DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 340

SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

411-340-0010 Statement of Purpose
(Amended 12/28/2013)

(1) The rules in OAR chapter 411, division 340 prescribe standards, responsibilities, and procedures for support services brokerages to assist adults with intellectual or developmental disabilities to identify and address support needs and for providers paid with support services funds, including resources available through the state plan and waiver, to provide services so that an adult with an intellectual or developmental disability may live in his or her own home or in the family home.

(2) Services provided under these rules are intended to identify, strengthen, expand, and where required, supplement private, public, formal, and informal support available to adults with intellectual or developmental disabilities so that an adult with an intellectual or developmental disability may exercise self-determination in the design and direction of his or her life.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0020 Definitions
(Amended 12/28/2013)

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 340:

(1) "Abuse" means "abuse of an adult" as defined in OAR 407-045-0260.

(2) "Abuse Investigation and Protective Services" means the reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required by OAR 407-045-0310.

(3) "Activities of Daily Living (ADL)" means basic personal everyday activities, including but not limited to tasks such as eating, using the restroom, grooming, dressing, bathing, and transferring.

(4) "Adaptive Behavior" means the degree to which an individual meets the standards of personal independence and social responsibility expected for age and culture group.

(5) "ADL" means "activities of daily living" as defined in this rule.

(6) "Administration of Medication" means the act of placing a medication in or on an individual's body by a person responsible for the individual's care and employed by, or under contract to, the individual or as applicable the individual's legal or designated representative or provider organization.

(7) "Administrative Review" means the formal process that is used when an individual, or as applicable the individual's legal or designated representative, is not satisfied with the decision made by a brokerage about a complaint involving the provision of services or a provider.

(8) "Adult" means an individual 18 years or older with an intellectual or developmental disability.

(9) "Alternative Resources" means possible resources, not including support services, for the provision of supports to meet an individual's needs. Alternative resources includes but is not limited to private or public insurance, vocational rehabilitation services, supports available through the Oregon Department of Education, or other community supports.

(10) "Annual Plan" means the written summary a personal agent completes for an individual who is not enrolled in waiver or Community First Choice services. An Annual Plan is not an Individual Support Plan and is not a plan of care for Medicaid purposes.

(11) "Attendant Care" means assistance with activities of daily living, instrumental activities of daily living, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding, as described in OAR 411-340-0130.

(12) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210.

(13) "Basic Benefit" means the type and amount of support services available to each eligible individual, specifically:

(a) Access to the brokerage services listed in OAR 411-340-0120(1); and if required

(b) For individuals who have not had a service level determined, access to an amount of support services funds used to assist with the purchase of supports listed in OAR 411-340-0130.

(14) "Basic Supplement" means an amount of support services funds in excess of the basic benefit to which an individual, who has not had a service level determined, may have access in order to purchase necessary supports based on demonstration of extraordinary long-term need on the Basic Supplement Criteria Inventory (Form DHS 0203).

(15) "Basic Supplement Criteria Inventory (Form DHS 0203)" means the written inventory of an individual's circumstances that is completed and scored by a brokerage to determine whether the individual, who has not had a service level determined, is eligible for a basic supplement.

(16) "Behavior Support Plan (BSP)" means the written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow to cause an individual’s challenging behaviors to become unnecessary and to change the provider's own behavior, adjust environment, and teach new skills.

(17) "Behavior Support Services" mean the services consistent with positive behavioral theory and practice that are provided to assist with behavioral challenges due to an individual's intellectual or developmental disability that prevents the individual from accomplishing activities of daily living, instrumental activities of daily living, health related tasks, and

cognitive supports to mitigate behavior. Behavior support services are provided in the home or community.

(18) "Benefit Level" means the total annual amount of support services funds for which an individual, who has not had a service level determined, is eligible. The benefit level includes the basic benefit and any exceptions to the basic benefit financial limits.

(19) "Brokerage" means an entity or distinct operating unit within an existing entity that uses the principles of self-determination to perform the functions associated with planning and implementation of support services for individuals with intellectual or developmental disabilities.

(20) "Brokerage Director" means the director of a publicly or privately-operated brokerage, who is responsible for administration and provision of services according to these rules, or the brokerage director's designee.

(21) "Case Management" means the functions performed by a services coordinator or personal agent. Case management includes determining service eligibility, developing a plan of authorized services, and monitoring the effectiveness of services and supports.

(22) "CDDP" means "community developmental disability program" as defined in this rule.

(23) "Certificate" means the document issued by the Department to a brokerage, or to a provider organization requiring certification under OAR 411-340-0170(2), that certifies the brokerage or provider organization is eligible to receive state funds for support services.

(24) "Choice" means an individual's expression of preference, opportunity for, and active role in decision-making related to services received and from whom, including but not limited to case management, providers, services, and service settings. Personal outcomes, goals, and activities are supported in the context of balancing an individual's rights, risks, and personal choices. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated verbally, through sign language, or by other communication methods.

(25) "Choice Advising" means the impartial sharing of information about case management and other service delivery options available to individuals with intellectual or developmental disabilities provided by a person that meets the qualifications identified in OAR 411-340-0150(5).

(26) "Chore Services" mean the services described in OAR 411-340-0130 that are needed to restore a hazardous or unsanitary situation in an individual's home to a clean, sanitary, and safe environment.

(27) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for plan authorization, delivery, and monitoring of services for individuals with intellectual or developmental disabilities according to OAR chapter 411, division 320.

(28) "Community First Choice (K Plan)" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(29) "Community Living and Inclusion Supports" mean the services described in OAR 411-340-0130 designed to assist an individual in acquiring, retaining, and improving the self-help, socialization, and non-activities of daily living or instrumental activities of daily living skills necessary for the individual to reside successfully in home and community-based settings.

(30) "Community Nursing Services" mean the services described in OAR 411-340-0130 that include nurse delegation, training, and care coordination for an individual living in his or her own home.

(31) "Community Transportation" means the services described in OAR 411-340-0130 that enable an individual to gain access to community services, activities, and resources that are not medical in nature.

(32) "Complaint" means a verbal or written expression of dissatisfaction with services or providers.

(33) "Comprehensive Services" means developmental disability services and supports that include 24-hour residential services provided in a licensed home, foster home, or through a supported living program. Comprehensive services are regulated by the Department alone or in combination with an associated Department-regulated employment or

community inclusion program. Comprehensive services are in-home services provided to an individual with an intellectual or developmental disability when the individual receives case management services from a community developmental disability program. Comprehensive services do not include support services for adults with intellectual or developmental disabilities enrolled in brokerages.

(34) "Cost Effective" means being responsible and accountable with Department resources by offering less costly alternatives when providing choices that adequately meet an individual's support needs. Less costly alternatives include other programs available from the Department, the utilization of assistive devices, natural supports, architectural modifications, and alternative resources. Less costly alternatives may include resources not paid for by the Department.

(35) "CPMS" means the Client Process Monitoring System. CPMS is the Department's computerized system for enrolling and terminating services for individuals with intellectual or developmental disabilities.

(36) "Crisis" means:

(a) A situation that would result in civil court commitment under ORS 427.215 to 427.306 and for which no appropriate alternative resources are available; or

(b) Risk factors described in OAR 411-320-0160 are present for which no appropriate alternative resources are available.

(37) "Crisis Diversion Services" mean the services authorized and provided according to OAR 411-320-0160 that are intended to maintain an individual at home or in the family home while the individual is in emergent status. Crisis diversion services may include short-term residential placement services indicated on an individual's Support Services Brokerage Crisis Addendum, as well as additional support as described in an Individual Support Plan.

(38) "Day" means a calendar day unless otherwise specified in these rules.

(39) "Department" means the Department of Human Services.

(40) "Designated Representative" means a parent, family member, guardian, advocate, or other person authorized in writing by an individual to serve as the individual's representative in connection with the provision of funded supports, who is not also a paid provider for the individual. An individual is not required to appoint a designated representative.

(41) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(42) "Director" means the director of the Department's Office of Developmental Disability Services or the director's designee.

(43) "Emergent Status" means an individual has been determined to be eligible for crisis diversion services according to OAR 411-320-0160.

(44) "Employer-Related Supports" mean the activities that assist an individual, and when applicable the individual's legal or designated representative or family members, with directing and supervising provision of services described in the individual's Individual Support Plan. Employer-related supports include but are not limited to:

(a) Education about employer responsibilities;

(b) Orientation to basic wage and hour issues;

(c) Use of common employer-related tools, such as job descriptions; and

(d) Fiscal intermediary services.

(45) "Entry" means admission to a Department-funded licensed or certified developmental disability service provider.

(46) "Environmental Accessibility Adaptations" mean the physical adaptations described in OAR 411-340-0130 that are necessary to ensure the health, welfare, and safety of an individual in the individual's home, or that enable an individual to function with greater independence in the individual's home.

(47) "Exit" means termination or discontinuance of a Department-funded developmental disability service by a licensed or certified provider organization.

(48) "Family":

(a) Means a unit of two or more people that includes at least one individual with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the individual with an intellectual or developmental disability by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general, such as child-rearing, maintenance of the residence, and basic living expenses; and

(iii) Joint responsibility for supporting the individual with an intellectual or developmental disability when the individual is related to one of the partners by blood, marriage, or legal adoption.

(b) The term "family" is defined as described above for purposes of:

(A) Determining an individual's eligibility for brokerage services as a resident in the family home;

(B) Identifying people who may apply, plan, and arrange for individual services; and

(C) Determining who may receive family training.

(49) "Family Training" means the training and counseling services described in OAR 411-340-0130 that are provided to an individual's family

to increase the family's capacity to care for, support, and maintain the individual in the individual's home.

(50) "Fiscal Intermediary" means a person or entity that receives and distributes support services funds on behalf of an individual, who employs people to provide services, supervision, or training in the individual's home or community according to the individual's Individual Support Plan.

(51) "Founded Reports" means the Department's or Law Enforcement Authority's (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(52) "Functional Needs Assessment" means a comprehensive assessment that documents:

(a) Physical, mental, and social functioning; and

(b) Risk factors, choices and preferences, service and support needs, strengths, and goals.

(53) "General Business Provider" means an organization or entity selected by an individual, or as applicable the individual's legal or designated representative, and paid with support services funds that:

(a) Is primarily in business to provide the service chosen by the individual, or as applicable the individual's legal or designated representative, to the general public;

(b) Provides services for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the person who actually provides support for the individual.

(54) "Habilitation Services" mean the services designed to assist an individual in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the individual's home and community-based settings.

(55) "Hearing" means the formal process following an action that would terminate, suspend, reduce, or deny a service. A hearing is a formal process required by federal law (42 CFR 431.200-250). A hearing is also known as a Medicaid Fair Hearing and contested case hearing.

(56) "Home" means an individual's primary residence that is not under contract with the Department to provide services to an individual as a certified foster home or licensed or certified residential care facility, assisted living facility, nursing facility, or other residential support program site.

(57) "Home and Community-Based Waiver Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with section 1915(c) and 1115 of the Social Security Act.

(58) "IADL" means "instrumental activities of daily living" as defined in this rule.

(59) "ICF/MR" means intermediate care facilities for the mentally retarded. Federal law and regulations use the term "intermediate care facilities for the mentally retarded (ICF/MR)". The Department prefers to use the accepted term "individual with intellectual disability (ID)" instead of "mental retardation (MR)". However, as ICF/MR is the abbreviation currently used in all federal requirements, ICF/MR is used.

(60) "Incident Report" means the written report of any injury, accident, act of physical aggression, or unusual incident involving an individual.

(61) "Independence" means the extent to which an individual exerts control and choice over his or her own life.

(62) "Independent Provider" means a person selected by an individual, or as applicable the individual's legal or designated representative, and paid with support services funds to personally provide services to the individual.

(63) "Individual" means an adult with an intellectual or developmental disability applying for, or determined eligible for, developmental disability services.

(64) "Individual Cost Limit" means the maximum annual benefit level available under the Support Services Waiver version OR.0375.R02.03. The support services waiver is available at http://www.oregon.gov/dhs/spd/qa/ssa_waiver_icfmr.pdf. Printed copies may be obtained by contacting the Department of Human Services, Developmental Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-10, Salem, Oregon 97301.

(65) "Individual Support Plan (ISP)" means the written details of the supports, activities, and resources required for an individual to achieve and maintain personal outcomes. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. Individual support needs are identified through a functional needs assessment. The manner in which services are delivered, providers, and the frequency of services are reflected in an ISP. The ISP is the individual's plan of care for Medicaid purposes and reflects whether services are provided through a waiver, state plan, or natural supports.

(66) "Instrumental Activities of Daily Living (IADL)" mean the activities other than activities of daily living required to continue independent living, including but not limited to:

(a) Meal planning and preparation;

(b) Budgeting;

(c) Shopping for food, clothing, and other essential items;

(d) Performing essential household chores;

(e) Communicating by phone or other media; and

(f) Traveling around and participating in the community.

(67) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other people;

(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which people without an intellectual or developmental disability participate, together with regular contact with people without an intellectual or developmental disability; and

(c) Individuals with intellectual or developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with people in the community.

(68) "Intellectual Disability" means "intellectual disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(69) "ISP" means "Individual Support Plan" as defined in this rule.

(70) "K Plan" means "Community First Choice" as defined in this rule.

(71) "Legal Representative" means an attorney at law who has been retained by or for an individual, or a person or agency authorized by a court to make decisions about services for an individual.

(72) "Level of Care" means an individual meets the following institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities (formerly referred to as an ICF/MR):

(a) The individual has a condition of an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria for developmental disability services as described in OAR 411-320-0080; and

(b) The individual has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(73) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who, while acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with an intellectual or developmental disability has suffered abuse, or comes in

contact with any person whom the official has reasonable cause to believe abused an adult with an intellectual or developmental disability. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section of this rule, except that a psychiatrist, psychologist, clergy, or attorney is not required to report if the communication is privileged under ORS 40.225 to 40.295.

(74) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(75) "Natural Supports" means the voluntary resources available to an individual from the individual's relatives, friends, significant others, neighbors, roommates, and the community that are not paid for by the Department.

(76) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse or licensed practical nurse pursuant to ORS chapter 678.

(77) "Nursing Care Plan" means the plan developed by a nurse that describes the medical, nursing, psychosocial, and other needs of an individual and how those needs are met. The Nursing Care Plan includes the tasks that are taught or delegated to a qualified provider or the individual's family. When a Nursing Care Plan exists, it is a supporting document for the individual's Individual Support Plan.

(78) "Occupational Therapy" means the services described in OAR 411-340-0130 that are provided by a professional licensed under ORS 675.240 that are defined under the approved state plan, except that the amount, duration, and scope specified in the state plan do not apply.

(79) "OSIP-M" means "Oregon Supplemental Income Program-Medical" as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for individuals who meet the eligibility criteria described in OAR chapter 461.

(80) "Person-Centered Planning":

(a) Means a timely and formal or informal process that is driven by an individual with an intellectual or developmental disability that gathers and organizes information that helps an individual:

(A) Determine and describe choices about personal goals, activities, services, providers, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with the individual's cultural considerations, needs, and preferences.

(81) "Personal Agent" means a person who is a case manager for the provision of case management services, works directly with individuals and the individuals' legal or designated representatives and families to provide or arrange for support services as described in these rules, meets the qualifications set forth in OAR 411-340-0150(5), and is a trained employee of a brokerage or a person who has been engaged under contract to the brokerage to allow the brokerage to meet responsibilities in geographic areas where personal agent resources are severely limited. A personal agent is an individual's person-centered plan coordinator as defined in the Community First Choice state plan.

(82) "Physical Therapy" means the services described in OAR 411-340-0130 that are provided by a professional licensed under ORS 688.020 that are defined under the approved state plan, except that the amount, duration, and scope specified in the state plan do not apply.

(83) "Plan of Care" means the written plan of Medicaid services an individual needs as required by Medicaid regulation. Oregon's plan of care is the Individual Support Plan.

