

STATE OF ILLINOIS

**Medicaid Home and Community-Based Services Waivers
for Individuals with Developmental Disabilities**

PROVIDER MANUAL

September 2007

**State of Illinois: Medicaid Home and Community-Based Services Waivers
for Individuals with Developmental Disabilities
Provider Manual**

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SECTION I. INTRODUCTION

The purpose of the manual is to complement the approved waivers, not to supplant them. Any lack of clarity or apparent conflict among the documents is certainly unintended. Should the reader observe such a situation, the approved waiver documents are the final authority.

The State of Illinois Department of Human Services (DHS) Division of Developmental Disabilities' (Division) mission is to "provide a full array of quality, outcome-based, person- and community-centered services and supports for individuals with developmental disabilities and their families in Illinois". To help accomplish this mission, the State submitted applications to and received approval from the Federal Centers for Medicare and Medicaid Services (CMS) for the following three 1915(c) Home and Community-Based Services (HCBS) waiver programs:

- **Waiver for Adults with Developmental Disabilities (Adult DD Waiver)**
- **Supports Waiver for Children and Young Adults with Developmental Disabilities (Children's Support Waiver)**
- **Waiver for Residential Supports for Children and Young Adults with Developmental Disabilities (Children's Residential Waiver)**

The waivers afford participants and families the choice between participant direction and more traditional service delivery, or a combination. The number of individuals served each year is based on available State appropriation levels.

The Division of Developmental Disabilities operates these waiver programs under an Interagency Agreement with the Department of Healthcare and Family Services (HFS), which administers the Medicaid program in Illinois.

The purpose of this Provider Manual is to provide uniform direction for providing waiver services for DHS-designated Pre-Admission Screening/Individual Service and Support Advocacy (PAS/ISSA) agencies, case managers (sometimes called QMRPs or Service Facilitators) and other waiver service providers.

General Medicaid Overview

The Illinois Department of Healthcare and Family Services (HFS), formerly the Department of Public Aid (DPA), Division of Medical Programs is responsible for providing health care coverage for adults and children who qualify for Medicaid. The DHS Family Community Resource Center (FCRC), formerly known as the DPA/DHS local office, determines Medicaid eligibility based on HFS criteria and also determines eligibility for Food Stamps. Individuals must be enrolled in Medicaid to be enrolled in the waiver programs. Special Medicaid eligibility rules and application procedures apply for children determined clinically eligible for the new Children's Waivers. See Section II for detailed waiver clinical eligibility criteria. Participants must maintain Medicaid enrollment, including spenddown met status if applicable, to ensure continuation of payment to providers for services delivered. Medicaid enrollment enables the individual to receive covered services included in the Medicaid State Plan, in addition to waiver services. This Manual contains policy and procedural details and is designed to be used with applicable programmatic rules and guidelines.

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A. Overview of Waivers

Section 1915(c) of the Federal Social Security Act allows a state to operate Home and Community-Based Services (HCBS) waivers within its Medicaid program if certain requirements are met. Please see Section III of this manual for descriptions of the covered waiver services. The federal waiver requirements include:

- The State must submit a request and receive approval from the federal Centers for Medicare and Medicaid Services (CMS) to operate a waiver. The approved waiver thus becomes the intergovernmental agreement that, together with applicable federal Medicaid regulations, governs operation of the waiver.
- The waiver must be a cost-effective alternative to placement in a Medicaid-funded institutional setting, such as an Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD). In Illinois, federal ICF/DDs include both private facilities and state-operated developmental centers.
- The State and CMS limit the total annual expenditures and the number of people served in each waiver.
- The State must have a quality management strategy in place to ensure the protection of each waiver participant's rights, health, safety and welfare.

Below is an overview of each of the 1915(c) Medicaid waivers addressed in this Provider Manual. For all three waivers, each participant is assigned an Individual Service and Support Advocate (ISSA) who serves as an independent advocate, participates in service plan development and monitors service provision. For the two children's waiver programs, the ISSA will assist the participant and family during the transition period to adult services. The ISSA will inform the participant and family about adult service options and ensure necessary eligibility screenings are completed.

1. Waiver for Adults with Developmental Disabilities

The Adult DD Waiver provides:

- Supports to eligible adults with developmental disabilities ages 18 and older. The number of participants served each year is based on available State appropriation levels.
- Supports designed to prevent or delay out-of-home residential services for participants or alternative residential services for participants who would otherwise need Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD) level of service. See Table 1 in Section II for eligibility criteria and the Procedures Manual for Developmental Disabilities Pre-Admission Screening Agencies (PAS Manual) for detailed information about level of care/level of service requirements.

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- Choice between participant direction and more traditional service delivery, or a combination.

The Adult DD Waiver provides services to waiver participants through:

- a. **Home-Based Support Services (HBS)**. Participants who choose home-based support services may select from a menu of services based on their individual needs within an overall monthly services cost maximum. Typical services chosen by participants may include day programs, as well as direct services provided by domestic employees or by agency employees. Participants also have a variety of therapies and other services available to them.
- b. **Residential Services**. Based on need, participants are provided with residential services and supports from the licensed provider of their choice. These participants may also select day programs and have a variety of therapies and other services available to them.

2. Children's Support Waiver

The Children's Support Waiver provides:

- Supports to eligible children and young adults with developmental disabilities ages three through 21 who live at home with their families. Children who are wards of the State are not eligible. The number of participants served each year is based on available State appropriation levels.
- Supports designed to prevent or delay the need for out-of-home residential services for these children and young adults who would otherwise need ICF/DD level of service.
- Choice between participant direction and more traditional service delivery, or a combination.

In combination with school-based services, natural supports, other community resources, and Medicaid State Plan services, services provided through the Children's Support Waiver assist the family in meeting the participant's needs. Within a monthly allocation for each Waiver participant, families select from a menu of services based on the participant's needs. For qualified service providers, families may select from traditional agencies, as well as individual providers identified by the family.

3. Waiver for Residential Support for Children with Developmental Disabilities

The Children's Residential Waiver provides:

- Twenty-four hour residential support to eligible children and young adults with developmental disabilities from age three through age 21 as an alternative to ICF/DD services. Children who are wards of the State are not eligible for this program. The number of participants served each year is based on available State appropriation levels.

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SECTION II. PARTICIPANT ELIGIBILITY AND WAIVER PROGRAM ENROLLMENT

Individuals applying for waiver services must first qualify for and be enrolled in the Illinois Medicaid program. This section provides information on how providers can confirm as needed an individual's Medicaid eligibility and then provides information about participant enrollment in the waiver programs.

A. Confirming Participant Medicaid Eligibility

1. Department of Healthcare and Family Services (HFS) Toll-Free Provider Hotline

Enrolled service providers and PAS/ISSA agencies may call the HFS Provider hotline during state working hours to verify an individual's Medicaid enrollment. Providers may make up to six inquiries per call. **The toll-free number is 1-800-842-1461.**

When using the automated system, callers must:

- Enter their Medicaid provider identification number. The identification number for waiver providers is generally the 9-digit Federal Employer Identification Number (FEIN) or Social Security Number (SSN) followed by 100 (Adult Waiver), 400 (Children's Support Waiver) and 700 (Children's Residential Waiver) (e.g., 123456789100 (FEIN/SSN + 100)).
- Enter the individual's Medicaid Recipient Identification Number (RIN) and the month of service for which they need eligibility information.

Callers who do not know the individual's RIN may talk with a Provider hotline staff member. To confirm eligibility when speaking with a staff member, callers must provide the individual's name, birth date and SSN.

2. HFS Provider Website

HFS maintains a website, Medical Electronic Data Interchange (MEDI), on which registered users (service providers) may verify an individual's Medicaid eligibility status. The website contains information on how to use the system. The website address is:

www.myhfs.illinois.gov/

First time users should:

- Click on Getting Started and/or MEDI/IEC training to learn about MEDI, system requirements and user information.
- Register using your Illinois driver's license number.
- Click on login after registering and provide the requested information, including your Medicaid provider ID (see above).

After this one-time registration, users may use MEDI to verify individual Medicaid enrollment. Medicaid waiver service providers may not use the MEDI system to submit

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claims or to access remittance advices.

Note: The message “Eligible for DHS social services,” means the individual is not enrolled in Medicaid. Some individuals have been assigned a Recipient ID Number (RIN) without being enrolled in Medicaid. PAS/ISSA staff, case managers, and Service Facilitators should make every effort to enroll these people in Medicaid.

B. Medicaid HCBS Waiver Clinical Eligibility Criteria

A DHS-designated Pre-Admission Screening/Individual Service and Support Advocacy (PAS/ISSA) agency screens applicants for Medicaid HCBS waiver-funded services clinical eligibility and offers an informed choice of services. The Procedures Manual for Developmental Disabilities Pre-Admission Screening Agencies (PAS Manual) contains guidance for PAS agencies on clinical eligibility determinations. Copies are available upon request from the Division of Developmental Disabilities.

Clinical eligibility criteria, also known as level of care or level of service criteria, for Medicaid HCBS Waiver funding are presented in Table 1. As part of the waiver eligibility determination process, individuals must be evaluated to determine level of service needs. Persons within the PAS agencies completing initial level of service evaluations and re-evaluations must be Qualified Mental Retardation Professionals (QMRP) as defined in Federal ICF/MR Regulations. The QMRPs must inform participants and/or their legal representatives, about their options during the level of service determination process. The QMRP presents participants/legal representatives with all service options, including both Waiver and ICF/DD services that the participant is eligible to receive, regardless of availability, in sufficient detail so they are able to make informed choices. QMRPs must accommodate participants/legal representatives who have limited English proficiency or who do not speak verbally. The QMRP is not permitted to make recommendations regarding where services and supports should be provided, or by which provider(s).

The QMRP provides the participants/legal representatives with additional information and materials on the service options they choose to pursue and arranges for and facilitates conversations with potential service providers.

For each individual determined eligible for the waiver, the QMRP must complete Appendix 2, Form DD-1238, Choice of Supports and Services. This form specifically documents the participant’s/legal guardian’s decision to choose waiver services as an alternative to ICF/DD services. This form also states that choice of supports and services may be changed in the future and must be signed by the participant/legal representative.

C. Special Medicaid Eligibility for Children in the Children’s Waivers

Children who are determined clinically eligible for either of the Children’s Waivers who are under the age of 19 can apply for Medicaid under special eligibility rules that can waive family income for families who would not otherwise qualify for Medicaid benefits for their child, based on the parent’s income. The PAS agency that determines clinical eligibility for the Children’s Waivers can assist families to apply for Medicaid for their child. For children found clinically eligible for the new waivers and for whom funding is authorized, PAS agencies will follow special procedures to help the family apply for Medicaid benefits. This will ensure that the child’s Medicaid application is given special handling. Please contact the PAS agency in your area for more information about the Children’s Waiver Medicaid application process.

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For young adults determined eligible for the Children's Waiver, the PAS agency will assist the individual to apply for Medicaid benefits as an adult through the local DHS office. Please contact PAS for more information about the Medicaid application for young adults.

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Table 1: 1915(c) Waiver Clinical Eligibility Criteria

Waiver	Clinical Eligibility Criteria
<p>Waiver for Adults with Developmental Disabilities</p>	<p>Individuals must:</p> <ol style="list-style-type: none"> 1. Be aged eighteen or older. 2. Be a resident of Illinois living in Illinois. 3. Be enrolled in Medicaid in Illinois. 4. Have a developmental disability, either mental retardation or a related condition. Applicants must be determined disabled according to the provisions of Title II of the Social Security Act, Federal Old-Age, Survivors and Disability Insurance Benefits (42 U.S. C. 421). 5. Be assessed as eligible for ICF/MR level of care/level of service: <ul style="list-style-type: none"> • Manifested mental retardation before the age of 18, as described in 42 Code of Federal Regulations Chapter IV [10-1-96 edition], Section 483.102(b)(3), or manifested a related condition before the age of 22, as defined in 42 Code of Federal Regulations Chapter IV [10-1-96 Edition], Section 435.1009. • If a related condition, have substantial functional deficits in three out of six major life areas. • Have been determined to need active treatment for the developmental disability, as defined in 42 Code of Federal Regulations Chapter IV [10-1-96 Edition], Section 483.440 [a]. <p>See the Procedures Manual for Developmental Disabilities Pre-Admission Screening Agencies for more complete information regarding these definitions and level of service requirements.</p> 6. Not be in need of nursing assessment, monitoring, intervention, and supervision of their condition or needs on a 24-hour basis. 7. Not be receiving services in a nursing facility, skilled nursing facility, ICF/DD, state-operated facility, skilled nursing facility for pediatrics, hospice facility, sheltered care facility, assisted living facility or hospital. If receiving services in a long term care facility or hospital, be prepared to move to an appropriate setting prior to receiving Developmental Disability waiver-funded services. 8. Not be receiving services funded through another Medicaid waiver program at the time Developmental Disability waiver-funded services are authorized. This includes the Division of Rehabilitation Services Home Services Program, the Department on Aging Community Care program, the University of Illinois Division of Specialized Care for Children Technology-Dependent/Medically-Fragile Children’s Waiver Program, and the Supportive Living Facility (SLF) program. If receiving other waiver services, the participant must terminate the other waiver services and choose the adult DD waiver prior to and as a condition of receiving developmental disabilities waiver services. <p>The number of individuals served each year will be based on available appropriations. New enrollees will be selected from the Prioritization of Urgency of Need For Services (PUNS) database, a database maintained by the Division of Developmental Disabilities of individuals potentially in need of state-funded DD services within the next five years. The selection criteria will provide for selection of individuals on several bases, including urgency of need, length of time on the database, and randomness.</p>

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Waiver	Clinical Eligibility Criteria
Children's Support Waiver	<p>Individuals must:</p> <ol style="list-style-type: none"> 1. Be between the ages of three and 21. 2. Reside at home with their families. 3. Be a resident of Illinois living in Illinois. 4. Be enrolled in Medicaid in Illinois. 5. Have mental retardation or a related condition. 6. Be assessed as eligible for ICF/MR level of service: <ul style="list-style-type: none"> • If a related condition, have substantial functional deficits in three out of six major life areas. • Have been determined to need active treatment for the developmental disability. <p>See the PAS Manual for detailed information about level of care/level of service requirements.</p> 7. Not be a ward of the State. 8. Not be in need of nursing assessment, monitoring, intervention, and supervision of their condition or needs on a 24-hour basis. 9. Not be receiving services in a long-term care facility or hospital. If receiving services in a long term care facility or hospital, be prepared to move to an appropriate setting prior to receiving Developmental Disability waiver-funded services. 10. Not be receiving services funded through another Medicaid waiver program at the time Developmental Disability waiver-funded services are authorized. This includes the Division of Rehabilitation Services Home Services Program and the University of Illinois, Division of Specialized Care for Children Technology-Dependent Medically Fragile Children's Waiver Program. If receiving other waiver services, the participant must terminate the other waiver services and choose the DD Children's Support Waiver prior to and as a condition of receiving developmental disabilities waiver services. <p>The number of individuals served each year will be based on available appropriations. New enrollees will be selected from the Prioritization of Urgency of Need For Services (PUNS) database, a database maintained by the Division of Developmental Disabilities of individuals potentially in need of state-funded DD services within the next five years. The selection criteria will provide for selection of individuals on several bases, including urgency of need, length of time on the database, and randomness.</p>

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Waiver	Clinical Eligibility Criteria
Children's Residential Waiver	<p>Individuals must:</p> <ol style="list-style-type: none"> 1. Be between the ages of three and 21. 2. Be a resident of Illinois living in Illinois. 3. Be enrolled in Medicaid in Illinois. 4. Have mental retardation or a related condition. 5. Be assessed as eligible for ICF/MR level of service: <ul style="list-style-type: none"> • If a related condition, have substantial functional deficits in three out of six major life areas. • Have been determined to need active treatment for the developmental disability. <p>See the PAS Manual for detailed information about level of care/level of service requirements.</p> 6. Be in need of children's residential waiver supports. 7. Not be a ward of the State. 8. Not be in need of nursing assessment, monitoring, intervention and supervision of their condition or needs on a 24-hour basis. 9. Not be receiving services in a long-term care facility or hospital. If receiving services in a long term care facility or hospital, be prepared to move to an appropriate setting prior to receiving Developmental Disability waiver-funded services. 10. Not be receiving services funded through another Medicaid waiver program at the time Developmental Disability waiver-funded services are authorized. This includes the Division of Rehabilitation Services Home Services Program and the University of Illinois Division of Specialized Care for Children Technology-Dependent Medically Fragile Children's Waiver Program. If receiving other waiver services, the participant must terminate the other waiver services and choose the DD Children's Residential Waiver prior to and as a condition of receiving developmental disabilities waiver services. <p>The number of individuals served each year will be based on available appropriations. New enrollees will be selected from the Prioritization of Urgency of Need For Services (PUNS) database, a database maintained by the Division of Developmental Disabilities of individuals potentially in need of state-funded DD services within the next five years. The selection criteria will provide for selection of individuals on several bases, including urgency of need, length of time on the database and randomness.</p>

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D. Priority HCBS Waiver Enrollment Criteria

1. Adult DD Waiver Program

For residential services, the State gives priority within available waiver capacity to eligible persons according to the following priority population criteria, in priority order, beginning with the most critical need:

- a. Individuals who are in crisis situations (e.g., including but not limited to, persons who have lost their caregivers or persons who are in abusive or neglectful situations).
- b. Individuals who are wards of the Department of Children and Family Services and are approaching the age of 18 and individuals who are aging out of children's residential services funded by the Division of DD.
- c. Individuals who reside in state-operated developmental centers.
- d. Bogard class members, i.e., certain individuals with developmental disabilities who currently reside or previously resided in a nursing facility.
- e. Individuals with mental retardation who reside in state-operated mental health hospitals.
- f. Individuals with aging caregivers.
- g. Individuals who reside in private ICF/DDs.

