
**NEW MEXICO DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES SUPPORTS
DIVISION (DDSD)**

FISCAL YEAR 2012

**STATE GENERAL FUND
Services for Individuals with
Developmental Disabilities,
and**

**FAMILY INFANT TODDLER PROGRAM /
MEDICAID EPSDT**

**Services for infants and toddlers (birth to three) with,
or at risk of Developmental Delays and their families**

SERVICE DEFINITIONS AND STANDARDS

EFFECTIVE JULY 1, 2011

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INTRODUCTION

These standards apply to the services provided under State General Funded provider agreements with the Developmental Disabilities Supports Division of the Department of Health for State Fiscal Year 2012 (July 1, 2011 through June 30, 2012). Services included in these standards are those provided to families of infants and toddlers (birth to 3) with, or risk for, developmental delays and those provided to individuals with developmental disabilities. For Early Intervention and other Family Infant Toddler Program services these standards clarify, interpret, and further enforce the Human Services Department regulations governing the provision of Medicaid Early Periodic Screening Diagnosis and Treatment services under “Special Rehabilitation Services”, (8.320.4 NMAC, effective 12/1/03).

The standards address each service provided under State General Funded contracts and agreements with the Developmental Disabilities Supports Division, with the exception of Outcome Based Services and Special Projects (Outcome Based Service and Special Project requirements will be individually described in each Scope of Service incorporated into the State General Funded contracts affected). These standards also include personnel requirements for people employed by or contracting with agencies providing State General Funded services, known herein as *the provider*. Individuals should expect to receive services that meet these standards.

GENERAL REQUIREMENTS

Pertinent laws and regulations governing the provision of services under the State General Funded contract with the Developmental Disabilities Supports Division of the Department of Health includes, but is not limited to:

- Fair Labor Standards Act and Child Labor Laws
 - New Mexico Nursing Practice Act (26 NMAC 12.2) and NM Board of Nursing requirements governing certified medication aides and administration of medications.
 - The Federal Individuals with Disabilities Education Act (IDEA), Part C
 - DDS/DOH Requirements for Family Infant Toddler Early Intervention Services (7 NMAC 30.8)
 - DDD/DOH Service Plans for Individuals with DD Living in the Community (7 NMAC 26.5)
 - DDD/DOH Rights of Individuals with DD Living in the Community (7 NMAC 26.5)
 - DDD/DOH Client Complaint Procedures (7 NMAC 26.4)
 - DDD/DOH Program Standards for DD Community Agencies (7 NMAC 26.6)
 - DDD/DOH Individual Transition Planning Process (7 NMAC 26.5)
 - DDD/DOH Dispute Resolution Process (7 NMAC 26.8)
 - DHI/DOH Statewide Incident Management System Policies and Procedures
 - DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities
 - Reporting and Documentation of DDS Training Requirements
 - Policies and Procedures for Centralized Admission and Discharge Process for New Mexicans with Disabilities
 - Policy for Behavioral Support Services
 - DHI/DOH Criminal Records Screening for Caregivers (7 NMAC 1.9)
 - The Department of Health Provider Agreements for FY 2012
 - And any rules, regulations, policies, director’s releases or interpretive memorandum published by DDS/DOH that specify applicability to the State General Funded services described herein.
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STANDARDS FOR SERVICE PERSONNEL

PURPOSE

The purpose of the standards for service personnel is to establish requirements for the provision of services under State General Funded contracts with the Developmental Disabilities Supports Division of the Department of Health. These standards apply to personnel who provide the following State General Fund services: Respite Services (Children and Adult), Adult DD Residential Services and Adult Day Services. The standards apply whether the personnel are directly employed or subcontracting with the provider agency, and are in addition to the requirements set forth in the remaining sections of the State General Funded Service Standards.

INTRODUCTION

It is the intention of the Developmental Disabilities Supports Division that State General Funded providers comply with these personnel standards in order to promote the health and safety of individuals served.

GENERAL PERSONNEL REQUIREMENTS

All personnel must be of good integrity and possess adequate physical, mental and emotional stability to provide services in a safe and responsible manner.

The provider must screen all personnel regarding their qualifications, references, and employment history. In addition, all providers must comply with the Criminal Records Screening for Caregivers (7 NMAC 1.9) as implemented by the Department of Health, Division of Health Improvement.

EXCEPTION: Any agency providing Home Health Aide, Homemaker/Companion Services under a Home Health Care Agency pursuant to the New Mexico Department of Health, Health Facility Licensing and Certification Bureau (7 NMAC 28.2) is exempt from these personnel standards.

QUALIFICATIONS FOR DIRECT SERVICE PERSONNEL

Direct service personnel are persons paid to provide face-to-face service to the individual.

Direct service personnel must be eighteen (18) years or older. *Exceptions: Habilitation services provided under Adult DD Vocational/Habilitation Services can employ direct care personnel under the age of 18 years, but the employee must work directly under a supervisor, who is physically present at all times; and the agency can assure the served individual is not limited in access to all services and supports.*

1. Direct service personnel should be available to communicate in the language required by the individual or in the use of specific augmentative communication system utilized by the individual.
2. Direct service personnel must meet the competencies specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities (2/23/07). (*Exception: Respite Services*)
3. Direct service personnel must have the ability to read and carry out the requirements in an Individualized Family Service Plan (IFSP) or an Individual Service Plan (ISP).

SUPERVISION REQUIREMENTS

Personnel who are directly responsible for the supervision of direct service personnel must meet the following requirements.

1. Employees who supervise direct service personnel or serve as a member of a supervisory team must be twenty-one (21) years of age or older.
2. Must possess a high school diploma or G.E.D.

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3. Employees who supervise direct service personnel must have a minimum of one-year experience working with individuals with disabilities or related field; OR a degree in a related field may substitute for experience.
 4. Employees who supervise direct service personnel must meet the competencies specified in the Developmental Disabilities Supports Division Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators.
 5. Must have the ability to read and carry out the requirements in an IFSP and an ISP.
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RESPITE

Respite is a flexible family support service that provides short term, temporary care to people with disabilities or children who are at risk for developmental delay. This service allows families to take a break from the daily routine of care giving. Respite care providers assist the individual in activities of daily living, promote the individual's health and safety, as well as maintain a clean and safe environment. The family, in collaboration with the provider, will schedule respite services.

SCOPE OF SERVICE

Respite services include but are not limited to:

- Assisting the individual to enhance self-help skills and carry out activities of daily living;
- Providing non-medical health care;
- Preparing or assisting the individual in activities of daily living including preparation of meals, eating, sleeping, washing etc.;
- Providing opportunities for community and neighborhood integration and involvement;
- Providing opportunities for leisure, play and other recreational activities;
- Providing opportunities and support to the individual to make choices in regard to daily activities depending on age and skill level.

SERVICE REQUIREMENTS

Specific requirements and conditions that apply to respite services are:

- The staff to participant ratio is typically 1:1 or 1:2 in family household or community settings for the period of time in which an individual is receiving respite services. A decision based on the participant's needs and the respite provider's capabilities should be made on a case-by-case basis if the respite provider is going to serve more than one individual at time.
- Service provision in a small group is permissible when appropriate to the individual and family; however; a minimum of a 1:4 staff to participant ratio must be maintained if the respite is provided to a group.
- The decision regarding the location in which respite will be provided shall be made in consultation with the family. Locations where respite may be provided include the following:
 1. The individual's/family's home,
 2. The respite care provider's home,
 3. A community setting of the family's choice (e.g. community center, swimming pool, park etc.),
 4. A center based setting, such as a respite home, provider location or day care center.
- Respite hours are allocated up to a maximum of 200 hours per year per eligible recipient. Exceptions to the 200 hour cap may be made with prior written approval from DDSD (using Form RSP-001).
- While the 200 hour limit is a guide, the respite coordinator should meet with the family to determine each family's needs and how they will utilize respite. For example:
 - If the family wants 2 hrs per week in order to do laundry, this would amount to 104 hours (2hrs X 52 weeks) per year.
 - If the family wants one day per month for the parents to spend time together this would be 96 hours (8 hrs X 12months) per year.
- Families/Individuals may request respite care hours overnight or more than one day.

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- If respite is provided in the respite provider's home, the homeowner or renter of the home where the service is provided shall ensure the safety of the home including but not limited to the presence of a smoke detector and fire extinguisher. Agencies providing respite services will verify that respite providers who provide respite services in their own home are made aware of this requirement.
 - Respite providers should not provide skilled nursing tasks including G-tube replacement, oxygen adjustment, suctioning etc. The family or a qualified nurse working within their scope of practice must complete skilled nursing procedures.

ELIGIBILITY REQUIREMENTS FOR RESPITE SERVICES INCLUDES THE FOLLOWING:

1. A child age 0 through 3 years must be eligible for Early Intervention Services and have Respite identified as a service in the Individualized Family Service Plan (IFSP).
2. A child age 3 years through 21 must have been determined eligible, and/or have received Early Intervention Services, and met the established condition or the developmental delay eligibility criteria under the Family Infant Toddler Program. A child may also be determined eligible by being developmentally disabled in accordance with DDSD Policy, and/or have been determined developmentally delayed or developmentally disabled by the Public School system. Children ages 3-21 who were formerly eligible for services through the FIT program under the medical, biological or environmental risk categories/definitions will need to meet Public Education Department (PED) special education requirements and be eligible for special education services in the preschool to high school grades in order to receive respite services.
3. An adult age 22 or older must have been determined developmentally disabled in accordance with DDSD Policy.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative requirements:

- The provider will assure the eligibility of individuals receiving services and will maintain a participant record containing documentation pertinent to service delivery such as contact notes, hours of training, hours of service. The provider may require advance notice from the individual/family for the scheduling of respite.
- The provider will establish and maintain financial reporting and accounting for each individual/family served.
- The provider will prepare and submit quarterly summary reports to the DDSD - Family Infant Toddler Program staff assigned to their region of the State, using the format specified by the Family Infant Toddler Program.
- The provider shall not charge any fee to families for Respite. The provider may charge for meals or entrance fees if these occur during the time respite is provided.