(84) "Plan Year" means 12 consecutive months that, unless otherwise set according to the conditions of OAR 411-340-0120, begins on the start date specified in an individual's first authorized Individual Support Plan (ISP)

after entry to a brokerage. Subsequent plan years begin on the anniversary of the start date of the initial ISP.

(85) "Policy Oversight Group" means the group that meets the requirements of OAR 411-340-0150(1) that is formed to provide individual-based leadership and advice to each brokerage regarding issues such as development of policy, evaluation of services, and use of resources.

(86) "Positive Behavioral Theory and Practice" means a proactive approach to behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abusive or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(87) "Prescription Medication" means any medication that requires a physician's prescription before the medication may be obtained from a pharmacist.

(88) "Primary Caregiver" means the person identified in an Individual Support Plan as providing the majority of service and support for an individual in the individual's home.

(89) "Productivity" as defined in ORS 427.005 means:

(a) Engagement in income-producing work by an individual that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual in work contributing to a household or community.

(90) "Progress Note" means a written record of an action taken by a personal agent in the provision of case management, administrative tasks, or direct services, to support an individual. A progress note may also be a recording of information related to an individual’s services, support needs, or circumstances, which is necessary for the effective delivery of support services.

(91) "Protection" and "Protective Services" mean the necessary actions taken as soon as possible to prevent subsequent abuse or exploitation of an individual, to prevent self-destructive acts, or to safeguard an individual's person, property, and funds.

(92) "Protective Physical Intervention" means any manual physical holding of, or contact with, an individual that restricts the individual's freedom of movement.

(93) "Provider" means a person, organization, or business selected by an individual, or as applicable the individual's legal or designated representative, and paid with support services funds to provide support according to the individual's Individual Support Plan.

(94) "Provider Organization" means an entity selected by an individual, or as applicable the individual's legal or designated representative, and paid with support services funds that:

(a) Is primarily in business to provide supports for individuals with intellectual or developmental disabilities;

(b) Provides supports for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the person who actually provides support for the individual.

(95) "Provider Organization Director" means the director of a provider organization, who is responsible for the administration and provision of services according to these rules, or the provider organization director's designee.

(96) "Psychotropic Medication" means a medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior, including but not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(97) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services.

(98) "Regional Crisis Diversion Program" means the regional coordination of the management of crisis diversion services for a group of designated counties that is responsible for the management of the following developmental disability services:

(a) Crisis intervention services;

(b) Evaluation of requests for new or enhanced services for certain groups of individuals eligible for developmental disability services; and

(c) Other developmental disability services that the counties comprising the region agree are delivered more effectively or automatically on a regional basis.

(99) "Relief Care" means the intermittent services described in OAR 411-340-0130 that are provided on a periodic basis of not more than 14 consecutive days for the relief of, or due to the temporary absence of, a person normally providing supports to an individual.

(100) "Self-Administration of Medication" means an individual manages and takes his or her own medication, identifies his or her own medication and the times and methods of administration, places the medication internally in or externally on his or her own body without staff assistance upon written order of a physician, and safely maintains the medication without supervision.

(101) "Self-Determination" means a philosophy and process by which individuals with intellectual or developmental disabilities are empowered to gain control over the selection of support services that meet their needs. The basic principles of self-determination are:

(a) Freedom. The ability for an individual with an intellectual or developmental disability, together with freely-chosen family and friends, to plan a life with necessary support services rather than purchasing a predefined program;

(b) Authority. The ability for an individual with an intellectual or developmental disability, with the help of a social support network if needed, to control a certain sum of resources in order to purchase support services;

(c) Autonomy. The arranging of resources and personnel, both formal and informal, that assists an individual with an intellectual or developmental disability to live a life in the community rich in community affiliations; and

(d) Responsibility. The acceptance of a valued role in an individual's community through competitive employment, organizational affiliations, personal development, and general caring for others in the community, as well as accountability for spending public dollars in ways that are life-enhancing for the individual.

(102) "Self Direction" means that an individual, or as applicable the individual's legal or designated representative, has decision-making authority over services and takes direct responsibility for managing services with the assistance of a system of available supports and promoting personal choice and control over the delivery of waiver and state plan services.

(103) "Service Level" means the amount of services determined necessary to meet an individual's identified support needs.

(104) "Services Coordinator" means an employee of a community developmental disability program or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, and monitor services, and to act as a proponent for individuals with intellectual or developmental disabilities. A services coordinator is an individual's person-centered plan coordinator as defined in the Community First Choice state plan.

(105) "Skills Training" means the activities described in OAR 411-340-0130 that are intended to maximize an individual’s independence through training, coaching, and prompting the individual to accomplish activities of daily living, instrumental activities of daily living, community living and inclusion, supported employment, and health-related skills.

(106) "Social Benefit" means a service or financial assistance solely intended to assist an individual with an intellectual or developmental disability to function in society on a level comparable to that of a person who does not have an intellectual or developmental disability. Social benefits are pre-authorized by an individual's personal agent and provided according to the description and limits written in an individual's Individual Support Plan.

(a) Social benefits may not:

(A) Duplicate benefits and services otherwise available to a person regardless of intellectual or developmental disability;

(B) Provide financial assistance with food, clothing, shelter, and laundry needs common to a person with or without an intellectual or developmental disability; or

(C) Replace other governmental or community services available to an individual.

(b) Assistance provided as a social benefit is reimbursement for an expense previously authorized in an individual's Individual Support Plan (ISP) or an advance payment in anticipation of an expense authorized in an individual's previously authorized ISP.

(c) Assistance provided as a social benefit may not exceed the actual cost of the support required by an individual to be supported in the individual's home.

(107) "Special Diet" means the specially prepared food or particular types of food described in OAR 411-340-0130 that are specific to an individual's medical condition or diagnosis and needed to sustain an individual in the individual's home.

(108) "Specialized Equipment and Supplies" means the devices, aids, controls, supplies, or appliances described in OAR 411-340-0130 that enable an individual to increase the individual's ability to perform activities of daily living or to perceive, control, or communicate with the environment in which the individual lives.

(109) "Specialized Supports" means the treatment, training, consultation, or other unique services described in OAR 411-340-0130 that are provided by a social or sexual consultant to achieve outcomes in an Individual Support Plan that are not available through state plan services.

(110) "Speech, Hearing, and Language Services" mean the services described in OAR 411-340-0130 that are provided by a professional licensed under ORS 681.250 that are defined under the approved state plan, except that the amount, duration, and scope specified in the state plan do not apply.

(111) "State Plan" means Community First Choice or state plan personal care.

(112) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(113) "Support" means the assistance that an individual requires, solely because of the affects of the individual's intellectual or developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is subject to change with time and circumstances.

(114) "Support Services" mean the services of a brokerage listed in OAR 411-340-0120 as well as the uniquely determined activities and purchases arranged through the brokerage that:

(a) Complement the existing formal and informal supports that exist for an individual living in the individual's own home or family home;

(b) Are designed, selected, and managed by an individual or the individual's legal or designated representative (as applicable);

(c) Are provided in accordance with an individual's Individual Support Plan; and

(d) May include purchase of supports as a social benefit required for an individual to live in the individual's home or the family home.

(115) "Support Services Brokerage Crisis Addendum" means the short-term plan that is required by the Department to be added to an Individual Support Plan to describe crisis diversion services an individual is to receive while the individual is in emergent status.

(116) "Support Services Expenditure Guideline" means a publication of the Department that describes allowable uses for support services funds. The Department's support services expenditure guideline is maintained on the Department's website (http://www.oregon.gov/dhs/dd/adults/ss_exp_guide.pdf). Printed copies may be obtained by contacting the Department of Human Services, Developmental Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-10, Salem, Oregon 97301.

(117) "Support Services Funds" mean the public funds designated by the brokerage for assistance with the purchase of supports according to an Individual Support Plan.

(118) "Supported Employment Services" mean the services described in OAR 411-340-0130 that provide support for individuals for whom competitive employment is unlikely without ongoing support to perform in a work setting. Supported employment services occur in a variety of settings, particularly work sites in which people without disabilities are employed.

(119) "These Rules" mean the rules in OAR chapter 411, division 340.

(120) "Transition Costs" mean the expenses described in OAR 411-340-0130, such as rent and utility deposits, first month’s rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility or intermediate care

facility for individuals with intellectual or developmental disabilities (formerly referred to as an ICF/MR) to a community-based home setting where the individual resides.

(121) "Unusual Incident" means any incident involving an individual that includes serious illness or an accident, death, injury or illness requiring inpatient or emergency hospitalization, a suicide attempt, a fire requiring the services of a fire department, an act of physical aggression, or any incident requiring an abuse investigation.

(122) "Variance" means the temporary exception from a regulation or provision of these rules that may be granted by the Department as described in OAR 411-340-0090.

(123) "Volunteer" means any person assisting a provider without pay to support the services and supports provided to an individual.

(124) "Waiver Services" means "home and community-based waiver services" as defined in this rule.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0030 Certification of Support Services Brokerages and Provider Organizations
(Amended 12/28/2013)

(1) CERTIFICATE REQUIRED.

(a) No person or governmental unit acting individually or jointly with any other person or governmental unit may establish, conduct, maintain, manage, or operate a brokerage without being certified by the Department under this rule.

(b) No person or governmental unit acting individually or jointly with any other person or governmental unit may establish, conduct, maintain, or operate a provider organization without either certification under this rule or current Department license or certification as described in OAR 411-340-0170(1).

(c) Certificates are not transferable or assignable and are issued only for the brokerage, or for the provider organization requiring certification under OAR 411-340-0170(2), and people or governmental units named in the application.

(d) Certificates issued on or after November 15, 2008 are effective for a maximum of five years.

(e) The Department shall conduct a review of the brokerage, or the provider organization requiring certification under OAR 411-340-0170(2), prior to the issuance of a certificate.

(2) CERTIFICATION. A brokerage, or a provider organization requiring certification under OAR 411-340-0170(2), must apply for an initial certificate and for a certificate renewal.

(a) The application must be on a form provided by the Department and must include all information requested by the Department.

(b) The applicant requesting certification as a brokerage must identify the maximum number of individuals to be served.

(c) To renew certification, the brokerage or provider organization must make application at least 30 days, but not more than 120 days, prior to the expiration date of the existing certificate. On renewal of brokerage certification, no increase in the maximum number of individuals to be served by the brokerage may be certified unless specifically approved by the Department.

(d) Application for renewal must be filed no more than 120 days prior to the expiration date of the existing certificate and extends the effective date of the existing certificate until the Department takes action upon the application for renewal.

(e) Failure to disclose requested information on the application or providing incomplete or incorrect information on the application may result in denial, revocation, or refusal to renew the certificate.

(f) Prior to issuance or renewal of the certificate, the applicant must demonstrate to the satisfaction of the Department that the applicant is capable of providing services identified in a manner consistent with the requirements of these rules.

(3) CERTIFICATION EXPIRATION, TERMINATION OF OPERATIONS, OR CERTIFICATE RETURN.

(a) Unless revoked, suspended, or terminated earlier, each certificate to operate a brokerage or provider organization expires on the expiration date specified on the certificate.

(b) If a certified brokerage or provider organization is discontinued, the certificate automatically terminates on the date operation is discontinued.

(4) CHANGE OF OWNERSHIP, LEGAL ENTITY, LEGAL STATUS, OR MANAGEMENT CORPORATION. The brokerage, or provider organization requiring certification under OAR 411-340-0170(2), must notify the Department in writing of any pending action resulting in a 5 percent or more change in ownership and of any pending change in the brokerage's or provider organization's legal entity, legal status, or management corporation.

(5) NEW CERTIFICATE REQUIRED. A new certificate for a brokerage or provider organization is required upon change in a brokerage's or provider organization's ownership, legal entity, or legal status. The brokerage or provider organization must submit a certificate application at least 30 days prior to change in ownership, legal entity, or legal status.

(6) CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may deny, revoke, or refuse to renew a certificate when the Department finds the brokerage or provider organization, the brokerage or provider organization director, or any person holding 5 percent or greater financial interest in the brokerage or provider organization:

(a) Demonstrates substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized and the brokerage or provider organization fails to correct the noncompliance within 30 calendar days of receipt of written notice of non-compliance;

(b) Has demonstrated a substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized during two inspections within a six year period (for the purpose of this rule, "inspection" means an on-site review of the service site by the Department for the purpose of investigation or certification);

(c) Has been convicted of a felony or any crime as described in OAR 407-007-0275;

(d) Has been convicted of a misdemeanor associated with the operation of a brokerage or provider organization;

(e) Falsifies information required by the Department to be maintained or submitted regarding services of individuals, program finances, or individuals' funds;

(f) Has been found to have permitted, aided, or abetted any illegal act that has had significant adverse impact on individual health, safety, or welfare; or

(g) Has been placed on the Office of Inspector General's list of excluded or debarred providers (http://exclusions.oig.hhs.gov/).

(7) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. Following a Department finding that there is a substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in section (6) of this rule has occurred, the Department may issue a notice of certificate revocation, denial, or refusal to renew.

(8) IMMEDIATE SUSPENSION OF CERTIFICATE. When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the certificate holder, immediately suspend a certificate without a pre-suspension hearing and the brokerage or provider organization may not continue operation.

(9) HEARING. An applicant for a certificate or a certificate holder may request a hearing pursuant to the contested case provisions of ORS

chapter 183 upon written notice from the Department of denial, suspension, revocation, or refusal to renew a certificate. In addition to, or in lieu of a hearing, the applicant or certificate holder may request an administrative review by the Department's director. An administrative review does not preclude the right of the applicant or certificate holder to a hearing.

(a) The applicant or certificate holder must request a hearing within 60 days of receipt of written notice by the Department of denial, suspension, revocation, or refusal to renew a certificate. The request for a hearing must include an admission or denial of each factual matter alleged by the Department and must affirmatively allege a short plain statement of each relevant, affirmative defense the applicant or certificate holder may have.

(b) In the event of a suspension pursuant to section (8) of this rule and during the first 30 days after the suspension of a certificate, the brokerage or provider organization may submit a written request to the Department for an administrative review. The Department shall conduct the review within 10 days after receipt of the request for an administrative review. Any review requested after the end of the 30-day period following certificate suspension is treated as a request for a hearing under subsection (a) of this section. If following the administrative review the suspension is upheld, the brokerage or provider organization may request a hearing pursuant to the contested case provisions of ORS chapter 183.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0040 Abuse and Unusual Incidents in Support Services Brokerages and Provider Organizations
(Amended 12/28/2013)

(1) ABUSE PROHIBITED. No adult or individual as defined in OAR 411-340-0020 shall be abused nor shall any employee, staff, or volunteer of the brokerage or provider organization condone abuse.

(a) Brokerages and provider organizations must have in place appropriate and adequate disciplinary policies and procedures to

address instances when a staff member has been identified as an accused person in an abuse investigation as well as when the allegation of abuse has been substantiated.

(b) All employees of a brokerage or provider organization are mandatory reporters. The brokerage or provider organization must:

(A) Notify all employees of mandatory reporting status at least annually on forms provided by the Department; and

(B) Provide all employees with a Department-produced card regarding abuse reporting status and abuse reporting.

(2) INCIDENT REPORTS.

(a) A brokerage or provider organization must prepare an incident report for instances of potential or suspected abuse or an unusual incident as defined in OAR 411-340-0020, involving an individual and a brokerage or provider organization employee. The incident report must be placed in the individual's record and must include:

(A) Conditions prior to or leading to the potential or suspected abuse or unusual incident;

(B) A description of the potential or suspected abuse or unusual incident;

(C) Staff response at the time; and

(D) Review by the brokerage administration and follow-up to be taken to prevent recurrence of the potential or suspected abuse or unusual incident.

(b) A brokerage or provider organization must send copies of all incident reports involving potential or suspected abuse that occurs while an individual is receiving brokerage or provider organization services to the CDDP.

(c) A provider organization must send copies of incident reports of all potential or suspected abuse or unusual incidents that occur while the

individual is receiving services from a provider organization to the individual's brokerage within five working days of the potential or suspected abuse or unusual incident.