For support services, the Division gives priority within available waiver capacity to eligible persons who have been identified as individuals who are not receiving any support services from the Division or the Division of Rehabilitation Services (except vocational rehabilitation services). Within this population, if requests exceed available capacity, the Division will prioritize:

- a. Individuals whose primary caregiver is age 60 or older, but is not yet in crisis; or
- b. Individuals who have exited special education within the last five years; or
- c. Individuals who are living with only one caregiver.

D. Notification to Providers of Waiver Participant Eligibility

Sharing of assessment information is essential to the development of a timely and appropriate individual service plan. Sharing of other documentation of PAS actions and determinations is necessary to ensure that participants are made aware of their rights and that all providers are informed about each participant's status. The PAS/ISSA agency must send the following information to the responsible case manager or Service Facilitator when the Waiver Program clinical eligibility determination process is complete and services are being initiated:

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1. Copies of all paper DHS DD-PAS forms.
2. A print-screen of the Presentation and Selection of Service Options (DHS DD PAS-10).
3. For adults, the Inventory for Client and Agency Planning (ICAP) summary information.
4. Psychological and other assessments relevant to the service planning process.
5. Documentation of notification of appeal and other rights, as applicable.
6. Documentation of informed choice of ICF/DD or waiver services on Appendix 2, Choice of Services (DD-1238).

E. Participant Service Termination

1. Provider Requests for Service Termination

Termination of waiver services to an individual can be recommended by the provider only if there is documentation that the basis for termination is in accordance with program rules.

In such situations, termination of services can be recommended only after consultation with the individual; the individual's guardian; and other persons from the individual's support network as the individual or the guardian chooses and in compliance with appeal rights requirements specified in the waiver rule (89 Ill. Adm. Code 120).

2. Termination of Waiver Services

Termination of Waiver services to an individual can occur only if:

- a. The ISSA has been consulted and concurs. In the event conflicts arise that cannot be resolved among the parties involved, the provider or the ISSA shall make a referral to the Department for technical assistance; and
 - b. The individual or guardian has waived or exhausted his or her appeal rights.
3. If the above criteria are met, the service provider completes a Service Termination Approval Request (STAR) and sends it to the PAS/ISSA agency for signature. The PAS/ISSA agency sends it to DHS DD Network staff for approval.

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SECTION III. WAIVER SERVICES

Table 2 provides an overview of the services available under each waiver program and Table 3 provides an overview of the services available under each option of the Adult DD Waiver. These overviews are followed by more detailed descriptions of each service.

Table 2: Available Services by Waiver Program

All services require authorization by the Division of Developmental Disabilities.

Services that require additional prior approval are marked with an asterisk.

Service	Waiver		
	Adult	Children's Supports	Children's Residential
Individual Service and Support Advocacy	X	X	X
Residential Habilitation Services			
Community-Integrated Living Arrangement (CILA)	X		
Community Living Facility (CLF)	X		
Temporary Intensive Staffing *	X		
At Home Day Program *	X		
Child Group Home			X
Day Habilitation and Other Day Program Services			
Developmental Training (DT)	X		
Supported Employment (SEP) *	X		
Adult Day Care *	X		
Regular Work/Sheltered Employment	X		
Other Day Program *	X		
Behavior Services			
Behavior Intervention and Treatment	X	X	X

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Service	Waiver		
	Adult	Children's Supports	Children's Residential
Behavior Counseling	X		
Psychotherapy	X		
Therapies			
Physical Therapy * +	X		
Occupational Therapy * +	X		
Speech Therapy * +	X		
Adaptive Equipment, Assistive Technology, Vehicle Modifications and Home Accessibility Modifications *			
Adaptive equipment *	X	X	X
Assistive Technology *	X	X	X
Home Accessibility Modifications *	X	X	
Vehicle modifications * #	X	X	
Home-Based Support Services			
Service Facilitation	X	X	
Personal Support	X	X	
Crisis Services *	X		
Nursing +	X		
Emergency Home Response Services	X		
Transportation (Non-Medical)	X		
Training and Counseling Services for Unpaid Caregivers	X	X	

* Services that require both authorization and prior approval are marked with an asterisk.

Vehicle Modifications are part of the transportation component of the residential rate.

+ These services are available for children up to age 19 through the Medicaid State Plan.

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Table 3: Available Services by Adult DD Waiver Option

Service	Adult DD Waiver	
	Traditional Residential/ Day Services	Home-Based Support Services
Individual Service and Support Advocacy	X	X
Residential Habilitation Services		
Community-Integrated Living Arrangement (CILA)	X	
Community Living Facility (CLF)	X	
Temporary Intensive Staffing *	CILA or DT only	X (in DT only)
At Home Day Program *	CILA only	
Day Habilitation and Other Day Program Services		
Developmental Training (DT)	X	X
Supported Employment (SEP) *	X	X
Adult Day Care *	X	X
Regular Work/Sheltered Employment	X	X
Other Day Program *	CILA only	
Behavior Services		
Behavior Intervention and Treatment	X	X
Behavior Counseling	X	X
Psychotherapy	X	X
Therapies		
Physical Therapy *	X	X
Occupational Therapy *	X	X
Speech Therapy *	X	X

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Service	Adult DD Waiver	
	Traditional Residential/ Day Services	Home-Based Support Services
Adaptive Equipment, Assistive Technology, Vehicle Modifications and Home Accessibility Modifications		
Adaptive equipment *	X	X
Assistive Technology *	X	X
Home Accessibility Modifications *	X	X
Vehicle modifications *	X	X
Self-Directed Services		
Service Facilitation		X
Personal Support		X
Crisis Services *		X
Nursing		X
Emergency Home Response Services		X
Transportation (Non-Medical)		X
Training and Counseling Services for Unpaid Caregivers		X

* Services that require both authorization and prior approval are marked with an asterisk.

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A. Individual Service and Support Advocacy (ISSA)

Note: This service is available in all three Waiver Programs.

Waiver participants receive ISSA services at least four times each year, approximately once per quarter, from one of 18 designated Pre-Admission Screening/Individual Service and Support Advocacy (PAS/ISSA) agencies. ISSA staff, who must be qualified mental retardation professionals as defined in federal ICF/MR regulations, serve as an independent resource for families in considering options and resolving issues with providers or services. ISSA staff participate in the development of the individual service plan and approve the final plan, as well as monitor its implementation and the general health, safety and well being of the participant.

ISSA represents the Department's interests in determining whether waiver services are being provided in the interest of and to the satisfaction of individuals receiving the services; alerts the Department when additional monitoring, intervention or technical assistance are necessary; and provides support to individuals, guardians, and providers in working through a variety of service issues, including those requiring conflict resolution, increased communication, and possible changes in support levels.

ISSA is designed to assist but not supplant the guardian and other appropriate advocates in fulfilling their responsibilities. The ISSA contacts the participant and guardian, if one has been appointed, prior to any service planning meetings to identify areas of concern, answer questions, and generally help them prepare for the meetings.

Participants, families or guardians may at any time contact ISSA staff to present a complaint or discuss unresolved issues or problems affecting the participant's health and welfare. ISSA staff will work with the responsible case manager or Service Facilitator to resolve grievances or complaints, particularly those between the participant and service providers. If the grievance continues, ISSA staff will continue the process by involving provider staff of increasing authority, up to and including the executive director of the Service Facilitation or direct service provider. If the grievance cannot be resolved, ISSA staff may contact DHS staff for technical assistance or intervention.

Additionally, the responsible case manager, Service Facilitator, and ISSA inform participants, families and guardians, if one has been appointed, about protections from abuse, neglect, and exploitation. The information provided includes the process for reporting allegations to the to the Department of Children and Family Services hotline for children through the age of 17, as well as the process for reporting allegations to the DHS Office of the Inspector General, for adults aged 18 and older. Participants, families and guardians are informed that anyone who suspects abuse, neglect or exploitation may report an allegation. Information is presented both verbally and in writing.

B. Residential Habilitation Services

Note: These services are available in the Adult DD Waiver and the Children's Residential Waiver.

1. Residential habilitation services are available, based on need, to participants who request the service and meet the priority population criteria for residential services.
2. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports

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include case management, adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

- a. Residential habilitation includes the reduction of maladaptive behaviors through positive behavioral supports and other methods.
 - b. Residential habilitation may include necessary nursing assessment, direction and monitoring by a registered professional nurse, and support services and assistance by a registered professional nurse or a licensed practical nurse to ensure the participant's health and welfare. These include monitoring of health status, medication monitoring, and administration of injections or suctioning. It also includes administration and/or oversight of the administration of oral and topical medications consistent with the Illinois Nursing and Advanced Practice Nursing Act (225 ILCS 65) and the Mental Health and Developmental Disabilities Administrative Act. Nursing services are considered an integral part of residential habilitation services. Meeting the routine nursing needs of participants receiving 24-hour residential services is the responsibility of the residential service provider who may employ or contract with a professional nurse to perform their professional duties including the oversight and training of direct support staff. Nursing supports are part-time and limited; 24-hour nursing supports, similar to those provided in a nursing facility (NF) or Intermediate Care Facility for individuals with Developmental Disabilities (ICF/DD), are not available to participants in the Waivers. These services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.
 - c. Residential habilitation includes non-medical transportation between the residence and other community locations where habilitation occurs. These other community locations may include other services, stores, and recreational and socialization activities. Transportation is an integral part of funding for Community-Integrated Living Arrangements, Community Living Facilities or Child Group Homes, depending on which residential service the participant receives. Training and assistance in transportation usage are provided as needed. For the Children's Residential Waiver, transportation services exclude transportation to and from school.
3. Residential habilitation may be provided in a variety of ways, including:
- a. **Community-Integrated Living Arrangement (CILA)** is a living arrangement provided to Adult DD Waiver participants in a group home, family home or apartment where eight or fewer unrelated adults with developmental disabilities reside under supervision of the community developmental services agency. Residents receive a comprehensive individualized array of residential habilitation, personal support services and supports under the direction of a community support team within the local agency. Four CILA models are defined below:
 - b. **Twenty-four-hour CILA** homes have on-site shift staff available during all times when participants are present. Staff provide both scheduled and unscheduled supports and services as needed by participants.

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- c. **Host family CILA** serves individuals with developmental disabilities in their own residence. Host families consist of one or more persons who are unrelated to the individual with a developmental disability and who are under contract with the provider agency to provide host family services. No more than two individuals with developmental disabilities may reside with any single host family. The two support models are:
- i. **Traditional care** is the full-time residence of the paid caregivers. The paid caregivers own, lease or rent the residence.
 - ii. **Shared living** may house either full or part-time paid caregivers in which individuals other than shift staff employees provide more than 50 percent of the residential coverage. The individuals, caregivers or provider agency own, lease or rent the residence.

The difference between traditional care and shared living models is shift employees routinely share supervision, care and training responsibilities with the host family caregivers in the shared living model.

- d. **Intermittent CILA** serves individuals whose service plan documents that they do **not** require 24-hour on-site staff presence and documents the situations in which individuals may safely be away from direct staff supervision. Intermittent Residential services in apartments or family homes have staff available on-call 24-hours per day. On-site shift staff are available to provide both scheduled and unscheduled supports and services as needed by the participants served and as specified in each participant's service plan.
- e. **Family CILA** is similar to Intermittent CILA, except that individuals are provided support in the family home.
- f. **Community Living Facility (CLF)** serves Adult DD Waiver participants in a licensed residential setting. A Community Living Facility is not a nursing or medical facility and, to be eligible under the waiver, serves no more than 16 adults.
- g. **Temporary Intensive Staffing** provides funding for Adult DD Waiver participants with additional time-limited intensive staffing to provide temporary intensive supports for individuals receiving CILA or DT services who have a time-limited immediate need for intensive staffing.
- h. **At Home Day Program** is a part of the residential habilitation program for Adult DD Waiver participants. At Home Day Programs are based in the individual's CILA home and provide a structured individualized program of in-home and community habilitation activities for individuals who are unable to participate in out-of-home day programs because the individual:
- Has an illness or medical conditions or severe maladaptive behaviors that prevent participation in a traditional day program.

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- Is over the age of 60 and declines to participate in traditional out-of-home day programs.
- Is unable to locate a traditional day program to serve him/her or appropriate to meet his/her needs.

The At Home Day Program requires prior approval. See Section VIII for prior approval requirements for At Home Day Program.

- i. **Child Group Home** is available to Children's Residential Waiver participants, and is a residential program licensed by the Department of Children and Family Services to serve no more than ten children. Child Group Home services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. Child Group Homes are designed to provide a structured environment and a range of habilitative and therapeutic services to children and adolescents who cannot reside in their own home.

C. Day Program Services

Note: These services are available only in the Adult DD Waiver Program.

1. **Developmental Training** is a program of day habilitation that provides assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.
 - a. Developmental Training focuses on enabling the participant to attain or maintain his or her maximum functional level and services are coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings.

Developmental Training includes a range of adaptive skills in the areas of motor development, attention span, safety, problem solving, quantitative skills, and capacity for individual living. Developmental training may enhance a participant's ability to engage in productive work activities through a focus on such habilitative goals as compliance, attendance, and task completion. Developmental Training may include training and supports designed to maintain skills and functioning and to prevent or slow regression.

Developmental Training includes the reduction of maladaptive behaviors through positive behavioral supports and other methods.

- b. To foster community integration and learning in natural environments, Developmental Training may be furnished in generic non-residential community environments, as well as in sites specifically certified for Developmental Training.

Such community-based Developmental Training programs include purposeful and meaningful activities designed to improve, maintain, or prevent the loss of

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independence, skills and functions enabling each participant to access and participate in relationships, activities and functions of community life. Activities may consist of job exploration activities (not paid employment) or volunteer work, recreation, educational experiences in natural community settings, maintaining family contacts and purposeful activities and services where persons without disabilities are present.

- c. Developmental Training includes transportation between the residence and other community locations where Developmental Training occurs. The cost of this transportation is included in the rate paid to providers of Developmental Training services. Training and assistance in transportation usage are provided as needed.
- d. Developmental Training does **not** include the following:
 - Special education and related services (as defined in Section 601 (16) and (17) of the Individuals with Disabilities Education Act) which otherwise are available to the participant through a local education agency
 - Vocational rehabilitation services which otherwise are available to the participant through a program funded under Section 110 of the Rehabilitation Act of 1973.

2. **Supported Employment (SEP)**

- a. Supported Employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely without supports, and who, because of their disabilities, need supports to perform in a regular work setting. Supported employment includes activities needed to sustain paid work by participants, including supervision and training.
- b. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant.
- c. Supported employment is conducted in a variety of settings; particularly work sites where persons without disabilities are employed. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment may be provided in integrated and competitive work settings in a business or industry that primarily employs people without disabilities.

Supported employment does not include sheltered work or other similar types of vocational services furnished in specialized facilities.

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- d. Supported employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Such assistance may include: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.
 - e. Transportation will be provided between the participant's place of residence and the employment site or between habilitation sites (in cases where the participant receives waiver services in more than one place) as a component part of supported employment services. The cost of this transportation is included in the rate paid to providers of supported employment services.
 - f. See Section VIII for prior approval requirements for Supported Employment.
3. **At Home Day Program.** See Residential Habilitation above.
4. **Adult Day Care**
- a. Adult day care is available to participants who are aged 60 and older. Participants who are not yet 60 may also be served if day habilitation or employment services are determined by the service planning team not to be appropriate because the participant is medically fragile.
 - b. Adult day care services are generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).
 - c. Transportation between the participant's place of residence and the adult day care center is provided as a component part of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care.
 - d. Adult Day Care provided in a setting governed by the Community Care Program rule (89Ill. Adm. Code 240) of the Department on Aging.
 - e. See Section VIII for prior approval requirements for adult day care.

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5. Regular Work/Sheltered Employment

Regular Work/Sheltered Employment provides long-term employment in a sheltered environment for individuals whose functional levels require supervision but who are not precluded from future movement into a Supported Employment position or a competitive employment position. Regular Work/Sheltered Employment provides general work supervision, including direction and on-the-job training in such areas as work expectations, workplace behavior, compliance to workplace safety standards, production and task completion. This program provides the opportunity to participate in productive work and to be compensated for that work in accordance with the Fair Labor Act of 1938 (29 U.S.C. 208).

While this service is offered to Waiver participants, the payments for the services by the State are not claimed under Medicaid.