B. Staffing Requirements:

The provider must adhere to the following requirements regarding employees or contract personnel hired as respite providers:

- A parent, spouse, primary caregiver or surrogate parent may not provide respite services if they reside in the same dwelling as the individual served.
- Respite care providers must be at least 18 years old.
- Respite care providers must be certified in First Aid and CPR. CPR must be obtained for the population for which they will be serving (either infants, adults or both).

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- Respite care providers providing care to more than one participant must complete a forty (40) hour training program. Training can be specific to that participants needs. CPR and First Aid may count towards this requirement.
 - Respite care providers recruited specifically for a single participant must complete a twenty (20) hour training program. Training can be specific to that participants needs. CPR and First Aid may count towards this requirement.
 - Respite care providers may access the topics/requirements for training specified in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals. This training document is available from DDSD training unit and on the DDSD website.
 - Respite care providers may receive individual-specific training by the parent or family of the individual who needs respite, which can count towards a portion of the training requirement.
 - Respite care providers may take other training as relevant to participants such as: HIPAA Privacy, videotapes on specific conditions or syndromes, child abuse reporting, research on the Internet for specific conditions etc.
 - The agency may allow a reasonable period of time for completing additional training requirements but the time frame may not exceed 6 months from the date of hire.
 - Respite care providers must also participate in ongoing training with a minimum of ten (10) hours per year after the first year. The respite provider and employer should agree on training topics to be covered.
 - Criminal records checks are mandatory and must be completed in accordance with the DHI/DOH Criminal Records Screening for Caregivers (7 NMAC 1.9)
 - Respite providers must meet the DDSD Standards for Service Personnel located in front of this document

REIMBURSEMENT

Request for reimbursement for respite services under State General Funds shall be submitted monthly in accordance with directions provided by the DDSD - Administrative Services Bureau (ASB) at the Department of Health.

Respite providers should utilize the service component that corresponds with the age of the individual. The component categories are as follows:

- Children's Respite (birth - 21): Reporting Category 700026
- Adult Respite (22 & older): Reporting Category 700015

The Unit Rate for all services = \$ 13.25 per hour. A provider Agreement amendment is needed in order to move funds between the above Service Units

Reimbursement for Respite Services is based on an hourly rate, based on face-to-face contact.

Non-billable hours include:

- Travel to and from the individual's home, except when the individual is being transported.
- Attendance at training and other personnel development activities, which are not face-to-face contacts with the individual/family, preparation of billing statements, progress notes, and/or quarterly reports.

Respite Services provided under State General Fund (SGF) are not available to Medicaid Waiver recipients. Respite Services cannot be co-funded with Adult AGF DD Residential Services. Respite Services cannot be billed for the same hour (s) of the same day (s) with any other DDSD Service.

CHILD FIND AND PUBLIC AWARENESS

Child find and public awareness activities promote identification and referral of eligible children with, or at risk for, developmental delays for early intervention services and assist the child in becoming Medicaid eligible (where appropriate). These activities include public awareness, child find activities and interagency planning, presentations and coordination to improve child identification and/or service delivery, and presumptive eligibility activities

SCOPE OF SERVICE

Child Find and Public Awareness activities include but are not limited to the following:

- Development of materials to inform the general public about the benefits and availability of early intervention.
- Distribution of public awareness materials at sites that are frequented by parents of children of young children (Materials include those produced by the provider and those generated by the New Mexico Family Infant Toddler Program).
- Outreach to potential primary referral sources (including physicians; nurses; child care providers; social workers; Early Head Start grantees; home visiting providers; Women Infant & Children (WIC); homeless and domestic violence shelters, etc.) regarding early intervention and informing them of their responsibility of helping the family with a referral if their child is identified as having or being at risk for developmental delays.
- Providing opportunities for developmental screening and other child find activities within the geographical area that they serve.
- Coordinating efforts with other agencies and organizations (including public schools, Head Start programs, health centers etc.) regarding child find activities and events such as public health fairs or community outreach clinics.
- Conducting presentations/ seminars within the geographical area served on issues regarding early intervention in order to heighten awareness regarding early intervention and the availability of services.
- Conduct a PE-MOSA (Presumptive Eligibility – Medicaid On Site Application Assistance) to assist families in accessing Medicaid eligibility (where appropriate).

SERVICE REQUIREMENTS

The following conditions and requirements apply to Child Find and Public Awareness:

- Screening and other child find activities are available to any child who is birth to three years old if the family has a concern about their child's development. (Note: A child does not have to receive a screening in order to receive a developmental evaluation).
- Public Awareness materials developed should meet the cultural and linguistic needs of the population served.
- All public awareness materials developed must indicate that the provider agency is "funded in part by the NM Department of Health - Family Infant Toddler (FIT) Program".
- Child Find and Public Awareness activities must be provided to all communities, Indian reservations/Pueblos, and/or military bases within the geographical area served, as listed in the contract. Providers should identify and target any underserved groups by comparing numbers served compared to Census data.
- Interagency collaboration with other providers (including Children's Medical Services, Medically Fragile, NMSD; NMBVI, etc.) is important to ensure a streamlined referral and intake process and to avoid duplication.

- In counties where there is more than one FIT provider agency, providers shall coordinate child find and public awareness activities and events in order to prevent duplication of effort and to efficiently use time and resources, e.g. deciding who will do outreach to which referral sources; who will distribute FIT public awareness materials to which sites; and coordination of child find events, etc. This coordination should be reflected in the annual Child Find / Public Awareness Plan.
- In counties where there is more than one FIT provider agency, referral sources should be informed that the referral is to the Family Infant Toddler (FIT) Program and that there are “x” number of FIT providers that provide service coordination and early intervention services in the county that can receive a referral. The provider will promote the FIT program by using the FIT public awareness materials that list all providers in that area. If there is a request for information regarding a particular agency, that information can be passed out at that time.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- Establish and maintain financial reporting and accounting for expenditures under this service.
- Maintain a record of time spent by staff towards the scope of service listed above.
- Maintain a log of where, when and how (e.g. by mail, presentations, visit by staff etc.) materials have been distributed.
- Send one copy of all public awareness materials produced to the FIT Program regional manager.
- Ensure that demographic and referral information on all children and families is entered into the Family Infant Toddler Program database. Information must be entered on all children and families that are referred to early intervention, even if they are found to not be eligible for IDEA part C services.
- Ensure compliance with the regulations for the Family Infant Toddler Early Intervention Program 7 NMAC 30.8.
- Submit an Annual Performance Report (APR) within the required timeframe (usually within 60 days following the end of the fiscal year) and in the format provided by the Family Infant Toddler Program
- Submit an annual Child Find / Public Awareness plan within the first 60 days of the fiscal year using the template provided by the FIT Program.
- Submit a report using the template provided by the FIT Program within 30 days of the end of each quarter.

B. Staffing Requirements

Any staff within the provider agency can conduct Child Find and Public Awareness activities. Screening activities should only be conducted under the direct supervision of a Developmental Specialist II.

REIMBURSEMENT

Request for reimbursement for child find / public awareness shall be submitted monthly in accordance with directions provided by the DDS - Administrative Services Bureau at the Department of Health.

Reporting Category 700024

Unit Rate: \$1.00

Reimbursement shall be made based on cost reimbursement i.e. the invoice shall be based on the activity that occurred that month.

Reimbursement for Child Find / Public Awareness activities will not occur until the FIT Program has received and approved the annual Child Find / Public Awareness plan.

COMPREHENSIVE MULTIDISCIPLINARY EVALUATION

The Comprehensive Multidisciplinary Evaluation is designed to inform the eligibility determination process through a timely, non-discriminatory, comprehensive and interdisciplinary approach. The evaluation is designed to determine the developmental status of the child and must cover the following developmental areas:

- Cognitive
- Physical/ motor (including vision and hearing)
- Communication
- Social or emotional
- Adaptive behavior

SCOPE OF SERVICE

This service includes activities provided by early intervention personnel in order to complete an initial comprehensive multidisciplinary developmental evaluation (in accordance with 7.30.8 NMAC) for children who are referred to the FIT Program. Evaluation personnel should have a background in child development and be trained in the tool they are administering.

Activities required include:

- The team shall use all phases of the Infant-Toddler Developmental Assessment (IDA) as the approved statewide tool as part of the Comprehensive Multidisciplinary Evaluation.
- Given the unique characteristics of infants and the challenges of determining their developmental levels:
 - For infants under one (< 1) month of age (adjusted) the IDA will not be used. Instead one of the approved tools below shall be used together with informed clinical opinion.
 - For infants over one (>1) month of age (adjusted) and under four (<4) months of age (adjusted) the IDA shall be used in conjunction with one of the following approved tools:
 - Approved tools for infants include:
 - AIMS (Alberta Infant Motor Scale)
 - TIMP (Test of Infant Motor Performance)
 - Infant Toddler Sensory Profile
 - Peabody Developmental Motor Scale (PDMS-2)
 - Motor Skills Acquisition Checklist
 - Other tools as approved by the FIT Program.
- Other domain specific tools may be used in addition to the IDA as part of the Comprehensive Multidisciplinary Evaluation (CME). If the IDA does not indicate a 25% delay, a domain specific tool can be used to determine eligibility under developmental delay.
- A review and summary of the child's records related to current health status and prior medical history.
- Vision and hearing tests or screenings must be addressed in order for the CME to be complete. A statement summarizing the results must be provided in the written evaluation report and may include newborn hearing results, OAE and tympanometer results, NMSBVI screening tool or vision and hearing screening by a well child exam.
- The completion of a typed Comprehensive Multidisciplinary Evaluation (CME) report that summarizes the child's functioning in each developmental domain, gives a picture of the child's overall functioning and ability to participate in family and community life, makes recommendations regarding the child's eligibility and recommends approaches and strategies to be considered by the IFSP team when developing outcomes.

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- A FIT Program “Evaluation Summary Form”, which summarizes the evaluation results, may be used if the full evaluation report will not be completed at the time of the initial IFSP. However, the full evaluation report must be completed and given to the team within 30 days of the evaluation.

This service unit includes the participation of early intervention personnel in determining the child’s eligibility for the FIT Program.

