's 18th birthday. DHW's goal is to provide a process to smoothly transition to the adult program and minimize any interruptions in services.

Six to nine months prior to turning 18, an application can be submitted for adult DD waiver services, however, the only adult DD service that can begin prior to the age of 18 is plan development.

Medicaid staff in the adult program will complete an intake process then forward the application and any other intake documents to the Independent Assessment Provider (IAP) to determine program eligibility for adult DD services.

Upon receiving the referral from DHW, the IAP can begin the assessment process and determine eligibility prior to the child's 18th birthday. Documentation is needed for eligibility determination for adult services. Participants may need to be referred for evaluations and diagnosis or asked to obtain evaluations through their school (for autism a standardized autism assessment such as the *ADOS* , for seizure disorders a recent neurological evaluation is helpful, a physician's evaluation for cerebral palsy, etc.) When eligibility has been determined due to an Intellectual Disability, a psychological evaluation using an adult IQ test is most often required to determine eligibility for the adult program. It is very helpful to have this completed prior to transition to adult programs.

The IAP will send the participant a letter indicating if they are eligible for DD and waiver services and the budget amount. If the participant is deemed ineligible, the letter will include information on their right to appeal of the decision.

Remember from Chapter One, Self-Directed Community Supports (SDS) is a program option for adults eligible for the Adult Developmental Disabilities Waiver. Family-Directed Community Supports (FDS) is a program option for children eligible for the Developmental Disabilities Waiver and the Home and Community Based Services - State Plan Option. Simply stated, the eligibility criteria for the FDS program is broader than the eligibility criteria for the adult program, SDS. Not all children on in FDS program will be waiver level of care, thus may not be eligible to continue in the SDS program. Participants who are eligible for the adult DD Waiver can choose the Traditional pathway or the SDS pathway. Participants who choose SDS will be referred back to a Medicaid Care Manager to continue this process.

Participants that choose the adult Traditional pathway will make a decision regarding what agency they would like to have as their Plan Developer and begin the person-centered planning process that leads to the development of an adult DD services plan that will guide services through the next year.

Financial Eligibility

Participants transitioning from children to adult services must complete the process to get adult Supplemental Security Income (SSI) benefits in order to continue their Idaho Medicaid. In most cases, this process cannot be completed until the child turns 18. It is critical to follow the Social Security Administration's adult disability determination process timely as letting it lapse will affect the participant's Medicaid eligibility.

Transition from adolescence to adulthood

The years between 14 and 18 of age are important years in the transition process. There are many considerations beyond DHW disability services. Please see *Appendix M* for helpful tools in navigating this transition. Below are considerations to keep in mind during the transition process:

Adolescence

- Initiate transition planning with IEP team annually beginning at age 14
- Include functional academics to support independence and life skills
    - math (budget, money management skills)
    - Reading (identification and comprehension, community safety signs)
    - Writing (filling out forms, signing checks, writing resumes)
    - Pre-Vocational skills
- Computer use
- Identify career interests and skills; additional education or training requirements
- Broaden experiences with community activities and expand friendships.
- Obtain a state of Idaho ID card and learn how/when to use it

Approaching Adulthood

Self-Determination

- Knowledge of one's own disability and learning style
- Knowledge of rights
- Knowledge of appropriate, effective communication and assertiveness skills

Independent Living Skills

- Planning for emergencies and crises - are there other health and safety issues?
- Community training (banks, post office, shopping, libraries, transportation, etc.)
- Residential living skills (cleaning, paying bills, other household maintenance tasks)
- Communication skills
- Recreation/leisure and social relationships
- Self-medication/health and Safety

Other Issues to Consider

- Guardianship
- Special needs trusts/estate planning
- Insurance
- Income and benefits maintenance (Medicaid, SSI)

Adulthood

- Adult Care Management (Idaho Bureau of Developmental Disability Services)
- Social Security and Medicaid

Career Exploration and Development

- DVRS (Division of Vocational Rehabilitation Services) is a possible resource
- Vocational evaluation
- Job exploration and job sampling, apprenticeships and part-time employment
- Supported Employment
- Vocational/ technical school

SSI & Children Turning 18

SSI or “Supplemental Security Income” is a federal program that provides monthly payments to individuals with limited income and few assets who are 65 years of age, blind or have another disabilities. The program, ran by the Social Security Administration, is not financed from Social Security taxes or the Social Security Trust fund, rather by the general revenue funds of the US Treasury.

Applicants with disabilities must meet Social Security's definition of a disability to be eligible for assistance. A disability is a "physical or mental impairment that is expected to keep an individual from doing any substantial work for at least a year or is expected to result in death."

