

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Supports for Participant Direction	Information and Assistance in Support of Participant Direction
Other Service	Adaptive Equipment
Other Service	Assistive Technology
Other Service	Behavior Intervention and Treatment
Other Service	Home Accessibility Modifications
Other Service	Personal Support
Other Service	Temporary Assistance
Other Service	Training and Counseling Services for Unpaid Caregivers
Other Service	Vehicle Modifications

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12020 information and assistance in support of self-direction

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Information and Assistance in Support of Participant Direction assists the participant (or the participant’s family or representative, as appropriate) in arranging for, directing and managing services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal support workers, managing workers, and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant

or family is specified in the service plan.

ISC agencies may not employ persons who may also provide this waiver service or other waiver services to participants.

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

This service is included in the participant's annual cost maximum. see Appendix C-4. There is no specific service maximum.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-based agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Information and Assistance in Support of Participant Direction

Provider Category:

Agency

Provider Type:

Community-based agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Entity under contract with the Operating Agency that does not also provide Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Intellectual Disabilities Professional.

ISC agencies may not employ persons who may also provide this waiver service or other waiver services to participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (DHS)

Frequency of Verification:

Upon enrollment and annually

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C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adaptive Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
▼	▼
Category 2:	Sub-Category 2:
▼	▼
Category 3:	Sub-Category 3:
▼	▼
Category 4:	Sub-Category 4:
▼	▼

Service Definition (Scope):

Adaptive equipment, as specified in the plan of care, includes (a) devices, controls, or appliances that enable participants to increase or maintain their ability to perform activities of daily living; (b) devices, controls or appliances that enable participants to perceive, control, access or communicate with the environment in which they live; (c) such other durable equipment not available under the State plan that is necessary to address participant functional limitations; and (d) necessary initial training from the vendor to use the adaptive equipment.

Items reimbursed with Waiver funds do not include any equipment and supplies furnished by the school program or by the 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. All purchased items shall be the property of the participant or the participant's family.

The cost of the service may include the performance of assessments to identify the type of equipment needed by the participant.

The cost of the service may include training the participant or caregivers in the operation and/or maintenance of the equipment. This service is subject to prior approval by the Operating Agency.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

This service is not included in the participant's annual cost maximum.

There is a \$15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications, and vehicle modifications. See Appendix C-4.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Equipment

Provider Category:

Agency

Provider Type:

Equipment Vendors

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled vendor approved by the waiver case manager and participant/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes --

(A) the evaluation of the assistive technology needs of a participant, 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:

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) 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 support plan;

(E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

(F) 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.

Items reimbursed with Waiver funds do not include any assistive technology furnished by the school program or by 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. All purchased items shall be the property of the participant or the participant's family.

The cost of the service may include the performance of assessments to identify the type of equipment or technology needed by the participant.

The cost of the service may include training the participant or caregivers in the operation and/or maintenance of the equipment or technology.

This service is subject to prior approval by the Operating Agency.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

This service is not included in the individual's annual cost maximum.

There is a \$15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications, and vehicle modifications. See Appendix C-4.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
 Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Equipment Vendors

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled vendor approved by the waiver case manager and participant/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA
Frequency of Verification:
 Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavior Intervention and Treatment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services <input type="checkbox"/>	10040 behavior support <input type="checkbox"/>
Category 2:	Sub-Category 2:
<input type="checkbox"/>	<input type="checkbox"/>
Category 3:	Sub-Category 3:
<input type="checkbox"/>	<input type="checkbox"/>
Category 4:	Sub-Category 4:
<input type="checkbox"/>	<input type="checkbox"/>

Service Definition (Scope):

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 an individual 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 skills with social value, lessen behavioral excesses related to their disabilities and improve communication skills. Key elements are:

- Approach is tailored to address the specific behavioral needs of the participant;
- Targeted skills are broken down into small attainable tasks;
- 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 support plan and coordinated with the participant’s individual education plan (IEP); and
- Success is closely monitored with detailed data collection.

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 participant-centered support plan and must be approved by the participant, family, Individual Service and Support Advocate and the other members of the planning team. Trained team members implement the planned behavior services. When responsible relatives implement behavior services, these hours are not billable to the Waiver. The behavior consultant monitors progress on at least a monthly basis and more frequently if needed to address issues with the participant’s outcomes. A progress report is prepared by the behavior consultant and sent to the support planning team every six months. This progress report is available to State staff upon request to evaluate the efficacy of the treatment.