The payment rate for Regular Work/Sheltered Employment includes transportation costs.

6. Other Day Program

Other Day Program is an out-of-home, center-based program that provides a structured individualized program of community habilitation activities for adults for whom the more traditional day programs are not available or appropriate and who choose to participate in a variety of approved alternative day activities. Other Day Program requires prior approval and is available only to individuals who are receiving CILA residential services under the waiver.

See Section VIII for prior approval requirements for Other Day Program.

D. Professional Services

1. Behavior Services

To receive behavior services under the waivers, the services must be based on behavioral assessments documenting the ongoing need for the service, be included in the individualized service plan and must receive written approval from the service planning team. Prior approval is **not** required for behavior services.

a. Behavior Intervention and Treatment

Note: This service is available in all three Waiver Programs.

Behavior intervention and treatment includes a variety of individualized, behaviorally based treatment models consistent with best practice and research on effectiveness that are directly related to the participant's therapeutic goals. Interventions include, but are not limited to: Applied Behavior Analysis, Relationship Development Intervention (RDI) and Floor Time. These services are designed to assist participants to develop or enhance skills with social value, lessen behavioral excesses and improve communication skills. The key elements are:

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- The approach is tailored to address the participant’s specific behavioral needs.
- Targeted skills are broken into small attainable tasks.
- Direct support staff, informal caregiver and family training is a key component so that skills can be generalized and communication promoted, especially in the areas of prevention, intervention and stabilization.
- Services must be directly related to the participant’s therapeutic goals contained in the service plan and, if applicable, coordinated with the participant’s individual education plan (IEP).
- Success is closely monitored with detailed data collection.

For each of the waivers, the following individuals are among the vital members of the behavior team and must be involved in the initial training session to initiate services, and must remain involved with the behavior consultant so that they are able to carry through and reinforce the behaviors being worked on by the team.

- *Adult DD Waiver:* Direct support staff and unpaid informal caregivers of participants receiving intensive behavior treatment.
- *Children’s Support Waiver:* Families of children receiving intensive behavior treatment. The parents need not be available for all treatment sessions, but must be present at team meetings.
- *Children’s Residential Waiver:* Direct support staff and families of participants receiving intensive behavior treatment.

A behavior consultant assesses the participant, including analysis of the presenting behavior and its antecedents and consequences, and develops written behavior strategies based upon the participant’s individual needs. The strategies are a component of the service plan and must be approved by the participant, guardian if one has been appointed, family, responsible case manager or Service Facilitator, Individual Service and Support Advocate and the other members of the planning team. Trained team members implement the planned behavior services. *For the Children’s Support Waiver, responsible relatives implementing behavior services may not bill these hours to the Waiver Program.*

The behavior consultant performs the following activities:

- Monitors progress on at least a monthly basis and more frequently if needed to address issues with the participant’s outcomes.

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- Revises the behavior strategies as needed to ensure efficacy and prepares a progress report to the service planning team every six months. This progress report is available to State staff upon request to evaluate the efficacy of the treatment.
- Supervises implementation of the behavior plan, including training of the personal support staff, unpaid informal caregivers and family to ensure they properly apply the interventions, understand the specific services and outcomes for the participant being served, and know the procedures for regularly reporting participant progress.
- Works closely with the participant's informal caregivers, direct support workers family, teachers and other school personnel and personal support workers in the participant's home and other natural environments.

b. Behavior Counseling (Individual and Group)

Note: This service is available only in the Adult DD Waiver.

Behavior Counseling is a treatment approach in which a licensed professional meets with one or more individuals in ongoing periodic formal sessions, and uses relationship skills to promote the individuals' abilities to deal with daily living issues associated with their emotional, cognitive or behavioral problems using a variety of supportive and re-educative techniques.

The individual service planning team must recommend behavior counseling prior to an individual receiving service. The individual service plan must include documentation of the individual's need for behavior counseling and the services to be provided by the licensed professional.

A behavior counseling plan must be developed and approved in writing by the service planning team within 45 days of initial contact. This plan should include:

1. A brief summary that describes the emotional, cognitive or behavioral concerns to be addressed by counseling. The description should note the frequency and severity of problem behaviors.
2. A summary of psychiatric diagnoses and medications and their effects on behavior if the individual is dually diagnosed with a mental illness or is taking psychoactive medications.
3. Description of person-centered, specific, measurable goals that will be addressed by counseling. Goals should include timeframes for estimated attainment.
4. Description of specific, person-centered counseling strategies to be provided by the counselor to assist the individual to meet the goals.

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Each individual or group counseling contact requires a clinical narrative documenting the specific counseling service provided as well as the specific date and time that the service was rendered. The counselor or psychotherapist must maintain documentation that reflects a brief description of the session's focus and periodic reviews of progress towards established treatment goals.

Counseling includes:

1. Participation in individual service plan development and review, consultation with other members of the service planning team related to the need for counseling supports, as well as previous attempts to address the needs.
2. The development of the individualized counseling plan.
3. Assessing information on the frequency and severity of the individual's presenting problems.
4. Individual face-to-face contacts addressing goals identified in the individual's counseling plan.

Group counseling includes sessions in which the counselor meets with two or more individuals to address goals identified in their individualized counseling plans.

B. Psychotherapy (Individual and Group)

Note: This service is available only in the Adult DD Waiver.

Psychotherapy is a treatment approach in which a licensed professional deliberately establishes a relationship with one or more individuals seen simultaneously, if applicable, in ongoing periodic formal sessions with the goal of ameliorating or reducing the symptoms of emotional, cognitive or behavioral disorder and promoting positive emotional, cognitive and behavioral development.

The individual service planning team must recommend psychotherapy prior to the individual receiving services. The individual service plan must include documentation of an individual's need for psychotherapy and the services to be provided by the licensed professional.

A psychotherapy plan must be developed and approved in writing by the service planning team within 45 days of initial contact. This plan should include:

1. A brief description of the emotional, cognitive or behavioral concerns to be addressed by therapy. The description should note the frequency and severity of the problem behaviors, as well as previous attempts to address the concerns.
2. A summary of psychiatric diagnoses and medications and their effects on behavior if the individual is dually diagnosed with a mental illness or is taking psychoactive medications.

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3. A description of person-centered, specific, measurable goals that will be addressed by therapy. Goals should include timeframes for estimated attainment.
4. A description of specific, person-centered therapeutic strategies to be provided by the behavior therapist to assist the individual to meet the goals.

Each individual or group therapy contact requires a clinical narrative documenting the specific therapy service provided as well as the specific date and time that the service was rendered. The counselor or psychotherapist must maintain documentation that reflects a brief description of the session's focus and periodic reviews of progress toward established therapy goals.

Psychotherapy includes:

1. Participation in individual service plan development and review, consultation with other members of the service planning team related to the need for therapy supports.
2. Development of the individualized psychotherapy plan.
3. Assessing information on the frequency and severity of an individual's presenting problems.
4. Individual face-to-face contacts addressing goals identified in the individual's psychotherapy plan.

Group therapy includes sessions in which therapist meets with two or more individuals to address goals identified in their individualized psychotherapy plans.

2. Therapies in addition to those covered by the Medicaid State Plan

Note: These services are available only in the Adult DD Waiver.

Physical therapy, occupational therapy and speech therapy for restorative purposes are covered under the Medicaid State Plan. Adult Waiver participants are eligible for additional physical, occupational and speech therapy services of a habilitative, not a restorative nature, when prior approved.

See Section VIII for prior approval requirements for therapies.

Each of the therapies must be recommended in writing by the individual service planning team. The team must develop an individual service plan that includes documentation of the individual's specific therapy needs and the specific services to be provided by the licensed professional. All services must be included in the single, comprehensive, integrated service plan regardless of funding source.

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The focus of ongoing, long-term habilitative physical therapy, occupational therapy and speech therapy services should be working with the individual, family members, direct support workers and others to incorporate effective therapeutic activities in daily life rather than on intensive professional treatments focused on short-term acute restorative needs.

E. Adaptive Equipment, Assistive Technology, Vehicle Modifications and Home Accessibility Modifications

These services all require prior approval by the Division. See Section VIII for prior approval requirements for these items.

1. Adaptive Equipment

Note: This service is available in all three Waiver Programs.

- a. Adaptive equipment, as specified in the service plan, includes performance of assessments to identify the type of equipment needed by the participant; devices, controls or appliances that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, access or communicate with the environment in which they live; other durable medical equipment not available under the Medicaid State Plan that is necessary to address participant functional limitations; and necessary initial training from the vendor to use the adaptive equipment. It may also include necessary maintenance and repairs to adaptive equipment. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that **are not** of direct remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Some examples of covered adaptive equipment include reachers; grabbers; voice-activated, motion-activated and electronic devices; and specialized computer software. Lift chair mechanisms, communication devices and mobility devices may be covered **if not** covered by the Medicaid State Plan.

- b. Some examples of items that **are not** covered adaptive equipment are furniture, recreational or quality of life items, such as televisions, stereos, boom boxes, fitness equipment, microwave ovens and other general appliances.
- c. Medical equipment and supplies are **not** considered adaptive equipment.

2. Assistive Technology

Note: This service is available in all three Waiver Programs.

Assistive technology devices are items, pieces of equipment, or product systems, whether acquired commercially, modified, or customized, used to increase, maintain, or improve functional capabilities of participants. Assistive technology services directly assist a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes the following:

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- Evaluation of the participant’s assistive technology needs, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant.
- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants.
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the individual service plan.
- Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant
- Training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

3. Home Accessibility Modifications

Note: This service is available in the Adult DD Waiver and the Children’s Support Waiver.

- a. Home Accessibility Modifications include those physical adaptations to the private residence of the participant or the participant’s family, required by the participant’s service plan, necessary to ensure the health, welfare and safety of the participant or and which enable the individual to function with greater independence in the home and necessary repair to the adaptations. Home accessibility modifications may be either permanent or not permanent. Permanent home modifications are either structural modifications or items that are attached to the home. All services must be provided in accordance with applicable State or local building codes.

For modifications to agency-owned CILA sites, please see the CILA User Guide.

- b. Examples of home accessibility modifications include:
- Ramps.
 - Lifts/elevators necessary to enter or leave the home or to access a bedroom or a bathroom, including porch or stair lifts and hydraulic, manual or electric lifts.
 - Bathroom modifications, including roll-in showers, sink modifications, bathtub modifications, toilet modifications, grab bars, adapted water faucet controls, floor

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urinal and bidet adaptations and plumbing modifications and turnaround space adaptations.

- Widening of doorways/hallways (may include minimally necessary floor covering to cover the new floor area).
 - Specialized accessibility/safety adaptations/additions including grab bars; necessary handrails beyond those normally required by building codes; lowered or adaptive door handles; adapted fire alarms, sprinklers, smoke detectors and doorbells; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronically-activated devices; fire safety adaptations; and electrical wiring associated with the above.
- c. Excluded are those adaptations or improvements to the home that are of general utility. Examples of items that **are not** considered to be covered home modifications include:
- Cosmetic refurbishment.
 - Items that add value to the home.
 - Roof repair.
 - Installation or repair of furnace/air conditioning.
 - Replacement of floor covering; replacement or repair of stairs, windows, driveways or sidewalks.
 - Installation of hot tubs, spas, whirlpool tubs, saunas and replacing an existing tub with a new tub.
 - Room renovation, exterior renovation, or renovations to a porch or deck.
 - Adaptations that add to the total square footage of the home.
 - Seasonal items such as swimming pools and related equipment.

Modifications to basements or attics are generally **not** included, due to safety concerns, egress concerns and potential isolation from the rest of the family. Fencing is generally **not** included unless elopement behavior is present and cannot be addressed in other ways.

4. Vehicle Modifications

Note: This service is available in the Adult DD Waiver and the Children's Support Waiver.

- a. Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation to accommodate the special needs

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of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of vehicle modifications include:

- Lifts or ramps.
 - Door modifications.
 - Seating modifications.
 - Safety/security modifications.
 - Inside height modifications.
- b. The following modifications are specifically excluded from coverage:
- Adaptations or improvements to the vehicle that are of general utility, and are not of direct remedial benefit to the participant.
 - Purchase or lease of a vehicle.
 - Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
- c. The participant, a family member with whom the participant lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the participant and is not a paid provider of such services must own the adapted vehicle.

F. Self-Directed Service Options

Self-directed services are available in the Children’s Support Waiver and through the Home-Based Support Services (HBS) option in the Adult DD Waiver. The individual service descriptions below identify the services that are available within each option. See Section V for additional information about self-directed service options.

Some specific waiver services included in the array of self-directed services require prior approval. See Section VIII, Service Authorization and Prior Approval, for additional information.

1. Service Facilitation

Note: This service is available in the Adult DD Waiver and the Children’s Support Waiver.

This service is available within the monthly maximum to all Children’s Support Waiver participants, and to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS).

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Service facilitation includes case management services that assist participants and families in gaining access to needed Waiver and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services.

Service Facilitators are responsible for day-to-day oversight and administration of the service plan and for ensuring participant health, safety and welfare.

Service facilitators assist the participant, family and guardian, if one has been appointed, in the following:

- Designing an array of habilitation and support services to meet the participant's needs.
- Convening a service planning team, or convening the team as directed by the participant, family or guardian. In addition to the participant, guardian (if applicable), family members and/or other individuals important to the participant, service facilitator, and ISSA, the team may include other professionals and service providers as needed.
- Writing or updating the individual service plan at least annually or more often, if needed, based on assessment information and discussion among the participant, guardian, family and other members of the service planning team.
- Ensuring the completion of service agreements or service authorizations between the participant and service providers.
- Working with the fiscal employer agency to monitor the expenditure of funds according to the individual budget, service plan and service agreements/authorization.
- Working with the fiscal employer agency to determine that domestic employee providers of services, such as Personal Support and Non-Medical Transportation, are qualified and competent to provide the specific services the participant is receiving.

2. Personal Support

Note: This service is available in the Adult DD Waiver and the Children's Support Waiver.

This service is available within the monthly maximum to all Children's Support Waiver participants and to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS).

Personal Support services include a range of training and assistance to enable participants to accomplish tasks that they would normally do for themselves if they did not have a disability. These services may include:

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- Teaching adaptive skills to assist the individual to reach personal goals.
- Personal assistance in activities of daily living.
- Assistance in performing age-appropriate housekeeping chores such as bed making, dusting and vacuuming, which are essential to the health and welfare of the participant, rather than for the participant's family.
- Services provided on a short-term basis because of the absence or need for relief of the primary caregivers.

Personal Support services may be provided on an episodic or on a continuing basis. Health-related services may include skilled or nursing care and medication administration to the extent permitted by State law. Personal Support may be provided in the participant's home and may include supports necessary to participate in generic community activities outside the home. Participants may not receive Personal Support services during the typical school day relative to the age of the participant or during times when educational services are being provided.

The need for Personal Support and the scope of the needed services must be documented in the individual service plan. The service authorizations must specify the monthly number of hours of Personal Support and the hourly rate. The hourly rates are subject to review and approval by the Division on either a targeted or a random sample basis.

Personal Support **is not** intended to:

- Include professional services, home cleaning services, recreation fees or other community services used by the general public.
- Provide one-to-one supports in a day program. An enhanced day program rate may be requested as necessary to meet this need within the monthly maximum.

All Personal Support providers, whether agencies or domestic employees, must comply with the same timekeeping and audit trail requirements as providers of other waiver services. Personal Support services are included in the participants' monthly cost limit/individual budget. The State has not set a specific service maximum.

Individual providers of Personal Support who are not employed by a provider agency receive ongoing supervision by the employer of record who can be the participant and/or legal representative, other family member or close associate. The employer of record (participant and/or legal representative, family or close associate) is also responsible for hiring, training, ensuring competency, and firing individual providers. The Service Facilitator and fiscal employer agent are available to assist with these responsibilities if the participant or family needs such assistance. The fiscal employer agent provides assistance with provider enrollment, payroll processing and billing.

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3. Crisis Services

Note: This service is available only in the Adult DD Waiver Program.

This service is available to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS). The cost of these services is **not** counted toward the monthly maximum.

Crisis Services include the same activities, requirements and responsibilities as Personal Support set forth in the above subsection. They are provided on a temporary emergency basis because of the absence or incapacity of the persons who normally provide unpaid care. This may include persons who provide substantial amounts of unpaid care, but who also receive payment for some hours of Personal Support.

Absence or incapacity of the primary caregiver(s) must be due to a temporary cause, such as hospitalization, illness, injury or other emergency situation. Crisis Services are not available for caregiver absences for vacations, educational or employment-related reasons or other non-emergency reasons.

No Crisis Services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

See Section VIII for prior approval requirements for Crisis Services.

4. Nursing

Note: This service is available only in the Adult DD Waiver Program.

Nursing services are available within the monthly maximum to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS).

Nursing services are in addition to any Medicaid State Plan nursing services for which the participant may qualify, and must be listed in the service plan, and be within the scope of the Illinois Nursing and Advanced Practice Nursing Act (225 ILCS 65).

5. Emergency Home Response Services

Note: This service is available only in the Adult DD Waiver Program.