(3) IMMEDIATE NOTIFICATION

(a) The brokerage must immediately report to the CDDP, and the provider organization must immediately report to the CDDP with notification to the brokerage, any incident or allegation of potential or suspected abuse falling within the scope of OAR 407-045-0260.

(A) When an abuse investigation has been initiated, the CDDP must provide notice according to OAR 407-045-0290.

(B) When an abuse investigation has been completed, the CDDP must provide notice of the outcome of the investigation according to OAR 407-045-0320.

(b) In the case of emergency overnight hospitalization due to illness or injury to an individual, the brokerage or provider organization must immediately notify:

(A) The individual's legal representative, parent, next of kin, designated contact person, or other significant person (as applicable); and

(B) In the case of a provider organization, the individual's brokerage.

(c) In the event of the death of an individual, the brokerage or provider organization must immediately notify:

(A) The Medical Director of the Department;

(B) The individual’s legal representative, parent, next of kin, designated contact person, or other significant person (as applicable);

(C) The CDDP; and

(D) In the case of a provider organization, the individual's brokerage.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0050 Inspections and Investigations in Support Services Brokerages and Provider Organizations
(Amended 12/28/2013)

(1) Support services brokerages and provider organizations certified under these rules must allow the following types of investigations and inspections:

(a) Quality assurance and on-site inspections;

(b) Complaint investigations; and

(c) Abuse investigations.

(2) The Department, CDDP, or proper authority perform all inspections and investigations.

(3) Any inspection or investigation may be unannounced.

(4) All documentation and written reports required by this rule must be:

(a) Open to inspection and investigation by the Department, CDDP, or proper authority; and

(b) Submitted to the Department within the time allotted.

(5) When abuse is alleged or death of an individual has occurred and a law enforcement agency, the Department, or CDDP has determined to initiate an investigation, the brokerage or provider organization may not conduct an internal investigation without prior authorization from the Department. For the purposes of this rule, an "internal investigation" is defined as:

(a) Conducting interviews with the alleged victim, witness, the accused person, or any other person who may have knowledge of the facts of the abuse allegation or related circumstances;

(b) Reviewing evidence relevant to the abuse allegation, other than the initial report; or

(c) Any other actions beyond the initial actions of determining:

(A) If there is reasonable cause to believe that abuse has occurred;

(B) If the alleged victim is in danger or in need of immediate protective services;

(C) If there is reason to believe that a crime has been committed; or

(D) What, if any, immediate personnel actions must be taken.

(6) The Department or the CDDP shall conduct abuse investigations as set forth in OAR 407-045-0250 to OAR 407-045-0360 and shall complete an abuse investigation and protective services report according to OAR 407-045-0320.

(7) Upon completion of the abuse investigation by the Department, CDDP, or a law enforcement agency, a provider may conduct an investigation without further Department approval to determine if any other personnel actions are necessary.

(8) Upon completion of the abuse investigation and protective services report, in accordance with OAR 407-045-0330, the sections of the report that are public records and not exempt from disclosure under the public records law shall be provided to the appropriate brokerage or provider organization.

(9) The brokerage or provider organization may be required to submit to the Department a plan of improvement for any noncompliance found during an inspection pursuant to section (1)(a) of this rule.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0060 Complaints in Support Services Brokerages
(Amended 12/28/2013)

(1) COMPLAINTS. Brokerages must develop and implement written policies and procedures regarding individual complaints and a formal complaint process. These policies and procedures must at minimum address:

(a) Receipt of complaints. If a complaint is associated in any way with abuse, the recipient of the complaint must immediately report the issue to the CDDP and notify the brokerage director and, if applicable, the provider organization director. The brokerage must maintain a log of all complaints regarding the brokerage, provider organization, or independent provider that the brokerage receives from individuals, others acting on the behalf of individuals, and from provider organizations acting in accordance with OAR 411-340-0170(2)(a)(C)(v).

(A) The complaint log must, at a minimum, include the following:

(i) The date the complaint was received;

(ii) The name of the person taking the complaint;

(iii) The nature of the complaint;

(iv) The name of the person making the complaint, if known; and

(v) The disposition of the complaint.

(B) Brokerage personnel issues and allegations of abuse may be maintained separately from a central complaint log. If a complaint results in disciplinary action against a staff member,

the documentation on the complaint must include a statement that disciplinary action was taken.

(b) Informal complaint resolution. An individual or a person acting on behalf of the individual must have an opportunity to informally discuss and resolve any allegation that a brokerage, provider organization, or independent provider has taken action that is contrary to law, rule, policy, or that is otherwise contrary to the interest of the individual and that does not meet the criteria for an abuse investigation. Choosing an informal resolution does not preclude an individual or a person acting on behalf of the individual from pursuit of resolution through formal complaint processes.

(c) Investigation of the facts supporting or disproving the complaint.

(d) Taking appropriate actions. The brokerage must take steps to resolve the complaint within five working days following receipt of the complaint. If the complaint cannot be resolved informally, or if the individual or the person acting on behalf of the individual so chooses at any time, the individual or the person acting on behalf of the individual may request a formal resolution of the complaint and, if needed, must be assisted by the brokerage with initiating the formal complaint process.

(e) Review by the brokerage director. If a complaint involves brokerage staff or services and if the complaint is not resolved according to subsection (b) to (d) of this section or if the individual or the person acting on behalf of the individual requests one, a formal review must be completed by the brokerage director and a written response must be provided to the individual or the person acting on behalf of the individual within 30 days following receipt of the complaint.

(f) Agreement to resolve the complaint. Any agreement to resolve a complaint that has been formally reviewed by the brokerage director must be in writing and must be specifically approved by the individual or the person acting on behalf of the individual. The brokerage must provide the individual or the person acting on behalf of the individual with a copy of the agreement.

(g) Administrative review. Unless the individual is a Medicaid recipient and the individual or the person acting on behalf of the individual has elected to initiate the hearing process according to section (3) of this rule, the complaint may be submitted to the Department for administrative review when the complaint cannot be resolved by the brokerage and the complaint involves the provision of services or a provider.

(A) Following a decision by the brokerage director regarding a complaint, the complainant may request an administrative review by the Department's director.

(B) The individual or the person acting on behalf of the individual must submit to the Department a request for an administrative review within 15 days from the date of the decision by the brokerage director.

(C) Upon receipt of a request for an administrative review, the Department's director shall appoint an Administrative Review Committee and name the chairperson. The Administrative Review Committee is comprised of a representative of the Department, a CDDP representative, and a brokerage representative. The Administrative Review Committee representatives may not have any direct involvement in the provision of services to the individual or have a conflict of interest in the specific case being reviewed.

(D) The Administrative Review Committee shall review the complaint and the decision by the brokerage director and make a recommendation to the Department's director within 45 days of receipt of the complaint unless the individual or the person acting on behalf of the individual and the Administrative Review Committee mutually agree to an extension.

(E) The Department's director shall consider the report and recommendations of the Administrative Review Committee and make a final decision. The decision is in writing and issued within 10 days of receipt of the recommendation by the Administrative Review Committee. The written decision contains the rationale for the director's decision.

(F) The decision of the Department's director is final. Any further review is pursuant to the provision of ORS 183.484 for judicial review.

(h) Documentation of complaint. Documentation of each complaint and resolution of the complaint must be filed or noted in the individual's record.

(2) NOTIFICATION. Upon enrollment and annually thereafter, and when a complaint is not resolved according to section (1)(b) through (1)(d) of this rule, the brokerage must inform each individual, or as applicable the individual's legal or designated representative, orally and in writing, using language, format, and methods of communication appropriate to the individual's needs and abilities, of the following:

(a) Brokerage grievance policy and procedures, including the right to an administrative review and the method to obtain an administrative review; and

(b) The right of a Medicaid recipient to a hearing as pursuant to section (3) of this rule and the procedure to request a hearing.

(3) DENIAL, TERMINATION, SUSPENSION, OR REDUCTION OF SERVICES FOR INDIVIDUAL MEDICAID RECIPIENTS.

(a) Each time the brokerage takes an action to deny, terminate, suspend, or reduce an individual's access to services covered under Medicaid, the brokerage must notify the individual, or as applicable the individual's legal or designated representative, of the right to a hearing and the method to request a hearing. The brokerage must mail the notice by certified mail or personally serve the notice to the individual, or as applicable the individual's legal or designated representative, 10 days or more prior to the effective date of an action.

(A) The brokerage must use form SDS 0947, Notification of Planned Action, or a comparable Department-approved form for such notification.

(B) This notification requirement does not apply if an action is part of, or fully consistent with an individual's ISP, and the individual, or as applicable the individual's legal or designated representative, has agreed with the action by signature to the ISP.

(b) A notice required by section (3)(a) of this rule must include:

(A) The action the brokerage intends to take;

(B) The reasons for the intended action;

(C) The specific Oregon Administrative Rules that support, or the change in federal or state law that requires, the action;

(D) The appealing party's right to request a hearing in accordance with OAR chapter 137, ORS chapter 183, and 42 CFR Part 431, Subpart E;

(E) A statement that the brokerage files on the subject of the hearing automatically becoming part of the hearing record upon default for the purpose of making a prima facie case;

(F) A statement that the actions specified in the notice take effect by default if a Department representative does not receive a request for a hearing from the individual, or as applicable the individual's legal or designated representative, within 45 days from the date that the brokerage mails the notice of action;

(G) In cases of an action based upon a change in law, the circumstances under which a hearing is granted; and

(H) An explanation of the circumstances under which brokerage services are continued if a hearing is requested.

(c) If an individual, or as applicable the individual's legal or designated representative, disagrees with a decision or proposed action by the brokerage to deny, terminate, suspend, or reduce an individual's access to services covered under Medicaid, the

individual, or as applicable the individual's legal or designated representative, may request a hearing as provided in ORS chapter 183. The request for a hearing must be in writing on form DHS 443 and signed by the individual or the individual's legal or designated representative (as applicable). The signed form (DHS 443) must be received by the Department within 45 days from the date the brokerage mailed the notice of action.

(d) An individual, or as applicable the individual's legal or designated representative, may request an expedited hearing if the individual, or as applicable the individual's legal or designated representative, feels that there is immediate, serious threat to the individual's life or health if the normal timing of the hearing process is followed.

(e) If an individual, or as applicable the individual's legal or designated representative, requests a hearing before the effective date of the proposed action and requests that the existing services be continued, the Department shall continue the services.

(A) The Department must continue the services until whichever of the following occurs first:

(i) The current authorization expires;

(ii) The administrative law judge issues a proposed order and the Department issues a final order; or

(iii) The individual is no longer eligible for Medicaid benefits.

(B) The Department must notify the individual, or as applicable the individual's legal or designated representative, that the Department is continuing the service. The notice must inform the individual, or as applicable the individual's legal or designated representative, that if the hearing is resolved against the individual, the Department may recover the cost of any services continued after the effective date of the continuation notice.

(f) The Department must reinstate services if:

(A) The Department takes an action without providing the required notice and the individual, or as applicable the individual's legal or designated representative, requests a hearing;

(B) The Department fails to provide the notice in the time required in this rule and the individual, or as applicable the individual's legal or designated representative, requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the individual, or as applicable the individual's legal or designated representative, but the location of the individual, or as applicable the individual's legal or designated representative, becomes known during the time that the individual is still eligible for services.

(g) The Department must promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the individual or if the Department decides in the individual's favor before the hearing.

(h) The Department representative and the individual, or as applicable the individual's legal or designated representative, may have an informal conference without the presence of an administrative law judge to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for the Department and the individual, or as applicable the individual's legal or designated representative, to settle the matter;

(B) Ensure the individual, or as applicable the individual's legal or designated representative, understands the reason for the action that is the subject of the hearing request;

(C) Give the individual, or as applicable the individual's legal or designated representative, an opportunity to review the information that is the basis for that action;

(D) Inform the individual, or as applicable the individual's legal or designated representative, of the rules that serve as the basis for the contested action;

(E) Give the individual, or as applicable the individual's legal or designated representative, and the Department the chance to correct any misunderstanding of the facts;

(F) Determine if the individual, or as applicable the individual's legal or designated representative, wishes to have any witness subpoenas issued; and

(G) Give the Department an opportunity to review the Department's action or the action of the brokerage.

(i) At any time prior to the hearing date, the individual, or as applicable the individual's legal or designated representative, may request an additional conference with the Department representative. At the Department representative's discretion, the Department representative may grant an additional conference if the additional conference facilitates the hearing process.

(j) The Department may provide the individual, or as applicable the individual's legal or designated representative, the relief sought at any time before the final order is issued.

(k) An individual, or as applicable the individual's legal or designated representative, may withdraw a hearing request at any time prior to the issuance of a final order. The withdrawal is effective on the date the Department or the Office of Administrative Hearings receives the request for withdrawal. The Department must issue a final order confirming the withdrawal to the last known address of the individual or the individual's legal or designated representative (as applicable). The individual, or as applicable the individual's legal or designated representative, may cancel the withdrawal up to 10 working days following the date the final order is issued.

(l) Proposed and final orders.

(A) In a contested case, the administrative law judge must serve a proposed order on the individual, or as applicable the individual's legal or designated representative, and the Department.

(B) If the administrative law judge issues a proposed order that is adverse to the individual, the individual, or as applicable the individual's legal or designated representative, may file an exception to the proposed order to be considered by the Department. The exception must be in writing and must be received by the Department no later than 10 days after service of the proposed order. The individual, or as applicable the individual's legal or designated representative, may not submit additional evidence after this period unless the Department grants prior approval.

(C) After receiving an exception, if any, the Department may adopt a proposed order as a final order or may prepare a new order. Prior to issuing the final order, the Department may issue an amended proposed order.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0070 Support Services Brokerage and Provider Organization Personnel Policies and Practices
(Amended 12/28/2013)

(1) Brokerages and provider organizations must maintain up-to-date written position descriptions for all staff as well as a file, available to the Department or CDDP for inspection that includes written documentation of the following for each staff:

(a) Reference checks and confirmation of qualifications prior to hire;

(b) Written documentation of an approved background check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370;

(c) Satisfactory completion of basic orientation, including instructions for mandatory reporting and training specific to intellectual or developmental disabilities and skills required to carry out assigned work if the employee is to provide direct assistance to individuals;

(d) Written documentation of employee notification of mandatory reporter status;

(e) Written documentation of any founded report of child abuse or substantiated abuse;

(f) Written documentation of any complaints filed against the staff and the results of the complaint process, including any disciplinary action; and

(g) Legal eligibility to work in the United States.

(2) Any employee providing direct assistance to individuals must be at least 18 years of age and capable of performing the duties of the job as described in a current job description signed and dated by the employee.

(3) An application for employment at the brokerage or provider organization must inquire whether an applicant has had any founded reports of child abuse or substantiated abuse.

(4) Any employee of the brokerage or provider organization, or any subject individual defined by OAR 407-007-0210, who has or will have contact with an eligible individual of support services, must have an approved background check in accordance with OAR 407-007-0200 to 407-007-0370 and under ORS 181.534.

(5) Effective July 28, 2009, a person may not be authorized as a provider or meet qualifications as described in this rule if the person has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(6) Section (5) of this rule does not apply to employees of the brokerage or provider organization who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(7) Each brokerage and provider organization regulated by these rules must be a drug-free workplace.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0080 Support Services Brokerage and Provider Organization Records
(Amended 12/28/2013)

(1) CONFIDENTIALITY. Brokerage and provider organization records of services to individuals must be kept confidential in accordance with ORS 179.505, 45 CFR 205.50, 45 CFR 164.512 Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 HIPAA, and any Department rules or policies pertaining to individual service records.

(2) DISCLOSURE AND CONFIDENTIALITY. For the purpose of disclosure from individual medical records under these rules, brokerages, and provider organizations requiring certification under OAR 411-340-0170(2), are considered "providers" as defined in ORS 179.505(1) and ORS 179.505 is applicable.

(a) Access to records by the Department does not require authorization by an individual or an individual's legal or designated representative or family.