When a child with a disability turns 18, several things happen in relation to his/her Supplemental Security Income (SSI) benefits. First, the young adult must reapply with the Social Security Administration for SSI benefits as an adult. The Social Security Administration will use a different disability criteria than what was used to evaluate a child’s disability. (If a child has been receiving Social Security - Child’s benefits, when he/she turns 18, he/she will have to apply to begin receiving benefits as a “Disabled Child” who is an adult.)

Participants can prepare for this re-application by keeping medical and school records updated and complete. Participants may be asked to provide records that document a condition and how it affects the ability to work. This may include records such as:

- ✓ Hospital stays and surgeries
- ✓ Visit to doctors and clinics, dates, reasons and address,
- ✓ Names of medicines
- ✓ Work History (employer, address and dates worked)
- ✓ Counseling and therapy
- ✓ School information including special classes, programs or tutoring
- ✓ A list of teachers and counselors who have knowledge of the child’s condition

The family’s income and resources will no longer be considered when determining an adult’s financial SSI eligibility; only the participant’s resources and income will count. Once a child turns 18, the amount of his/her SSI check will be based on his/her monthly income and living arrangement.

Parents or legal guardians should receive a packet from the Social Security Administration with information about re-determination of the participant’s benefits as an adult. It is critical that you respond promptly to this letter. If you don’t receive a letter, contact your local Social Security Administration office. Request that SSI coverage be extended, if necessary, while an adult eligibility determination is being made.

Guardianship

At the age of 18, a parent’s natural guardianship ceases by law, whether or not their child has a disability - regardless of the severity of the disability. Any person attaining the age of 18 is recognized as a competent adult by law, and remains so unless found incapacitated by a court of law. Without the court determination that an individual is incapacitated, that individual retains all constitutional rights and is responsible for making his own decisions. These rights include the rights to make decisions regarding residence, medical care, contracts, marriage and lifestyle.

Not all persons with a developmental disability need a guardian. Support from family or other trusted people can provide necessary support to make important decisions. Other types of support (e.g., joint bank account, rep payee, power of attorney), assistance and counseling maybe all that is necessary.

Parents often wish to try to protect their child by establishing some control over their adult child's life. They may fear that their adult child may not act responsibly, be taken advantage of or make poor decisions. Unfortunately, a guardianship is not typically an effective means to prevent this. Although legal authority is established upon the appointment of a guardian, the guardianship itself cannot stop a protected person from taking actions that their parents may not agree with.

Disability Rights Inc, Idaho has published a very helpful guide on guardianships and conservatorships. This publication "*Self-Advocacy Guide to Guardianships*" is found on their website at: http://www.disbtilyurithtsidaho.org/resources/upblications.aspx

Residential Services

As children reach adulthood, they often prepare to leave the nest. Adults with a developmental disability may live independently in the community with varying levels of support. Regardless of the living situation, it is important that individuals have both choice and independence to keep them health and safe.

NOTES:

APPENDIX N: SAMPLE APPLICATIONS FOR EMPLOYMENT

SAMPLE APPLICATION #1

POSITION:

Name (First, MI, Last):
Mailing Address: City State Zip
Home Phone Number: Message Phone Number:
Email Address: May we use email to contact you? Yes □ No □

ADDITIONAL INFORMATION

Are you a U.S. citizen, permanent resident, or a foreign national with authorization to work in the U.S.? Yes □ No □
Have you ever been convicted of, or entered a plea of guilty, no contest, or had a withheld judgment to a felony or misdemeanor? Yes □ No □ If Yes, please explain:

EDUCATION (Schools after high school, or special training received)
School Name:
Location Enrolled: Last Attended:
Degree Discipline Graduate? Yes □ No □
(repeat as needed)

WORK HISTORY (repeat as needed)
Name of Employer and Employer's Address:
Job Title:
Employer's Phone Number:
Supervisor's Name:
From (Month/Year): To (Month/Year): Hrs. per Week: May we contact this employer? Yes □ No □
Reason for Leaving:

JOB TYPE/SHIFT
(Check all you would be interested in)
Full-time □ Part-time □ Temporary □ 6 Month □ 9 Month □ Seasonal □ Nights □

PERSONAL REFERENCES (3 persons not related to you by blood or marriage.)

Name:
Address: City State Zip
Telephone:
Connection To You (i.e., Friend, Co-Worker): Occupation:

I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, my application may be rejected, my name removed from consideration, or my employment terminated.