SERVICE REQUIREMENTS

These conditions and requirements apply to the Comprehensive Multidisciplinary Evaluation:

- Children are eligible for this service who:
- Are from birth to three years old (If a child is referred to the FIT Program fewer than 45 days prior to the child’s third birthday an evaluation will not be conducted.)
- Reside in the state of New Mexico
- Have been referred for evaluation or early intervention services
- Have received prior informed consent from their parent(s)
 - The provider is responsible for determining eligibility for early intervention services, and maintaining documentation of eligibility status on file.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- Establish and maintain financial reporting and accounting for each child.
- Establish and maintain a confidential record for each family served that includes signed consent and release forms, progress notes and contact logs.
- The typed report that addresses all developmental domains, vision, hearing, and medical information, shall serve as documentation for Comprehensive Multidisciplinary Evaluation.
- The provider will develop a quality assurance plan that includes, but is not limited to developing an ongoing monitoring process that evaluates the quality, and effectiveness of services provided and the families’ satisfaction with services.
- Ensure that demographic and eligibility data is entered into the FIT Program database FIT-KIDS (Key Information Data System).
- Comprehensive Multidisciplinary Evaluations must be provided to all families referred in the geographical area served under the DDSD contract.
- Submit an Annual Performance Report (APR) within the required timeframe (usually within 60 days following the end of the fiscal year) and in the format provided by the Family Infant Toddler Program
- Conduct Correction of Noncompliance activities, as necessary, in accordance with requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency), and must be twofold. (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant, and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (although late), unless the child is no longer within the jurisdiction of the early intervention program
- The provider shall not charge any fee to families for the Comprehensive Multidisciplinary Evaluation.

B. Staffing Requirements

- The agency must provide adequate supervision to all staff providing Comprehensive Multidisciplinary Evaluation.
- Personnel conducting a Comprehensive Multidisciplinary Evaluation must have a BS/BA or higher and Developmental Specialists must be certified at level II or III. Personnel must be trained and/or licensed to administer instruments used in an evaluation.
- The Multidisciplinary evaluation team shall include personnel from two or more of the following disciplines:
 1. Audiologist – licensure from the NM Audiology Board
 2. Developmental Specialist certification II or III –in accordance with Family Infant Toddler Program regulations (7.30.8 NMAC) and DDSD Policy
 3. Family therapist – licensure from the Counseling and Therapy Practice Board as a Family Therapist, Professional Clinical Mental Health Counselor, Professional Mental Health Counselor, or Registered Mental Health Counselor
 4. Nurse – licensure from the NM Board of Nursing as a registered nurse
 5. Nutritionist – licensure from the NM Nutrition and Dietetics Practice Board
 6. Occupational Therapist– licensure from the NM Board of Occupational Therapy Practice
 7. Physical Therapist – licensure from the NM Physical Therapy Licensing Board
 8. Psychologist – licensure from the NM Board of Psychologist Examiners
 9. Social worker – licensure from the NM Board of Social Work Examiners
 10. Speech/Language Pathologist – licensure from the NM Board Speech, Language Pathology, Audiology and Hearing Aid Dispensers Board

REIMBURSEMENT

Request for reimbursement for Comprehensive Multidisciplinary Evaluation shall be submitted in accordance with directions provided by the DDSD - Administrative Services Bureau (ASB) at the Department of Health.

Comprehensive Multidisciplinary Evaluation

Reporting Category	700023
Rate: \$625.00	Unit: one completed evaluation
Medicaid	H2000 TL
Rate: TBA	Unit: one completed evaluation

This unit is paid for the initial multidisciplinary developmental evaluation that is completed in accordance with 7.30.8 NMAC. This rate covers the work of multidisciplinary evaluation team members in conducting direct assessment activities, administering instruments and tools with child and family, reviewing records and/ or reports, and writing the comprehensive developmental evaluation report. While the "Evaluation Summary Form" may be used, this unit cannot be billed until the full report has been written.

This unit may be billed only one time per eligible child and billing may only be submitted once the written evaluation report has been completed. Ongoing assessment activities with the child and family are billed based on the location where services were provided.

If a child is evaluated and determined not eligible, or exits the FIT Program and, due to concerns is referred again to the FIT Program at least 6 months after the previous evaluation, the provider may bill for an additional comprehensive multidisciplinary evaluation.

If the CME cannot be completed before the child moves to another community e.g. they are in temporary housing (Shelter, foster home etc.) time spent conducting the evaluation can be billed as ongoing assessment under Early Intervention (see Early Intervention Services).

FAMILY SERVICE COORDINATION

Family service coordination services are activities carried out by a designated individual to assist and enable the families of children from birth to three, to access, and if determined eligible, receive early intervention services. The family service coordinator helps to develop the Individual Family Service Plan (IFSP); assists the family in receiving all services identified; coordinates those services; ensures that they are delivered in a timely manner, and seeks additional services and or supports that may help the child or family. The family service coordinator works with the family to determine their service needs and if the family chooses to be involved in service coordination responsibilities they should be supported in that role.

SCOPE OF SERVICE

Family service coordination includes but is not limited to the following:

- Coordinating intake, evaluations and assessments and determining eligibility.
- Facilitating and participating in the development of the initial and annual Individual Family Service Plan (IFSP) as well as the 6-month review of the IFSP.
- Facilitating and participating in the initial, annual and exit ratings for the Early Childhood Outcomes.
- Assisting families in identifying and accessing all available services and resources, not just those related to the child's condition (e.g. housing, mental health services etc.).
- Coordinating and monitoring the delivery of services (including subcontractors and providers from other agencies).
- Informing families of advocacy services and empowering the family to enhance their own service coordination skills.
- Coordinating with medical and health providers.
- Facilitating the development of a transition planning process for each child and family.
- Gathering and researching resource information for the family and making referrals where appropriate.

SERVICE REQUIREMENTS

These conditions and requirements apply to family service coordination:

- Family service coordination shall be provided upon referral of the child and family to the FIT Program. Family service coordination is therefore provided during the intake and evaluation process prior to determining the child's eligibility. (Note: For newborns the intake, evaluation and IFSP will be conducted after the child and family return home).
- If a child is referred to Part C fewer than 45 days prior to the child's third birthday an intake and evaluation will not be conducted. The service coordinator will let the family know of preschool options available in the community, e.g. Preschool Special Education; Head Start; private preschools, etc. and will assist with a referral to those entities.
- During the intake process the family service coordinator will have the family complete a "Freedom of Choice Form" to select a FIT Provider in counties where there is more than one provider agency. The Freedom of Choice Form will also be used when a family is transferring into a county where there is more than one FIT Provider agency.
- The family service coordinator, together with the family and the evaluation team determine eligibility for the FIT Program and maintain documentation of eligibility status on file. If it is determined that the child does not meet any of the eligibility criteria, family service coordination will be discontinued. Parents of children who are not eligible for the FIT Program will be given the opportunity to enroll in

the statewide “Ages & Stages for Kids” (ASK) developmental tracking program. The family service coordinator will send in the completed referral form to the ASK office.

- A family will have only one family service coordinator, designated on the IFSP, regardless of whether the child may be eligible for more than one program. Families must be informed when there is a change in their family service coordinator and if the family service coordinator is on extended leave, another service coordinator must be assigned.
- The family service coordinator will complete the Public and Private Insurance form with each family at intake and at least annually to determine if the child is or may be eligible for Medicaid or if they are covered under a private insurance plan.
- A family may direct the level of support and assistance that they need from their family service coordinator and may choose to perform some of the service coordinator functions themselves. A family may not be paid to provide service coordination for their child and family.
- The family service coordinator shall make contact with the family once a month, at a minimum, in order to meet the requirement for “coordinating and monitoring the delivery of services”. If a face-to-face visit with the family will not occur that month due to a family reason, then that will be documented in the case notes in the child’s record.
- The family service coordinator will explore with each family their need for family supports including parent-to-parent support, parent training, respite and other resources and referrals.
- The service coordinator will coordinate the collection of information and data for the Early Childhood Outcome score to be determined by the IFSP team at the time of the initial and subsequent annual IFSPs.
- The family service coordinator will coordinate with the Medically Fragile Case Management Program if the child is also eligible for medically fragile services in order to align and avoid duplication of services. This may include joint meetings and sharing of records with the consent of the parent(s).
- If the child is transferred during the month.- when the family service coordinating provider changes during the month, if it occurs after the 15th of the month, the “original” service coordinator is authorized to bill for that month. If it occurs before the 15th of the month, then the new service coordinator bills for the entire month. Providers shall not postpone the transfer of a child until after the 15th of the month in order to bill
- If a child is transferring from another state or another FIT provider where the child/family received early intervention services, family service coordination will be provided to the family immediately, and the family’s IFSP from their previous agency will function as the plan for services until a new IFSP is developed. If the child is being transferred from another FIT Provider, the “FIT Program Child/Family Transfer” form must be completed by the transferring agency according to the specified requirements on the form. The form and documents must be sent to the receiving agency within four (4) working days of the receiving agency being notified of the transfer by phone. The receiving agency will hold an IFSP meeting to review and update as necessary within 30 days of the transfer.
- The family service coordinator will manage the transition process beginning with the transition plan, which is included in the IFSP by the child’s 2nd birthday (24 months of age). The family service coordinator will also plan and schedule the transition conference at least 3 months prior to the child’s third birthday, including sending the referral, assessment summary form and invitation to all parties who will be attending the meeting. The family service coordinator facilitates the transition conference and follows-up on implementation of the action steps to ensure a smooth and effective transition for the child and family.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- Establish and maintain financial reporting and accounting for each family served.
- Establish and maintain a confidential record for each family served, which include the following: signed consent and release forms; current evaluation and assessment results; documentation of eligibility determination; Medical and other appropriate records; IFSP documents; progress notes and contact notes.
- Contact notes / case notes must include date, time in/time out, a brief description of the service provided and the first initial and last name of the Service Coordinator. Documentation must include all time spent with the family and work done on behalf of the family, regardless of the length of time required for billing purposes.
- A quality assurance plan will be developed that includes, but is not limited to developing an ongoing monitoring process, which provides for the evaluation of quality, effectiveness of the services provided and the family's satisfaction with the service.
- Maintain accreditation from a national accrediting body (example: CARF; the Council on Accreditation; NAEYC etc.) for at least two consecutive accreditation (2 or 3 year) periods. A waiver to the accreditation can be requested from DDSD two consecutive accreditation periods.
- Utilize the state FIT Program IFSP Forms for all eligible children and families.
- Ensure that demographic, IFSP and delivered services data is entered into the Family Infant Toddler Program database and that this is submitted to the Developmental Disabilities Supports Division in accordance with instructions.
- Ensure compliance with the regulations for the Family Infant Toddler Early Intervention Program 7.30.8 NMAC
- Service coordination must be provided from the time of referral to all eligible children and families in the geographical area served under the DDSD contract.
- Submit an Annual Performance Report (APR) within the required timeframe and in the format provided by the FIT Program.
- Conduct Correction of Noncompliance activities, as necessary, in accordance with requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency), and must be twofold. (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant, and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (although late), unless the child is no longer within the jurisdiction of the early intervention program
- The provider shall not charge any fee to families for Service Coordination.
- Ensure that case loads allow for the service coordinator to perform the roles and responsibilities of service coordination.