The behavior consultant supervises implementation of the behavior strategies. This includes training of the personal support staff and family to ensure that they apply the interventions properly, understand the specific services and outcomes for the participant being served, and know the procedures for reporting participant progress. Professionals working closely with the participant’s family, teachers and other school personnel and personal support workers

provide services in the participant's home and other natural environments (not including schools).

Families of participants receiving intensive behavior treatment are vital members of the behavior team. They 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. The parents need not be available for all treatment sessions, but must be present at team meetings.

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

This service is included in the participant's annual cost maximum. See Appendix C-4.

No specific service maximum. No direct treatment may be delivered under the Waiver during the typical school day relative to the age of the child 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.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior consultant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Behavior Intervention and Treatment

Provider Category:

Individual

Provider Type:

Behavior consultant

Provider Qualifications

License (*specify*):

- 225 ILCS 15/1 et. Seq.
- 68 Ill. Adm. Code 1400

Certificate (*specify*):

- Board certified behavior analyst (bacb.com)

Other Standard (*specify*):

- Licensed Clinical psychologist (see above)
- Masters level professional who is certified as a Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)(see above)
- Bachelor's level professional who is certified as an Associate Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)
- Professional who is certified to provide Relationship Development Assessment. Information is at rdiconnect.com
- Early Intervention Specialist with a Development Therapy credential or equivalent experience and training
- Professional with a Bachelor's Degree in a human service field and who has completed at least 1,500 hours of training or supervised experience in the application of behaviorally-based therapy models consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorder.

The Provider must be a Medicaid Enrolled Vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency (DHS)

Frequency of Verification:

Upon enrollment and annual verification of national certification (OA)

Appendix C: Participant Services

C-I/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Accessibility Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Those physical adaptations to the private residence of the participant, required by the participant's support plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, central air conditioning, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. Seasonal items such as swimming pools and related equipment are excluded. All services shall be provided in accordance with applicable State or local building codes.

This service is subject to prior approval by DHS Operating Agency.

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

This service is not included in the participant's annual cost maximum.

There is a \$15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications and vehicle modifications.

Within the five-year maximum, there is also a \$5,000 maximum per address for permanent home modifications for rented homes. See Appendix C-4.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
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Provider Category	Provider Type Title
Individual	Independent contractor
Agency	Construction companies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Modifications

Provider Category:

Individual

Provider Type:

Independent contractor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled vendor approved by the waiver casemanager and participant/family

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Modifications

Provider Category:

Agency

Provider Type:

Construction companies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled vendor approved by the waiver casemanager and participant/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Support

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Personal Support includes teaching adaptive skills to assist the participant to reach personal goals, providing personal assistance in activities of daily living, and providing respite for caregivers.

Supports are typically provided in such areas as eating, bathing, dressing, personal hygiene, community integration, preparation of meals (excluding the cost of the meals), and other activities of daily living. Supports may be provided to assist the participant to perform 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.

The Personal Support Worker may assist the participant to implement a behavioral, occupational therapy, physical therapy, or speech therapy plan to the extent permitted by state law and as prescribed in the support plan. Implementation activities include assistance with exercise routines, range of motion, reading the therapist's directions, helping the participant remember and follow the steps of the plan or hands-on assistance. It does not include the actual service the professional therapist provides.

Personal support is not intended to include professional services, home cleaning services, or other community services used by the general public.

Personal Support may be provided in the participant's home and may include supports necessary to participate in community activities outside the home.

The need for Personal Support and the scope of the needed services must be documented in the participant-centered support plan. The amount of Personal Support must be specified in Service Agreements.

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

This service is included in the participant's annual cost maximum. See Appendix C-4. No specific service maximum. No Personal Support services may be delivered during the typical school day relative to the age of the child or during times when educational services are being provided.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based agencies and Special Recreation Associations.
Individual	Personal Support Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Support

Provider Category:

Agency 

Provider Type:

Community-Based agencies and Special Recreation Associations.

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The Agency must be under contract with the Operating Agency. Per these contracts, employees must complete DHS-approved direct support personnel training and pass competency-based training assessments (40 hours of classroom and 80 hours of on-the-job training) and be certified as direct support personnel.

All employees must have had criminal background and Health Care Worker Registry checks completed prior to employment.

For employees providing services to children under the age of 18, a DCFS CANTS registry check is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (DHS)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Support

Provider Category:

Individual 

Provider Type:

Personal Support Worker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Aged 18 or older, and is deemed by the guardian or family to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the support plan.

All personal support workers must have had criminal background and Health Care Worker Registry checks completed prior to employment.