This service is available within the monthly maximum to participants who are authorized for Home-Based Support Services (HBS) within the Adult DD Waiver. Emergency Home Response Services are limited to adults who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Emergency home response service (EHRS) is an electronic device that enables Adult DD Waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's

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phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center. Installation, upkeep and maintenance of devices/systems may be provided.

6. Transportation (Non-Medical)

Note: This service is available only in the Adult DD Waiver Program.

This service is available within the monthly maximum to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS).

Non-Medical transportation includes services to enable individuals to gain access to waiver and other community services, activities and resources specified by the service plan. This service is offered in addition to medical transportation services available under the Medicaid State Plan and must not replace them. Whenever possible, participants should use family, neighbors, friends or community agencies which can provide this service without charge.

Transportation to and from covered Medicaid State Plan services and to and from day program services is excluded.

7. Training and Counseling Services for Unpaid Caregivers

Note: These services are available in the Adult DD Waiver and the Children's Support Waiver.

These services are available within the monthly maximum to all Children's Support Waiver participants and to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS).

This service includes training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, an individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a participant served in the waiver. This service may not be provided to train paid caregivers. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the participant's service plan.

Training furnished to individuals who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the service plan. Counseling similarly must be aimed at assisting unpaid individuals who support the participant to understand and address participant needs.

Caregivers who are compensated for direct services under this Waiver may not receive this service.

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8. Day Programs

Note: These services are available only in the Adult DD Waiver Program.

The below services are available within the monthly maximum to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS) option. See Section III.C for additional information about these services.

- a. Developmental Training
- b. Supported Employment
- c. Adult Day Care
- d. Regular Work/Sheltered Employment

The statewide day program maximums (115 hours per month, 1,100 hours per state fiscal year for any combination of day programs) and the agreed hours in the service agreement determine the maximum hours a provider may bill for day programs. The Division of Developmental Disabilities recommends that providers limit billing for day program services to 92 hours per month for individuals in self-directed options so that the individuals may access other needed services within the monthly maximum throughout the state fiscal year. Billing for 92 hours per month is sufficient to allow day program providers to be paid for the full state fiscal year (92 x 12 = approximately 1,100 hours). Please see Section X for additional billing guidance.

9. Behavior Services

The below services are available within the monthly maximum to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS). See Section III.D for more information about these services

- a. Behavior Intervention and Treatment
- b. Individual and Group Counseling
- c. Individual and Group Psychotherapy

The provider may bill for services that directly benefit the individual, that are within the statewide maximums and the agreed hours in the service agreement and that the provider delivered personally and documented.

10. Therapies, in addition to those covered in the Medicaid State Plan

Note: These services are available only in the Adult DD Waiver Program.

These services are available within the monthly maximum to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS). See Section

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III.D for additional information about these services and Section VIII for prior approval requirements for therapies.

- a. Physical Therapy
- b. Occupational Therapy
- c. Speech Therapy

The therapist may bill for services that directly benefit the individual, that are within the statewide maximums and the agreed hours in the service agreement and that the therapist delivered and documented

11. Adaptive Equipment, Assistive Technology, Home Accessibility Modifications and Vehicle Modifications

Note: These services are available in the Adult DD Waiver and the Children's Support Waiver.

These services are available to all Children's Support Waiver participants, and to Adult DD Waiver participants who are authorized for Home-Based Support Services (HBS). The cost of these services **is not** counted toward the monthly maximum. See Section III.E for more information about these services.

See Section VIII for prior approval requirements for these items.

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SECTION IV. INDIVIDUAL SERVICE PLAN

The development of a good comprehensive individual service plan is key to identifying the supports and services the individual needs and wants, assisting the individual to live successfully in the community, ensuring providers understand and fulfill their roles and responsibilities and ensuring funds are used in the best interest of the individual. The process must be as simple as possible so that all participants can understand their roles.

All three Waivers use a participant-centered planning approach directly involving the participant and the participant's guardian, if one has been appointed, as members of the service planning team along with the responsible case manager (also called a QMRP or Service Facilitator), direct service providers, Individual Service and Support Advocate (ISSA) and any other persons important to the participant (including family members where chosen by the participant).

The responsible case manager or Service Facilitator contacts the participant and guardian, if one has been appointed, prior to any service planning meetings to identify areas of concern, answer questions, and generally help them prepare for the meetings.

The responsible case manager or Service Facilitator convenes the service planning meetings. The case manager or Service Facilitator is responsible for ensuring that the written plan addresses the individual's needs and preferences and includes all required components. Below is a summary of service plan requirements:

A good individual service plan:

- Is a single, comprehensive document that prioritizes and structures the delivery of all services and supports across environments.
- Provides for supports and coordination for the participant to access school-based services (if applicable), generic resources and Medicaid State Plan services.
- Includes relevant and timely assessment information, including individual preferences, abilities and needs.
- Contributes to the continuous movement of the participant toward the achievement of the participant, family or guardian's preferences.
- Describes how opportunities of choice will be provided, including specifying means for:
 - Supporting the participant, family or guardian, if one has been appointed, to indicate preferences among options presented, by whatever communication methods necessary.
 - Providing the necessary support and training for the participant and family to be able to indicate preferences, including a description of any training and support needed to fully participate in the planning process and other choice making.
 - Assisting the participant, family or guardian to understand the negative consequences of choices that may involve risk.

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- Is based on assessed needs and individual preferences, including an annual ICAP or other children's functional assessment tool.
- Is based on principles of community inclusion and self-determination.
- Is designed to promote needed individual and family supports for individuals who live in a family home.
- Includes functional goals and methods to measure progress toward those goals.
- Identifies all services and supports to be provided, regardless of provider or funding source, including type, training methods if applicable, frequency, duration and staff assigned.
- Addresses such areas as communications, maladaptive or inappropriate behaviors, mobility/ambulation issues, basic self-care skills and vocational/self-sufficiency skills.
- Documents health needs and supports needed and/or provided, including doctor and dentist visits, medications, medication administration, self-medication training and oversight.
- Documents efforts to reduce reliance on psychoactive medications used for behavior management, unless contraindicated by clinical evidence.
- Identifies any specific circumstances when the individual may stay alone or access the community independently, if applicable.
- Includes activities to address any poor choices by the individual, either by minimizing the potential harm or explaining why choices cannot be honored safely.
- Includes name, title, credentials, agency affiliation and relationship to individual for all participants in service plan development.
- Is signed by the individual and guardian, the responsible case manager or Service Facilitator, all service providers and the Independent Service and Support Advocate (ISSA) to show their participation in the development of the plan.
- Is completed within 30 days of service initiation and is updated at least annually by the service planning team and is reviewed and revised as needed by the responsible case manager or Service Facilitator.
- May be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the participant, team, or provider; however, the plan must exist in written format.

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The responsible case manager or Service Facilitator must:

- Monitor the implementation of each participant's service plan:
 - At least monthly for participants in residential services
 - At least once every two months for participants in adult self-directed options and the Children's Support Waiver
- Revise the plan by following the same process as set out above, whenever necessary, to reflect changes in the participant's needs and preferences, achievement of goals or skills outlined within the plan or any determination made that any service being provided is unresponsive.
- Involve the ISSA in service plan development and problem resolution.
- Refer issues that cannot be resolved to the Division of Developmental Disabilities for technical assistance.

The responsible ISSA must:

- Actively participate in the development of the participant's service plan
- Assist the participant and guardian in actively participating in service plan development
- Indicate concurrence with the service plan through signature, work locally to resolve issues or, if all attempts at problem solution fail, refer issues to the Division of Developmental Disabilities for technical assistance.
- Monitor the implementation of each participant's service plan at least quarterly, and undertake follow-up activities as appropriate and necessary.

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SECTION V. SELF-DIRECTED SERVICES AND INDIVIDUAL BUDGETING

Note: This section applies only to the Adult DD Waiver and Children's Support Waiver.

A. SELF-DIRECTED SERVICES

Self-direction is available to all Children's Support Waiver participants, and to Adult DD Waiver participants who choose the Home-Based Support Services (HBS) option. Within established overall cost limits, these options are designed to give participants the opportunity to direct some or all of their services. Participants also have the option of receiving agency-directed services if they desire.

No more than **three** unrelated individuals with developmental disabilities may live in a single home. Homes will be located to promote inclusion of individuals in their neighborhoods and communities and to avoid concentrating individuals with disabilities in a single neighborhood or community.

The Adult DD Home-Based Support Services (HBS) option provides participant direction opportunities for participants who live in their families' homes or in homes the participants own or lease. The Children's Support Waiver supports participants in their families' homes.

All participants receive assistance in directing service delivery options from independent Individual Service and Support Advocates (ISSAs). Participants also receive assistance in paying domestic employees and certain service providers from a Fiscal Employer Agent.

Upon initiation of self-directed services, the Service Facilitator provides to the participant or guardian a manual that includes guidelines for selecting personal support workers, financial management services information, rights and responsibilities, and other Waiver requirements. The Service Facilitator and the ISSA assist the participant and guardian to understand the service options available under the Waiver, and review the information with participants at least annually as part of the service planning process.

The Service Facilitator documents the participant's choice of the type of supports and providers as part of the individual service plan. See Section IV, Individual Service Plan, for additional information about service plans. The Service Facilitator assists the individual to complete Service Agreements or Service Authorizations with each provider selected to work with the individual and gives copies of the Service Authorizations to the fiscal employer agent.

If at any time the participant or family voluntarily decides they no longer want to receive self-directed services, they can request agency-based services and supports. Typically, the individual must give 30-day advance written notice to the employee; however, this is not mandatory. The participant then selects a community agency to provide and direct Waiver services. Such changes are discussed among those responsible for service planning and the Service Facilitator documents agreed upon changes in the service plan and Service Agreements or Service Authorizations. The Service Facilitator gives copies of the revised Service Authorizations to the Fiscal Employer Agent.

If an investigation determines that the participant, participant's guardian, if one has been appointed, or participant's family committed fraud regarding self-directed program funds, the participant or family may be involuntarily restricted from self-directed services by the Division. This determination by the Division is subject to appeal to the Medicaid Agency. The outcome of the appeal process is final. In this event, agency-based services are made available and documented in the service plan.

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Please refer to Section III.F, Self-Directed Service Options, for additional information on Home-Based Support Services.

B. INDIVIDUAL BUDGETING

Upon being authorized for self-directed services, the participant, and family or guardian are informed in writing by the Division and in person by the ISSA about the overall cost limit, self-directed opportunities, and budget amount authority. Once services have begun, the Division, the Service Facilitator and the ISSA keep the participant and guardian informed of any adjustments to the overall amount.

- The monthly maximum budget for the Children's Support Waiver and Home-Based Support Services (HBS) is based on the service plan, but may not exceed the overall Waiver monthly cost limit.
 - For the Children's Support Waiver and for adults in HBS who are still in school, the monthly maximum is two times the Supplemental Security Income (SSI) amount.
 - For participants in HBS who are no longer in school, the monthly maximum is three times the Supplemental Security Income (SSI) amount.
- Excluded from the annual and monthly cost maximum calculations are Individual Service and Support Advocacy (ISSA) services, and tangible items such as accessibility modifications and adaptive equipment/assistive technology. These services and tangible items are subject to separate limits.
- Participants, guardians, Service Facilitators, fiscal employer agent and ISSA staff receive a rate chart that contains information on the statewide rates and any utilization limits by service type. The State updates the rate chart periodically when rate adjustments are implemented, based on State appropriations. Rate updates are published and included in the manual.

The service plan specifies the types of and amounts of covered services needed by the participant within the overall cost limits. Statewide rates apply for some services. For other services, the participant is given the authority, with help from the local Service Facilitator, to negotiate individual rates. Limits in spending are in place based on the monthly budget, and participants are encouraged by members of the service planning team to allocate authorized services throughout the month to avoid premature depletion of program funds.

A written Service Agreement is executed between the participant, the local Service Facilitator and each service provider (except domestic employees). For domestic employees, a Service Authorization is completed and sent to the fiscal employer agent instead. The Service Authorization is signed by the employer of record (the participant, guardian, or employer representative) and the Service Facilitator. The Service Agreement/Authorization defines the terms of the services to be provided including the effective date, the rate of payment, the maximum units of service to be provided each month and the maximum monthly charge.

All services provided must be for the direct benefit of the individual.

Service Facilitators assist participants and guardians to ensure that all services and service changes are within the monthly budget. Any adjustments must be within the participant's overall monthly service

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cost limit, and are allowed without prior approval by the State. Service Facilitators must share changes in Service Agreements/Service Authorizations with the Fiscal Employer Agent and ISSA for monitoring purposes.

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SECTION VI. PROVIDER REQUIREMENTS

A. Applicable Rules and Standards

Both federal and state rules and regulations governing Medicaid programs apply to services funded under the Medicaid Home and Community-Based Services (HCBS) Waivers. Table 4 provides the major rules for implementing Medicaid-funded home and community-based services. Also, click on Rules & Policies at www.dhs.state.il.us/ to access DHS rules.

Table 4: Rules for Implementing Medicaid-Funded Home and Community-Based Services

Rule No.	Rule Title	Adult	Children's Supports	Children's Residential
89 Ill. Adm. Code 140.11 and 140.12	Providers must be enrolled in and eligible to participate in the Illinois Medical Assistance Program.	X	X	X
DHS Rule 50	Office of the Inspector General: Investigations of Alleged Abuse or Neglect and Deaths in State-Operated and Community Agency Facilities. (59 Ill. Adm. Code 50) – for participants aged 18 and older only. Found at: www.ilga.gov/commission/jcar/admincode/059/05900050sections.html	X	X	X
DHS Rule 51	Office of Inspector General: Adults with Disabilities Abuse Project. (59 Ill. Adm. Code 51) – for participants aged 18 and older only. Found at: www.ilga.gov/commission/jcar/admincode/059/05900051sections.html	X	X	
DHS Rule 115	Community-Integrated Living Arrangements (CILA). (59 Ill. Adm. Code 115). Found at: www.ilga.gov/commission/jcar/admincode/059/05900115sections.html	X		
DHS Rule 116	Administration of Medication in Community Settings. (59 Ill. Adm. Code 116). Found at: www.ilga.gov/commission/jcar/admincode/059/05900116sections.html	X		X
DHS Rule 119	Developmental Training (DT). (59 Ill. Adm. Code 119). Found at: www.ilga.gov/commission/jcar/admincode/059/05900119sections.html	X		
DHS Rule 120	Medicaid Home and Community-Based Services Waiver Program for Individuals with Developmental Disabilities. (59 Ill. Adm. Code 120). Found at: www.ilga.gov/commission/jcar/admincode/059/05900120sections.html	X	X	X

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Rule No.	Rule Title	Adult	Children's Supports	Children's Residential
DoA Rule 240	Community Care Program. (89 Ill. Adm. Code 240). This rule governs Adult Day Care providers and is found at: www.ilga.gov/commission/jcar/admincode/089/08900240sections.html	X		
DPH Rule 370	Community Living Facilities (CLF). (77 Ill. Adm. Code 370). Found at: www.ilga.gov/commission/jcar/admincode/077/07700370sections.html	X		
DCFS Rule 401	Licensing Standards for Child Welfare Agencies. Found at: www.state.il.us/dcfspolicy/pr_policy_rules.shtml			X
DCFS Rule 403	Licensing Standards for Group Homes. Found at: www.state.il.us/dcfspolicy/pr_policy_rules.shtml			X
DCFS Rule 384	Behavior Treatment in Residential Child Care Facilities. Found at: www.state.il.us/dcfspolicy/pr_policy_rules.shtml			X
DCFS Rule 331	Unusual Incidents. Found at: www.state.il.us/dcfspolicy/pr_policy_rules.shtml			X
DCFS Rule 385	Background Checks. Found at: www.state.il.us/dcfspolicy/pr_policy_rules.shtml			X
325 ILCS 5	The Abused and Neglected Child Reporting Act (ANCRA) sets forth the requirements for reporting and responding to situations of abuse and neglect against children under the age of 18.		X	X
225 ILCS 64/25	Health Care Worker Background Check Act	X	X	X
HFS Rule 104	Practice in Administrative Hearings. (89 Ill. Adm. Code 104, Subpart A: Assistance Appeals). Found at: www.hfs.illinois.gov/lawsrules/index.html . Click on Rule 104.	X	X	X
210 ILCS 30/6.2	The Abused and Neglected Long Term Care Facilities Reporting Act. The implementing rules are found at 59 Ill. Adm. Code 50 (for incidents that occur on-site at a developmental disabilities-funded community agency) and 59 Ill. Adm. Code 51 (for incidents that occur in private homes or in non-licensed community homes).	X	X	X

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Rule No.	Rule Title	Adult	Children's Supports	Children's Residential
320 ILCS 20/	Illinois Elder Abuse and Neglect Act. Adult Day Care providers must be in compliance with these provisions.	X	X	X
405 ILCS 5	Mental Health and Developmental Disabilities Code. Prohibits providers from using any of the following interventions: seclusion (time-out in a locked room); withholding food and/or drink; electric shock stimuli; or punishment or discipline.	X	X	X
89 Ill. Adm. Code 384	Behavior Treatment in Residential Child Care Facilities			X
740 ILCS 110	Mental Health and Developmental Disabilities Confidentiality Act	X	X	X

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Providers must adhere to the additional standards in Table 5 for participating in the Home and Community-Based Services (HCBS) waiver programs.