(b) For the purpose of disclosure of non-medical individual records, all or portions of the information contained in the non-medical individual records may be exempt from public inspection under the personal privacy information exemption to the public records law set forth in ORS 192.502(2).

(3) GENERAL FINANCIAL POLICIES AND PRACTICES. The brokerage or provider organization must:

(a) Maintain up-to-date accounting records consistent with generally accepted accounting principles that accurately reflect all revenue by source, all expenses by object of expense, and all assets, liabilities, and equities;

(b) As a provider organization, or as a brokerage offering services to the general public, establish and revise, as needed, a fee schedule identifying the cost of each service provided. Billings for Medicaid funds may not exceed the customary charges to private individuals for any like item or services charged by the brokerage or provider organization; and

(c) Develop and implement written statements of policy and procedure as are necessary and useful to assure compliance with any Department rule pertaining to fraud and embezzlement.

(4) RECORDS RETENTION. Records must be retained in accordance with OAR chapter 166, division 150, Secretary of State, Archives Division.

(a) Financial records, supporting documents, statistical records, and all other records (except individual records) must be retained for a minimum of three years after the close of the contract period.

(b) Individual records must be kept for a minimum of seven years.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0090 Support Services Brokerage and Provider Organization Request for Variance
(Amended 12/28/2013)

(1) Variances may be granted to a brokerage or provider organization:

(a) If the brokerage or provider organization lacks the resources needed to implement the standards required in these rules;

(b) If implementation of the proposed alternative services, methods, concepts, or procedures would result in services or systems that meet or exceed the standards in these rules; or

(c) If there are other extenuating circumstances.

(2) Variances may not be granted to OAR 411-340-0130 and OAR 411-340-0140.

(3) The brokerage or provider organization requesting a variance must submit to the Department, in writing, an application that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The proposed alternative practice, service, method, concept, or procedure;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) If the variance applies to an individual's services, evidence that the variance is consistent with an individual's currently authorized ISP.

(4) The Department may approve or deny the variance request. The Department's decision shall be sent to the brokerage or provider organization and to all relevant Department programs or offices within 45 calendar days of the receipt of the variance request.

(5) The brokerage or provider organization may appeal the denial of a variance request by sending a written request for review to the Department's director, whose decision is final.

(6) The Department shall determine the duration of the variance.

(7) The brokerage or the provider organization may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0100 Eligibility for Support Services Brokerage Services
(Amended 12/28/2013)

(1) Individuals determined eligible according to this rule may not be denied brokerage services or otherwise discriminated against on the basis of age, diagnostic or disability category, race, color, creed, national origin, citizenship, income, or duration of Oregon residence.

(2) The CDDP of an individual's county of residence may find the individual eligible for brokerage services when:

(a) The individual is an Oregon resident who has been determined eligible for developmental disability services by the CDDP;

(b) The individual is an adult living in the individual's own home or family home;

(c) At the time of initial entry to the brokerage, the individual is not enrolled in comprehensive services;

(d) At the time of initial entry to the brokerage, the individual is not receiving short-term services from the Department because the individual is eligible for, and at imminent risk of, civil commitment under ORS chapter 427.215 through 427.306; and

(e) The individual, or as applicable the individual's legal or designated representative, has chosen to use a brokerage for assistance with design and management of personal supports.

(3) Individuals are not eligible for services by more than one brokerage unless the concurrent eligibility:

(a) Is necessary to affect transition from one brokerage to another;

(b) Is part of a collaborative plan between the affected brokerages; and

(c) Does not duplicate services and expenditures.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0110 Standards for Support Services Brokerage Entry and Exit
(Amended 12/28/2013)

(1) The brokerage must make accurate, up-to-date, information about the brokerage available to individuals referred for services and the individuals' legal or designated representatives. This information must include:

(a) A declaration of brokerage philosophy;

(b) A brief description of the services provided by the brokerage, including typical timelines for activities;

(c) A description of processes involved in using the services, including application and referral, assessment, planning, and evaluation;

(d) A declaration of brokerage employee responsibilities as mandatory abuse reporters;

(e) A brief description of individual responsibilities for use of public funds;

(f) An explanation of individual rights, including an individual’s right to:

(A) Choose a brokerage from among Department-contracted brokerages in an individual's county of residence that is serving less than the total number of individuals specified in the brokerage's current contract with the Department;

(B) Choose a personal agent among those available in the selected brokerage;

(C) Select providers among those willing, available, and qualified according to OAR 411-340-0160, OAR 411-340-0170,

and OAR 411-340-0180 to provide supports authorized through the individual's ISP;

(D) Direct the services of providers; and

(E) Raise and resolve concerns about brokerage services, including specific rights to notification and hearing for Medicaid recipients according to OAR 411-340-0060 when services covered under Medicaid are denied, terminated, suspended, or reduced.

(g) Indication that additional information about the brokerage is available on request. The additional information must include but not be limited to:

(A) A description of the brokerage's organizational structure;

(B) A description of any contractual relationships the brokerage has in place, or may establish, to accomplish the brokerage functions required by rule; and

(C) A description of the relationship between the brokerage and the brokerage's Policy Oversight Group.

(2) The brokerage must make the information required in section (1) of this rule available using language, format, and presentation methods appropriate for effective communication according to individuals' needs and abilities.

(3) ENTRY INTO BROKERAGE SERVICES.

(a) To enter brokerage services:

(A) An individual must be determined by the CDDP to be eligible for brokerage services according to OAR 411-340-0100; and

(B) The individual, or as applicable the individual's legal or designated representative, must choose to receive services from a selected brokerage.

(b) The Department may implement guidelines that govern entries when the Department has determined that such guidelines are prudent and necessary for the continued development and implementation of support services.

(c) The brokerage may not accept individuals for entry beyond the total number of individuals specified in the brokerage's current contract with the Department.

(4) EXIT FROM A BROKERAGE.

(a) An individual must exit a brokerage:

(A) At the written request of the individual, or as applicable the individual's legal or designated representative, to end the service relationship;

(B) If an individual requests case management services from a CDDP. The brokerage must refer the individual to the local CDDP for case management within 10 working days of the request;

(C) No fewer than 30 days after the brokerage has served written notice of intent to exit the individual from brokerage services, when the individual, or as applicable the individual's legal or designated representative, either cannot be located or has not responded to repeated attempts by brokerage staff to complete ISP development or monitoring activities, and does not respond to the notice of intent to terminate; or

(D) Upon entry into a comprehensive service.

(b) Any individual being exited from a brokerage must be given written notice of the intent to terminate service at least 10 days prior to the termination.

(c) Each brokerage must have policies and procedures for notifying the CDDP of an individual's county of residence when the individual plans to exit, or exits, brokerage services. Notification method,

timelines, and content must be based on agreements between the brokerage and CDDP's of each county in which the brokerage provides services.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0120 Support Service Brokerage Services
(Amended 12/28/2013)

(1) Each brokerage must provide or arrange for the following services as required to meet individual support needs:

(a) Assistance for individuals to determine needs and plan supports in response to needs;

(b) For individuals who have not had a service level determined, develop individualized budgets based on available resources;

(c) Assistance for individuals to find and arrange the resources to provide planned supports;

(d) Assistance with development and expansion of community resources required to meet the support needs of individuals served by the brokerage;

(e) Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct providers;

(f) Fiscal intermediary services in the receipt and accounting of support services funds on behalf of individuals in addition to making payment to providers with the authorization of an individual;

(g) Employer-related supports; and

(h) Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.

(2) SELF-DETERMINATION. Brokerages must apply the principles of self-determination to provision of services required in section (1) of this rule.

(3) PERSON-CENTERED PLANNING. A brokerage must use a person-centered planning approach to assist individuals to establish outcomes, determine needs, plan for supports, and review and redesign support strategies.

(4) HEALTH AND SAFETY ISSUES. The planning process must address basic health and safety needs and supports, including but not limited to:

(a) Identification of risks, including risk of serious neglect, intimidation, and exploitation;

(b) Informed decisions by the individual, or as applicable the individual's legal or designated representative, regarding the nature of supports or other steps taken to ameliorate any identified risks; and

(c) Education and support to recognize and report abuse.

(5) PERSONAL AGENT SERVICES.

(a) An individual entered into brokerage services must be assigned a personal agent for case management services.

(b) INITIAL DESIGNATION OF PERSONAL AGENT.

(A) The brokerage must designate a personal agent for individuals newly entered in support services within 10 working days from the date entry becomes known to the brokerage.

(B) In the instance of an individual transferring into a brokerage from another brokerage, the brokerage must designate a personal agent within 10 days of entry to the new brokerage.

(C) The brokerage must send a written notice that includes the name, telephone number, and location of the personal agent or brokerage to the individual, and as applicable the individual's

legal or designated representative, within 10 working days from the date entry becomes known to the brokerage.

(D) Prior to implementation of an individual's initial ISP, the brokerage must ask the individual, or as applicable the individual's legal or designated representative, to identify any family and other advocates to whom the brokerage must provide the name, telephone number, and location of the personal agent.

(c) CHANGE OF PERSONAL AGENT. Changes of personal agents initiated by the brokerage must be kept to a minimum. If the brokerage must change personal agent assignments, the brokerage must notify the individual, or as applicable the individual's legal or designated representative, and all current providers within 10 working days of the change. The notification must be in writing and include the name, telephone number, and address of the new personal agent, if known, or of a contact person at the brokerage.

(d) OSIP-M ELIGIBILITY. If an individual loses OSIP-M eligibility, a personal agent must assist the individual in identifying why OSIP-M eligibility was lost. Whenever possible, the personal agent must assist the individual in becoming eligible for OSIP-M again. The personal agent must document efforts taken to assist the individual in becoming OSIP-M eligible.

(6) PARTICIPATION IN PROTECTIVE SERVICES. The brokerage and personal agent are responsible for the delivery of protective services, in cooperation with the CDDP, through the completion of activities necessary to address immediate health and safety concerns.

(7) CHOICE ADVISING. Choice advising regarding the provision of case management and other services must be provided to individuals who are eligible for, and desire, developmental disability services. Choice advising must be provided at least annually.

(8) LEVEL OF CARE DETERMINATION.

(a) The brokerage must assure that individuals, who are eligible or become eligible for OSIP-M after entry into the brokerage, receive a

level of care determination. Individuals, who are eligible or become eligible after entry into the brokerage, must:

(A) Be offered the choice between home and community-based services or institutional care;

(B) Be provided a notice of fair hearing rights; and

(C) Have the level of care determination reviewed annually or at any time there is a significant change in a condition that qualified the individual for the level of care.

(b) The level of care determination must be documented in a progress note in the individual's record. The level of care determination must be completed no more than 90 days prior to the authorization of the individual's initial ISP and no more than 60 days prior to the annual reauthorization.

(9) FUNCTIONAL NEEDS ASSESSMENT. The brokerage must complete a functional needs assessment at least annually for any individual who is enrolled in waiver or Community First Choice services. The functional needs assessment must be completed:

(a) Within 30 days of entry into a brokerage;

(b) Within 30 days of establishing eligibility for OSIP-M and determining level of care;

(c) Within 60 days prior to the authorization of an ISP; and

(d) Within 45 days from the time the individual, or as applicable the individual's legal or designated representative, requests a functional needs assessment.

(10) INDIVIDUAL SUPPORT PLANS.

(a) An individual who is accessing waiver or Community First Choice services must have an authorized ISP.

(A) The ISP must be facilitated, developed, and authorized by a personal agent.

(B) The ISP must be authorized within 60 days of the completion of a functional needs assessment and at least annually thereafter.

(C) The brokerage must provide a written copy of the most current ISP to the individual and the individual's legal or designated representative (as applicable).

(b) The ISP must address all the support needs identified in a functional needs assessment. The ISP or attached documents must include:

(A) The individual's name and the name of the individual's legal or designated representative (as applicable);

(B) A description of the supports required that is consistent with the individual's functional needs assessment, including the reason the support is necessary;

(C) The projected dates of when specific supports are to begin and end;

(D) A list of personal, community, and public resources that are available to the individual and how the resources may be applied to provide the required supports. Sources of support may include waiver services, state plan services, state general funds, or natural supports;

(E) The manner in which services are delivered and the frequency of services;

(F) The providers of supports to be purchased with support services funds or the type of provider, such as an independent provider, provider organization, or general business provider, when the provider is unknown or is likely to change frequently;

(G) The setting in which the individual resides as chosen by the individual;

(H) The individual's strengths and preferences;

(I) The clinical and support needs as identified through a functional needs assessment;

(J) Individually identified goals and desired outcomes;

(K) The services and supports (paid and unpaid) to assist the individual to achieve identified goals and the providers of the services and supports, including voluntarily provided natural supports;

(L) The risk factors and the measures in place to minimize the risk factors, including back up plans;

(M) The identity of the person responsible for case management and monitoring the ISP;

(N) A provision to prevent unnecessary or inappropriate care;

(O) The alternative settings considered by the individual;

(P) Schedule of ISP reviews;

(Q) Any changes in support needs identified in a functional needs assessment; and

(R) Any revisions to the ISP that may alter:

(i) The amount of support services funds required;

(ii) The amount of support services required;

(iii) Types of support purchased with support services funds; and

(iv) The type of support provider.

(c) ISP SCHEDULE. The schedule of the support services ISP, developed in compliance with this rule after an individual enters a brokerage, may be adjusted one time for any individual entering a brokerage in the following circumstances. An adjustment interrupts any plan year in progress and establishes a new plan year for the individual beginning on the date the first new ISP is authorized.

(A) Brokerages, with the consent of an individual, or as applicable an individual's legal or designated representative, may designate a new ISP start date.

(i) An adjustment may only occur one time per individual upon ISP renewal.

(ii) An ISP date adjustment must be clearly documented in the ISP.

(B) A new ISP start date may be designated for individuals transitioning from family support services regulated by OAR chapter 411, division 305, children's intensive in-home services (CIIS) regulated by OAR chapter 411, division 300, or medically fragile children (MFC) services regulated by OAR chapter 411, division 350, when those individuals are 18 years of age. The date of an individual's first new support services ISP after entry to the brokerage may be adjusted to correspond to the expiration date of the individual's ISP in place at the time the individual turns 18 years of age when the ISP, developed while the individual is still receiving family support, CIIS, or MFC services, has been authorized for implementation prior to, or upon, the individual's entry to the brokerage.

(C) A new ISP start date may be designated for individuals transitioning from other Department-paid services who are required by the Department to transition to support services. The date of the individual's first support services ISP may be adjusted to correspond to the expiration date of the individual's plan for services when the plan for services:

(i) Has been developed according to regulations governing Department-paid services the individual receives prior to transition;

(ii) Is current at the time designated by the Department for transition to support services; and

(iii) Is authorized for implementation prior to, or upon, the individual's entry to the brokerage.

(d) ISP AUTHORIZATION.

(A) An initial and annual ISP must be authorized prior to implementation.

(B) A revision to an initial or annual ISP that involves the types of support purchased with support services funds must be authorized prior to implementation.

(C) A revision to an initial or annual ISP that does not involve the types of support purchased with support services funds does not require authorization. Documented verbal agreement to the revision by the individual, or as applicable the individual’s legal or designated representative, is required prior to implementation of the revision.

(D) An ISP is authorized when:

(i) The signature of the individual, or as applicable the individual's legal or designated representative, is present on the ISP or documentation is present explaining the reason an individual who does not have a legal or designated representative may be unable to sign the ISP.

(I) Acceptable reasons for an individual without a legal or designated representative not to sign the ISP include physical or behavioral inability to sign the ISP.

(II) Unavailability is not an acceptable reason for an individual, or as applicable the individual's legal or designated representative, not to sign the ISP.

(III) In the case of a revision to an initial or annual ISP that is in response to immediate, unexpected change in circumstance, and is necessary to prevent injury or harm to the individual, documented verbal agreement may substitute for a signature for no more than 10 working days.