All personal support workers providing services to children under the age of 18, are required to have a DCFS CANTS registry check.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Service entity

Waiver Operating Agency (DHS)
Frequency of Verification:
Upon enrollment

Desk audit reviews by the Operating Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Temporary Assistance

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Temporary Assistance is provided on an emergency basis because of the 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 another emergency situation. Temporary Assistance services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons.

The definition of Temporary Assistance includes the same activities, requirements and responsibilities as Personal Support services. The participant, legal representative, the service provider and the support planning team may set mutually acceptable rates for this service. The rates must be specified in the Service Agreements and are subject to review and approval by the OA on either a targeted or a random sample basis. This service is subject to prior approval by the OA.

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

The service is not included in the participants annual cost maximum. Temporary assistance may not exceed \$2000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days.

Temporary assistance may not be delivered during the typical school day or during times when education services are provided.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-based agencies
Individual	Personal Support Worker (Domestic Employee)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Temporary Assistance

Provider Category:

Agency

Provider Type:

Community-based agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The agency must be under contract with the operating agency. Per contract requirements, employees must complete DHS approved direct support personnel training and pass competency-based training assessment and be certified as direct support personnel.

All employees must have a criminal background check and healthcare registry check completed prior to employment.

Employees providing services to children under the age of 18 must have a DCFS CANTS registry check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Temporary Assistance

Provider Category:

Individual

Provider Type:

Personal Support Worker (Domestic Employee)

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Aged 18 or older, and is deemed by the parent or guardian to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the support plan.

All personal support workers must have had criminal background, Health Care Worker Registry checks and DCFS CANTS registry checks for workers providing services to participants under age 18.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Training and Counseling Services for Unpaid Caregivers

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, 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 in order to train paid caregivers or school workers. Training includes instruction about treatment regimens and other services included in the support plan, use of equipment specified in the support 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 support 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 support plan. Counseling similarly must be aimed at assisting unpaid individuals who support the participant to understand and address participant needs.

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

This service is included in the participant's annual cost maximum. See Appendix C-4.

No specific service maximum.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Counselors
Agency	Specialized Training Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
 Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:

Individual

Provider Type:

Licensed Counselors

Provider Qualifications

License (specify):

- 225 ILCS 15/1 et. seq.
- 68 Ill. Adm. Code 1400
- 225 ILCS 20/1 et seq.
- 68 Ill. Adm. Code 1470
- 225 ILCS 55/1 et seq.
- 68 Ill. Adm. Code 1283
- 225 ILCS 107/1 et seq.
- 68 Ill. Adm. Code 1375

Certificate (specify):

Other Standard (specify):

Training programs or events deemed qualified by the participant family and approved by the waiver casemanager. Examples include CPR instruction, first aid, and programs on disability-specific topics such as behavior intervention techniques, epilepsy, autism, etc.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency (DHS)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
 Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:

Agency

Provider Type:

Specialized Training Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
 Training programs or events deemed qualified by the participant/family and approved by the waiver casemanager. Examples include CPR instruction, first aid, and programs on disability-specific topics such as behavior intervention techniques, epilepsy, autism, etc.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency (DHS)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the support 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. The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant;
2. Purchase or lease of a vehicle; and
3. Scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

The family with whom the participant lives must own the vehicle that is adapted.

This service is subject to prior approval by the Waiver Operating Agency.

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

This service is not included in the participant's annual cost maximum.
There is a \$15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications, and vehicle modifications.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment vendor and installer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Equipment vendor and installer

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Medicaid Enrolled Vendor

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
 Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
 As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
 As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
 As an administrative activity. Complete item C-1-c.

- c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case Management Services are provided by Qualified Intellectual Disability Professionals (QIDP) staff working for Independent Service Coordination (ISC) agencies, under contract with the Operating Agency. These QIDP's are referred to as Individual Service and Support Advocates (ISSA) locally.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- No. Criminal history and/or background investigations are not required.
- Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal background checks with the Illinois State Police are required for direct service staff hired by agencies providing Information and Assistance in Support of Participant Direction, Personal Support, and Individual Service and Support Advocates. These agencies may not knowingly hire or retain any person in a full-time, part-time or contractual direct service position if that person has been convicted of committing or attempting to commit one or more of the offenses in the Illinois Health Care Worker Background Check Act (225 ILCS 64/25), unless the person obtains a waiver for the conviction.