Table 5: Additional Provider Standards

Provider Type	Standard
All providers	Meet Medicaid waiver provider enrollment requirements.
Adult residential and day programs PAS/ISSA providers Child Group Home agencies Service Facilitation agencies Personal Support Provider Agencies	Follow DHS Service Agreement/Contract and Contract Attachment A requirements. Contract and contract attachment language may be found at: www.dhs.state.il.us/serviceProviders/grantsContracts/ Specific provider requirements, such as licensure and certification requirements, staff background checks (criminal, Health Care Workers Registry, and CANTS) and staff training, are identified in Table 6 in Section VII of this manual.
Licensed Professionals	Comply with Department of Financial and Professional Regulation applicable regulations.
Medicaid Waiver Enrolled Providers	Ensure that entities and individuals who are excluded from participation in the Illinois Medicaid program do not serve as an employee, administrator, operator or in any other capacity. The HFS maintains a list of terminated or suspended providers and barred entities and individuals at the following website: www.state.il.us/agency/oig/sanctionlist.asp

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B. General Waiver Provider Requirements

1. Informing Individuals of Rights

This subsection outlines provider requirements for informing individuals about their rights regarding the waiver programs. See the Rights of Individuals (DD-1201) form and Notice of Individual Right to Appeal (DD-1202) for applicable individual rights.

a. Notification of General Waiver Rights

The responsible case manager or Service Facilitator must ensure and document that the participant and legal representative have received a complete explanation of their rights and responsibilities at the time of service initiation and upon request.

The service provider agency providing case management/Service Facilitation must maintain documentation of the notifications in the individual record. Documentation in the service provider's individual file that the Pre-Admission Screening/Individual Service and Support Advocacy (PAS/ISSA) agency has provided explanation of rights and responsibilities to individuals at service initiation as part of the Pre-Admission Screening process (PAS) is acceptable. The responsible case manager or Service Facilitator may use the Rights of Individuals (DD-1201) form or an equivalent signed notification form as long as it includes all the rights contained on the DD-1201.

b. Notification of Waiver Appeal Rights

The waiver right to appeal applies to eligibility determinations, as well as to denial, suspension, reduction or termination of covered waiver services.

The Pre-Admission Screening/Individual Service and Support Advocacy (PAS/ISSA) agency and responsible case manager/Service Facilitator must ensure and document that the individual and guardian have received an explanation of the rights and processes of appeal when waiver services are first initiated, upon request and as part of any notice of eligibility or service denial, suspension, reduction or termination. Documentation in the service provider agency's individual file that the PAS/ISSA agency has provided notification of appeal rights to the individual is acceptable.

Providers may use the Notice of Individual Right to Appeal (DD-1202) form, or an equivalent signed notice as long as it includes all rights to appeal, including the right to appeal to the HFS, to document in the individual record at the service provider agency that specific waiver appeal rights have been explained to the individual and guardian.

c. Notice of Action

The PAS/ISSA agency must provide the individual applying for or receiving waiver-funded services, and guardian if one has been appointed, a written notice of any determination or re-determination that the individual is not or is no longer waiver eligible. The responsible case manager/Service Facilitator must also provide the individual or guardian a written notice of any termination, exclusion, reduction or

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suspension of waiver services. Documentation that the notice of action has been sent must be maintained in the individual record.

Additional information about the required contents of the notice of action, process for making an appeal, grounds for appeal, time limits, circumstances when services must be continued pending the outcome of the appeal, and the Department of Healthcare and Family Services appeal process are contained in the waiver rule (59 Ill. Adm. Code 120.100 and 120.110).

2. Confidentiality Requirements

The responsible case manager/Service Facilitator must ensure and document that the individual or legal representative has been informed of confidentiality rights and has granted permission to release personal and program information for administrative purposes. Appendix 3, Release of Information (DD-1214), or an equivalent release may be used to document this permission. This release covers release of individual information, billing and claiming information and information needed for quality assurance monitoring, audits and waiver claims monitoring, as determined by DHS.

The release form must:

- Be signed by the participant or by the participant's legal representative, if one has been legally appointed.
- Have both a signature date and a specific termination date.
- Have a termination date that is no more than five years from the signature date.
- Be renewed so that there is always a current, valid release.

If a service provider must disclose confidential information for special purposes other than those directly related to waiver administration, the service provider must obtain specific prior permission from the participant or legal representative. The provider must also inform the persons to whom the provider furnishes the information that this material is confidential, is subject to the provisions of the Mental Health and Developmental Disabilities Confidentiality Act and, if applicable, the federal Health Insurance Portability and Accountability Act, and must be protected from further disclosure.

The service provider agency must maintain in the individual record copies of the current DD-1214, and other releases if applicable.

3. Termination/Changes in Services

Termination of waiver service authorizations requires Division of Developmental Disabilities approval and the decision is subject to waiver appeal rights. See Section VI.B for more information about appeal rights. Providers must inform individuals and guardians of their appeal rights and obtain Network staff approval prior to terminating waiver services to an individual. Providers must submit Appendix 20, Service Termination Approval Request (STAR), to the PAS/ISSA agency when requesting termination of service authorizations.

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The PAS/ISSA agency reviews and signs its approval of the termination and submits the STAR to the Division for approval.

Applicable program rules contain criteria for termination of a covered waiver service to an individual.

Additional criteria are:

- a. The individual was issued an award but did not initiate services with the timeframe specified in the award.
- b. The individual is being transferred to other waiver or non-waiver services, such as residential services, and the individual, guardian and the provider of other services have agreed upon the transfer. The Department may initiate or may request the PAS/ISSA agency to initiate a Service Termination Approval Request if necessary to terminate the waiver services no longer being received.
- c. The individual, guardian or family submits false information or engages in activity that results in misuse of funds.
- d. The individual, guardian or family fails to cooperate with necessary home visits by the responsible case manager or Service Facilitator or by ISSA or other state-approved monitors.
- e. The individual has not used waiver services for nine consecutive months. This requirement may be waived for extenuating circumstances and Division of Developmental Disabilities staff have approved an extension.
- f. The individual is no longer living in Illinois.

If an individual changes the type of waiver service or changes residential provider, the current provider must submit Appendix 20, Service Termination Approval Request (STAR), before the newly requested services can be approved and authorized. For example, for an individual leaving home-based supports (HBS) and moving to CILA, the home-based support services must be terminated officially before CILA services can be authorized and paid.

Submitting a Service Termination Approval Request **is not** necessary to change day program, home-based support service facilitation agency or therapy provider.

4. Assistance with Participant Benefits

a. Medicaid Enrollment

The PAS/ISSA agency and responsible case manager/Service Facilitator should assist the applicant, guardian or family in completing the forms and compiling the necessary documentation and background information, including the verification of income and assets, to apply for Medicaid and to maintain continuous Medicaid enrollment. The application may either be brought in or mailed to the local DHS Family Community Resource Center (FCRC) office, formerly known as the DPA/DHS local office.

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b. Re-determination of Medicaid Eligibility

The FCRC caseworker conducts re-determinations of Medicaid eligibility annually or as necessary. Responsible case managers or Service Facilitators and individuals are responsible for ensuring that enrollment is reauthorized in a timely manner. Providers **may not** be paid for covered waiver services during time periods when the individual's Medicaid enrollment lapses.

If necessary, providers are also responsible for completing Appendix 9, the Notice of DHS Community-Based Services (HFS-2653), to document for the DHS FCRC caseworker that the individual initially meets or continues to meet his/her Medicaid spenddown obligation.

For individuals who have spenddown obligations, DHS has developed a file transfer process to document a waiver participant's continuing spenddown met status. In most situations, this file transfer takes the place of the HFS-2653 after the first few months of service. The provider is responsible for completing the HFS-2653 in situations when the automated process does not have necessary information.

c. Re-Determination of Waiver Programmatic Eligibility

The Medicaid waiver requires an annual re-determination of individual waiver eligibility by the Individual Service and Support Advocate (ISSA), who is a QMRP and is independent of the providers of direct services. The re-determination must include a review of all eligibility factors. The purpose of the review is to verify continued eligibility for the Medicaid waivers and to establish continuing need for an ICF/DD level of service.

The ISSA must document results of this re-determination on Appendix 10, the Re-determination of Medicaid Adult DD Waiver Eligibility (DD-1213.1). The completed DD-1213.1 must be maintained in the Independent Service Coordination agency files, subject to periodic review.

The ISSA must also enter the annual waiver programmatic eligibility (active treatment) determination and date in the Reporting of Community Services (ROCS) software and transmit it to DHS in a timely manner. DHS will reject payment for ISSA services unless an annual re-determination has been transmitted within the past twelve months.

The Individual Service and Support Advocacy (ISSA) Guidelines contain specific guidance on these requirements and process.

d. Food Stamps

The DHS Family Community Resource Center (FCRC) determines Food Stamp eligibility. The responsible case manager or Service Facilitator should assist the applicant, guardian or family in completing the forms and compiling the necessary documentation and background information, including the verification of income,

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assets, shelter and medical costs, to apply for Food Stamps and to maintain Food Stamp eligibility.

e. Notifying DHS of Changes in Participant Status

The responsible case manager or Service Facilitator must notify the DHS Division of DD and the DHS Family Community Resource Center (FCRC) of the following changes in the individual's status:

- ***Change of address.*** Address changes are done on the client data in ROCS and by telephone/mail to the FCRC.
- ***Change in Social Security (SSI/SSDI) benefits or other earned or unearned income.***
 - Benefits and income changes must be done on the client income screen in ROCS and by telephone/mail to the FCRC, no later than five calendar days after the change.
 - DHS requires that SSI (SSDI) benefits received by individuals receiving residential services be applied toward the residential costs. Individuals may retain a monthly personal allowance.
- ***Death.*** Notification of death must be done on the Service Termination Approval Request (STAR) form, on the ROCS client data screen in ROCS and by telephone/mail to the FCRC, no later than five calendar days after the change. Deaths must also be reported to the Office of the Inspector General according to their requirements.

The responsible case manager or Service Facilitator must also notify the local Social Security Office of changes in address or earned income, of placement into or from a long-term care facility, including Intermediate Care Facility for Developmental Disabilities (ICFDD), state-operated facility and nursing facility, or death. Notification for individuals who receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits must be made as soon as possible to facilitate necessary updates or adjustments in the amount of the SSI or SSDI benefit.

Appendix 9, HFS-2653, may be used to notify the local DHS FCRC of changes in the costs of services, types of services or termination of services that affect the amount that may be applied toward the spenddown obligation. Notification of these changes must be made no later than five calendar days after the change.

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SECTION VII. PROVIDER ENROLLMENT AND QUALIFICATIONS

A. Waiver Provider Enrollment

1. Overview

All waiver agencies, individual providers and companies such as construction and transportation companies and equipment vendors must be enrolled with the Department of Healthcare and Family Services (HFS) as Medicaid Waiver providers to provide services under the HCBS waiver programs and be screened against the federal Health and Human Services excluded provider database. All licensed professionals, behavior analysts and personal support domestic employees must be enrolled individually. All providers must be established as Developmental Disability providers with the Department of Human Services. Establishment requires transmission of provider data in ROCS or through the Fiscal Employer Agent. Agencies providing services must work with Division Network staff to determine whether or not they require a formal Service Agreement/contract with the Department.

HFS enrolls all willing and qualified providers. HFS and DHS or the Financial Management Services entity, as authorized under a written agreement with HFS (the Medicaid Agency), maintain the provider agreements.

a. Licensed Professional Providers

Division staff check all professional licensure or registration status upon waiver enrollment. The State's Department of Financial and Professional Regulation (DFPR) licenses or registers Speech/Language Pathologists, Occupational Therapists, Physical Therapists, Clinical Psychologists, Clinical Social Workers, Marriage/Family Therapists, Clinical Professional Counselors, Professional Counselors, Registered Nurses, and Practical Nurses.

The Department of Healthcare and Family Services works with DFPR to assure that all licensed professionals are included in the database match between DFPR and the Medicaid Management Information System (MMIS) provider database. The database match is transmitted monthly between HFS and DFPR to verify ongoing provider licensure status. If the match finds that the licensure or registration has expired, the provider is disenrolled and the participant is assisted to find other service providers.

b. Non-Licensed Providers and Agency Staff

The State monitors non-licensed and approved providers such as personal support workers and behavior analysts through targeted desk reviews and on-site visits. The Division has specific training requirements for direct support workers who work for community agencies and ongoing continuing education requirements for Qualified Mental Retardation Professionals, including case managers and Service Facilitators. Direct support workers are trained via a protocol developed by the State or via one approved by the State as comparable.

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c. **Child Group Homes** (*Children's Residential Waiver only*)

The Department of Children and Family Services (DCFS), the State's child protective agency, licenses all community-based agencies providing Child Group Home services, based on regularly scheduled on-site surveys. In addition, DHS will monitor every two years that contractual requirements specified in the Child Group Home contract are met.

In addition to the information provided in this manual, information regarding provider qualifications and program guidelines is continuously available on the DHS website at the website in # 2 below. Information specific to Child Group Homes is continuously available on the Department of Children and Family Services website at: <http://dcfswebresource.prairienet.org/>.

2. **General Provider Enrollment Requirements**

Agencies that provide adult residential and day services, ISSA services, Child Group Home services, Home-Based Support Services Service Facilitation and Personal Support must have a DHS contractual service agreement. Copies of the standard DHS service agreement and contract attachments are available for viewing at:

www.dhs.state.il.us/serviceProviders/grantsContracts/.

All waiver service providers must complete the following required forms:

- Appendix 11: HFS Waiver Program Provider Agreement (HFS-1413A).

Note: Any waiver provider may choose to bill the Department of Healthcare and Family Services (HFS), instead of DHS. To do so, a provider must complete and sign the HFS Program Provider Agreement (HFS-1413) instead of the HFS-1413A prior to billing HFS.

- Appendix 12: HFS Provider Enrollment Application (HFS-2243).
- Appendix 13: Internal Revenue Service (IRS) W-9

These forms contain the terms and conditions of participation in the Medicaid Home and Community-Based Services (HCBS) waiver programs.

Domestic employees send the forms to the Fiscal Employer Agent for execution. Other providers send the forms to the DHS Medicaid Waiver Unit for execution.

B. Service-Specific Provider Requirements and Qualifications

Some waiver providers must meet specific requirements and qualifications in addition to those General Provider Enrollment requirements specified in the above subsection. Table 6 provides additional requirements and qualifications specific to providers by service type.

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Table 6. Summary of Specific Provider Qualifications and Credentials

No.	Program Name	Program Code	Required Provider Qualifications and Credentials
1.	Individual Service and Support Advocates (ISSA)	50D	<p>Individual Service and Support Advocacy must be provided by:</p> <ul style="list-style-type: none"> • Qualified staff of an independent agency that does not provide direct services. • Staff must be a qualified mental retardation professional as defined in federal ICFMR regulations. • Staff who have had required background checks. <p>Agencies must comply with:</p> <ul style="list-style-type: none"> • Requirements of the DHS contract and contract attachments. • Requirements of Rule 120, Medicaid Home and Community-Based Services Waiver Program for Individuals with Developmental Disabilities (59 Ill. Adm. Code 120) in serving individuals enrolled in the waiver programs. • Comply with the requirements of Rule 50, Office of Inspector General Investigations of Alleged Abuse or Neglect and Deaths in State-Operated and Community Agency Facilities. • Comply with the requirements of Rule 51, Office of Inspector General: Adults with Disabilities Abuse Project. • Comply with the requirements of DCFS Rule 331, Unusual Incidents, if serving children. <p>The <u>Individual Service and Support Advocacy (ISSA) Guidelines</u> contain specific guidance on the qualifications and responsibilities of the ISSA.</p>

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
2.	Residential Habilitation Services		<p>Providers of waiver residential habilitation must comply with the following, in addition to the items specific to each service type (i.e., CILA, CLF, Child Group Home or temporary intensive staffing):</p> <ul style="list-style-type: none"> • Requirements of the DHS contract and contract attachments. • Requirements of Rule 120, Medicaid Home and Community-Based Services Waiver Program for Individuals with Developmental Disabilities (59 Ill. Adm. Code 120) in serving individuals enrolled in the waiver programs. • The requirements of the Rule 116, Administration of Medication in Community Settings. • Comply with the requirements of Rule 50, Office of Inspector General Investigations of Alleged Abuse or Neglect and Deaths in State-Operated and Community Agency Facilities.
2.a	Community-Integrated Living Arrangement (CILA)	60D, 61D, 65H	Providers of Community-Integrated Living Arrangement (CILA) supports and services must be licensed under Rule 115, the CILA licensure rule (59 Ill. Adm. Code 115).
2.b	Community Living Facility (CLF)	67D	<p>All Waiver Community Living Facilities (CLF) Providers must:</p> <ul style="list-style-type: none"> • Be licensed by the Department of Public Health according to Rule 370 (77 Ill. Adm. Code 370), including requirements for reporting of deaths and allegations of abuse and neglect to the Department of Public Health. • Serve no more than 16 residents, be located in state and not be located on a campus setting.
2.c	Temporary Intensive Staffing provider	53D, 53R	Temporary intensive staffing providers must meet the qualifications to be a CILA or Developmental Training (DT) provider.
2.d	Child Group Home	17D	<p>Providers of Child Group Home services must:</p> <ul style="list-style-type: none"> • Be a licensed Child Welfare Agency (89 Ill. Adm. Code 401) with Child Group Home license (89 Ill. Adm. Code 403). • Comply with the requirements of the Unusual Incidents rule (89 Ill. Adm. Code 331) and Behavior Treatment in Residential Child Care Facilities (89 Ill. Adm. Code 384).