_____ _____
Signature Date

Sample Application #2

PERSONAL INFORMATION

Name (Last, First, Middle) Other Names Used:
Address: City State Zip
Telephone: Home Cell/ Message: Email Address:
Are you applying for: ☐ F/T ☐ P/T ☐ Temp/Seasonal
What shifts will you work? ☐ Days ☐ Nights
May We Contact Present Employer? ☐ Yes ☐ No
Available Start Date:
Are you legally eligible to work in the United States? ☐ Yes ☐ No

EDUCATION/TRAINING

School Name Location
High School College
Other (Business, Vocational, Military)
Dates Attended From: To:
Diploma, Degree & Major Graduated?
Do you have a valid driver's license? ☐ Yes State:_____ ☐ No
Class:_____ Endorsements:_____
Are you legally eligible to work in the United States ? ☐ Yes ☐ No
Other (Business, Vocational, Military)

EMPLOYMENT HISTORY (Please Start With the Most Recent, Ending With Age 18, Excluding Part-Time Positions Held While Obtaining Higher Education—Use Additional Paper as Necessary.):

Employer: Position Held:
Address: City State Zip
Telephone: Supervisor Name:
Dates From: To:
Primary Duties: Reason for Leaving:

TECHNOLOGY SKILLS (List All Skills & Software Applications You Have Experience Using):

Word Processing: Spreadsheet:
Other Software: Database:
Professional Licenses or Certificates Held:

PERSONAL REFERENCES (3 persons not related to you by blood or marriage.)

Name: Occupation:
Address: City State Zip
Telephone: Connection To You (i.e., friend, co-worker):
Have you ever been charged with a crime (other than a minor traffic infraction)? Yes No
If yes, when & where: _____
Please Explain: _____

I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, my application may be rejected, my name removed from consideration, or my employment may be terminated.

I understand and agree that, if hired, my employment is for no definite period and either Employer or I may terminate our relationship at any time, and that this employment application does not constitute an employment contract.

Signature of Applicant:_____ Date:_____

Appendix O: Some of the Important Differences Between Consumer-Directed Services For Children and Adults

Minor Children	Adults
SCOPE	
Children who do not meet institutional level of care (waiver eligibility) can access the Family-Directed Services option through 1915i HCBS. IDAPA 16.03.13.010	Adults must meet institutional level of care (be waiver eligible) to access Self-Direction. 16.03.13.010
SUPPORT BROKER	
A qualified parent or legal guardian may act as their child's unpaid Support Broker. IDAPA 16.03.13.110	The participant must purchase support broker services. A parent cannot be their adult child's Support Broker.
Support Brokers must attend the initial Support Broker training. IDAPA 16.03.13.135	The initial Support Broker training is optional.
Support Brokers are required to assist children enrolled in the Family-Directed Services option as they transition to adult DD services. IDAPA 16.03.13.136	
COMMUNITY SUPPORT WORKER	
A parent or legal guardian may not be a paid Community Support Worker. IDAPA 16.03.13.140	A parent or legal guardian can be a paid Community Support Worker for their adult child. IDAPA 16.03.13.140
A Community Support Worker: a. Must not supplant the role of the parent or legal guardian; b. Cannot be paid to fulfill any obligations that the parent or legal guardian is legally responsible to fulfill for their child. IDAPA 16.03.13.140	
BUDGET	
A child's family-directed budget does not include all services related to their developmental disability. Some examples of services NOT included in a child's budget include: medical, school-based, mental health services, transportation, durable medical equipment, physical therapy, occupational therapy, and speech therapy.	Adult self-directed budgets include all services related to an individual's developmental disability. Some examples of services that ARE included in their budget include: durable medical equipment, physical therapy, speech therapy, mental health, and transportation. Adult self-directed budgets do not include medical services.
DECISION - MAKING AUTHORITY	
The parent or legal guardian is responsible for decisions made on behalf of a child participant. IDAPA 16.03.13.020	The participant, or legal guardian if one exists, is responsible for decisions made on behalf of an adult participant. IDAPA 16.03.13.020

This list contains primary differences between FDS and SDS programs, there are additional differences in forms, procedures and processes.

Appendix P: GLOSSARY OF ACRONYMS AND DEFINITIONS

ALLOWABLE EXPENSES: Goods and Services have meet the funding criteria in the Consumer-Direction program, allowable expenses vary according to the needs and abilities of the participant.

CHC, CHBC: Criminal History Background Check: A Support Broker must comply with IDAPA 16.05.06 Rules Governing Mandatory Criminal History Checks. The process followed by the Department of Health and Welfare of verifying that a potential employee does not have any criminal record that would prohibit him or her from working with children or vulnerable adults.

CIRCLE OF SUPPORTS: People who encourage and care about the participant and provide unpaid supports.