B. Staffing Requirements

Service Coordinators must possess one of the following qualifications:

- A bachelor's degree in social work; counseling; psychology, nursing; special education; early childhood education or closely related field.
- Individuals with a bachelor's degree in another field can substitute two (2) years of direct experience in serving individuals with disabilities and/or families.

- If there are no suitable candidates with the previously described qualifications, individuals with an Associates degree or a registered nurse (who does not have a baccalaureate degree in nursing) and who have a minimum of three (3) years of experience in community health or social service settings can be employed as a service coordinator.
- An exemption to the above requirements can be approved by DDS in order to hire service coordinators who meet the cultural or linguistic needs of the population served or if the applicant is a parent of a child with special needs (NOTE a parent can not be paid to provide service coordination to their own family). The agency should submit a letter to the Developmental Disabilities Supports Division requesting an exemption.
- Service coordinators must attend the required service coordination trainings (online and classroom) within a year of hire.
- Service coordinators must take the on-line service coordination training (this is the on-line training without credit) every 3 years in order to update themselves on revised requirements.
- Provider will ensure that the service coordinators receive in-house training / mentoring until they are able to attend the FIT service coordination trainings and before working independently with families.
- Service coordinators will receive reflective supervision at least once every month.

REIMBURSEMENT

Request for reimbursement for service coordination under State General Funds shall be submitted in accordance with directions provided by the DDS - Administrative Services Bureau (ASB) at the Department of Health.

Reporting Category	700021
Unit Rate: \$155.00	1 (one) unit per month maximum
Medicaid	T2023 TL
Unit Rate: \$155.00	1 (one) unit per month maximum

- Reimbursement for service coordination is a monthly rate.
- Reimbursement for service coordination is provided for both face-to-face contacts with the family and work done on behalf of the family (coordinating services, advocating, submitting applications etc.).
- A minimum of one (1) accumulated hour of service coordination must occur in order to be reimbursed for that month. Documentation must include all time spent with the family and work done on behalf of the family, including work beyond the one hour minimum. Travel time may not be included.
- The Service Coordinator should keep clear records of their time spent with and on behalf of families for audit purposes.
- Service coordination may be billed for the month(s) prior to the Initial IFSP being in place as part of the intake process.
- Service coordination will end by the last day of the month in which the child turns three for any child eligible under Biological / Medical Risk or Environmental Risk.
- Service coordination may be reimbursed for up to one (1) month after the child has successfully transitioned to preschool or another appropriate setting. This option is available to ensure that the transition process is smooth and effective and must be agreed upon by the family and documented in the IFSP transition plan. In order to be reimbursed a minimum of one hour per month must be provided.

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- If the Service Coordinator has a dual role, (i.e. they provide another service to the child and family such as special instruction, speech therapy etc.) the time spent providing the other service should not be counted towards service coordination. All activities under each role should be documented separately and distinctly
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EARLY INTERVENTION

Early Intervention services are designed to meet the developmental needs of each eligible child and the needs of the family related to enhancing the child's development. Specific services, supports, and strategies are designed to promote development in one or more of the following areas:

- Cognitive
- Physical/motor
- Communication
- Social or emotional
- Adaptive behavior

Early Intervention services support the parents in achieving child/ family outcomes and are incorporated in the everyday routines, activities and places of the child and family.

SCOPE OF SERVICE

Early intervention services include the ongoing delivery of support provided to families in order to enhance their ability to meet their child's development. Early intervention services are provided within everyday routines, activities and places of the child and family. Early intervention services are selected in order to meet the child/ family outcomes that are decided on by the IFSP team. Early intervention services may include:

- Assistive Technology devices, adaptive equipment, and services
- Audiological services
- Developmental Instruction
- Family Therapy, Counseling and Training
- Health Services (to enable the child to benefit from other early intervention services)
- Medical services (for diagnostic or evaluation purposes)
- Nursing services
- Nutrition services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Social Work Services
- Speech/Language Pathology Services
- Transportation (to enable the child/ family to receive early intervention services)
- Vision Services

SERVICE REQUIREMENTS

These conditions and requirements apply to Early Intervention Services:

- Children are eligible for this service who are between the ages of birth to three years old, and who meet one of the following definitions:
 1. Developmental delay, if a delay of at least 25% in one or more areas of development is indicated per a Comprehensive Multidisciplinary Evaluation

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2. Established condition, as diagnosed by a physician or other Primary Care Provider (PCP) (see eligibility list published by the FIT Program).
 3. At risk for developmental delay due to a biological or medical risk, as diagnosed by a physician or other PCP (see eligibility list published by the FIT Program).
 4. At risk for developmental delay due to environmental risk factors, in accordance with a completed Environmental Risk Assessment (ERA) Tool. Information for the ERA tools can be gathered from the family and from other community providers (CYFD; shelter staff, etc.).
- The provider is responsible for determining eligibility for the FIT Program, and maintaining documentation of eligibility status on file. The child's continued eligibility for the FIT Program must be re-determined each year by the time of the annual IFSP. The Infant-Toddler Developmental Assessment (IDA) tool will be used to determine the child's continued eligibility.
 - Parents of children who are not eligible for the FIT Program will be given the opportunity to enroll in the "Ages and Stages for Kids" (ASK) developmental tracking program.
 - Supports and services will be incorporated into the family's everyday routines, activities and places. Services will also be provided in the early childhood setting (Early Head Start, child care etc.), if that is where the child spends their day, utilizing inclusive practices, supporting the center staff and not pulling the child out of the classroom.
 - The provider must ensure that evening and weekend services are available, as needed, for working parents and parents attending school.
 - Services must be provided in natural environments, defined as places that are natural or normal for children of the same age who have no apparent developmental delay. Justification on the Individualized Family Service Plan (IFSP) is required if the team determines that outcomes cannot be met in a natural environment.
 - If the provider operates early intervention services with a group of children in a center (where the parents are not present) the center must be licensed by CYFD in accordance with 8.16.2 NMAC or accredited by a national organization if not under the jurisdiction of CYFD.
 - All services must be delivered in accordance with the frequency and intensity indicated on the IFSP.
 - IFSP frequency and intensity must be written at smallest denominator reasonable, e.g. 60 minutes per week, rather than 240 minutes per month.
 - Service provision in any given week / month may exceed the amount on the IFSP (e.g. if an IFSP meeting is held that month OR special instruction is provided twice in a week in order to make up for services missed OR if the early intervention session goes beyond the amount planned for on the IFSP).
 - Changes to the frequency, intensity, location or method of services on the IFSP shall be made by striking out the existing end date and entering the new end date and entering the staff's initials. Then adding the revised service on a new line. The same process would be used to end a serve before the next IFSP. The family shall sign a Prior Written Notice form giving their consent to the change.
 - Families of children eligible under Biological / Medical Risk or Environmental Risk are limited to receive up to 24 hours of ongoing early intervention services per year. The year is from one IFSP to the next annual IFSP. The following are not included in the 24 hours: participation at an IFSP meeting; participation at transition conferences, Service Coordination; or Evaluation & Assessments and consultation between personnel.
 - For children whose third (3rd) birthday is before July 01st 2012 and who are eligible under developmental delay or established condition the family has the following choice regarding when their child will transition. If the child's third birthday falls within the school year the family can choose whether their child will transition at the beginning of that school year or remain in early intervention until the beginning of the next school year.

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- For any child eligible under the Biological / Medical Risk or Environmental Risk category, early intervention services will end by the last day of the month in which the child turns three. Note: through appropriate assessments the IFSP team should determine that the child is not eligible under the established condition or developmental delay category before ending services.
 - The provider is responsible for providing, purchasing or arranging through other community resources any services (listed above), listed on the IFSP.
 - Each Early Intervention service, with the exception of consultation and evaluation & assessment methods/service types, must be delivered within 30 days of the parent(s) consent to the start date for the service on the IFSP.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- Establish and maintain financial reporting and accounting for each child
- Establish and maintain a confidential record for each family served that includes the following: signed consent and release forms; documentation of Written Prior Notice as required by FIT Procedural Safeguards (7.30.8.14.D NMAC), current evaluation and assessment reports; IFSP documents, progress notes and contact logs
- The provider shall keep 'contact logs'/ 'encounter sheets' that must include: date; time in/ time out; a brief description of service provided; the first initial and last name of the person providing the service; and their discipline / qualification. A separate 'contact log'/ 'encounter sheet' must be completed for each discipline providing a service, including co-visits. For group services time in/ time out shall be recorded for all attendees including staff.
- The provider will develop a quality assurance plan that includes, but is not limited to developing an ongoing monitoring process that evaluates the quality, and effectiveness of services provided and the families' satisfaction with services.
- Submit an Annual Performance Report (APR) within the required timeframe and in the format provided by the FIT Program.
- Conduct Correction of Noncompliance activities, as necessary, in accordance with requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency), and must be twofold. (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant, and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (although late), unless the child is no longer within the jurisdiction of the early intervention program.
- Ensure that demographic, IFSP, transition, Early Childhood Outcomes (ECO) and delivered service data is accurately entered into the FIT Program database FIT-KIDS (Key Information Data System)
- Early intervention services must be provided in accordance with the IFSP to all eligible children and families in the geographical area served under the DDSD provider agreement.
- The provider shall not charge any fee to families for early intervention services

B. Staffing Requirements

- All Developmental Specialists (including supervisors) are required to be certified and work only within the scope allowed under the level of certification in accordance with "Certification and Re-certification Requirements for Developmental Specialists". All newly hired personnel must apply for Developmental Specialist Certification within one month of the date of hire.