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
3.	Day Programs		<p>Providers of waiver day programs must comply with the following, in addition to the items specific to each service type (i.e., DT, SEP, Adult Day Care, At Home Day, Other Day):</p> <ul style="list-style-type: none"> • Requirements of the DHS contract and contract attachments. • Requirements of Rule 120, Medicaid Home and Community-Based Services Waiver Program for Individuals with Developmental Disabilities (59 Ill. Adm. Code 120) in serving individuals enrolled in the waiver programs. • Comply with the requirements of Rule 50, Office of Inspector General Investigations of Alleged Abuse or Neglect and Deaths in State-Operated and Community Agency Facilities. • Comply with the requirements of Rule 51, Office of Inspector General: Adults with Disabilities Abuse Project.
3.a	Developmental Training	31U, 31A	<p>Providers of Developmental Training (DT) services must:</p> <ul style="list-style-type: none"> • Be a certified Developmental Training (DT) provider under Rule 119, which governs Developmental Training (59 Ill. Adm. Code 119). • Be open and serving all enrolled individuals in DT at least five hours per weekday, and be open and providing services at least 240 days per year.
3.b	Supported Employment – Individual	39U, 36U	
3.c	Supported Employment – Group	39G, 36G	
3.d	Adult Day Care	35U	<p>Adult day care providers must:</p> <ul style="list-style-type: none"> • Have a current contract with the Department on Aging. • Must be in compliance with Rule 240, Community Care Program (89 Ill. Adm. Code 240).

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
3.e	Regular Work/ Sheltered Employment	38U	
3.f	At Home Day Program	37U	At Home Day Program providers must: <ul style="list-style-type: none"> • Have CILA licensure. • Be provided by the same agency as the individual’s residential services.
3.g	Other Day Program	30U	Other Day program providers must receive written approval to provide this service from the Division of Developmental Disabilities staff as part of the individual prior approval process.
4.	Professional Services		
4.a	Behavior Intervention and Treatment	56U	Behavior intervention and treatment providers must be one of the following provider types. A Level I provider must be a: <ul style="list-style-type: none"> • Licensed clinical psychologist, or • Nationally certified Behavior Analyst (certified by the Behavior Analyst Certification Board). A Level II provider must be a: <ul style="list-style-type: none"> • Nationally certified Associate Behavior Analyst (certified by the Behavior Analyst Certification Board), • Professional certified to provide Relationship Development Assessments, • Early Intervention Specialist with a Developmental Therapy credential or equivalent experience and training, or • Professional with a Bachelor’s Degree and who has completed at least 1,500 hours or training or supervised experience in the application of behaviorally-based therapy models.

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
4.b	Counseling – Individual and Group	57U, 57G	Behavior counseling providers must be one of the following: <ul style="list-style-type: none"> • Licensed clinical psychologist, • Clinical social worker, • Social worker, • Marriage or family therapist, • Clinical professional counselor, or • Professional counselor.
4.c	Psychotherapy – Individual and Group	58U, 58G	Psychotherapy providers must be one of the following: <ul style="list-style-type: none"> • Licensed clinical psychologist, • Clinical social worker, • Marriage or family therapist, or • Clinical professional counselor.
4.d	Physical Therapy	52P	Physical therapy providers must be one of the following: <ul style="list-style-type: none"> • A licensed physical therapist. • A licensed physical therapy assistant under the direct supervision of a licensed therapist enrolled as a Medicaid State Plan Provider and waiver provider. The assistant is not required to enroll in the Medicaid State Plan nor the waiver program. Services are billed by the licensed supervisor.

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
4.e	Occupational Therapy	52O	Occupational therapy providers must be one of the following: <ul style="list-style-type: none"> • A licensed occupational therapist. • A certified occupational therapy assistant under the direct supervision of a licensed therapist enrolled as a Medicaid State Plan Provider and waiver provider. The assistant is not required to enroll in the Medicaid State Plan nor the waiver program. Services are billed by the licensed supervisor.
4.f	Speech/Communication Therapy	52S	Speech therapy providers must be licensed speech/language pathologists.
5.	Self-Directed Services (Children’s and Adult Home-Based Support Services)		

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
5.a	Service Facilitation	55A	<p>Service Facilitation providers must:</p> <ul style="list-style-type: none"> • Be an agency that is in compliance with contractual requirements and that does not also provide Individual Service and Support Advocacy services. • Comply with the requirements of Rule 50, Office of Inspector General Investigations of Alleged Abuse or Neglect and Deaths in State-Operated and Community Agency Facilities. • Comply with the requirements of Rule 51, Office of Inspector General: Adults with Disabilities Abuse Project. • Comply with the requirements of DCFS Rule 331, Unusual Incidents, if serving children. • Employ or contract with staff who are professionals as defined in federal regulations as a Qualified Mental Retardation Professional (QMRP). All staff in this role must be QMRPs. • Employ or contract with staff who are approved by the Division of Developmental Disabilities as a QMRP and must meet the training requirements set by the Department for QMRPs. All staff in this role must meet these requirements. • Employ or contract with staff who pass Criminal Background, Health Care Workers Registry and CANTS (if working with children) checks completed by the employing agency prior to delivering Service Facilitation.

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
5.b	Personal Support	55D	<p>Personal Support Service providers must comply with the following:</p> <ul style="list-style-type: none"> • Agencies must be an entity that is in compliance with contractual requirements. • Agencies must have required all employees to pass Criminal Background and Health Care Workers Registry checks completed by the employing agency prior to delivering Personal Support. • Agencies providing services under the Children's Support Waiver shall require all employees having access to children (through age 17) to pass State Central Register (CANTS) and Illinois Sex Offender Registry checks prior to delivering Personal Support. • Agencies must require personal support workers to meet requirements for Direct Support Personnel training prior to providing Personal Support. • Domestic employees of the individual/guardian/employer representative must be aged 18 or older, have a high school degree or passed the Test for General Education Development (GED), and must be deemed by the individual's guardian or family to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the service plan. By signing the Service Authorization, the individual, guardian, or employer representative deems the domestic employee qualified and agrees to provide necessary training and supervision. • Domestic employees hired on or after July 1, 2007 must pass Criminal Background and Health Care Workers Registry checks prior to delivering Personal Support. If they are serving children (through age 17), they must also pass State Central Register and Illinois Sex Offender Registry checks prior to delivering Personal Support. • For the Children's Home-Based Support Services program, payment will not be made for Personal Support services by the participant's parents, guardian, siblings, aunts, uncles, first cousins, or grandparents, whether related by blood or marriage (in-laws) or through a step relationship. • For Adult Home-Based Support Services program, payment will not be made for Personal Support services by the spouse or child of the participant. Other relatives who provide Personal Support must meet the same standards as Personal Support workers who are unrelated to the participant. • For the Adult Waiver, there are special IRS requirements that apply if a guardian is also the domestic employee. Per the IRS, the same person cannot be both the employer and the domestic employee. An employer representative must be identified to take on the responsibilities of the employer of record. The representative can be anyone chosen by the participant or guardian who can sign the service authorization and time sheets.

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
5.c	Crisis Services	53C	Providers of Crisis Services must meet the same qualifications as Personal Support.
5.d	Nursing – RN	55N	Registered professional nurse licensed to practice in the State of Illinois
5.e	Nursing – LPN	55P	Licensed practical nurse under the direction of a registered nurse who is licensed to practice in the State of Illinois
5.f	Transportation (Non-Medical)	55T	<p>Non-Medical Transportation providers must:</p> <ul style="list-style-type: none"> • Have a valid driver’s license and be licensed to drive in Illinois. • Have proof of automobile liability insurance in accordance with State law. <p>Providers of non-medical transportation services may include enrolled providers who are:</p> <ul style="list-style-type: none"> • An agency that is approved to provide Service Facilitation or Personal Support services or domestic employees who are deemed by the individual, guardian or family to be qualified to provide Personal Support, or • Bus companies, taxi companies and other public transportation companies. <p>Employees of transportation companies are exempt from the Criminal Background check and Health Care Workers Registry check requirements and from training requirements.</p>
5.g	Emergency Home Response Services	55W	Company approved by the Department on Aging or the DHS Division of Rehabilitation Services to provide this service.

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No.	Program Name	Program Code	Required Provider Qualifications and Credentials
5.h	Counseling Services for Unpaid Caregivers	55C	Providers of counseling services for unpaid caregivers must be: <ul style="list-style-type: none"> • A licensed clinical psychologist, • A licensed clinical social worker, • A licensed social worker, • A licensed clinical professional counselor, • A licensed professional counselor, or • A licensed marriage and family counselor.
5.i.	Training Services for Unpaid Caregivers	55B	Providers of Training for Unpaid Caregivers must be training programs, workshops or events deemed qualified by the participant/guardian and approved by the Service Facilitator. Examples include CPR instruction, first aid, and programs on disability-specific topics such as epilepsy, autism, etc.
6.	Adaptive Equipment	53E	Approved vendor.
7.	Assistive Technology	53T	Approved vendor.
8.	Home Accessibility Modifications	53H	Approved company or worker.
9.	Vehicle Accessibility Modifications	53V	Approved vendor.

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C. Criteria for Provider Termination

The HFS Waiver Program Provider Agreement (HFS-1413A) includes the criteria for provider termination from waiver program participation. See Appendix 11 for a copy of the Agreement. Examples of criteria for provider termination are:

- The provider violates any of the terms and conditions of participation in the HFS Waiver Program Provider Agreement (HFS-1413A).
- The provider no longer meets the Medicaid waiver provider standards applicable for the service, for example, is no longer licensed by the Department of Financial and Professional Regulation or is no longer in compliance with licensure or contractual requirements.
- The provider is terminated or suspended by the HFS pursuant to 89 Ill. Adm. Code 104 and 140.
- The provider submits false, duplicate or fraudulent bills.
- The provider fails to notify the DHS promptly of overpayments of which the provider becomes aware or fails to reimburse the State promptly for any overpayments.
- The provider does not maintain adequate documentation of actual service delivery to support bills submitted.

For those providers required to sign a contract with the DHS, the DHS contract and contract attachments contain additional criteria for provider termination from program participation. Copies of the DHS contract and attachments are available on the DHS website at:

www.dhs.state.il.us/serviceProviders/grantsContracts/

Waiver participants may choose to terminate services from a particular provider at any time regardless of the cause above.

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SECTION VIII. SERVICE AUTHORIZATION AND PRIOR APPROVAL

A. General Requirements

DHS must authorize all waiver services. Waiver services may **not** be initiated for an individual before an award letter or written authorization from the DHS Division of Developmental Disabilities is received. The Department is **not** financially liable for services prior to the effective date of the award letter/written authorization.

Providers must submit the application information packets to the PAS/ISSA agency. PAS/ISSA agencies must submit application packets for the requested services to the Network Facilitator when requesting service authorization. Providers and PAS/ISSA agencies should address questions about service authorization to the Network Facilitators or Network Representatives.

The application packets include:

- CILA packets in accordance the CILA Individual Rate Determination Model User Guide
- Appendix 6, Application for Individual Service Authorization and packet for Home-Based Support Services (HBS), Developmental Training, Children's Support Waiver services, Child Group Home services, and other fee-for-service programs

Providers electronically transmit the following additional information to DHS Central Office **prior to** service authorization:

- The PAS/ISSA agency must transmit the determination that the individual meets the waiver eligibility criteria. The effective date on the Reporting of Community Services (ROCS) system is the date the determination was made as documented on the Determination of Developmental Disability and Associated Treatment Needs (DDPAS-5).

NOTE: DHS will not process fee-for-service bills for payment unless this information is transmitted timely, the SSN is correct and the effective date of the service authorization is on or before the service date on the bill.

- Providers must complete and transmit client case information in the Reporting of Community Services (ROCS) system.

NOTE: The provider must transmit acceptable client case information in ROCS before any fee-for-service programs may be paid.

Providers must complete the following forms at the time of initial service authorization and maintain them in the individual's file.

- Appendix 3, Release of Information (DD-1214), completed annually or as needed and maintained by the primary direct service provider. The primary provider is the agency that provides the primary case management or Service Facilitation services.
- Appendix 5, Notice of Individual Right to Appeal (DD-1202), or equivalent, completed as needed and maintained by the primary direct service provider.

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- Appendix 4, Rights of Individuals (DD-1201), or equivalent, completed as needed and maintained by the primary direct service provider.
- Appendix 2, Choice of Supports and Services (DD-1238), completed and maintained by the PAS/ISSA agency.

B. Prior Approval Requirements by Service Type

Some waiver services (Supported Employment, Adult Day Care, At Home Day Program, Other Day Program, Temporary Intensive Staffing, Occupational Therapy, Physical Therapy, Speech Therapy, Adaptive Equipment, Assistive Technology, Vehicle Modifications and Home Accessibility Modifications, and Crisis Services) have additional prior approval requirements. Prior approval requirements for each of these service types are detailed below.

The Department will mail an award letter or a denial letter with appeal rights with the results of its consideration of the prior approval request. The letters are sent to the participant, case manager/Service Facilitator, and ISSA agency.

1. Supported Employment

Participants in the Adult DD Waiver seeking waiver Supported Employment Program funding must **first** apply at the local district office of the DHS Division of Rehabilitation Services (DRS) to determine if they qualify for federal Vocational Rehabilitation (VR) funding. At the time of formal application for Vocational Rehabilitation funding, individuals should provide the VR counselor with documentation of their developmental disability, including the functional limitations caused by their disability.

If approved by the DRS counselor, the federal Vocational Rehabilitation program funds necessary short-term supported employment services. Only individuals for whom federal Vocational Rehabilitation funding is **not** available and individuals who have exhausted Vocational Rehabilitation funding for Supported Employment may request waiver funding for needed Supported Employment services.

Requests for waiver Supported Employment Program (SEP) funding must be submitted to Network staff and must include documentation that Vocational Rehabilitation funding for the individual is **not** available. Documentation may take one of **two** forms:

- Documentation from the DRS counselor that the individual is denied Vocational Rehabilitation services.
- Documentation from the DRS counselor that the individual needs to transition from short-term Vocational Rehabilitation-funded services to extended/long term services and that short-term Vocational Rehabilitation-funded services are being terminated.

2. Adult Day Care, At Home Day Program and Other Day Program

Requests for prior approval for Adult Day Care, At Home Day program, and Other Day programs must be submitted to Network staff. The prior approval requests must include:

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- a. An explanation of why the individual is appropriate for and needs these services, including diagnoses, age, health/medical issues and behavioral issues, if any.
- b. An explanation of why Developmental Training, Supported Employment or Regular Work/Sheltered Employment program options are not appropriate, including the individual's special needs that cannot be met by a traditional day program.
- c. Names of providers that were contacted and the reasons that each provider gave for declining to serve the individual. If applicable, include reasons why the individual or the individual's guardian rejected day programs.
- d. For At Home Day Program, an individual program plan that describes the services the individual will receive. The plan should provide a detailed weekly schedule that includes the time staff are directly working with the individual. If the individual has been rejected for or refuses to attend traditional day services, the plan should include goals that would transition the individual into an appropriate day program.
- e. For Other Day Program, the identity of the service provider, a general program plan, a description of the services to be provided to the individual and the qualifications of the entity providing the services.
- f. Statement of support for the request from the PAS/ISSA agency.

3. Temporary Intensive Staffing

Prior approval requests submitted to the Network Facilitator must include documentation of the individual's behavioral or medical needs for which Temporary Intensive Staffing is required.

4. Physical Therapy, Occupational Therapy and Speech Therapy

The Medicaid State Plan covers some therapy services for Medicaid beneficiaries. These services typically include assessments and short-term restorative services.

Adult DD Waiver participants may be eligible to receive additional long-term habilitative therapy services under the Waiver when prior approved. Therapy authorizations under the waiver are generally continued across state fiscal years as long as the individual needs and is receiving the service.

a. Therapy Services Received Under the Medicaid State Plan

The Medicaid State Plan, in addition to the Waiver Program, covers the following therapy services for Medicaid beneficiaries of all ages:

- Therapy evaluations as needed for individuals who are enrolled in Medicaid without prior approval. The Medicaid State Plan enrolled therapist does the evaluation and submits the bill directly to the Department of Healthcare and Family Services (HFS) according to HFS procedures.