CONSUMER DIRECTION: The program option which offers Consumer-Directed Services to eligible participants who chose the program option called My Voice, My Choice.

COMMUNITY SUPPORT WORKER: An individual, agency or vendor selected and paid by the participant to provide community support worker services.

CSW: Community Support Worker: An individual, agency, or vendor selected and paid by the participant to provide Community Support Worker Services.

DEPARTMENT, DHW: This term refers to the Department of Health and Welfare.

EIN: Employee Identification Number.

EMPLOYER: The individual who has the legal authority to make program decisions. In the Family-Direction program, the employer is the minor child's parents or legal guardian. In the Self-Direction program, the employer is the participant, or the legal guardian if one exists.

FACS: Family And Community Services - Division Of Health And Welfare.

FDSO, FDCS, FDS: Family-Directed Service Community Option: A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver and the Children's Home and Community Based Services State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."

FEA: Fiscal Employer Agent: An agency that provides Financial Management Services to participants who have chosen the Consumer-Directed Community Supports option.

FMS: Financial Management Services: Services provided by a Fiscal Employer Agent. including manage money for individuals or businesses. Services include financial guidance and support, tracking individual expenditures, monitoring overall budgets, performing payroll services and handling billing and employment related documentation responsibilities.

HEALTH AND SAFETY: A participant's health, welfare and safety including danger to himself and others.

IAP: Independent Assessment Provider: The entity that determines eligibility and individual budget for DD services.

ICDE: Idaho Center For Disabilities Evaluation: The designated contractor utilized by the Department of Health and Welfare to determine eligibility for developmental disabilities services.

ICF/ID: Intermediate Care Facility For The Intellectually Disabled (previously MR): This refers to both a specific type of institution and a specific level of care.

ISP: INDIVIDUAL SUPPORT PLAN: The plan that developed by participants in the traditional Developmental Disabilities Waiver program.

MARKET RATE: An amount for payment of goods and services in the CDSO program that are within the norms for that local area based on the service, education and experience of the provider.

MY VOICE, MY CHOICE: The name of the Consumer-Directed Services program in Idaho.

MV,MC Workbook: My Voice, My Choice Workbook: The participant workbook for Consumer-Directed Services completed prior to the *SSP* to determine risks, needs, preferences, and supports.

PARTICIPANT: A person eligible for and enrolled in the Consumer-Directed Services Programs. The participant is also an employer, unless they are a minor (FDS) or have a guardian (SDS).

PARTICIPANT EXPERIENCE OUTCOMES: Information gathered through an interview with the participant by the Department, that will address the following participant outcomes: Access to care, choice and control, respect and dignity, community integration, and inclusion.

PES: Participant Experience Survey: The series of questions used to monitor and discuss participant satisfaction with their ability to self-direct their services.

QUALITY ASSURANCE REVIEWS: Part of DHW's quality assurance measures. Reviews in which DHW will assess ongoing participant health and safety, compliance with the approved *SSP* and compliance with IDAPA rules and program policies. Reviews may also address access to Consumer-Directed services, participant direction of plans and services, participant choice and direction of providers, safe and effective environments, and participant satisfaction with services and outcomes. Community support workers and support brokers will be included in these measures, including a review of performance evaluations, satisfaction surveys, quarterly review of services provided by a legal guardian, if applicable, and spot audits of time sheets and billing records.

RMS: Regional Medicaid Services: Medicaid services are available through the local offices in each Department region. There are seven regions in Idaho. Each office has at least one care manager and quality assurance specialist assigned to the area.

SB: Support Broker: An individual hired by the employer who advocates on behalf of the participant, and assists with planning, negotiating and budgeting as outlined in IDAPA Rules.

SDSO, SDCO, SDS: Self Direction Services Community Option: The program option which offers consumer-directed services to participants who meet criteria for ICF/MR Waiver Level of Care for developmental disabilities services.

SIB-R: Scales Of Independent Behavior-Revised: An assessment tool used to gauge the age-equivalency of a person's functional abilities.

SSP: Support And Spending Plan: a document that functions as a participant's plan of care when the participant is eligible for and has chosen a consumer-directed service option. This document identifies the goods or services, or both, selected by a participant, including those goods, services, and supports available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each of the identified goods and services. The participant uses this document to manage his individualized budget.

TRADITIONAL ADULT DD WAIVER SERVICES. A program option for participants eligible for the Adult Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."

TRADITIONAL CHILDREN'S DD WAIVER SERVICES. A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."

TRADITIONAL CHILDREN'S HCBS STATE PLAN OPTION SERVICES. A program option for children eligible for the Children's Home and Community-Based Services (HCBS) State Plan Option consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."