(ii) The signature of the personal agent involved in the development of, or revision to, the ISP is present on the ISP; and

(iii) A designated brokerage representative has reviewed the ISP for compliance with Department rules and policy.

(e) PERIODIC REVIEW OF ISP AND RESOURCES.

(A) A personal agent must conduct and document reviews of an individual's ISP and resources with the individual and the individual's legal or designated representative (as applicable).

(B) At least annually, as part of preparation for a new ISP, the personal agent must:

(i) Evaluate an individual's progress toward achieving the purposes of the ISP and assess and revise goals as needed;

(ii) Note effectiveness of the use of support services funds based on personal agent observation as well as individual satisfaction;

(iii) Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports; and

(iv) Record final support services fund costs.

(11) ANNUAL PLANS. An Annual Plan must be completed for individuals who do not access waiver or Community First Choice services.

(a) The Annual Plan must be completed within 60 days of an individual's enrollment into support services.

(b) A written Annual Plan must be documented in an individual's record as an Annual Plan or as a comprehensive progress note and consist of:

(A) A review of the individual's current living situation;

(B) A review of any personal health, safety, or behavioral concerns;

(C) A summary of the individual's support needs; and

(D) Actions to be taken by the personal agent and others.

(12) PROFESSIONAL OR OTHER SERVICE PLANS.

(a) A Nursing Care Plan must be attached to an ISP when support services funds are used to purchase services requiring the education and training of a licensed professional nurse.

(b) A Support Services Brokerage Crisis Addendum, or other document prescribed by the Department for use in these circumstances, must be attached to the ISP when an individual enrolled in a brokerage is in emergent status in a short-term, out-of-home, residential placement as part of the individual's crisis diversion services.

(13) TRANSITION TO ANOTHER BROKERAGE. At the request of an individual enrolled in brokerage services who has selected another brokerage, or as applicable the individual's legal or designated representative, the brokerage must collaborate with the receiving brokerage and the CDDP of the individual's county of residence to transition support services.

(a) If the Department has designated and contracted funds solely for the support of the transitioning individual, the brokerage must notify the Department to consider transfer of the funds for the individual to the receiving brokerage.

(b) The ISP in place at the time of request for transfer may remain in effect 90 days after entry to the new brokerage while a new ISP is negotiated and authorized.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0125 Crisis Supports in Support Services
(Amended 12/28/2013)

(1) The brokerage must, in conjunction with its Regional Crisis Diversion Program, attempt to provide supports that mediate a crisis risk factor for adults who are:

(a) Entered in support services; and

(b) Determined to be in crisis as described in section (2) of this rule.

(2) CRISIS DETERMINATION.

(a) An individual enrolled in support services is eligible for crisis diversion services when:

(A) A brokerage has referred an individual to the Regional Crisis Diversion Program because the brokerage has determined that one or more of the following crisis risk factors, not primarily related to a significant mental or emotional disorder or substance abuse, are present and for which no appropriate alternative resources are available:

(i) An individual is not receiving necessary supports to address life-threatening safety skill deficits;

(ii) An individual is not receiving necessary supports to address life-threatening issues resulting from behavioral or medical conditions;

(iii) An individual currently engages in self-injurious behavior serious enough to cause injury that requires professional medical attention;

(iv) An individual undergoes, or is at imminent risk of undergoing, loss of primary caregiver due to the primary caregiver's inability to provide supports;

(v) An individual experiences a loss of home due to a protective service action; or

(vi) An individual is not receiving the necessary supports to address significant safety risks to others, including but not limited to:

(I) A pattern of physical aggression serious enough to cause injury;

(II) Fire-setting behaviors; or

(III) Sexually aggressive behaviors or a pattern of sexually inappropriate behaviors.

(B) The Regional Crisis Diversion Program has determined crisis eligibility according to OAR 411-320-0160; and

(C) The individual's ISP has been revised to address the identified crisis risk factors and the revisions:

(i) May resolve the crisis; and

(ii) May not contribute to new or additional crisis risk factors.

(b) A functional needs assessment must be completed for any individual determined to be in crisis as described in this section of this rule.

(3) CRISIS SUPPORTS.

(a) An ISP for an individual in emergent status may authorize short-term, out-of-home, residential placement. Residential placement does not exit an individual from support services.

(b) The individual's personal agent must:

(A) Participate with the Regional Crisis Diversion Program staff in efforts to stabilize supports and return costs to the individual's benefit level;

(B) Assist with the identification of qualified providers who may be paid in whole, or in part, using crisis diversion funding except in the case of short-term, out-of-home, residential placements with a licensed or certified provider;

(C) Complete and coordinate the Support Services Brokerage Crisis Addendum when an individual in emergent status requires a short-term, out-of-home, residential placement; and

(D) Monitor the delivery of supports provided, including those provided through crisis funding.

(i) Monitoring is done through contact with the individual, any providers, and the individual's legal or designated representative and family (as applicable).

(ii) Monitoring is done to collect information regarding supports provided and progress toward outcomes that are identified as necessary to resolve the crisis.

(iii) The personal agent must document the information described in subparagraph (ii) of this paragraph in the individual's record and report to the Regional Crisis Diversion Program or CDDP as required.

(c) Support services provided during emergent status are subject to all requirements of this rule.

(d) All supports authorized in an ISP continue during the crisis unless prohibited by other rule, policy, or the supports contribute to new or additional crisis risk factors.

(4) TRANSITION TO COMPREHENSIVE SERVICES. When an individual eligible for crisis supports may have long-term support needs that may not be met through support services:

(a) The brokerage must immediately notify the CDDP of the individual’s county of residence;

(b) The brokerage must coordinate with the CDDP and the Regional Crisis Diversion Program to facilitate a timely exit from support services and entry into appropriate, alternative services; and

(c) The brokerage must assure that information required for a potential provider of comprehensive services is available as needed for a referral to be made.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0130 Using Support Services Funds to Purchase Supports
(Amended 12/28/2013)

(1) A brokerage may use support services funds to assist individuals to purchase supports in accordance with an ISP when:

(a) Supports are necessary for an individual to live in the individual's own home or in the individual's family home;

(b) For an individual who has not had a service level determined, a functional needs assessment has determined the individual's support needs;

(c) An enrolled individual meets the criteria for level of care;

(d) An enrolled individual is eligible for OSIP-M;

(e) Cost-effective arrangements for obtaining the required supports, applying public, private, formal, and informal resources available to the eligible individual are specified in the individual's ISP;

(A) Support services funds are not intended to replace the resources available to an individual from the individual's natural supports. Support services funds may be authorized only when the individual's natural supports are unavailable, insufficient, or inadequate to meet the needs of the individual.

(B) Support services funds are not available when an individual’s support needs may be met by alternative resources. Support services funds may be authorized only when alternative resources are unavailable, insufficient, or inadequate to meet the needs of the individual.

(f) For an individual who has not had a service level determined, the ISP projects the amount of support services funds, if any, that may be required to purchase the remainder of necessary supports that are within the benefit level; and

(g) The ISP has been authorized for implementation.

(2) A brokerage may use support services funds to assist individuals that do not meet the criteria in section (1)(c) or (1)(d) of this rule in the following circumstances:

(a) The individual meets the crisis criteria described in OAR 411-340-0125; or

(b) Up to the individual's 18th birthday, the individual was receiving children’s intensive in-home services as described in OAR chapter 411, division 300 or in-home supports as described in OAR chapter 411, division 308.

(3) An individual is no longer eligible to access support services funds when the individual is eligible for support services funds based on section (2)(b) of this rule and --

(a) The individual does not apply for a disability determination and OSIP-M within 10 business days of the individual’s 18th birthday;

(b) The Social Security Administration or the Department's Presumptive Medicaid Disability Determination Team finds that the individual does not have a qualifying disability; or

(c) The individual is determined by the state of Oregon to be ineligible for OSIP-M.

(4) Goods and services purchased with support services funds on behalf of individuals are provided only as social benefits.

(5) LIMITS OF FINANCIAL ASSISTANCE. For individuals who have not had a service level determined, the use of support services funds to purchase individual supports in any plan year is limited to the individual's annual benefit level.

(a) An individual must have access throughout the plan year to the total annual amount of support services for which they are eligible that are determined to be necessary to implement an authorized ISP, even if there is a delay in implementation of the ISP, unless otherwise agreed to in writing by the individual or the individual's legal or designated representative (as applicable).

(b) The Department may require that annual benefit level amounts be calculated and applied on a monthly basis when an individual's eligibility for Medicaid changes during a plan year, an individual's benefit level changes, or when an individual's ISP is developed and written to be in effect for less than 12 months.

(A) When an individual's benefit level changes, except in the case of an individual whose benefit level changes as the result of a change in eligibility for access to support services funds, the monthly benefit level is 1/12 of the annual benefit level for which the individual would be eligible should the change in

benefit level remain in effect for 12 calendar months. The monthly benefit level is applied each month from the date the change in benefit level occurred for the remainder of the plan year.

(B) In the case of an individual with an ISP developed for a partial plan year, the monthly benefit level is 1/12 of the annual benefit level for which the individual would be eligible should the individual's ISP be in effect for 12 calendar months. The monthly benefit level is applied each month during which the ISP developed for a partial plan year is in effect.

(6) EXCEPTIONS TO BASIC BENEFIT FINANCIAL LIMITS.

(a) Exceptions to the basic benefit annual support services fund limits described in this section do not apply to individuals who have had a service level determined. Existing individual’s exceptions to the basic benefit may remain until a service level is determined for the individual. No new exceptions to the basic benefit level are allowed.

(b) Individuals whose source of support funds are in whole, or in part, an individual-specific redirection of funds through a Department contract from a Department-regulated residential, work, or day habilitation service to support services funds, or to comprehensive in-home support funds regulated by OAR chapter 411, division 330 prior to entry to a brokerage, may have access to the amount specified in the Department contract as available for the individual's use. This provision is only applicable when each transition is separate and specific to the individual and the services being converted are not subject to statewide service transitions.

(A) Individual plan year costs must always be less than the individual cost limit; and

(B) The brokerage must review the need for supports and their cost-effectiveness with the individual, and as applicable the individual's legal or designated representative, at least annually and must make budget reductions when allowed by the individual's ISP.

(c) Individuals whose support funds were specifically assigned through a Department contract to self-directed support services prior to the date designated by the Department for transfer of the individual from self-directed support services to a brokerage, may have access to the amount specified in the Department contract as available for the individual's use.

(A) Individual plan year costs must always be less than the individual cost limit; and

(B) The brokerage must review the need for supports and their cost-effectiveness with the individual, and as applicable the individual's legal or designated representative, at least annually and must make budget reductions when allowed by the individual's ISP.

(d) Medicaid recipients may have access to a basic supplement for ADLs to purchase needed support services under the following conditions:

(A) The individual must have additional assistance needs with ADLs after development of the individual's ISP within the basic benefit, extraordinary long-term need fund limit, or other exceptions provided in this rule. ADLs include:

(i) Basic personal hygiene -- providing or assisting with such needs as bathing (tub, bed bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene;

(ii) Toileting, bowel, and bladder care -- assisting to and from the bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, managing menses, cleansing an individual or adjusting clothing related to toileting, emptying a catheter drainage bag or assistive device, ostomy care, or bowel care;

(iii) Mobility, transfers, and repositioning -- assisting with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(iv) Nutrition -- preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with adaptive utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(v) Medication and medical equipment -- assisting with ordering, organizing, and administering medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring for choking while taking medications, maintaining equipment, or monitoring for adequate medication supply; and

(vi) Delegated nursing tasks.

(B) Assistance means an individual requires help from another person with ADLs. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete one of the tasks described in subsection (A) of this section.

(i) "Cueing" means giving verbal, audio, or visual clues during an activity to help an individual complete the activity without hands-on assistance.

(ii) "Hands-on" means a provider physically performs all or parts of an activity because an individual is unable to do so.

(iii) "Monitoring" means a provider observes an individual to determine if assistance is needed.

(iv) "Reassurance" means to offer an individual encouragement and support.

(v) "Redirection" means to divert an individual to another more appropriate activity.

(vi) "Set-up" means the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment so that an individual may perform an activity.

(vii) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task if the individual be unable to complete the task independently.

(C) The supplement for ADLs must be used to meet identified support needs related to ADLs. The supplement for ADLs may also be used for the following services if they are incidental to the provision of ADLs, essential for the health and welfare of the individual, and provided solely for the individual receiving support services:

(i) Housekeeping tasks necessary to maintain the eligible individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and laundry. Only the housekeeping activities related to the eligible individual’s needs may be considered in housekeeping;

(ii) Grocery and other shopping necessary for the completion of ADL and IADL tasks;

(iii) Assistance with necessary medical appointments, including help scheduling appointments, arranging medical transportation services, follow up from appointments, or assistance with mobility, transfers, or cognition in getting to and from appointments;

(iv) Observation of an individual's status and reporting of significant changes to physicians, health care professionals, or other appropriate people;

(v) First aid and handling emergencies, including addressing medical incidents related to conditions such as seizures, aspiration, constipation, or dehydration or responding to an individual’s call for help during an emergent situation or for unscheduled needs requiring immediate response ; and

(vi) Cognitive assistance or emotional support provided to an individual due to the individual's intellectual or developmental disability, including helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive functions.

(D) The supplement for ADL support may not be used for any of the following services:

(i) Shopping;

(ii) Transportation;

(iii) Money management;

(iv) Mileage reimbursement;

(v) Social companionship; or

(vi) Relief care.

(E) Activities and goals related to the provision of ADL services must be sufficiently documented in the individual's ISP.

(F) Planned expenses must be based upon the least costly means of providing adequate services and must only be to the extent necessary to meet the documented ADL needs.

(G) The supplement for ADLs may not cause the cost per any plan year to exceed the individual cost limit. There is an exception for individuals receiving both support services under these rules who had a benefit level at the individual cost limit and state plan personal care services under OAR chapter 411, division 034, as of June 30, 2005. These individuals may continue to access the basic supplement and the supplement for ADLs until the individual terminates their receipt of support services or becomes ineligible for one of the supplements. The combined basic benefit, the basic supplement, and supplement for ADLs must remain above the individual cost limit to remain eligible for this exception.

(H) For Medicaid recipients receiving state plan personal care services under OAR chapter 411, division 034 entering support services after June 30, 2005, the Medicaid Personal Care Assessment (Form SDS 0531A) serves as the individual's authorized ISP for a period not to exceed 90 days.

(I) The supplemental ADL services are not intended to replace the resources available to an individual receiving support services under these rules from their natural supports.

(7) AMOUNT, METHOD, AND SCHEDULE OF PAYMENT.

(a) The brokerage must disburse, or arrange for disbursement of, support services funds to qualified providers on behalf of individuals in the amount required to implement an authorized ISP. The brokerage is specifically prohibited from reimbursement of individuals or individuals' families for expenses related to services and from advancing funds to individuals or individuals' families to obtain services.

(b) The method and schedule of payment must be specified in written agreements between the brokerage and the individual or the individual's legal or designated representative (as applicable).

(8) TYPES OF SUPPORTS PURCHASED. For ISPs that have not been developed based on a service level determined by a functional needs assessment, supports eligible for purchase with support services funds are:

(a) Chore services. Chore services may be provided only in situations where no one else in the household is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer agency, or third-party payer is capable of or responsible for providing these services;

(b) Community living and inclusion supports;

(c) Environmental accessibility adaptation;

(d) Family training;

(A) Family training must be provided:

(i) By licensed psychologists, medical professionals, clinical social workers, or counselors as described in OAR 411-340-0160(7); or

(ii) In organized conferences and workshops that are limited to topics related to the individual's intellectual or developmental disability, identified support needs, or specialized medical or habilitative support needs.

(B) Family training may not be provided to paid care providers.

(e) Homemaker services. Homemaker services may be provided only when the person regularly responsible for general housekeeping activities as well as caring for an individual in the home is temporarily absent, temporarily unable to manage the home as well as care for self or the individual in the home, or needs to devote additional time to caring for the individual;

(f) Occupational therapy services;

(g) Personal emergency response systems;

(h) Physical therapy services;

(i) Respite;

(A) Respite may be provided in the individual's or respite provider's home, a foster home, a group home, a licensed day care center, or a community care facility that is not a private residence.