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- Developmental Specialists, including sub-contractors, must receive reflective supervision at least once a month. Sub-contractors must find their own supervision, if the agency does not provide this for them. The name of the supervisor of DS sub-contractors must be stated on the sub-contracting approval form. Supervision of therapists and other early intervention personnel is provided according to their licensing board's requirements.
 - The provider may not subcontract for Developmental Specialists certified as a DS I Basic or DS I – Advanced.
 - All Developmental Specialists must have a current written Individual Personnel Development Plan (IPDP), which includes the Self Assessment Tool, as required for re-certification in accordance with policy “Certification and Re-certification Requirements for Developmental Specialists”. Subcontractors must also maintain current Individualized Personnel Development Plans. All IPDPs must be updated at least annually.
 - Early Intervention personnel must meet one of the following qualifications:
 1. Audiologist – licensure from the NM Audiology Board
 2. Developmental Specialist – Certification in accordance with FIT Program regulations (7.30.8 NMAC) and DDS Policy
 3. Education of the Deaf and Hard and Hearing - Certification
 4. Education of the Blind and Visually Impaired – Certification from NMSBVI and / or Teaching license
 5. Family therapist – licensure from the Counseling and Therapy Practice Board as a Family Therapist, Professional Clinical Mental Health Counselor, Professional Mental Health Counselor, or Registered Mental Health Counselor
 6. Nurse – licensure from the NM Board of Nursing as a registered nurse or licensed practical nurse
 7. Nutritionist – licensure from the NM Nutrition and Dietetics Practice Board
 8. Occupational Therapist (or OT Assistant) – licensure from the NM Board of Occupational Therapy Practice
 9. Orientation and Mobility Specialist – Certification from ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals).
 10. Physical Therapist (or PT Assistant) – licensure from the NM Physical Therapy Licensing Board
 11. Psychologist (or Psychologist Associate) – licensure from the NM Board of Psychologist Examiners
 12. Social worker – licensure from the NM Board of Social Work Examiners
 13. Speech/Language Pathologist – licensure from the NM Board Speech, Language Pathology, Audiology and Hearing Aid Dispensers Board

REIMBURSEMENT

Request for reimbursement for early intervention shall be submitted monthly through the FIT-KIDS (Key Information Data System) in accordance with directions from the Department of Health.

Reimbursement is for the direct intervention time (face-to-face) with the child and family (with the exception of consultation). Reimbursement for this service is based on where the early intervention activity occurred and whether the method of providing the service was to an individual child and family or to a group.

Method Location	INDIVIDUAL	GROUP
HOME & COMMUNITY	Home & Community (Individual)	Home & Community (Group)
CENTER-BASED	Center-Based (Individual)	Center-Based (Group)

Home & Community (Individual):

“Home & Community Individual” is defined as a location away from the provider site (including but not limited to: the family’s or a relative’s home; child care setting; park or play area; or other community setting etc.), which involves travel for the early intervention personnel. *Home & Community (Individual)* is a service that is provided to an “individual” child and their family.

Reporting Category 700022
Unit Rate: \$ 25.50 Unit: Quarter Hour / 15 minutes
Medicaid T1027 TL
Unit Rate: \$ 25.50 Unit: Quarter Hour / 15 minutes

Home & Community (Group)

“Home & Community (Group)” is defined as an inclusive service location away from the provider/ contractor site (including, but not limited to a play area, swimming pool, park, Chapter House, community center, child care or a family's home), which involves travel for the early intervention personnel. *Home & Community (Group)* is provided to two or more eligible children/ families at the same time. Services delivered in a *Home & Community (Group)* must be documented as a strategy to meet the individualized child/ family's outcomes in their IFSP. The purpose of community-based groups is to 1) assist children and families in learning from and with other children and families in the community, and / or 2) facilitate integration/ participation of children and families into inclusive community settings. The ratio of staff to eligible children in *Home & Community (Group)* will be no greater than 1:4 (one staff to four eligible children).

Reporting Category 700022
Unit Rate: \$13.00 Unit: Quarter Hour / 15 minutes
Medicaid T1027 TL TJ
Unit Rate: \$13.00 Unit: Quarter Hour/ 15 minutes

Center-Based (Individual):

“Center-Based (Individual)” is defined as a service location that is operated by the provider, where the early intervention personnel providing services do not have to travel and where the child / family receive services individually. Note: If the FIT provider agency operates a licensed child care program, *center based (individual)* may be used to provide early intervention to an eligible child served in that setting, if the intervention is directed to one eligible child in that classroom and not a group of eligible children.

Reporting Category 700022
Unit Rate: \$ 12.95 Unit: Quarter Hour / 15 minutes

Medicaid T1027 TL TT
Unit Rate: \$12.95 Unit: Quarter Hour / 15 minutes

Center-Based (Group):

“Center-Based (group)” is defined as a service location that is operated by the provider, where the early intervention personnel providing services do not have to travel and where two or more eligible children / families receive services at the same time.

Reporting Category 700022
Unit Rate: \$ 6.50 Unit: Quarter Hour
Medicaid T1027 TL HQ
Unit Rate: \$6.50 Unit: Quarter Hour

- The following activities are considered to be in the unit rate and may not be billed separately:
 - Travel to and from the home or community location (except transporting the child to receive early intervention services)
 - Attendance at training and other personnel development activities
 - Impromptu meetings with other personnel or general staff meetings / “staffings”
 - Preparation of billing statements, progress notes, or reports, data entry
 - Supervision time
 - Preparation time for early intervention activity

The following are additional parameters regarding billing for Early Intervention Services:

- **Consultation between early intervention personnel**
 - Allows for discussion (usually without the family present) for the purposes of integrating and planning effective early intervention strategies.
 - This activity is reimbursable for up to twelve (12) hours a year for each service listed on the IFSP. These hours may be provided flexibly according to family needs and need not be provided consecutively each month.
 - Consultation does not need to be listed on the IFSP Services and Supports page, as long as the service is on the IFSP as either “Ongoing” or “E&A” Evaluation and Assessment).
 - Before consultation by this discipline can be provided, the service (either “ongoing”, or “E&A”) must be provided to the child and family in the natural environment.
 - In order to provide consultation the service must be provided face-to-face at least quarterly (either “ongoing”, or “E&A”)
 - Consultation must be documented as one of the strategies that will be used to meet the child/ family outcome(s). For example “the developmental specialist and the contracted physical therapist will meet one time per month to address issues related to the child’s positioning”.
 - Consultation may be with a co-worker, sub-contractor or employee of another agency.
 - Consultation may be in person or via the telephone. (Note: impromptu meetings about a child/family or general staff meetings are not billable).
 - Consultation between early intervention staff or subcontractors is always reimbursed at the center based (individual) rate. The only exception is when consultation must occur

with another entity (Early Head Start, child care, medical provider, etc.) and the early intervention staff have to travel to that location – then the home and community based rate may be billed. Documentation of consultation activities must be made in the 'contact logs'/ 'encounter sheets'.

- **Consultation at IFSPs:**
 - Reimbursable for early intervention personnel, if as a team member, they need to attend the IFSP meeting (or an IEP meeting for a child transitioning) in order to report on progress, contribute to the development of outcomes and strategies, and to determine the supports and services that will be utilized to meet the child/ family outcomes.
 - Is reimbursed based on the location of the IFSP meeting (for example if the IFSP is held at the family's home, the Home & Community rate would be billed).
 - Is not included in the 12 hours maximum per year of consultation (see Consultation between early intervention personnel above). Additional hours do not need to be added to the IFSP to cover attendance at the IFSP meeting.
 - If personnel from a particular discipline attends the IFSP but will not be providing ongoing services, this service must be added to the IFSP as a one time consultation.

- **Consultation after transition:**
 - Is reimbursable for up to four (4) hours, across all services on the IFSP, in order for intervention personnel to provide consultation to the Local Education Agency, Head Start or other early childhood staff regarding the child's intervention needs.
 - Is reimbursed based on the location where the activity occurred.
 - Must be provided within 1 month of the child's transition.
 - The need for this consultation must be documented in the transition plan in the IFSP, and
 - All consultation activities must be recorded in the progress notes.

- **Co-visit:**
 - Is used when more than one early intervention personnel provide intervention to the child/ family at the same time to allow for transdisciplinary and interdisciplinary practice to occur enhancing the integration of services and supporting a primary service provider approach.
 - Is reimbursed based on the location where the activity occurred.
 - Must be documented in the IFSP as one of the strategies to be used to meet the child/ family outcome(s) but does not need to be listed on the IFSP Supports and Services page
 - Cannot be used in order to provide supervision to staff or to travel together to reduce travel costs.

- **Assessment:**
 - the ongoing procedures used throughout the child's eligibility for the FIT Program to identify the unique strengths, needs, and developmental functioning, including assessments conducted for the NM - Early Childhood Outcomes (ECO) reporting.
 - Ongoing assessment is reimbursed based on the location of the assessment activity conducted.
 - Assessment does not need to be listed on the IFSP Services and Supports page, if the service is already listed as an ongoing service.
 - The service needs to be listed on the IFSP Services and Supports page if the service will be provided as a one-time "E&A" (Evaluation and Assessment) or as a periodic assessment (e.g. once a quarter) there is no ongoing service already listed.
 - Time writing a report or addendum to a report is not billable.
 - Assessment may be billed instead of a Comprehensive Multidisciplinary Evaluation (CME) for children in temporary housing (e.g. shelter, foster home etc.) when the child moves to another community before the CME is completed.