The Financial Management Service (FMS) entity/entities is required to obtain a criminal background checks and not enroll or retain independent personal support workers (domestic employees) if the person has been convicted as described above. The FMS vendor obtains the criminal background check on behalf of all individuals who hire independent personal support workers. The results are kept on file with the FMS vendor.

The Medicaid Enrollment Agreement signed by the providers, as well as the contractual agreement signed by the FMS entities, includes the requirement for background investigations. The OA annually reviews compliance with this provision through the statistically valid sample of Waiver participants by obtaining evidence of the completed investigations by their providers. In addition, the OA obtains and reviews on-going reports from the FMS entities of the dates of the completed investigations for the workers they enroll. The results of these reviews are shared with the MA on a summary basis.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

By statute, the Illinois Department of Children and Family Services (DCFS) maintains the State's child abuse and neglect registry. The registry is called the Child Abuse and Neglect Tracking System, or CANTS.

By statute, the Illinois Department of Public Health maintains an adult abuse and neglect registry. The registry is called the Healthcare Worker Registry.

Waiver providers are required by the OA to complete registry checks on all employees. Employees cannot be hired if they fail the CANTS registry checks. The results of the registry checks are documented by the provider in the employee's file.

The FMS entities conduct the registry checks for all personal support workers employed directly by the participant (domestic employees).

Abuse/Neglect screenings are required for all individuals providing Information and Assistance in Support of Participant Direction, Personal Support or Individual Service and Support Advocacy. Such individuals may not be employed in any capacity until the employer has checked the individual against:

- The Illinois Department of Public Health (IDPH) Health Care Worker Registry, and
- The Illinois Department of Children and Family Services (DCFS) State Central Register (Children's Abuse and Neglect Tracking System - CANTS).

If either database reports substantiated or indicated findings of physical or sexual abuse or egregious neglect, the person may not be employed.

The Medicaid Enrollment Agreement signed by the providers, as well as the contractual agreement signed by the FMS entities, includes the requirement for registry screenings. The OA annually reviews compliance with this provision through the statistically valid sample of Waiver participants by obtaining evidence of the completed screenings by their providers. In addition, the OA obtains and reviews on-going reports from the FMS entities of the dates of the completed screenings for the workers they enroll. The results of these reviews are shared with the MA on a summary basis.

The state law governing the IDPH Health Care Workers' Registry is the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30). The state law governing the State Central Register (DCFS CANTS) is the Abused and Neglected Child Reporting Act (325 ILCS 5/1).

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- Self-directed
- Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Payment for Waiver services is not made to parents, step-parents, spouses or any other relative of the participant who is a legally responsible individual as defined in Section C-2 (d) above. Personal Support and Temporary Assistance are the only Waiver service that may be provided by a relative. These services may be provided by relatives (excluding those mentioned above) as long as they meet the same provider qualifications and pass the required background checks as any other domestic employee providing Personal Support or Temporary Assistance. The service planning team referenced in Appendix D determines the services that are needed and identifies providers qualified and available to deliver those services. It is the team's decision whether a relative in the role of a provider would be in the best interest of the individual.

The Case Manager, also known as the ISSA, plays a key role in monitoring the implementation of the service plan and reporting any non-complaint issues or problems to the OA if direct interventions by the ISSA do not work.

The OA through it's representative sample, reviews Personal Support and Temporary Assistance services regardless of the provider relationship. Providers who are relatives are reviewed the same as any other provider.

- **Other policy.**

Specify:

- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Participants in the Children's Support Waiver and their families, Individual Service and Support Advocate, and other members of the service planning team, are responsible for selecting needed services and service providers, as the Children's Support Waiver is largely directed by participants and their families.

Information regarding provider qualifications and program guidelines is continuously available on the Operating Agency's website.

The State does not impose barriers to the free choice of willing and qualified providers.

The Operating Agency (DHS) reviews and approves service providers for participation in the Children's Support Waiver based only on the provider qualifications specified in the Waiver.

The State Medicaid Agency enrolls all willing and qualified providers that are chosen by participants in the Children's Support Waiver and their families.

Information regarding provider qualifications and program guidelines is continuously available on the Operating Agency's website at <http://www.dhs.state.il.us/page.aspx?item=47336>. This website lists all types of providers within the developmental disabilities services system, briefly describes what each does, lists requirements and qualifications, links those interested to regulatory documents and forms, and provides contact information.

Potential providers must review the regulatory documents linked to the website. They must also complete the required forms for their provider type and submit them to the contact person listed.