(B) Respite includes two types of care, neither of which may be characterized as eight-hours-a-day, five-days-a-week services or provided to allow care providers to attend school or work.

(i) Temporary respite must be provided on less than a 24-hour basis.

(ii) Twenty-four hour overnight care must be provided in segments of 24-hour units that may be sequential but may not exceed 14 consecutive days without permission from the Department.

(j) Special diets. Special diets may not provide or replace the nutritional equivalent of meals and snacks normally required regardless of intellectual or developmental disability.

(k) Specialized equipment and supplies as well as the following provisions:

(A) When specialized equipment and supplies are primarily and customarily used to serve a medical purpose, the purchase, rental, or repair of specialized equipment and supplies with support services funds must be limited to the types of equipment and supplies permitted under the state plan and specifically those that are not excluded under OAR 410-122-0080.

(B) Support services funds may be used to purchase more of an item than the number allowed under the state plan after the limits specified in the state plan have been reached, requests for purchases have been denied by the state plan or private insurance, and the denial has been upheld in an applicable hearing or private insurance benefit appeals process.

(C) Devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the individual's abilities to perform ADLs or to perceive, control, or communicate with the environment in which the individual lives, may be purchased with support services funds when the individual's intellectual or developmental disability otherwise prevents or limits the individual's independence in these areas. Equipment and supplies that may be purchased for this purpose must be of direct benefit to the individual and include:

(i) Adaptive equipment for eating, such as utensils, trays, cups, or bowls that are specially designed to assist an individual to feed him or herself;

(ii) Positioning devices;

(iii) Specially designed clothes to meet the unique needs of the individual, such as clothes designed to prevent access by the individual to the stoma, etc.;

(iv) Assistive technology items;

(v) Computer software used by the individual to express needs, control supports, plan, and budget supports;

(vi) Augmentative communication devices;

(vii) Environmental adaptations to control lights, heat, stove, etc.; or

(viii) Sensory stimulation equipment and supplies that help an individual calm, provide appropriate activity, or safely channel an obsession, such as vestibular swing, weighted blanket, or tactile supplies like creams and lotions;

(l) Specialized supports;

(m) Speech and language therapy services;

(n) Supported employment; and

(o) Transportation.

(9) TYPES OF SUPPORTS. When an ISP is based on a service level determined by a functional needs assessment, supports eligible for purchase with support services funds are:

(a) Community First Choice services:

(A) Community nursing services as described in section (10) of this rule;

(B) Chore services as described in section (11) of this rule;

(C) Attendant care as described in section (12) of this rule;

(D) Skills training as described in section (13) of this rule;

(E) Community transportation as described in section (14) of this rule;

(F) Specialized equipment and supplies as described in section (15) of this rule;

(G) Relief care as described in section (16) of this rule;

(H) Behavior support services as described in section (17) of this rule;

(I) Environmental accessibility adaptations as described in section (18) of this rule; and

(J) Transition costs as described in section (19) of this rule.

(b) Home and Community Based Waiver Services:

(A) Community living and inclusion supports as described in section (20) of this rule;

(B) Case management as defined in OAR 411-340-0020;

(C) Supported employment as described in section (21) of this rule;

(D) Family training as described in section (22) of this rule;

(E) Occupational therapy as described in section (23) of this rule;

(F) Physical therapy as described in section (24) of this rule;

(G) Speech, hearing, and language services, as described in section (25) of this rule;

(H) Special diets as described in section (26) of this rule; and

(I) Specialized supports as described in section (27) of this rule.

(10) COMMUNITY NURSING SERVICES.

(a) Community nursing services include:

(A) Evaluation, including medication reviews, and identification of supports that minimize health risks while promoting an individual's autonomy and self-management of healthcare;

(B) Collateral contact with a personal agent regarding an individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered ISP; and

(C) Delegation and training of nursing tasks to an individual’s provider so the provider may safely perform health related tasks.

(b) Community nursing services exclude direct nursing care.

(c) Community nursing services are not covered by other Medicaid spending authorities.

(11) CHORE SERVICES. Chore services may be provided only in situations where no one else is responsible or able to perform or pay for the services.

(a) Chore services include heavy household chores such as --

(A) Washing floors, windows, and walls;

(B) Tacking down loose rugs and tiles; and

(C) Moving heavy items of furniture for safe access and egress.

(b) Chore services may include yard hazard abatement to ensure the outside of the home is safe for the individual to traverse and enter and exit the home.

(12) ATTENDANT CARE SERVICES.

(a) ADL services include but are not limited to:

(A) Basic personal hygiene -- providing or assisting with such needs as bathing (tub, bed, bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene;

(B) Toileting, bowel, and bladder care -- assisting to and from the bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, managing menses, cleansing an individual or adjusting clothing related to toileting, emptying a catheter drainage bag or assistive device, ostomy care, or bowel care;

(C) Mobility, transfers, and repositioning -- assisting with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(D) Nutrition -- preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with adaptive utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(E) Medication and medical equipment including but not limited to assisting with ordering, organizing, and administering medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring an individual for choking while taking medications, assisting with the administration of medications, maintaining equipment, or monitoring for adequate medication supply; and

(F) Delegated nursing tasks.

(b) IADL services include but are not limited to:

(A) Light housekeeping -- tasks necessary to maintain an individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and laundry;

(B) Grocery and other shopping necessary for the completion of other ADL and IADL tasks;

(C) Assistance with necessary medical appointments, including help scheduling appointments, arranging medical transportation services, accompaniment to appointments, follow up from appointments, or assistance with mobility, transfers, or cognition in getting to and from appointments;

(D) Observation of an individual's status and reporting of significant changes to physicians, health care professionals, or other appropriate people;

(E) First aid and handling emergencies, including addressing medical incidents related to conditions such as seizures, aspiration, constipation, or dehydration or responding to an

individual’s call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(F) Cognitive assistance or emotional support provided to an individual due to an intellectual or developmental disability, including helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive functions.

(c) Attendant care services means an individual requires assistance with ADLs. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete any of the tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal, audio, or visual clues during an activity to help an individual complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an activity because an individual is unable to do so.

(C) "Monitoring" means a provider observes an individual to determine if assistance is needed.

(D) "Reassurance" means to offer an individual encouragement and support.

(E) "Redirection" means to divert an individual to another more appropriate activity.

(F) "Set-up" means the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment so that an individual may perform an activity.

(G) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task if the individual is unable to complete the task independently.

(13) SKILLS TRAINING. Skills training is specifically tied to the functional needs assessment and ISP and is a means for an individual to acquire, maintain, or enhance independence in supports otherwise provided through state plan or waiver services.

(a) Skills training may be applied to the use and care of assistive devices and technologies

(b) Skills training is authorized when:

(A) The anticipated outcome of the skills training, as documented in the ISP, is measurable;

(B) Timelines for measuring progress towards the anticipated outcome are established in the ISP; and

(C) Progress towards the anticipated outcome are measured and the measurements are evaluated by a personal agent no less frequently than every six months, based on the start date of the initiation of the skills training.

(c) When anticipated outcomes are not achieved, the personal agent must reassess the use of skills training with the individual.

(14) COMMUNITY TRANSPORTATION.

(a) Community transportation services include but are not limited to --

(A) Community transportation provided by common carriers, taxicab, or bus in accordance with standards established for these entities;

(B) Reimbursement on a per-mile basis for transporting an individual to accomplish an ISP goal related task; or

(C) Assistance with the purchase of a bus pass.

(b) Community transportation services exclude medical transportation, purchase of individual or family vehicles, routine

vehicle maintenance and repair, ambulance services, payment to the spouse of an individual receiving support services, and costs for transporting a person other than the individual.

(15) SPECIALIZED EQUIPMENT AND SUPPLIES. When specialized equipment and supplies are primarily and customarily used to serve a medical purpose, the purchase, rental, or repair of specialized equipment and supplies with support service funds must be limited to the types of equipment and supplies that are not excluded under OAR 410-122-0080.

(a) Specialized equipment and supplies may include the purchase of devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the individual's ability to perform and support ADLs and IADLs or to perceive, control, or communicate with the environment in which the individual lives.

(b) Specialized equipment and supplies may be purchased with support service funds when an individual's intellectual or developmental disability otherwise prevents or limits the individual's independence in areas identified in a functional needs assessment.

(c) Specialized equipment and supplies that may be purchased for the purpose described in subsection (b) of this section must be of direct benefit to the individual and may include:

(A) Supplies needed to assist with incontinence care such as gloves, pads, wipes, or incontinence garments;

(B) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders, alert systems for ADL or IADL supports, or mobile electronic devices;

(C) Assistive technology to provide additional security and replace the need for direct interventions to enable self direction of care and maximize independence, such as motion or sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems;

(i) Expenditures for assistive technology are limited to $5,000 per plan year without Department approval.

(ii) Any single device or assistance costing more than $500 must be approved by the Department prior to expenditure.

(D) Assistive devices, not covered by other Medicaid programs, to assist and enhance an individual's independence in performing ADLs or IADLs, such as durable medical equipment, mechanical apparatus, electrical appliances, or information technology devices.

(i) Expenditures for assistive devices are limited to $5,000 per plan year without Department approval.

(ii) Any single device or assistance costing more than $500 must be approved by the Department prior to expenditure.

(d) Specialized equipment and supplies may not include items not of direct medical or remedial benefit to the individual.

(e) Specialized equipment and supplies must meet applicable standards of manufacture, design, and installation.

(16) RELIEF CARE.

(a) Relief care includes two types of care, neither of which may be characterized as daily or periodic services provided to allow an individual's primary caregiver to attend school or work.

(b) Twenty-four hour overnight services must be provided in segments of 24-hour units that may be sequential but may not exceed 14 consecutive days without permission from the Department.

(17) BEHAVIOR SUPPORT SERVICES.

(a) Behavior support services consist of:

(A) Assessing an individual or the needs of the individual's family and the environment;

(B) Developing positive behavior support strategies, including a Behavior Support Plan if needed;

(C) Implementing the Behavior Support Plan with an individual's provider or family; and

(D) Revising and monitoring the Behavior Support Plan as needed.

(b) Behavior support services may include:

(A) Training, modeling, and mentoring an individual's family;

(B) Developing visual communication systems as behavior support strategies; and

(C) Communicating as authorized by an individual, or as applicable the individual's legal or designated representative, with school, medical, or other professionals about the strategies and outcomes of the Behavior Support Plan.

(c) Behavior support services exclude:

(A) Mental health therapy or counseling;

(B) Health or mental health plan coverage;

(C) Educational services, including, but not limited to consultation and training for classroom staff;

(D) Adaptations to meet needs of an individual at school; or

(E) An assessment in a school setting.

(18) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke alarms, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for an individual whose temperature sensitivity issues create behaviors or medical conditions that put the individual or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual;

(R) Modifications for the primary vehicle used by the individual that are necessary to meet the unique needs of the individual, such as lift, interior alterations to seats, head and leg rests, belts, special safety harnesses, or other unique modifications to keep the individual safe in the vehicle; and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, and central air conditioning; and

(B) Adaptations that add to the total square footage of the home,

(c) Environmental accessibility adaptations are limited to $5,000 per modification. A personal agent may request approval for additional expenditures through the Department prior to expenditure. Approval is based on the individual’s service and support needs and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental accessibility adaptations must be tied to supporting ADL, IADL, and health-related tasks as identified in the individual's ISP.

(e) Environmental accessibility adaptations over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the provider's file prior to payment.

(f) Environmental accessibility adaptations must be made within the existing square footage of the home, except for external ramps, and may not add to the square footage of the home.

(g) Payment to the contractor is to be withheld until the work meets specifications.

(19) TRANSITION COSTS.

(a) Transition costs are limited to individuals transitioning from a nursing facility, ICF/MR, or acute care hospital, to a home or community-based setting where the individual resides.

(b) Transition costs are based on an individual's assessed need determined during the person-centered service planning process and must support the desires and goals of the individual receiving services and supports. Final approval for transition costs must be through the Department prior to expenditure. The Department's approval is based on the individual’s need and the Department’s determination of appropriateness and cost-effectiveness.

(c) Financial assistance for transition costs is limited to:

(A) Moving and move-in costs, including movers, cleaning and security deposits, payment for background or credit checks (related to housing), or initial deposits for heating, lighting, and phone;

(B) Payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishings, such as a bed; and

(C) Other items necessary to re-establish a home.

(d) Transition costs are provided no more than twice annually.

(e) Transitions costs for basic household furnishings and other items are limited to one time per year.

(20) COMMUNITY LIVING AND INCLUSION SUPPORTS. Community living and inclusion supports assist individuals in acquiring, retaining, and improving skills around socialization, recreation and leisure, communication, participation in the community, and ability to direct supports.

(a) Support with socialization includes assisting participants in acquiring, retaining, and improving self-awareness and self control, social responsiveness, social amenities, and interpersonal skills.

(b) Support with community participation, recreation, or leisure includes assisting individuals in acquiring, retaining, and improving skills to use available community resources, facilities, or businesses.

(c) Support with communication includes assisting individuals in acquiring, retaining, and improving expressive and receptive skills in verbal and non-verbal language and the functional application of acquired reading and writing skills.

(d) Supports may be work-related and include instruction in skills an individual wishes to acquire, retain, or improve that enhance the individual's independence, productivity, integration, or maintain the individual’s physical and cognitive skills. Services may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety that are aimed at preparing an individual with an intellectual or developmental disability for paid employment.

(e) Supports may be used to reinforce skills or lessons taught in school, therapy or other settings. However, this will not duplicate Medicaid State Plan, IDEA or Office of Vocational Rehabilitation Services.

(21) SUPPORTED EMPLOYMENT SERVICES. Supported employment services assist an individual to choose, get, and keep a paid job in an integrated community business setting.

(a) Supported employment services includes job development, training, and on-going supervision to obtain paid employment.

(b) Training may focus on the individual and the individual's co-workers without disabilities capable of providing natural support.

(c) Supported employment services must not replace services available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

(d) Supported employment services under this rule must not replace or duplicate services that an individual currently receives through Department-contracted employment and alternative to employment services governed by OAR chapter 411, division 345.

(22) FAMILY TRAINING. Family training services are training and counseling services provided to an individual's family to increase the family's capability to care for, support, and maintain the individual in the home.

(a) Family training services include but are not limited to:

(A) Instruction about treatment regimens and use of equipment specified in an individual's ISP;

(B) Information, education, and training about an individual's disability, medical, and behavioral conditions; and

(C) Organized conferences and workshops specifically related to an individual's disability, identified support needs, or specialized medical or behavioral support needs.

(b) Family training services may be provided in various settings by various means, including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under ORS 677.100 or nursing under ORS 678.040, social workers licensed under ORS 675.530, or counselors licensed under ORS 675.715;

(c) Family training services exclude:

(A) Mental health counseling, treatment, or therapy;

(B) Training for paid care providers;

(C) Legal fees;

(D) Training for families to carry out educational activities in lieu of school;

(E) Vocational training for family members; and

(F) Paying for training to carry out activities that constitute abuse of an adult.

(d) Prior authorization by the brokerage is required for attendance by family members at organized conferences and workshops funded with support services funds.

(23) OCCUPATIONAL THERAPY. Occupational therapy services are the services of a professional licensed under ORS 675.240 that are defined and approved for purchase under the approved state plan, except that the limitation on amount, duration, and scope in the state plan do not apply. Occupational therapy services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the state plan have been reached, either through private or public resources.

(a) Occupational therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified occupational therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Occupational therapy services exclude:

(A) Goods and services available through an individual's private insurance or other public programs, such as the Oregon Health Plan, schools, or federal assistance programs for which an individual is eligible;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to a school.