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- **Telehealth (video-conferencing):** may be provided in accordance with Medicaid policy 8.310.13, which states:
 - A telehealth communication system must include both interactive audio and video and be delivered on a real-time basis at the originating (where the child and family are) and distant-sites (where the early intervention personnel are).
 - Use of the telehealth communications system fulfills the requirement for a face-to-face encounter.
 - Reimbursement for services at the originating-site and the distant-site are made at the same amount as when the services provided are furnished without the use of a telecommunication (e.g. if a provider is at the originating site with the child and family in the home they would bill at the home and community rate, and if a provider at the distant site is at the agency office, then the center rate will be used).
 - Telehealth must be documented in the IFSP as one of the strategies to be used to meet the child/ family outcome(s), but does not need to be listed on the Supports and Services page.
 - The service must be provided to the child and family in the natural environment before telehealth can be provided by the discipline.
 - Telehealth cannot be primary method of providing early intervention service i.e. the service must be provided to the child and family in the natural environment the majority (> 50%) of the time.
 - The provider shall obtain the consent of the parent to use telehealth services, including the technology / software that will be used.

 - **Prior authorization:**
 - Is required when ongoing early intervention services (excluding service coordination, consultation between personnel, respite, and other services not funded through the FIT Program) listed on the IFSP exceed 14 hours per month.
 - A prior authorization form must be submitted within one week after the IFSP meeting.
 - The FIT Program will respond with a decision within ten (10) working days after the receipt of request.
 - Services should be provided at the level indicated on the IFSP while prior authorization is being sought.
 - In the case of a denial of the request, the IFSP team will need to revise the supports and services page to ensure that hours are kept under the maximum 14 hours per month.
 - Circumstances which may justify the need for services over 14 hours per month include: children with significant developmental or medical needs; a diagnosis such as autism spectrum disorder where intensity of intervention is recommended practice; complex family circumstances that may require time-limited intensive intervention. A center based service model may not be used to justify services over 14 hours.

RESIDENTIAL SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

Adult Developmental Disabilities (DD) Residential Services are Supported Living and Independent Living services for individuals age 22 and older. (*Exception: This service is available with DDSD prior written approval to individuals age 21 and under who are living independently in the community, receiving no other residential supports, and have unmet support needs.*) Residential services are provided in accordance with each person's Individual Service Plan (ISP), as developed under 7 NMAC 26.5 ("ISP Development Process"). The use of natural and generic supports is encouraged in order to promote the individual's inclusion in the community as well as to reduce the need for paid provider services. Adult DD Residential Services are intended to provide the necessary assistance and support to meet the daily living and safety needs of individuals.

Supported Living: Supported Living Services are an intervention and support service that enables persons with developmental disabilities to live in a home setting with no more than four individuals and must be available up to 24-hours a day. Services and supports are provided in the individual's home, with the exception of activities that naturally occur in the community (banking, grocery shopping, etc.) For Supported Living Services, substantiated clinical necessity criteria includes documentation by the provider and the IDT that the individual needs paid staff care and support at least 340 hours each month.

Independent Living: Independent Living Services are an individual intervention and support service that enables persons with developmental disabilities to live independently in their own home or with family members in a more independent environment than Supported Living. Staff support is available as needed and is furnished on a planned periodic schedule of at least 20 hours of direct support per month. Services and supports should be provided in the individual's home, with the exception of activities that naturally occur in the community (banking, grocery shopping, etc.). This service is intended to assist individuals to develop, improve and maintain specific skills to live as independently as possible. Generally, this service is provided with a 1:1 staff to participant ratio; however, services may be provided to up to three individuals when individuals have similar learning goals. The Individual Service Plan for each individual must clearly document the rationale for providing services in a group setting.

SCOPE OF SERVICE

Adult DD Residential Services typically include, but are not limited to:

- Assistance with money management
- Meal planning and preparation
- Routine household maintenance and chores
- Training and education on self advocacy and sexuality
- Individual health maintenance and monitoring
- Arrangement of medical and dental appointments
- Arrangement of transportation
- Personal Care or activities of daily living (such as bathing, eating, dressing, and individual hygiene)
- Supervision of nursing duties, as needed
- Nutritional counseling services, as needed
- Assistance to individuals who require a wheelchair for mobility and need physical assistance for bathing, dressing and transfers.
- Activities in support of therapy plans. This includes Behavioral Consultation that may be a part of an individual's services and any private or Medicaid funded therapies and individual may receive.
- Assistance with development of natural support networks.
- Development of social and individual relationships
- Community integration/ access/ utilization
- Service coordination activities such as writing the ISP or other service coordination functions
- Assistance with self administration of medication and/or monitoring of medication and pharmacy needs

SERVICE REQUIREMENTS

Services shall be provided to adults, twenty-two (22) or older, who have been determined to meet developmental disabilities definition in accordance with the NMSA Chapter 16 Developmental Disability Community Services Act. The individual must have a developmental disability defined as:

A severe chronic disability other than mental illness that is: attributable to a mental or physical impairment, including the result from trauma to the brain, or combination of mental and physical impairments; the disability must have occurred before the person reaches the age of 22; it is expected to continue indefinitely; and, results in substantial functional limitations in three or more of the following areas:

- (1) self-care,
- (2) receptive and expressive language,
- (3) learning,
- (4) mobility,
- (5) self-direction,
- (6) capacity for independent living, and,
- (7) economic self-sufficiency.

The severe chronic disability must reflect the person's need for a combination and sequence of special, interdisciplinary or generic care treatment or other special support and services that are of a life-long or extended duration and are individually planned and coordinated. Services to individuals with developmental disabilities under twenty-two may be provided with prior approval by DDSD.

Service requirements of the Adult DD Residential Services direct service provider include, but are not limited to:

- Adult DD Residential Services must be available for up to 365 days a year.
- The total hours of service each month must meet the minimum requirements for each individual, as specified on their Individual Service Plan (ISP) and the minimum requirements for each specific service to allow for reimbursements.
- A special provision is listed below for the order of selection for the State General Fund Service Slots. A greater priority for selection for an SGF slot will be granted for individuals who are in crisis, as defined by DDSD Policy and Procedure.

When there is a vacancy in residential or day services, providers must consult with the Regional Office to determine the order of selection to fill the vacancy. Generally, order of selection will be based on first come, first serve, based on registration date on the Central Registry. Individuals who are registered on the Central Registry who are determined to be in "crisis" by DDSD Policy and Procedure will be given first priority for State General Funded services. These individuals will be granted the first open slot regardless of the "first come, first serve" basis that has historically governed the selection process.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- An ISP is necessary for each individual in Adult Residential Services. The provider agency must develop the ISP annually in accordance with the individual's ISP term and update periodically as outlined in the 7 NMAC 26.5 regulations. If an individual receives

both Adult Residential and Adult Day services, the residential agency will develop the ISP.

- Written quarterly reports summarizing individualized participant progress in meeting outcomes from the ISP's are required. Quarterly reports are to be written according to the individual's ISP term. The reports shall be sent to the local Regional Office of the DDSD by October 15th, January 15th, April 15th and July 15th.
- Monthly residential direct support hours can consist of the standard services listed under 'scope of services' as well as a maximum of two hours per month of accrued, non-face-to-face hours. The two non-face-to-face hours of direct support per month can be billed as long as the services are not defined as non-billable in these Standards (see Reimbursement Section below). Non-face-to-face direct support hours may include, but are not limited to, additional staff planning sessions for an individual to meet his or her Individual Service Plan outcomes, pre-vocational tasks, tasks to incentivize vocational or community integration or other innovative tasks or activities.

Supported Living: 340 hours of direct support per month.

Independent Living: 20 hours of direct support per month.

- Complete and submit monthly Form B: "Adult SGF Day Service or Residential Service Reports."

B. Participant Funds

- A person receiving services will be presumed able to manage his or her own funds unless the ISP documents and justifies his or her limitations regarding self-management and, where appropriate, reflects a plan to increase this skill.
- When an agency is the representative payee or when the service plan for the individual includes assistance with budgeting, money management, banking etc., the provider agency must have policies and procedures in place to ensure appropriate and equitable use of the individual's SSI payments or other personal funds. This must include a detailed accounting of all spending by the agency.

C. Staffing Requirements

- Provide adequate staffing to assure reasonable health, safety, and promote positive development.
- Responsible for the identification and provision of the appropriate staffing pattern.
- A parent, spouse, primary caregiver or surrogate parent may not provide Adult Residential services if they reside in the same dwelling as the individual served.
- Agencies must have an RN on staff or contract to perform and/or supervise nursing duties in order to address the needs identified on the ISP, if required.
- Agencies must have agreements or contracts in place for nutritional counseling services, in order to address the needs identified on the ISP, if required.
- Agency staff shall complete required trainings within established timelines, as stipulated in the Policy Governing the Training Requirements for Direct-Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities in Community-Based Programs Funded Through The Developmental Disabilities Medicaid Waiver Program or State General Funds (2/23/07).
- Agencies shall report to the DDSD Statewide Training Database as stipulated in the Reporting and Documentation of DDSD Training Requirements Policy (2/23/07) when staff members are hired, complete trainings, change positions, and/or leave the agency.

REIMBURSEMENT

Request for reimbursement for Adult DD Residential Services under State General Funds shall be submitted monthly in accordance with directions provided by the DDS - Administrative Services Bureau (ASB) at the Department of Health, using the following Component and Service Unit:

Reporting Category 700017

Unit Rate = \$1,530.00, 12 Units per Year Maximum

Independent Living: 20 hours of direct service per month will allow a provider to bill the entire monthly rate. If the number of hours of residential direct supports that are needed are between 0 and below 5 hours, the provider should transition/ move the participant into day services (i.e. the participant no longer needs residential services). No billing can be made for participants being served for less than 5 hours per month. If the provider provides between five and less than 10 hours per month, the provider can only bill for 25% of the total monthly rate. If the provider provides between 10 and less than 15 hours per month, the provider can only bill for 50% of the total monthly rate. If the provider provides between 15 and less than 20 hours per month, the provider can only bill for 75% of the total monthly rate. Providing 20 hours or more of service per month entitles the provider to bill the entire monthly rate. Generally, this service is provided with a 1:1 staff to participant ratio; however, services may be provided to up to three individuals when individuals have similar learning goals. The Individual Service Plan for each individual must clearly document the rationale for providing services in a group setting.

Supported Living: 340 hours of direct service per month will allow a provider to bill the entire month. Partial billing units are not allowed for Supported Living Services.

Reimbursement for Adult DD Residential Services is calculated on a monthly rate based upon Legislative appropriation.

Costs for room and board are the responsibility of the individual receiving the services. These costs may be paid through SSI or other personal funds.