Each provider must complete a Medicaid Provider Enrollment agreement, which is a three-way agreement among the provider, OA, and MA.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

CI Number and percent of licensed or certified providers who meet initial licensure/certification standards. Numerator: Number of newly enrolled licensed/certified providers who meet initial licensure/certification standards. Denominator: Total number of newly enrolled licensed/certified providers.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

C2 Number and percent of licensed or certified providers who continue to meet licensure/certification standards on an on ongoing basis. Numerator: Number of licensed or certified providers who continue to meet licensure/certification standards on an ongoing basis. Denominator: Total number of enrolled licensed/certified providers.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C3 Number and percent of non-licensed/non-certified providers reviewed, by provider type, who meet initial provider qualifications. Numerator: Number of non-licensed/non-certified providers who met initial provider qualifications. Denominator: Total number of newly enrolled non-licensed/non-certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Program Logs

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

C4 Number and percent of non-licensed/non-certified providers reviewed, by provider type, who continue to meet waiver provider qualifications. Numerator: Number of non-licensed/non-certified providers who continue to meet qualifications. Denominator: Total number of non-licensed/non-certified providers.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

- c. **Sub-Assurance:** The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C5 Number and percent of providers reviewed, by provider type, who meet waiver provider training requirements. Numerator: Number of providers who met training requirements. Denominator: Total number of providers subject to training requirements.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

C6 Number and percent of independent personal support providers (domestic employees) screened by the Financial Management Agency (on behalf of waiver participants who self-direct) who passed background and registry checks and thus were deemed eligible for hire. N: Number of domestic employees who passed initial checks. D: Total number of domestic employees hired.

Data Source (Select one):

Other

If 'Other' is selected, specify:

FMS Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The OA reviews the issues and identifies the most appropriate response. General responses may include work with participants and their providers, retraining staff, voiding claims, technical assistance, increased monitoring, revising service plans, and requiring plans of correction. The OA is responsible for seeing that these individual issues are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

In addition to the information contained in the OA's waiver manual, each participant receives an initial award letter that contains service limits.

The service limits are discussed verbally during the annual service planning process. The ISSA reviews service limits with the participant. The written participant-centered individual service plan (ISP) is signed by the participant, their parent, or legal guardian, and the ISSA. Providers responsible for the plan's implementation must also sign the plan.

Maximum for Modifications and Tangible Items

There is a \$15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications and vehicle modifications.

Within the five-year maximum, there is also a \$5,000 maximum per address for permanent home modifications for rented homes. Individual program limits were combined to allow participants greater flexibility within the tangible item budget to meet their unique needs.

Participants are informed of their right to request a fair hearing, in the event any requests are denied. Participants are notified of the limits in the Operating Agency's Waiver manual. Waiver casemanagers and ISSAs assist participants in understanding and managing the limits.

Temporary Assistance services may not exceed \$2,000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days. Under certain circumstances, the OA can provide verbal approval within 24 hours of receipt of a request for Temporary assistance services. Services can begin upon verbal approval.

The Independent Service and Support Advocate (ISSA) will submit a written request for prior authorization of this service on behalf of the individual. This request must be submitted to the OA within seven calendar days of identifying the need. The OA will respond in writing to the request within 30 calendar days. When an unplanned need occurs, however, Temporary Assistance services will begin upon receipt of verbal approval from the OA. The OA will provide verbal approval ASAP but no later than 24 hours of receipt of request, in those cases of unplanned need. Subsequent written approval is issued to the participant and ISSA by the OA.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

The annual supports budget limits are based on the Illinois Home-Based Support Services Law for Mentally Disabled Adults [405 ILCS 80]. The limits are indexed to Social Security benefit levels and are adjusted each January when Social Security benefits are adjusted. These statutory budget limits were set through a public legislative process that included opportunities for public comment by advocates and individuals with mental disabilities and their families.

The total amount of Waiver services provided in any month is determined by the service plan of the participant within the program maximums. The annual service plan is developed by the ISSA and other team members, and is based on assessments of the participant's needs.

Written notices of changes to limits are sent to all participants/guardians, Financial Management Service entity, and Individual Service and Support Advocacy (ISSA) entities.

We expect that this annual dollar maximum amount, currently \$17,592 for calendar year 2015 for participants in school, together with natural supports, general community resources, school-based services, and Medicaid State plan services will be sufficient to meet the participant's needs.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

All services provided in this waiver are delivered to individuals living in their private, family homes. Foster care and other types of residential settings are not covered by this Waiver. The family homes are presumed to be integrated HCB. The same rules mentioned above as they relate to residential and non-residential settings are non-applicable and do not require any action by the State. See Attachment #2.