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- Ongoing therapy services that are restorative in nature, such as those needed after an injury or hospitalization or other specific cause to restore the individual to a previous level of functioning. Prior approval from the HFS Bureau of Comprehensive Health Services is required before the Department of Healthcare and Family Services (HFS) will pay bills for ongoing physical therapy, occupational therapy and speech therapy services.

Questions about HFS Medicaid State Plan requirements and procedures should be directed to the HFS Bureau of Comprehensive Health Services at (217) 782-5565 or on the HFS website. Copies of the manuals for therapists that contain instructions and sample forms are available upon request from the HFS Provider Participation Unit at (217) 782-0538.

b. Prior Approval Requirements for Therapy Services Received Under the Adult DD Waiver

Waiver-funded physical therapy, occupational therapy and speech therapy services require prior approval from the Division of DD. The provider must submit the prior approval request to the Network Facilitator.

The provider **may not initiate** waiver-funded physical therapy, occupational therapy or speech therapy services for an individual before receiving written confirmation of service authorization. Questions about Division of DD service authorization should be directed to the Network Facilitators or Network Representatives.

A waiver prior approval request for up to **26 hours of therapy** per state fiscal year must include:

1. A completed and signed copy of Appendix 15, Medicaid Waiver Therapy Prior Approval Request form.
2. A signed and dated evaluation completed by a licensed physical therapist, occupational therapist or speech therapist. The evaluation must identify needed services and the reasons the individual needs the services because of chronic conditions related to his/her developmental disability. If HFS is terminating the individual from HFS-funded restorative services because the individual is making no further progress, the evaluation should include this information and a copy of the HFS denial of further services should be attached.
3. A copy of the physician's therapy order.
4. A HFS denial, only if the Division initially denied the requested therapy services as restorative and referred the individual to HFS. In such cases, the therapist may resubmit prior approval requests with documentation that the HFS has denied the services under the Medicaid State Plan.

A waiver prior approval request for up to **52 hours of therapy** per state fiscal year must include:

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- A completed and signed copy of Appendix 15, Medicaid Waiver Therapy Prior Approval Request form.
- A signed and dated evaluation completed by a licensed physical therapist, occupational therapist or speech therapist. The evaluation must identify needed services and the reasons the individual needs the services because of chronic conditions related to his/her developmental disability. If HFS is terminating the individual from HFS-funded restorative services because the individual is making no further progress, the evaluation should include this information and a HFS denial of further services should be attached.
- A letter from the physician describing the individual's needs and expected improvement due to the additional hours to justify why 26 hours of therapy are insufficient.
- A Department of Healthcare and Family Services (HFS) denial, only if the Division initially denied the requested therapy services as restorative and referred the individual to HFS. In such cases, the therapist may resubmit prior approval requests with documentation that the HFS has denied the services under the Medicaid State Plan.
- A copy of the current, complete, signed and dated individual service plan.

5. **Adaptive Equipment, Assistive Technology, Vehicle Modifications and Home Accessibility Modifications**

Waiver coverage for adaptive equipment, assistive technology, vehicle modifications and home accessibility modifications require prior approval. Equipment should **not** be purchased and work should **not** begin until an award letter has been received. The Department is **not** liable for any financial obligation for items purchased without an award letter or for funding beyond the amount in the award letter or from a vendor or contractor that is not enrolled as a Medicaid waiver provider.

The Department is a possible source of funding, but the Department is not a party to the contract for services between the participant, guardian and family and the vendor. Therefore, Department is **not** responsible for accepting the equipment or modifications from the vendor or contractor, nor is the Department responsible for enforcement of any warranty or the quality of workmanship provided by a contractor or vendor.

a. Prior Approval Criteria

1. General Approval Criteria

Adaptive equipment, assistive technology, vehicle modifications and home accessibility modifications must meet general criteria for prior approval. Requested equipment or modifications must:

- i. Be essential to address needs caused by the developmental disability and must be for direct benefit of the individual.

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- ii. Be necessary to prevent institutional placement, to deinstitutionalize an individual or to enable the individual to participate in specialized habilitative services for individuals with developmental disabilities. Quality of life enhancements that are not essential are not covered.
- iii. Increase independence and decrease reliance on supports and services provided by either paid or unpaid workers.
- iv. Be usable by the individual throughout the year and may not be for back-up or secondary use, except for back-up generators if necessary to ensure continuous operation of disability-related electrical equipment.
- v. Be the most cost effective way to address the developmental disability-related needs of the individual.
- vi. Be recommended as part of the individual service plan and be approved by the planning team.

General utility items or items perceived by the general taxpaying public as a luxury are excluded from coverage. See Section III.E for examples of items that **are not** covered.

2. **Additional Adaptive Equipment and Assistive Technology Approval Criteria**

In addition to the above general criteria, approval for adaptive equipment or assistive technology is also subject to the below criteria. Adaptive equipment and assistive technology must:

- i. **Not** be covered under the State Medicaid Plan. Waiver adaptive equipment is **not** available to meet medical needs such as requests related to diabetes, allergies, obesity or respiratory problems requiring oxygen and special medical equipment or supplies.
- ii. Be based on an assessment by a physician, physical therapist, occupational therapist or speech therapist, as appropriate to the disability, if DHS requests assessment information.
- iii. Be the property of the individual or the individual's family and be for the individual's use.

3. **Additional Home Accessibility Modifications Approval Criteria**

In addition to the above general criteria, approval for home accessibility modifications is also subject to the following criteria:

- i. Modifications must be in accordance with state or local building codes.

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- ii. For CILA homes, modifications must comply with the requirements of the CILA Start-Up Guidelines.
- iii. Homes must be the primary residence of the individual and the individual is expected to live in the home for a period of at least one year.
- iv. For rented or leased homes, individuals must have written permission of the landlord to make the modifications.

4. Additional Vehicle Modifications Approval Criteria

In addition to the above general criteria, approval for vehicle modifications is also subject to the following criteria:

- i. The vehicle must be the property of the individual or the individual's family and be for the individual's use.
- ii. The vehicle must be the individual's primary vehicle for basic transportation.
- iii. Vehicles that are five or more years old must have sufficient remaining useful life to justify the investment of the requested modifications.
- iv. Vehicle modifications will **not** be funded more than once in a five-year period. Replacement or repair of broken or worn out individual components of a lift mechanism may be considered on a case-by-case basis within the five-year period when not covered by a warranty or insurance.

Vehicle modifications do not include necessary general vehicle repairs, such as struts, shock absorbers, electrical system, tires, engine, transmission, muffler or, brakes or body work.

b. Prior Approval Request Submission Requirements

1. General Prior Approval Request Submission Requirements

The prior approval request must be submitted to your Network Facilitator and must include **all** of the following:

- i. A completed and signed copy of Appendix 16, Adaptive Equipment / Assistive Technology / Home and Vehicle Modification Request Cover Sheet.
- ii. A detailed description of the adaptive equipment, assistive technology, home accessibility modifications or vehicle modification and the reason they are necessary and related to the developmental

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disability. The description must address both specific and general criteria set forth above.

- iii. Two **detailed** cost estimates. Itemized costs must be given for all items requested or for each part of the modifications. For example, separate or itemize the costs for a roll-in shower, door widening and grab bars, as opposed to providing one estimate for bathroom accessibility remodeling.
- iv. Documentation that the responsible case manager or Service Facilitator and the Individual Service and Support Advocate (ISSA) have reviewed and recommend approval of the item.
- v. A Medicaid waiver enrollment packet for the equipment vendor or contractor, if not already enrolled. If the vendor or contractor is not yet known, the enrollment packet may be submitted after the award letter is received.

NOTE: Payment will **not** be made until the provider has completed the waiver enrollment process and HFS has processed the enrollment form.

- vi. Appendix 17, Payee Designation/ Authorization Form, if a payee agency will transmit bills using ROCS. If the vendor or contractor is not yet known, the payee designation form may be submitted after the award letter is received, but before the payee agency submits bills.
- vii. If approved, the Department will specify the lowest bid and least expensive option available. Please refer to Section VIII for additional information on purchasing more expensive items or modifications.

2. **Additional Prior Approval Submission Requirements for Adaptive Equipment, Assistive Technology or Vehicle Modifications**

In addition to the general submission requirements above, prior approval requests for adaptive equipment, assistive technology or vehicle modifications must also include:

- i. Information on whether the item is to be purchased, rented or repaired, and whether it is a new item or a replacement for a currently owned item.
- ii. Vehicle modification requests on vehicles that five or more years old must include an evaluation by a mechanic that determines the estimated remaining useful life of the vehicle.
- iii. A written denial from the Department of Healthcare and Family Services (HFS) for communication devices and wheelchairs. DHS

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may also require a written denial from HFS for other adaptive equipment or assistive technology.

- iv. A physician's order or an assessment by a physical therapist, occupational therapist or speech therapist, as appropriate to the disability and the item, if requested by DHS.

3. **Additional Prior Approval Submission Requirements for Home Accessibility Modifications**

In addition to the general submission requirements above, prior approval requests for home accessibility modifications must also include:

- i. Information on whether the individual owns, rents or leases the home.
- ii. Information on whether the modification is being done to an existing structure or if the home is all new construction.
- iii. Written permission from the landlord. The written permission must include a statement that the landlord understands the modifications are permanent and that the Department bears no responsibility for the home modification or for returning the building to its previous condition. The permission should also stipulate that the landlord will not change the rent due to the modifications.
- iv. Proof of home ownership if the home modification request exceeds \$5,000. For agency-owned or controlled homes, see the CILA Start-Up Guidelines for additional information.

6. **Crisis Services**

Prior approval requests must describe the reasons for the temporary absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause, such as hospitalization, illness, injury, or other emergency situation. Crisis Services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons.

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SECTION IX. WAIVER SERVICE RATES

The Department of Human Services establishes and approves waiver service rates, and the Department of Healthcare and Family Services, as the single state Medicaid agency, reviews and approves the rates. The Department of Human Services periodically adjusts the waiver service rates and funding for rate increases is subject to available funding.

The current Rate Chart is in Appendix 1.

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SECTION X. WAIVER SERVICE BILLING GUIDANCE

Bills for services delivered by contracted providers, most professionals and certain other entities are transmitted to DHS electronically through a File Transfer Protocol (FTP) process. Bills/timesheets for Personal Support services provided by domestic employees are sent to and paid by a fiscal/employer agent called Avenues to Consumer Employer Services and Supports (ACES\$). ACES\$ then transmits the paid bills to DHS through an FTP process.

A. Reporting of Community Services (ROCS)

Most providers and payees, including ACES\$, bill DHS for of waiver services using the fee-for-service billing software DHS provides free of charge, called the Reporting of Community Services (ROCS) system. Some providers use a functionally equivalent system of their own.

The ROCS system contains individual case information, provider information and billing information, including the results of DHS bill processing. The ROCS Manual contains instructions on how to use the system. Software updates and information are available on the DHS website at:

<http://www.dhs.state.il.us/mhdd/mh/repCommServices>.

Providers or payees may request the free ROCS software by following these two steps:

1. Complete Appendix 18, the Provider Information (DD-1246) form, and submit it to the Medicaid Waiver Unit at the address below.

DHS Division of DD Medicaid Waiver Unit
319 East Madison Street Suite 3M
Springfield, Illinois 62701
FAX (217) 558-2799

2. Request the software from the Office of Management Information Services (MIS) contacts listed below.

The ROCS Manual and periodic upgrades to the ROCS software are available on the DHS website: <http://www.dhs.state.il.us/mhdd/mh/repCommServices> or on diskette from the Office of Management Information Services (MIS). Providers can also contact MIS to receive ROCS technical assistance and ROCS basic agency software. Contact information for MIS is as follows:

Fax	(217) 524-0289
Telephone	(217) 785-9559
E-mail	rocs@dhs.state.il.us

B. Billing Submission Requirements

Domestic employees submit bills/timesheets directly to ACES\$ according to ACES\$ processing requirements.

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Bills from other providers and ACES\$ are processed for payment weekly by DHS. The deadline for receipt of File Transfer Protocol (FTP) transmissions is 5:00 PM on Mondays. Files received after that date will be processed the following Monday.

Bills for services delivered during a state fiscal year must be received, processed and accepted for payment by DHS before the end of the lapse period (typically early August) following the end of the state fiscal year for prompt payment. Providers may submit late bills to the Department and, if approved, then to the Illinois Court of Claims for payment.

1. General Requirements for Using File Transfer Protocol (FTP)

Providers use the ROCS software or their own software to report via File Transfer Protocol (FTP). The following providers are required to transmit bills via FTP:

- a. Agencies that have contracts with the DHS Division of Developmental Disabilities (except Adult Day Care).
- b. Payees that submit bills for eight or more individuals.
- c. ACES\$ for bills for reimbursement for payments to domestic employees

2. Paper Billing to DHS for Qualified Providers

Providers, except domestic employees, that do not have the ROCS software and serve fewer than eight individuals may submit paper bills monthly to the DHS address below. Appendix 19 provides copies of the billing forms and instructions.

Programmatic Vouchering Unit
DHS Office of Clinical, Administrative and Program Support
401 North 4th Street 2nd Floor
Springfield, IL 62702

Note: **New providers** must include their telephone number and attach a copy of the IRS W-9 to the first paper bill submitted to expedite payment.

3. Audit Trail Requirements

The service provider is responsible for submitting complete and accurate billings and for maintaining appropriately detailed documentation and audit trail information. Service providers must maintain documentation on file for at least six years from the date of service to establish an audit trail. Audit trail documentation and notes are subject to review by state staff or their designees. Documentation includes:

- a. Residential attendance records that are completed daily on-site and specify whether or not the individual was present or, if absent, identify the type of bedhold.
- b. Day services attendance records completed daily on-site and must include the number of hours each individual was actively involved in program activities during the day, start and end times, time out for lunch unless it is part of active programming, and any time spent not participating in program activities (such as a doctor's or therapist's appointment in the middle of the day). Day services cannot be billed at the same time that other waiver services (such as therapy, counseling, etc.) are being

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delivered and paid. See Appendix 22 for sample recommended day program timesheets.

- c. For services billed and paid on an hourly basis other than day program (ISSA, service facilitation, behavior services, therapies and personal support), staff logs must include the number of hours and minutes provided and the date and time of services to each individual. Progress and other case or activity notes should also support the hours billed.

4. Required Information When Submitting Bills

Providers must provide the following information when submitting bills for payment (please note applicability to ROCS system and paper billing submissions):

- a. **Social Security Number.** Providers must use the correct individual Social Security Number (SSN) in the Reporting of Community Services (ROCS) system and on all paper bills. PAS/ISSA agencies must also transmit the correct SSN when they transmit assessment and eligibility determination information. The SSN used must match the SSN on the Medicaid Management Information System (MMIS). The DHS Family Community Resource Center caseworker maintains the MMIS.

If the SSN in ROCS does **not** match MMIS, the provider must either do a Change Client ID in ROCS or work with the DHS Family Community Resource Center caseworker to correct the SSN in MMIS.

- b. **Recipient Identification Number (RIN).** Providers must enter the correct and current individual Recipient Identification Number (RIN) on the Reporting of Community Services (ROCS) client case information.
- c. **Individual Name.** Providers must enter the individual's name in ROCS exactly as it appears on the Medicaid card and enrollment in MMIS.

PAS/ISSA agencies must also transmit the individual's correct name when they transmit assessment and determination information. The name must match MMIS exactly.

If the name in ROCS does **not** match MMIS, the provider must either change the name in ROCS or work with the DHS Family Community Resource Center caseworker to correct the name in MMIS.

If the Social Security Number and Recipient Identification Number are not identical and correct in all databases, or if the name is different on ROCS and MMIS, the provider will **not** be paid for covered waiver services.

5. Payee and Alternate Payee Information

The individual service providers (except domestic employees who are paid by ACES\$) may designate an alternate payee to receive the payment or may choose to receive the payment

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directly from the state, consistent with federal and state Medicaid requirements as set out in 89 Ill. Adm. Code 140.24.

The individual service provider **must not** designate the individual or the individual's guardian or family as the payee. Doing so is contrary to Medicaid requirements and may have tax consequences for the individual, guardian or family.

To designate an alternate payee, the service provider must complete and submit Appendix 17, Payee Designation/ Authorization Form, signed by the provider and by the alternate payee and covering the dates of the services. This form must be renewed at the start of each state fiscal year.

The service provider must mail completed Payee Designation/Authorization Forms to the address below:

DHS Division of DD Medicaid Waiver Unit
319 East Madison Street Suite 3M
Springfield, Illinois 62701
FAX (217) 558-2799

Only a formally designated payee may submit bills for another service provider, except the fiscal employer agent will pay and transmit claims on behalf of domestic employees.

All payees must be established with DHS and the Office of the Comptroller. See Appendix 13 for required form, Request for Taxpayer Identification and Certification (IRS W-9), and instructions.

Service providers that do not wish to receive payment directly from the State do not need to complete an IRS-W-9.

For domestic employees, the fiscal employer agent (ACES\$) will issue a W-2 at the end of each calendar year. For other providers or payees who require one, the State will issue an IRS-1099, miscellaneous income form, at the end of each calendar year.

6. General Utilization Guidance

Table 7 provides information for billing/service reporting by service type.