(24) PHYSICAL THERAPY. Physical therapy services are the services of a professional licensed under ORS 688.020 that are defined and approved for purchase under the approved state plan, except that the limitation on amount, duration, and scope in the state plan do not apply. Physical therapy services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the state plan have been reached, either through private or public resources.

(a) Physical therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified physical therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Physical therapy services exclude:

(A) Goods and services available through either an individual's private insurance or public programs, such as the Oregon Health Plan, schools, or federal assistance programs for which an individual is eligible;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(25) SPEECH, HEARING, AND LANGUAGE SERVICES. Speech, hearing, and language services are the services of a professional licensed under ORS 681.250 that are defined and approved for purchase under the

approved state plan, except that the limitation on amount, duration, and scope specified in the state plan do not apply. Speech, hearing, and language services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the state plan have been reached, either through private or public resources.

(a) Speech, hearing, and language services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified speech therapy professional when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Speech, hearing, and language services exclude:

(A) Goods and services available through either an individual's private insurance or public programs, such as the Oregon Health Plan, schools, or federal assistance programs for which an individual is eligible;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(26) SPECIAL DIET. Special diets are specially prepared food or particular types of food, ordered by a physician and periodically monitored by a dietician, specific to an individual's medical condition or diagnosis that are needed to sustain an individual in the individual's home. Special diets are supplements and are not intended to meet an individual's complete daily nutritional requirements.

(27) SPECIALIZED SUPPORTS. Specialized supports include treatment, training, consultation, or other unique services provided by a social or sexual consultant necessary to achieve outcomes in an individual's ISP that are not available through state plan services or other support services listed in this rule. Specialized supports include:

(a) Assessing the needs of an individual and the individual's family, including environmental factors;

(b) Developing a plan of support;

(c) Training care providers to implement the plan of support;

(d) Monitoring implementation of the plan of support; and

(e) Revising the plan of support as needed.

(28) EDUCATIONAL SERVICES. Educational services for school age individuals, such as professional instruction, formal training, and tutoring in communication, socialization, and academic skills, are not allowable expenses covered by support services funds.

(29) CONDITIONS OF PURCHASE. The brokerage must arrange for supports purchased with support services funds to be provided:

(a) In settings and under contractual conditions that enable the individual to freely choose to receive supports and services from another qualified provider;

(A) Individuals who choose to combine support services funds to purchase group services must receive written instruction from the brokerage about the limits and conditions of such arrangements;

(B) Combined support services funds may not be used to purchase existing, or create new, comprehensive services;

(C) Individual support expenses must be separately projected, tracked, and expensed, including separate contracts, employment agreements, and timekeeping for staff working with more than one individual;

(D) A provider organization resulting from the combined arrangements for community living and inclusion supports or

supported employment services must be certified according to these rules; and

(E) Combined arrangements for residential supports must include a plan for maintaining an individual at home after the loss of roommates.

(b) In a manner consistent with positive behavioral theory and practice and where behavior intervention is not undertaken unless the behavior:

(A) Represents a risk to health and safety of the individual or others;

(B) Is likely to continue and become more serious over time;

(C) Interferes with community participation;

(D) Results in damage to property; or

(E) Interferes with learning, socializing, or vocation.

(c) In accordance with applicable state and federal wage and hour regulations in the case of personal services, training, and supervision;

(d) In accordance with applicable state or local building codes in the case of environmental accessibility adaptations to the home;

(e) In accordance with Oregon Board of Nursing rules in OAR chapter 851 when services involve performance of nursing services or delegation, teaching, and assignment of nursing tasks;

(f) In accordance with OAR 411-340-0160 through 411-340-0180 governing provider qualifications and responsibilities; and

(g) In accordance with the Department's Support Services Expenditure Guidelines.

(30) INDEPENDENT PROVIDER, PROVIDER ORGANIZATION, AND GENERAL BUSINESS PROVIDER AGREEMENTS AND

RESPONSIBILITIES. When support services funds are used to purchase services, training, supervision, or other personal assistance for individuals, the brokerage must require and document that providers are informed of:

(a) Mandatory reporter responsibility to report suspected abuse;

(b) Responsibility to immediately notify the people, if any, specified by the individual, or as applicable the individual's legal or designated representative, of any injury, illness, accident, or unusual circumstance that occurs when the provider is providing individual services, training, or supervision that may have a serious effect on the health, safety, physical or emotional well-being, or level of services required;

(c) Limits of payment:

(A) Support services fund payments for the agreed-upon services are considered full payment and the provider under no circumstances may demand or receive additional payment for these services from the individual, the individual’s family, or any other source unless the payment is a financial responsibility (spend-down) of an individual under the Medically Needy Program; and

(B) The provider must bill all third party resources before using support services funds unless another arrangement is agreed upon by the brokerage and described in an individual's ISP.

(d) The provisions of section (31) of this rule regarding sanctions that may be imposed on providers; and

(e) The requirement to maintain a drug-free workplace.

(31) SANCTIONS FOR INDEPENDENT PROVIDERS, PROVIDER ORGANIZATIONS, AND GENERAL BUSINESS PROVIDERS.

(a) A sanction may be imposed on a provider when the brokerage determines that, at some point after the provider's initial qualification and authorization to provide supports purchased with support services funds, the provider has:

(A) Been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of service;

(B) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(C) Surrendered his or her professional license or had his or her professional license suspended, revoked, or otherwise limited;

(D) Failed to safely and adequately provide the authorized services;

(E) Had a founded report of child abuse or substantiated abuse;

(F) Failed to cooperate with any Department or brokerage investigation or grant access to, or furnish, records or documentation, as requested;

(G) Billed excessive or fraudulent charges or been convicted of fraud;

(H) Made a false statement concerning conviction of crime or substantiated abuse;

(I) Falsified required documentation;

(J) Failed to comply with the provisions of section (30) of this rule or OAR 411-340-0140; or

(K) Been suspended or terminated as a provider by the Department or Oregon Health Authority.

(b) The following sanctions may be imposed on a provider:

(A) The provider may no longer be paid with support services funds;

(B) The provider may not be allowed to provide services for a specified length of time or until specified conditions for reinstatement are met and approved by the brokerage or the Department, as applicable; or

(C) The brokerage may withhold payments to the provider.

(c) If the brokerage makes a decision to sanction a provider, the brokerage must notify the provider by mail of the intent to sanction.

(d) The provider may appeal a sanction within 30 days of the date the sanction notice was mailed to the provider. The provider must appeal a sanction separately from any appeal of audit findings and overpayments.

(A) A provider of Medicaid services may appeal a sanction by requesting an administrative review by the Department's director.

(B) For an appeal regarding provision of Medicaid services to be valid, written notice of the appeal must be received by the Department within 30 days of the date the sanction notice was mailed to the provider.

(e) At the discretion of the Department, providers who have previously been terminated or suspended by the Department or by the Oregon Health Authority may not be authorized as providers of Medicaid services.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0140 Using Support Services Funds for Certain Purchases Is Prohibited
(Amended 12/28/2013)

(1) Effective July 28, 2009, support services funds may not be used to support, in whole or in part, a provider in any capacity who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(2) Section (1) of this rule does not apply to employees of individuals, individuals' legal representatives, employees of general business providers, or employees of provider organizations, who were hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(3) Support services funds may not be used to pay for:

(a) Services, materials, or activities that are illegal;

(b) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 407-045-0260;

(c) Materials or equipment that has been determined unsafe for the general public by recognized consumer safety agencies;

(d) Individual or family vehicles;

(e) Health and medical costs that the general public normally must pay, including but not limited to:

(A) Medications;

(B) Health insurance co-payments;

(C) Dental treatments and appliances;

(D) Medical treatments;

(E) Dietary supplements, including but not limited to vitamins and experimental herbal and dietary treatments; or

(F) Treatment supplies not related to nutrition, incontinence, or infection control.

(f) Ambulance services;

(g) Legal fees;

(h) Vacation costs for transportation, food, shelter, and entertainment that are normally incurred by a person on vacation, regardless of disability, and are not strictly required by the individual's need for personal assistance in all home and community-based settings;

(i) Individual services, training, or supervision that has not been arranged according to applicable state and federal wage and hour regulations;

(j) Services, activities, materials, or equipment that are not necessary, cost-effective, or do not meet the definition of support or social benefits as defined in OAR 411-340-0020;

(k) Educational services for school-age individuals over the age of 18, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills, and post-secondary educational services such as those provided through two- or four-year colleges for individuals of all ages;

(l) Services provided in a nursing facility, correctional institution, or hospital;

(m) Services, activities, materials, or equipment that may be obtained by the individual or the individual's family through alternative resources or natural supports;

(n) Unless under certain conditions and limits specified in Department guidelines, employee wages or contractor charges for time or services when the individual is not present or available to receive services, including but not limited to employee paid time off, hourly "no show" charge, and contractor travel and preparation hours;

(o) Services or activities for which the legislative or executive branch of Oregon government has prohibited use of public funds; or

(p) Notwithstanding abuse as defined in OAR 407-045-0260, services when there is sufficient evidence to believe that an individual, or as applicable the individual's legal or designated representative, has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the individual's ISP, refused to accept or delegate

record keeping required to use brokerage resources, or otherwise knowingly misused public funds associated with brokerage services

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0150 Standards for Support Services Brokerage Administration and Operations
(Amended 12/28/2013)

(1) POLICY OVERSIGHT GROUP. The brokerage must develop and implement procedures for incorporating the direction, guidance, and advice of individuals and family members of individuals in the administration of the organization.

(a) The brokerage must establish and utilize a Policy Oversight Group, of which the membership majority must be individuals with intellectual or developmental disabilities and family members of individuals with intellectual or developmental disabilities.

(b) Brokerage procedures must be developed and implemented to assure the Policy Oversight Group has the maximum authority that may be legally assigned or delegated over important program operational decisions, including such areas as program policy development, program planning and goal setting, budgeting and resource allocation, selection of key personnel, program evaluation and quality assurance, and complaint resolution.

(c) If the Policy Oversight Group is not also the governing body of the brokerage, then the brokerage must develop and implement a written procedure that describes specific steps of appeal or remediation to resolve conflicts between the Policy Oversight Group and the governing body of the brokerage.

(d) A Policy Oversight Group must develop and implement operating policies and procedures.

(2) FULL-TIME BROKERAGE DIRECTOR REQUIRED. The brokerage must employ a full-time director who is responsible for the daily operations

of the brokerage in compliance with these rules and who has authority to make budget, staffing, policy, and procedural decisions for the brokerage.

(3) DIRECTOR QUALIFICATIONS. In addition to the general staff qualifications of OAR 411-340-0070(1) and (2), the brokerage director must have:

(a) A minimum of a bachelor's degree and two years experience, including supervision, in the field of intellectual or developmental disabilities, social services, mental health, or a related field; or

(b) Six years of experience, including supervision, in the field of intellectual or developmental disabilities, social services, or mental health.

(4) FISCAL INTERMEDIARY REQUIREMENTS.

(a) A fiscal intermediary must:

(A) Demonstrate a practical understanding of laws, rules, and conditions that accompany the use of public resources;

(B) Develop and implement accounting systems that operate effectively on a large scale as well as track individual budgets;

(C) Establish and meet the time lines for payments that meet individuals' needs;

(D) Develop and implement an effective payroll system, including meeting payroll-related tax obligations;

(E) Generate service, management, and statistical information and reports required by the brokerage director and Policy Oversight Group to effectively manage the brokerage and by individuals to effectively manage supports;

(F) Maintain flexibility to adapt to changing circumstances of individuals; and

(G) Provide training and technical assistance to individuals as required and specified in the individuals' ISPs.

(b) A fiscal intermediary may not recruit, hire, supervise, evaluate, dismiss, or otherwise discipline those employed to provide services described in an individual's authorized ISP.

(c) FISCAL INTERMEDIARY QUALIFICATIONS.

(A) A fiscal intermediary may not:

(i) Be a provider of support services paid using support services funds; or

(ii) Be a family member or other representative of an individual for whom they provide fiscal intermediary services.

(B) The brokerage must obtain and maintain written evidence that:

(i) Contractors providing fiscal intermediary services have sufficient education, training, or work experience to effectively and efficiently perform all required activities; and

(ii) Employees providing fiscal intermediary services have sufficient education, training, or work experience to effectively and efficiently perform all required activities prior to hire or that the brokerage has provided requisite education, training, and experience.

(5) PERSONAL AGENT QUALIFICATIONS.

(a) Each personal agent must have knowledge of the public service system for developmental disability services in Oregon and at least:

(A) A bachelor’s degree in a behavioral science, social science, or a closely related field; or

(B) A bachelor's degree in any field and one year of human services related experience, such as work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or

(C) An associate's degree in a behavioral science, social science, or a closely related field and two years of human services related experience such as work providing assistance to individuals and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or

(D) Three years of human services related experience.

(b) A brokerage must submit a written variance request to the Department prior to employing a person not meeting the minimum qualifications for a personal agent set forth in subsection (a) of this section. The variance request must include:

(A) An acceptable rationale for the need to employ a person who does not meet the qualifications; and

(B) A proposed alternative plan for education and training to correct the deficiencies.

(i) The proposal must specify activities, timelines, and responsibility for costs incurred in completing the alternative plan.

(ii) A person who fails to complete the alternative plan for education and training to correct the deficiencies may not fulfill the requirements for the qualifications.

(6) PERSONAL AGENT TRAINING. The brokerage must provide or arrange for personal agents to receive training needed to provide or arrange for brokerage services, including but not limited to:

(a) Principles of self-determination;

(b) Person-centered planning processes;

(c) Identification and use of alternative support resources;

(d) Fiscal intermediary services;

(e) Basic employer and employee roles and responsibilities;

(f) Developing new resources;

(g) Major public health and welfare benefits;

(h) Constructing and adjusting individualized support budgets; and

(i) Assisting individuals to judge and improve quality of personal supports.

(7) INDIVIDUAL RECORD REQUIREMENTS. The brokerage must maintain current, up-to-date records for each individual receiving services and must make these records available to the Department upon request. The individual or the individual’s legal representative may access any portion of the individual's record upon request. Individual records must include at minimum:

(a) Application and eligibility information received from the referring CDDP;

(b) An easily-accessed summary of basic information, including the individual's name, family name (if applicable), individual's legal or designated representative (if applicable), address, telephone number, date of entry into the program, date of birth, sex, marital status, individual financial resource information, and plan year anniversary date;

(c) Documents related to determining eligibility for brokerage services and, for individuals who have not had a service level determined, the amount of support services funds available to the individual, including basic supplement criteria if applicable;

(d) Records related to receipt and disbursement of funds, including expenditure authorizations, expenditure verification, copies of CPMS expenditure reports, and verification that providers meet the requirements of OAR 411-340-0160 through 411-340-0180;

(e) Documentation, signed by the individual, or as applicable the individual's legal or designated representative, that the individual, or as applicable the individual's legal or designated representative, has been informed of responsibilities associated with the use of support services funds;

(f) Incident reports;

(g) The completed functional needs assessment and other assessments used to determine supports required, preferences, and resources;

(h) ISP and reviews. If an individual is unable to sign the ISP, the individual's record must document that the individual was informed of the contents of the ISP and that the individual's agreement to the ISP was obtained to the extent possible;

(i) Names of those who participated in the development of the ISP. If an individual was not able to participate in the development of the ISP, the individual's record must document the reason;

(j) Written service agreements. A written service agreement must be consistent with the individual's ISP and must describe at a minimum:

(A) Type of service to be provided;

(B) Hours, rates, location of services, and expected outcomes of services; and

(C) Any specific individual health, safety, and emergency procedures that may be required, including action to be taken if an individual is unable to provide for the individual's own safety and the individual is missing while in the community under the service of a contractor or provider organization.

(k) A written job description for all services to be delivered by an employee of the individual or the individual's legal or designated representative (as applicable). The written job description must be consistent with the individual's ISP and must describe at a minimum:

(A) Type of service to be provided;

(B) Hours, rates, location, duration of services, and expected outcomes of services; and

(C) Any specific individual health, safety, and emergency procedures that may be required, including action to be taken if an individual is unable to provide for the individual's own safety and the individual is missing while in the community under the service of an employee of the individual.