Non-billable hours include:

- Travel to and from the individual's home, except when the individual is being transported.
- Attendance at training and other personnel development activities that are not face-to-face with the individual.
- Preparation of billing statements, progress notes, or quarterly reports.

Adult DD Residential Services **CANNOT** be co-funded with Respite Services. Adult DD Residential Services cannot be billed at the same time as any other DOH funded service, except Behavior Consultation. Individuals can receive SGF services as long as they are not receiving any Medicaid Waiver or Personal Care Option Services.

DAY SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

Day services for adults with developmental disabilities provide a variety of community inclusion services to individuals age 22 and older. (*Exception: This service is available with DDSD prior written approval to individuals age 21 and under who are not currently participating in public education services.*) Services are provided in accordance with each person's Individual Service Plan (ISP), as developed under 7 NMAC 26.5 ("ISP Development Process"). The use of natural and generic supports is encouraged in order to promote the inclusion of the individual into the community as well as to reduce the need for paid provider services.

Day services are defined as those parts of an adult's waking hours when it can be clearly demonstrated that the individual is engaged in purposeful work, learning, skill development or community inclusion activities that are directly linked to the vision, outcomes and action plans documented in the Individual Service Plan (ISP). Day service activities may take place at any time during the individual's waking hours.

Individuals with developmental disabilities, who wish to work, will be offered employment as a priority service over all other day service options. Individual placements are the preferred service. All services will demonstrate appropriately high expectations, enriched opportunities for learning, skill building and use of least restrictive environments. Role development through Community Access services is also preferred as a way to connect individuals with their community in valued social roles.

Individuals are eligible for Adult Day Services provided that all other public funding sources (i.e. DVR and IDEA) have been exhausted prior to accessing State General Funded Adult Day Services. A new referral to DVR should be made under the following conditions:

- 1.) the individual is unemployed and wants employment supports to obtain employment; or,
- 2.) the individual is seeking different work; or,
- 3.) When someone has just been allocated to State General Fund Services and the individual is unemployed and wants employment supports to obtain employment.

Service Options

Adult DD Day Services is inclusive of, but not limited to, one or more of the following service models, as well as other related support services:

Individual Supported Employment: Face-to-face support of persons placed in community-based employment. Face-to-face support includes contact with current employers on behalf of specific individuals when required by the Individual Service Plan. Supported Employment also includes job development services provided by State General Fund Providers. Job development and related services **prior** to the job placement may be furnished for a maximum of ninety days per year. Job development services may only extend beyond the 90 days within a contractual year with **DDSD written approval**. Employment services are to be available 365 days a year, 24 hours a day. Services are driven by the individual's desired outcome and the individual's job schedule. Wages must be paid in accordance with federal, state and local wage and labor laws and regulations.

Group Supported Employment: On-site supervision of persons with developmental disabilities working as part of an integrated group in community based employment. These services can be offered to enclaves or integrated work crews or models, but not in a center-based provider facility. An integrated work setting is defined as a work setting in which at least 50% of the people employed in the setting are non-disabled, not including job coaches or other provider staff who work directly or indirectly with the individual. Wages must be paid in accordance with federal, state and local wage and labor laws and regulations.

Community Access: Access is defined as an individual having an identified place within a community, which matches their interests and skills. Access is achieved when an individual has developed a natural association and relationships within an informal or formal group/organization that share an interest, and come together on a regular basis for a common purpose. Individuals should not be just physically present in their community, but should be active members of their community. This includes engaging and interacting with non-disabled people in their neighborhood and community who share the person's interests, passions, and desired role. If wages are obtained, the person needs to move to Supported Employment Services. Community Access services are designed to assist individuals in the development and maintenance of valued social roles.

Community Access is generally provided in a one to one staff to participant ratio; however, services may be provided to up to three individuals with DDSD approval when each individual has similar goals. The Individual Service Plan for each individual must clearly document the rationale for providing services in a group setting.

Habilitation: A daily program of group activities designed to increase the individual's skills in performing routine functions. These services furnish opportunities for participants to develop and sustain functional skills to maximize an individual's independent actions in areas such as choice-making, communication, self care, identifying and pursuing vocational and leisure interests, and socialization. Adult Habilitation services take place outside the individual's residential setting. In-home Adult Habilitation services must be pre-authorized in writing by the Regional Office.

Work Services: Department of Labor certified or exempted programs of structured activities for groups of individuals fall under the category of work services. Work services consist of individuals engaged in training and/or sheltered work for wages. The setting for the program is a center-based facility or non-integrated work crews. Work services typically include subcontract work, prime manufacturing or retail sales.

For vocational services, compliance to the Federal Fair Labor Standards Act and applicable state and local wage and labor laws and regulations is required. The Department of Labor must certify or declare exempt programs of structured activities for groups of individuals engaged in training and sheltered work for wages.

Adult DD Day Services should be provided at the appropriate level for each individual to promote choice, growth and maintain health and safety.

SCOPE OF SERVICE

Adult DD Day Services typically include, but are not limited to:

- Arrangement of transportation
- Assistance with self administration of medication and/or monitoring of medication and pharmacy needs
- Assistance with the development of choice making skills
- Assistance with the development of natural support networks
- Facilitation of the implementation of behavior support plans
- Co-worker training,
- Development of social and individual relationships
- Education on rights and responsibilities in the work place
- Education on self advocacy
- Employer negotiations
- Facilitation of job accommodations and use of assistive technology
- Job coaching/ development/ placement
- Job sampling and on-site analysis
- Personal care activities of daily living
- Personal growth and development
- Service coordination activities such as writing or updating the ISP or other service coordination functions

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- Supervision of nursing duties, as needed
 - Nutritional counseling services, as needed

SERVICE REQUIREMENTS

Services shall be provided to adults, twenty-two (22) or older, who have been determined to meet the definition of developmentally disability in accordance with the NMSA Chapter 16 Developmental Disability Community Services Act (see above). Service requirements of the Adult DD Day Services direct service provider include, but are not limited to:

- Adult DD Day Services must take place outside the individual's home or any other residential setting unless written approval for in-home services has been obtained from the DDSD Regional Office.
- Supported Employment services under Adult DD Day Services must be in an integrated work setting. An integrated work setting is defined as a work setting in which at least 50% of the people employed in the setting are non-disabled, not including job coaches or other provider staff who work directly or indirectly with the individual.
- Supervision and support under Adult DD Day Services is usually furnished on a continual basis, as specified in the ISP and as scheduled by the provider. Supervision and support may include full or part-time supervision by the employer.

When there is a vacancy in residential or day services, providers must consult with the Regional Office to determine the order of selection to fill the vacancy. Generally, order of selection will be based on first come, first serve, based on registration date on the Central Registry. Exceptions to this include the following two circumstances: (1) Selection priority is granted for individuals who are in crisis or (2) for individuals who have utilized all of their DVR eligibility for job development and training and need ongoing "follow along" services.

Individuals who are registered on the Central Registry who are determined to be in "crisis" by DDSD Policy and Procedure will be given first priority for State General Funded services. Individuals will be granted the first open slot regardless of the "first come, first serve" basis that has historically governed the selection process.

Similarly, individuals who are going into services with the Division of Vocational Rehabilitation (DVR) prior to coming into SGF services will be given a priority status so that when they are discharged from DVR services, they will have the first chance at a vocational slot. These individuals would be given priority on the list for Supported Employment services under SGF.

Individuals who are on the Central Registry, but reside in long-term care facilities (i.e. nursing home), are eligible for SGF funded Adult Day Services. The Regional Office and the provider of Adult Day Services should consult and coordinate with the long-term care facility to ensure appropriate planning and implementation of services.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- An ISP is necessary for each individual in Adult Residential Services. The provider agency must develop the ISP annually in accordance with the individual's ISP term and update periodically as outlined in the 7 NMAC 26.5 regulations. If an individual receives both Adult Residential and Adult Day services, the residential agency will develop the ISP.
- Written quarterly reports summarizing individualized participant progress in meeting outcomes from the ISP's are required. Quarterly reports are to be written according to the individual's ISP term. The reports shall be sent to the local Regional Office of the DDSD by October 15th, January 15th, April 15th and July 15th.

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- Monthly Day/Employment direct support service hours can consist of standard day services listed under 'scope of services' as well as a maximum of two hours per month of accrued, non-face-to-face hours. The two non-face-to-face hours of direct support per month can be billed as long as they are not defined in these Standards as non-billable (see Reimbursement Section below). Non-face-to-face direct support hours may include, but are not limited to, additional staff planning sessions for an individual to meet his or her Individual Service Plan outcomes, pre-vocational tasks, tasks to incentivize vocational or community integration or other innovative tasks or activities.
 - Complete and submit monthly Form B: "Adult SGF Day or Residential Service Reports."
 - ISP – Individual Service Plan must be completed every year.
 - Community Access services are to be available 365 days a year, 24 hours a day based on individualized activity schedules.
 - Employment services are to be available 365 days a year, 24 hours a day. Services are driven by the individual's desired outcome and the job requirements of the employer.

B. Participant Funds

- A person receiving services will be presumed able to manage his or her own funds unless the ISP documents and justifies limitations to self-management and where appropriate, reflects a plan to increase this skill.

C. Staffing Requirements

- Provide adequate staffing to assure reasonable health, safety and promote positive development.
- Responsible for the identification and provision of the appropriate staffing pattern.
- Agencies may not employ or subcontract with an immediate family member or a spouse of the individual served to work in the setting in which the individual is served or to work directly with the individual.
- Must have arrangements in place for an RN or LPN to perform and/or supervise nursing duties and have arrangements in place for nutritional counseling services, in order to address the needs identified on the ISP, if required.
- Employees shall complete required trainings within established timelines, as stipulated in the Policy Governing the Training Requirements for Direct-Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities in Community-Based Programs Funded Through The Developmental Disabilities Medicaid Waiver Program or State General Funds (02/23/07).
- Agencies shall report to the DDSD Statewide Training Database as stipulated in the Reporting and Documentation of DDSD Training Requirements Policy (2/23/07) when staff members are hired, complete trainings, change positions, and/or leave the agency.