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Table 7: Billing Guidance by Service Type

Service	Program Code	Maximum Allowables and Units	Additional Guidance
Individual Service and Support Advocacy	50D	<ul style="list-style-type: none"> • Maximum Allowable: 25 hours per fiscal year, unless a written extension request is submitted and approved • Units: Hours and minutes rounded to the nearest 15 minutes. 	<p>Billable time includes:</p> <ul style="list-style-type: none"> • Participating in service plan development and monitoring • Visiting individuals, including travel time • Completing and filing required documents, such as the annual Re-determination of Waiver Eligibility and visiting notes • Telephone calls on behalf of the individual <p>See the ISSA Guidelines for more specific information</p> <p>Non-Billable time includes:</p> <ul style="list-style-type: none"> • Time spent assessing or determining initial eligibility of an individual for waiver services • Required follow-up visits during the first 30 days after service initiation • Time spent providing a service to an individual or family after the individual is no longer receiving the direct waiver service • QMRP training time or other general activities that are not for the direct benefit of the waiver participant; and • Time spent entering billing in ROCS

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Residential Services			
CILA: Individual Rate Model (may be 24-hour, host family, intermittent or family)	60D	<ul style="list-style-type: none"> • Maximum Allowable: 365 days per fiscal year (366 in leap year) • Units: Per Diem 	<p>For Program Codes 60D, 61D and 67D, providers should:</p> <ul style="list-style-type: none"> • Bill daily for every date the individual is present and receiving services in the residential site for at least part of the date (the date is considered to be from midnight to midnight). Use the code: P - present • Bill daily for intermittent and family CILA services, this also includes dates when only on-call availability of services was provided. Use the code: P - present • Bill Bedhold Days using the following bedhold codes: <ul style="list-style-type: none"> - F – vacation or family/home visits - H – hospitalization - C – convalescent care - S – State-operated facility stays - I – incarceration • For 60D, see the CILA rule, Ill. Adm. Code 115.15 c and the CILA Rate User Guide for additional guidance on CILA bedhold limitations. • For all, see the ROCS Manual for guidance on behold coding.
CILA: Non-Rate Model	61D		
Community Living Facility (CLF)	67D		
Child Group Home	17D		

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Hourly Intermittent CILA	65H	<ul style="list-style-type: none"> • Maximum Allowable: Agency funding maximum per fiscal year, no individual unit maximum. • Units: Hours and minutes rounded to the nearest 15 minutes. 	Only actual one-on-one staff hours of direct service are billable.
Temporary Intensive Staffing	53R 53D	<ul style="list-style-type: none"> • 53R is staffing in a residential setting. 53D is staffing in a DT setting. • Maximum Allowable: Temporary, one-to-one staffing, usually in 240-hour increments. • Units: Hour and minutes rounded to the nearest 15 minutes. 	Only actual one-on-one staff hours of direct service are billable.

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Day Programs			
General Guidance for All Day Programs	N/A	<p>Maximum Allowable:</p> <ul style="list-style-type: none"> • For participants in Home-Based Support Services, day programs are included in the participant’s monthly cost limit/individual budget. • State fiscal year maximum of 1,100 hours for any combination of day programs. • Monthly maximum is 115 hours for any combination of day programs. • Units: Client hours and minutes of individual participation. Minutes may be rounded to the nearest 15 minutes. • The payment rates include transportation costs. 	<ul style="list-style-type: none"> • The State designed day program rates to include an absentee factor to pay for a full State Fiscal Year of participation in the first 1,100 hours of billing. An individual may be absent 20 of the expected 240 days without reduction in annual payment amount. • Only hours when the individual is participating actively in day program activities are billable. • Hours when the individual is not participating in the program are not billable. Examples of time that are not billable include: <ul style="list-style-type: none"> – Holidays and weekends when the program is closed. – Time beyond regularly scheduled program hours for special events, such as extended field trips, overnight outings, etc. – Transportation time, unless the individual’s service plan indicates a need for transportation training and the training is being provided. – Time between arrival and the start of active programming. – Time after the end of active programming while waiting for transportation. – Lunchtime, unless the individual’s service plan indicates a need for active programming during lunch and the training is being provided. – Time spent receiving therapy services. Day program hours may not be billed when an individual is receiving direct professional behavior services or other non-day program services.

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Developmental Training	31A, 31U		
Supported Employment – Job Coach - Individual	39U		<p>For all Supported Employment Services:</p> <ul style="list-style-type: none"> • Hours billed may not also be billed to the Division of Rehabilitation Services Vocational Rehabilitation Program. • Paid supported employment bills will automatically be counted toward the Grant-in Aid Program (390 Program Code) for variance purposes. Billing these fee-for-service program codes and also service reports to program 390 for the same service time is not necessary. • When Supported Employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.
Supported Employment – No Job Coach - Individual	36U		
Supported Employment – Job Coach – Group	39G		
Supported Employment – No Job Coach – Group	36G		
Adult Day Care	35U		
At Home Day Program	37U		
Regular Work/Sheltered Employment	38U		Paid Regular Work/Sheltered Employment bills will automatically be counted toward the Grant-in Aid Program (380 Program Code) for variance purposes. Billing this fee-for-service program code and also service report to program 380 for the same service time is not necessary.
Other Day Program	30U		

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Behavior Services			
Behavior Services			<p>For all behavior services, therapists may bill for services that directly benefit the individual, that are within the statewide maximums and the agreed hours in the HBS Service Agreement, if applicable, and that the therapist delivered and documented.</p> <p>Behavior service hours may not be billed during day program hours, unless the professional is observing the behaviors in the natural environment while the individual is participating as usual in the day program.</p>

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Behavior Intervention and Treatment	56U	<p>Maximum Allowable:</p> <ul style="list-style-type: none"> • For Home-Based Support Services, Behavior Intervention and Treatment is included in the participant’s monthly cost limit/individual budget • Adult DD Waiver: State fiscal year maximum of 66 hours (including adult HBS). • Children’s Support Waiver (Children’s HBS): No fiscal year service maximum. • Children’s Residential Waiver: State fiscal year maximum of 66 hours. • Units: Hours and minutes rounded to the nearest 15 minutes. <p>The two levels are:</p> <p>Level 1 – For licensed clinical psychologists and certified behavior analysts</p> <p>Level 2 – For all other qualified providers</p>	No direct services may be delivered under the Waiver during the typical school day relative to the age of the participant or during times when educational services are being provided. Indirect services such as writing recommendations, planning and consultations with school personnel are permitted. Planning for school services and training for school staff may not be included.
Individual Counseling	57U	<ul style="list-style-type: none"> • Maximum Allowable: 60 hours per SFY of combined psychotherapy/ counseling • Units: Hours and minutes rounded to the nearest 15 minutes. 	Time billed may not also be billed to the Division of Mental Health Community Mental Health Medicaid Rehabilitation Option or Clinic Option (MRO/MCO).
Group Counseling	57G		
Individual Psychotherapy	58U		
Group Psychotherapy	58G		

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Therapies			
Physical Therapy	52P	<ul style="list-style-type: none"> • Maximum Allowables: 26 hours, or 52 hours with justification per state fiscal year for each therapy. • Units: Hours and minutes rounded to the nearest 15 minutes. 	<ul style="list-style-type: none"> • The therapist may bill for time spent working directly with the individual or, for occupational and physical therapy, the time a certified/licensed assistant under his or her direct supervision spends working directly with the individual in accordance with the individual service plan. Direct supervision means that the therapist is accessible at all times while the assistant is treating individuals. It also means that the therapist does on-site supervision every four to six sessions to assess progress and revise the treatments as needed. • Billable time includes: <ul style="list-style-type: none"> – Time spent with the individual demonstrating specific interventions to be used by family, direct support and other workers to ensure they will be done properly and frequently enough to be effective. – Participation in development of the individual service plan. • Non-billable time includes: <ul style="list-style-type: none"> – Time spent by the therapist supervising assistants. – Time spent in general staff training – Evaluations, including evaluations for equipment or fittings, may not be billed to the Division of DD. They must be billed to the Department of Healthcare and Family Services Medicaid State Plan instead. – Transportation time. – Time when the individual is receiving therapy services is not billable as day program services. – Time billed to the Department of Healthcare and Family Services for the service.
Occupational Therapy	52O		
Speech Therapy	52S		

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Adaptive Equipment, Assistive Technology, Home Accessibility Modifications and Vehicle Accessibility Modifications			
<p>General Guidance for all Items</p>		<p>Maximum Allowables:</p> <p>For Home-Based Support Services (HBS), this service is not included in the participant’s monthly cost limit/individual budget.</p> <p>For all three waivers, a \$15,000 maximum per individual per five-year period applies for any combination of adaptive equipment, assistive technology, home modifications and vehicle modifications, as applicable.</p>	<ul style="list-style-type: none"> • If an item or modification is approved for a specific purchase price, the vendor or contractor must accept the State payment as payment in full for that item or request as required by federal Medicaid regulations. The individual, the guardian, family members or the service provider may not supplement the State payment for the item or modifications approved. They may choose to purchase the item or modifications from a different vendor. • If the individual wishes to purchase a more expensive model than the one approved or if the modifications are more extensive than those approved, the individual, the guardian, family members or the service provider may pay additional private funds to cover the difference between the enhanced model purchased or modifications completed and the model/modifications approved for State Medicaid funding. • All work or items must be furnished or completed before the end of the state fiscal year in which the award was issued. Any award for adaptive equipment, assistive technology, vehicle modifications or home modifications is valid only during the state fiscal year (July 1 – June 30) specified on the award letter. If equipment delivery or modifications cannot be completed before the end of the state fiscal year in which the award was issued, the provider must notify the Department in writing. When network staff receive the notice, they will arrange for the award to be changed to the next state fiscal year.

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Adaptive Equipment	53E		For Program Codes 53E, 53T, 53H and 53V: <ul style="list-style-type: none"> • Home modifications to a home that is controlled by a waiver residential provider do not count toward the annual maximum for the individuals who reside there. • Vehicles owned or operated by residential or day program providers are not eligible for waiver-funded vehicle modifications. Transportation costs are covered in the residential or day program rates.
Assistive Technology	53T		
Home Accessibility Modifications	53H	Within the five-year maximum, there is also a \$5,000 maximum per address for permanent home modifications for rented homes.	
Vehicle Accessibility Modifications	53V		
Self-Directed Services (Home-Based Support Services and Children's Support Waiver)		<p>Maximum Allowable:</p> <p>Except as noted below, these services are included in the participant's monthly cost limit/individual budget.</p>	<p>Providers may only bill for services that are:</p> <ul style="list-style-type: none"> • For the direct benefit of the individual • Documented on the individual service plan • Within the statewide maximums (if applicable) • Within the agreed hours in the service agreement/service authorization • Delivered and documented

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Service Facilitation	55A	<p>No specific service maximum.</p> <p>Unit: Hours and minutes rounded to the nearest 15 minutes</p>	<p>The individual service plan/service agreement must set aside at least two hours per month to allow for routine required administrative activities.</p> <ul style="list-style-type: none"> • The hourly payment rate includes funding for both billable Service Facilitation direct service hours and necessary administrative expenses. • Billable services include: <ul style="list-style-type: none"> - On-site visits - Face-to-face time - Service planning and monitoring - Provider recruitment, enrollment and orientation to the program - Paperwork and telephone contacts - Counseling/training time with the family/informal supports upon request - Travel time (excluding commuting) - Advocacy regarding benefits and services, such as Medicaid. • Non-billable services include: <ul style="list-style-type: none"> - Commuting travel time (to and from the worker's home). - QMRP training (The Division of Developmental Disabilities Bureau of Human Resource Development reimburses for this cost separately). - General activities that are not for the direct benefit of the specific HBS participant. - Time spent by other staff at the Service Facilitator's agency (billing, payroll, etc.).

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Personal Support	55D	<p>Maximum Allowable: None.</p> <p>Unit: Hours and minutes rounded to the nearest 15 minutes</p>	<ul style="list-style-type: none"> • The individual, the guardian if one has been appointed, the service provider and the service planning team may negotiate mutually acceptable rates for Personal Support. The service authorizations must include the rates. • For domestic employees paid by ACES\$, payment for Personal Support is considered to be earned income for services delivered and therefore is considered to be taxable income. • Payment will not be made for Personal Support services provided by persons who do not meet provider qualifications. See Section VII Table 6 for requirements and restrictions on certain relatives. • Billable services include: <ul style="list-style-type: none"> – Face-to-face time. – Participation in service planning. – Writing progress notes. – Consulting with the Service Facilitator about the individual’s situation or services.

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Crisis Services	53C	<p>Maximum Allowables:</p> <ul style="list-style-type: none"> • This service is not included in the participant’s monthly cost maximum. • Crisis Services may not exceed \$2,000 in any single month and may not be authorized for more than 60 consecutive days. • Units: Hours and minutes rounded to the nearest 15 minutes 	<p>No Crisis Services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.</p> <p>Billable Crisis Services are the same as Personal Support.</p>
Nursing	55N - RN 55P - LPN	<p>Maximum Allowables:</p> <ul style="list-style-type: none"> • No more than 365 hours per state fiscal year for RN services • No more than 365 hours per state fiscal year for LPN services. • Units: Hours and minutes rounded to the nearest 15 minutes. 	<p>Billable services include:</p> <ul style="list-style-type: none"> • Face-to-face time. • Participation in service planning. • Writing progress notes. • Consulting with the Service Facilitator about the individual’s situation or services. • Consulting between the registered nurse and the licensed practical nurse as required for supervision. • Consulting with the physician regarding medical care.

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Emergency Home Response Services	55W	<p>Maximum Allowable: The State has not set a specific service maximum.</p> <p>Unit: Event mode. The two payment levels are: Level 1 - One-time installation cost Level 2 - Monthly service charge</p>	

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
Transportation (Non-Medical)	55T	<p>Maximum Allowable: No more than \$500 of the monthly cost limit may be used for non-medical transportation services.</p> <p>Unit: Event mode</p> <p>The payment rate for non-medical transportation is either the standard amount billed by the company or an amount based on the mileage rate set by the State for transportation.</p>	<ul style="list-style-type: none"> • Payment for Non-Medical Transportation services is considered to be earned income for services delivered and therefore is considered to be taxable income. • Billable services include: <ul style="list-style-type: none"> – Transporting the individual to and from places where needed services identified in the individual’s service plan are delivered. • Non-billable services include: <ul style="list-style-type: none"> – Transportation services provided by the spouse or child of the HBS participant. – Traveling when the individual is not in the car, such as to the place where the individual is picked up or from the place where the individual is dropped off. – Routine trips to activities in which other members of the individual’s family also participate, such as family outings, visits to friends or family, church or shopping trips. – Transportation to and from a day program may not be billed as non-medical transportation. The day program payment rate includes funding for transportation costs.
Counseling Services for Unpaid Caregivers	55C	<p>Maximum Allowable: The State has not specified a service maximum.</p> <p>Unit: Hours and minutes rounded to the nearest 15 minutes.</p>	
Training for Unpaid Caregivers	55B	<p>Maximum Allowable:</p>	

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Service	Program Code	Maximum Allowables and Units	Additional Guidance
		<p>The State has not specified a service maximum.</p> <p>Unit: Event mode</p> <p>The payment amount for training is the standard fee billed by the provider</p>	

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SECTION XI. USEFUL CONTACT INFORMATION

Department of Human Services (DHS)

Website	www.dhs.state.il.us
Toll-Free Number (voice)	(800) 843-6154
Toll-Free Number (TTY)	(800) 447-6404
PUNS toll-free number	(888) DDPLANS or (888) 337-5267
PUNS Website	www.DD.Illinois.gov

DHS Division of DD - Springfield
319 East Madison (Suites identified below)
Springfield IL 62701

Network Staff (Suite 2M)	(217) 524-2515
Community Reimbursement (Suite 2L)	(217) 782-0632
Medicaid Waiver (Suite 3M)	(217) 782-3719
Training (Suite 4J)	(217) 782-9438
Quality Assurance and System Improvement (Suite 2A)	(217) 782-2989

DHS Division of DD – Chicago
100 West Randolph St. Suite 6-400
Chicago IL 60601

DHS Management Information Services

ROCS Help Desk	(217) 785-9559
ROCS FAX	(217) 524-0289
ROCS E-mail	rocs@dhs.state.il.us
ROCS Software Upgrades, FTP and Manual	www.dhs.state.il.us/mhdd/mh/repCommServices

DHS Vouchering	(217) 557-6076
DHS Bureau of Accreditation, Licensure and Certification	(217) 557-9282
Both at: 401 North 4 th Street Springfield IL 62702	

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Department of Public Health – Health Care Worker’s Registry Personal Assistance	www.idph.state.il.us/nar (217) 785-5133
Department of Healthcare and Family Services Provider toll-free number and website to verify Medicaid enrollment MEDI Website	(800) 842-1461 www.myhfs.illinois.gov/
Illinois Office of the Comptroller (To set up direct deposit)	(800)-877-8078 (217) 557-0930
Doral Dental	(888) 286-2447
HIPAA National Provider ID#	(800) 465-3203