REIMBURSEMENT

Request for reimbursement for Adult DD Day Services under State General Funds shall be submitted monthly in accordance with directions provided by the DDSD - Administrative Services Bureau (ASB) at the Department of Health, using the following Component and Service Unit:

Reporting Category 700016

Unit Rate = \$739.00. 12 Units per Year Maximum

Billable Units for Day/ Vocational Services:

The full monthly unit may be billed as long as the individual receives 40 hours per month of any combination of day/ vocational services listed under the "Service Options" above. When the individual is engaged in Supported Employment, the hours that the individual is working will satisfy the service criteria as long as the individual receives at least 4 hours of direct service support each month. If the participant is working an average of 10 hours per week and the provider is providing at least 4 hours of direct support per month, the full monthly amount can be billed.

If the participant is working less than an average of 10 hours per week or is receiving any other day service, the provider must provide an average of 10 hours of service per week to bill the full monthly amount.

Partial Monthly Billing:

Reimbursements for all Adult Day Services are calculated on a monthly rate of \$739.00 per month. Partial Months can be billed in cases where the individual has been served for periods of less than one month. Partial billings should be calculated on the basis of quarter units with a quarterly unit rate of \$184.75. The following is a breakdown of the hour requirements to bill a quarter unit of each service type:

Supported Employment (including Individual and Job Development): One hour = one quarter unit

All other Adult Day Services: Ten hours = one quarter unit

The Division reserves the right to grant exceptions to the reimbursement standards outlined above in order to promote innovative approaches to service provision.

Non-billable hours include:

- Travel to and from the individual's home, except when the individual is being transported,
- Attendance at training and other personnel development activities which are not face-to-face with the individual
- Preparation of billing statements, progress notes, or quarterly reports.

Adult DD Day Services cannot be billed or reported along with any other DOH Service for the same hours of the same day, except Behavior Consultation. Individuals can receive SGF services as long as they are not receiving any Medicaid Waiver or Personal Care Option Services.

SELF-DIRECTED FAMILY SUPPORT PROGRAM

Self-Directed Supports are flexible and individual/family driven. Each eligible individual/family leads the decision making process and determines the type and amount of good or support needed up to the allowable stipend per individual/family. Individuals/families choose the supports and goods to be received based upon their needs and preferences. This program makes use of structured supports, as well as informal and natural supports from friends, neighbors, extended family and others within the community to support the individual/family in addressing needs (functional, social and medical) that relate to the individual's disability. Supports may be aimed at supporting the individual and/or other family members.

SCOPE OF SERVICE

Goods and supports that center around the person with disabilities may include, but are not limited to: health care, diagnosis and assessment, therapies (including alternative and/or non-traditional approaches), home health care, personal care, recreational and social activities, supports that promote community inclusion and/or employment, clothing, supports or food for special diets, transportation, retrofitting of a vehicle, adaptive equipment, supplies and training on their use, housing adaptation, and health insurance deductibles/co-payments.

Goods and supports that center on family members may include, but are not limited to: respite, family counseling, education for parents and siblings related to the needs of the individual with disabilities, daycare or other types of care for the individual with disabilities, mutual support groups, and housing modifications. Funds may also be used for fees related to training the employee/subprovider, specific to the individuals needs (e.g. CPR, positioning, use and maintenance of adaptive devices and equipment).

NOTE: The New Mexico State Auditor in a 1998 letter of interpretation to the Department of Health quotes Article IX, Section 14 of the New Mexico Constitution, commonly referred to as the anti-donation clause, which states in part, that "...neither the state nor any county ... shall directly or indirectly lend or pledge its credit or make any donation to or in aid of any person ... Nothing in this section shall be construed to prohibit the state or any county or municipality from making provision for the care or maintenance of sick or indigent persons ..." They further break this descriptive down as "... the long term enrichment or benefit to the recipient." They also state in their interpretation that, "Mortgage payments, rent and improvements, other than environmental modifications, appears to go beyond exceptions allowing provision of care and maintenance of sick and indigent persons." Also, "The intent of the program ... would allow the purchase of adaptive equipment, home renovation and additional personal attendant services."

SERVICE REQUIREMENTS

Eligibility:

The applicant must be a New Mexico resident. Individuals must meet the New Mexico definition for Developmental Disabilities. The individual must be registered with the Department of Health, Developmental Disabilities Supports Division Central Registry. This service is dependent upon the availability of State General Funds and participants are prioritized based on date registered on the Central Registry. Individuals are eligible for participation in Self-Directed Family Supports for a maximum of two fiscal years, unless they have placed their Developmental Disabilities Waiver allocation "On Hold" with the DDSDD eligibility unit. In the case where an individual has placed their DD Waiver allocation "On Hold," the individual may continue to receive Self-Directed Family Supports until they choose to accept DD Waiver allocation.

Funding Categories:

Goods and supports are based upon an approved Service Support Plan (SSP) and budget and must fall within one of the categories found below. The SSP will document the need for each support or good and will provide justification for all payroll and non-payroll expenditures. The SSP and SSP budget must

be approved by the local DDSD Regional Office or State General Fund Program Manager. The SSP will be reviewed and updated as needed, with a minimum of at least one review annually. The Family Resource Specialist or the DDSD Regional Office may be contacted for other available resources in each region that may be of assistance.

Items that may be purchased through this program are identified as Assistive Devices or batteries for assistive devices, nutritional supplements, incontinence aids, therapeutic wedges, positioning supports, instructional supports, instructional/vocational books and electronic devices (for educational and health/safety needs.) Health care covers insurance or health care expenses not otherwise covered under either Medicaid or traditional insurance plans. This includes preventative equipment, therapeutic interventions and acupuncture. Other health care expenses may be covered with written permission from the SGF Program Manager. Respite/Personal Care covers after school care, child care needs and adult or child respite. This category may also cover a personal assistant for the individual to participate in certain activities both within the community and home. Housing supports may be used to cover rent and utility deposits, household start-up expenses for the individual (this would not include household expenses for individuals who live with their immediate family), and home modifications (including environmental accommodations with health/safety justifications) that are directly related to the disability. Living Expenses includes appliances, furniture, and clothing. Transportation/Travel Assistance will cover bus passes, mileage to activities or appointments, travel expenses and retrofitting of a vehicle with specialized equipment, major car repairs (if approved by steering committee), and accommodations based on health and safety. Social/Community Supports includes peer companions for activities, pets, recreational activities, job coaching, and community guides. Fees/Memberships are defined as tuition for school of any type, membership fees to community organizations or clubs, and gym/health club fees. Educational supports include tutoring, educational software, and special classes.

Additionally, all goods and supports approved through this program must meet at least one of the following criteria:

1. Increase the individual's functioning as related to the disability
2. Increase the individual's safety in the residence or community
3. Support community inclusion or employment opportunities
4. No other public funds are available to cover the item or support

This program does not cover the following expenses, regardless of justification: fees for conferences or memberships where the individual does not participate, ongoing utilities, ongoing rent or mortgage payments, taxes, basic foods and non-specialized personal care items (i.e. shampoo, soap, toothpaste, etc). Also uncovered is direct payment to the parents of a minor child for respite, personal care or community access needs.

Individuals/families utilizing Self-Directed Supports will be the employer of record. As an alternative to employment, individuals/families may contract for supports. Individuals/families utilizing Self-Directed Supports must use the DDSD identified fiscal intermediary.

The individual/family will utilize the registration packet and information provided by the fiscal intermediary to guide them in their responsibilities as employer. The individual/family must attend trainings provided by the fiscal intermediary related to being an employer.

The individual/family will identify training needs and arrange appropriate training for direct care staff. The individual/family will provide authorization for supports and goods purchased. The individual/family will submit requests for payment to the fiscal intermediary on a timely basis. All payment requests must be submitted within 90 days of the date of purchase or support billing. The fiscal intermediary will distribute, collect and process all workers' time sheets as summarized on payroll summary sheets completed by the individual/family receiving supports.

AGENCY REQUIREMENTS

The fiscal intermediary will provide monthly statements of expenditures and declining balances to the individual/family and the DDS. The fiscal intermediary will withhold, file and deposit funds in accordance with federal Internal Revenue Service (IRS) and the Department of Labor (DOL) and State of New Mexico rules. The fiscal intermediary will complete reports required by the IRS and Social Security Administration, including preparation of the report for signature and filing by the individual/family. The fiscal intermediary will assure that workers are paid hourly rates in accordance with the federal and state laws and regulations, including local minimum wage.

The fiscal intermediary will process all non-labor invoices, including paying vendors as specified (according to the SSP budget) by the individual/family, if applicable. The fiscal intermediary will provide a customer service system that will respond to calls from the individual/family employers and their workers regarding issues such as withholdings, net payments, lost or late checks, reports and other documents.

The fiscal intermediary will act on behalf of the individual or family receiving supports and goods for the purpose of payroll reporting and non-payroll expenditures. The fiscal intermediary will make related payments as approved in the SSP budget, authorized by the state and the individual/family. The individual/family will provide the fiscal intermediary with authorization for all payroll reporting and non-payroll expenditures. The fiscal intermediary will provide an application package for use by individuals who hire their own staff.

REIMBURSEMENT:

Payment for goods and supports will be made in accordance with procedures established by the fiscal intermediary and will be consistent with the following criteria:

Only after notice of approval of the SSP will supports be provided or the goods purchased in the amount or quantity approved. In the case of payroll billing, a timesheet containing the following information will be submitted to the fiscal intermediary for payment:

- Name of employee
- Social Security Number
- Complete name and mailing address of the employer
- Dates of the time period covered by this billing
- Daily record of time worked
- Total hours worked during the time period
- In the case of a non-payroll billing, a receipt or invoice must include the following information:
 - Name of the payee
 - Complete mailing address of the payee
 - A description of the goods and/or support purchased
 - Date goods and/or services were purchased
 - Name of the person receiving the goods and/or support
 - Total amount due

The fiscal intermediary will assure a clear audit trail by maintaining appropriate records and documentation for the Self-Directed Family Supports Program that will include:

- A current account balance for each individual receiving this service
- A current account balance for each DDSD region in which services are provided.
- The fiscal intermediary will submit a monthly report to the individual/family

The fiscal intermediary will submit a monthly summary report to the DDSD SGF Program Manager.