(l) Personal agent correspondence and notes related to resource development and plan outcomes;

(m) Progress notes. Progress notes must include documentation of the delivery of services by a personal agent to support each case service provided. Progress notes must be recorded chronologically and documented consistent with brokerage policies and procedures. All late entries must be appropriately documented. Progress notes must, at a minimum, include:

(A) The month, day, and year the services were rendered and the month, day, and year the entry was made if different from the date service was rendered;

(B) The name of the individual receiving services;

(C) The name of the brokerage, the person providing the service (i.e., the personal agent's signature and title), and the date the entry was recorded and signed;

(D) The specific services provided and actions taken or planned, if any;

(E) Place of service. Place of service means the name of the brokerage and where the brokerage is located, including the address. The place of service may be a standard heading on each page of the progress notes; and

(F) The names of other participants (including titles and agency representation, if any) in notes pertaining to meetings with or discussions about the individual.

(n) Information about individual satisfaction with personal supports and the brokerage's services.

(8) SPECIAL RECORD REQUIREMENTS FOR SUPPORT SERVICES FUND EXPENDITURES.

(a) The brokerage must develop and implement written policies and procedures concerning use of support services funds. These policies and procedures must include but may not be limited to:

(A) Minimum acceptable records of expenditures:

(i) Itemized invoices and receipts to record purchase of any single item;

(ii) A trip log indicating purpose, date, and total miles to verify vehicle mileage reimbursement;

(iii) Itemized invoices for any services purchased from independent contractors, provider organizations, and professionals. Itemized invoices must include:

(I) The name of the individual to whom services were provided;

(II) The date of the services; and

(III) A description of the services.

(iv) Pay records, including timesheets signed by both employee and employer, to record employee services; and

(v) Documentation that services provided were consistent with an individual's authorized ISP.

(B) Procedures for confirming the receipt, and securing the use of, specialized equipment and supplies and environmental accessibility adaptations.

(i) When equipment is obtained for the exclusive use of an individual, the brokerage must record the purpose, final cost, and date of receipt.

(ii) The brokerage must secure use of equipment or furnishings costing more than $500 through a written agreement between the brokerage and the individual or the individual's legal representative that specifies the time period the item is to be available to the individual and the responsibilities of all parties if the item is lost, damaged, or sold within that time period.

(iii) The brokerage must ensure that projects for environmental accessibility adaptations involving renovation or new construction in an individual's home costing $5,000 or more per single instance or cumulatively over several modifications:

(I) Are approved by the Department before work begins and before final payment is made;

(II) Are completed or supervised by a contractor licensed and bonded in Oregon; and

(III) That steps are taken as prescribed by the Department for protection of the Department's interest through liens or other legally available means.

(iv) The brokerage must obtain written authorization from the owner of a rental structure before any environmental accessibility adaptations are made to the rental structure.

(b) Any goods purchased with support services funds that are not used according to an individual's ISP or according to an agreement securing the state's use may be immediately recovered.

(c) Failure to furnish written documentation upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, Centers for Medicare and Medicaid Services, or their authorized representatives, immediately or within timeframes specified in the written request, may be deemed reason to recover payments or deny further assistance.

(9) QUALITY ASSURANCE.

(a) The Policy Oversight Group must develop a Quality Assurance Plan and review the plan at least twice a year. The Quality Assurance Plan must include a written statement of values, organizational outcomes, activities, and measures of progress that:

(A) Uses information from a broad range of individuals, legal or designated representatives, professionals, and other sources to determine community support needs and preferences;

(B) Involves individuals in ongoing evaluation of the quality of their personal supports; and

(C) Monitors:

(i) Customer satisfaction with the services of the brokerage and with individual plans in areas such as individual access to supports, sustaining important personal relationships, flexible and unique support strategies, individual choice and control over supports, responsiveness of the brokerage to changing needs, and preferences of the individuals; and

(ii) Service outcomes in areas such as achievement of personal goals and effective use of resources.

(b) The brokerage must participate in statewide evaluation, quality assurance, and regulation activities as directed by the Department.

(10) BROKERAGE REFFERRAL TO AFFILIATED ENTITIES.

(a) When a brokerage is part of, or otherwise directly affiliated with, an entity that also provides services that an individual may purchase using private or support services funds, brokerage staff may not refer, recommend, or otherwise encourage the individual to utilize this entity to provide services unless:

(A) The brokerage conducts a review of provider options that demonstrates that the entity's services are cost-effective and best-suited to provide the services determined by the individual to be the most effective and desirable for meeting needs and circumstances represented in the individual's ISP; and

(B) The entity is freely selected by the individual and is the clear choice by the individual among all available alternatives.

(b) The brokerage must develop and implement a policy that addresses individual selection of an entity that the brokerage is a part of, or otherwise directly affiliated, to provide services purchased with private or support services funds. This policy must address, at minimum:

(A) Disclosure of the relationship between the brokerage and the potential provider;

(B) Provision of information about all other potential providers to the individual, or as applicable the individual's legal or designated representative, without bias;

(C) A process for arriving at the option for selecting a provider;

(D) Verification of the fact that the providers were freely chosen among all alternatives;

(E) Collection and review of data on services purchased by an individual enrolled in the brokerage by an entity that the brokerage is a part of or otherwise directly affiliated; and

(F) Training of personal agents and individuals in issues related to the selection of providers.

(11) GENERAL OPERATING POLICIES AND PRACTICES. The brokerage must develop and implement such written statements of policy and procedure in addition to those specifically required by this rule as are necessary and useful to enable the brokerage to accomplish the brokerage's objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0160 Standards for Independent Providers Paid with Support Services Funds
(Amended 12/28/2013)

(1) GENERAL INDEPENDENT PROVIDER QUALIFICATIONS. Each independent provider who is paid as a contractor, a self-employed person, or an employee of an individual, or as applicable the individual's legal or designated representative, to provide the services and supports in OAR 411-340-0130 must:

(a) Be at least 18 years of age;

(b) Have approval to work based on current Department policy and a background check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370. A subject individual as defined in OAR 407-007-0210 may be approved for one position to work in multiple homes within the jurisdiction of the qualified entity as defined in OAR 407-007-0210. The Department's Background Check Request form must be completed by the subject individual to show intent to work at various homes;

(c) Effective July 28, 2009, not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275;

(d) Be legally eligible to work in the United States;

(e) Not be the spouse of an individual receiving services;

(f) Demonstrate by background, education, references, skills, and abilities that he or she is capable of safely and adequately performing the tasks specified in an individual's ISP, with such demonstration confirmed in writing by the individual, or as applicable the individual's legal or designated representative, and including:

(A) Ability and sufficient education to follow oral and written instructions and keep any records required;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the provider has knowledge of emergency procedures specific to the individual receiving services.

(g) Hold a current, valid, and unrestricted appropriate professional license or certification where services and supervision requires specific professional education, training, and skill;

(h) Understand requirements of maintaining confidentiality and safeguarding individual information;

(i) Not be on the Office of Inspector General's list of excluded or debarred providers (http://exclusions.oig.hhs.gov/); and

(j) If providing transportation, have a valid driver's license and proof of insurance, as well as any other license or certification that may be required under state and local law, depending on the nature and scope of the transportation service.

(2) Section (1)(c) of this rule does not apply to employees of individuals, individuals' legal or designated representatives, employees of general business providers, or employees of provider organizations, who were hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(3) All providers must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and OAR 407-007-0290. The provider must notify the Department or the Department's designee within 24 hours.

(4) BEHAVIOR CONSULTANTS. Behavior consultants providing specialized supports must:

(a) Have education, skills, and abilities necessary to provide behavior consultation services, including knowledge and experience in developing Behavior Support Plans based on positive behavioral theory and practice;

(b) Have received at least two days of training in the Oregon Intervention Services Behavior Intervention System, and have a current certificate; and

(c) Submit a resume to the brokerage indicating at least one of the following:

(A) A bachelor's degree in special education, psychology, speech and communication, occupational therapy, recreation, art or music therapy, or a behavioral science field, and at least one year of experience with individuals who present difficult or dangerous behaviors; or

(B) Three years experience with individuals who present difficult or dangerous behaviors and at least one year of that experience includes providing the services of a behavior consultant.

(5) SOCIAL OR SEXUAL CONSULTANTS. Social or sexual consultants providing specialized supports must:

(a) Have the education, skills, and abilities necessary to provide social or sexual consultation services; and

(b) Submit a resume to the brokerage indicating at least one of the following:

(A) A bachelor's degree in special education, psychology, social work, counseling, or other behavioral science field and at least one year of experience with individuals; or

(B) Three years experience with individuals who present social or sexual issues and at least one year of that experience includes providing the services of a social or sexual consultant.

(6) NURSE. A nurse providing community nursing services must:

(a) Have a current Oregon nursing license; and

(b) Submit a resume to the brokerage indicating the education, skills, and abilities necessary to provide nursing services in accordance with state law, including at least one year of experience with individuals.

(7) FAMILY TRAINING PROVIDERS. Providers of family training must be:

(a) Psychologists licensed under ORS 675.030;

(b) Social workers licensed under ORS 675.530;

(c) Counselors licensed under ORS 675.715; or

(d) Medical professionals licensed under ORS 677.100.

(8) DIETICIANS. Dieticians providing special diets must be licensed according to ORS 691.415 through 691.465.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0170 Standards for Provider Organizations Paid with Support Services Funds
(Amended 12/28/2013)

(1) PROVIDER ORGANIZATIONS WITH CURRENT LICENSE OR CERTIFICATION. A provider organization certified, licensed, and endorsed under OAR chapter 411, division 325 for 24-hour residential services, or licensed under OAR chapter 411, division 360 for adult foster homes, or certified and endorsed under OAR chapter 411, division 345 for employment and alternatives to employment services or OAR 411-328-0550 to 411-328-0830 for supported living services, may not require additional certification as an organization to provide relief care, supported employment, community living and inclusion supports, community transportation, specialized supports, chore services, family training, or emergent services.

(a) Current license, certification, or endorsement is considered sufficient demonstration of ability to:

(A) Recruit, hire, supervise, and train qualified staff;

(B) Provide services according to ISPs; and

(C) Develop and implement operating policies and procedures required for managing an organization and delivering services, including provisions for safeguarding individuals receiving services.

(b) Provider organizations must assure that all people directed by the provider organization as employees, contractors, or volunteers to provide services paid for with support services funds meet the standards for qualification of independent providers described in OAR 411-340-0160.

(c) Provider organizations developing new sites, owned or leased by the provider organization, that are not reviewed as a condition of the current license or certification and where individuals are regularly present and receiving services purchased with support services funds, must meet the conditions of section (2)(f) of this rule in each such site.

(2) PROVIDER ORGANIZATIONS REQUIRING CERTIFICATION. A provider organization without a current license or certification as described in section (1) of this rule must be certified as a provider organization according to OAR 411-340-0030 prior to selection for providing the services listed in OAR 411-340-0130 and paid for with support services funds.

(a) The provider organization must develop and implement policies and procedures required for administration and operation in compliance with these rules, including but not limited to:

(A) Policies and procedures required in OAR 411-340-0040, OAR 411-340-0050, OAR 411-340-0070, OAR 411-340-0080, and OAR 411-340-0090 related to abuse and unusual incidents, inspections and investigations, personnel policies and practices, records, and variances.

(B) Individual rights. The provider organization must have, and implement, written policies and procedures that:

(i) Provide for individual participation in selection, training, and evaluation of staff assigned to provide the individual's services;

(ii) Protect individuals during hours of service from financial exploitation that may include but is not limited to:

(I) Staff borrowing from or loaning money to individuals;

(II) Witnessing wills in which the staff or provider organization is beneficiary; or

(III) Adding the staff member's or provider organization's name to the individual's bank account or other personal property without approval of the individual or the individual's legal representative (as applicable).

(C) Complaints. The provider organization must implement written policies and procedures for individuals' complaints. These policies and procedures must, at a minimum, provide for:

(i) Receipt of complaints from an individual or others acting on the individual's behalf. If the complaint is associated in any way with abuse or the violation of the individual's rights, the recipient of the complaint must immediately report the issue to the provider organization director and the CDDP;

(ii) Investigation of the facts supporting or disproving the complaint;

(iii) Taking appropriate actions on the complaint within five working days following receipt of the complaint;

(iv) Submission to the provider organization director. If the complaint is not resolved, the complaint must be submitted to the provider organization director for review. The provider organization director must complete a review and provide a written response to the individual or a person acting on the individual's behalf within 15 days of request for review;

(v) Submission to the brokerage. All complaints received from an individual or a person acting on the individual's behalf must be reported to the appropriate brokerage; and

(vi) Notification. Upon entry into the program and annually thereafter, the provider organization must inform each individual, or as applicable the individual's legal or designated representative, orally and in writing, using language, format, and methods of communication appropriate for the individual's needs and abilities, of the provider organization's complaint policy and procedures.

(D) Policies and procedures appropriate to scope of service, including but not limited to those required to meet minimum standards set forth in subsections (f) to (k) of this section and

consistent with written service agreements for individuals currently receiving services.

(b) The provider organization must deliver services according to a written service agreement.

(c) The provider organization must maintain a current record for each individual receiving services. The record must include:

(A) The individual's name, current home address, and home phone number;

(B) A current written service agreement, signed and dated by the individual or the individual's legal or designated representative (as applicable);

(C) Contact information for the individual's legal or designated representative (as applicable) and any other people designated by the individual, or as applicable the individual's legal or designated representative, to be contacted in case of incident or emergency;

(D) Contact information for the brokerage assisting the individual to obtain services; and

(E) Records of service provided, including type of services, dates, hours, and personnel involved.

(d) Staff, contractors, or volunteers who provide services to individuals must meet independent provider qualifications in OAR 411-340-0160. Additionally, those staff, contractors, or volunteers must have current CPR and first aid certification obtained from a recognized training agency prior to working alone with an individual.

(e) The provider organization must ensure that employees, contractors, and volunteers receive appropriate and necessary training.

(f) Provider organizations that own or lease sites, provide services to individuals at those sites, and regularly have individuals present and

receiving services at those sites, must meet the following minimum requirements:

(A) A written emergency plan must be developed and implemented and must include instructions for staff and volunteers in the event of fire, explosion, accident, or other emergency including evacuation of individuals served.

(B) Posting of emergency information:

(i) The telephone numbers of the local fire, police department, and ambulance service, or "911" must be posted by designated telephones; and

(ii) The telephone numbers of the provider organization director and other people to be contacted in case of emergency must be posted by designated telephones.

(C) A documented safety review must be conducted quarterly to ensure that the service site is free of hazards. Safety review reports must be kept in a central location by the provider organization for three years.

(D) The provider organization must train all individuals when the individuals begin attending the service site to leave the site in response to an alarm or other emergency signal and to cooperate with assistance to exit the site.

(i) Each provider organization must conduct an unannounced evacuation drill each month when individuals are present.

(ii) Exit routes must vary based on the location of a simulated fire.

(iii) Any individual failing to evacuate the service site unassisted within the established time limits set by the local fire authority for the site must be provided specialized training or support in evacuation procedures.

(iv) Written documentation must be made at the time of the drill and kept by the provider organization for at least two years following the drill. The written documentation must include:

(I) The date and time of the drill;

(II) The location of the simulated fire;

(III) The last names of all individuals and staff present at the time of the drill;

(IV) The amount of time required by each individual to evacuate if the individual needs more than the established time limit; and

(V) The signature of the staff conducting the drill.

(v) In sites providing services to individuals who are medically fragile or have severe physical limitations, requirements of evacuation drill conduct may be modified. The modified plan must:

(I) Be developed with the local fire authority, the individual or the individual's legal or designated representative (as applicable), and the provider organization director; and

(II) Be submitted as a variance request according to OAR 411-340-0090.

(E) The provider organization must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(F) At least once every three years, the provider organization must conduct a health and safety inspection.

(i) The inspection must cover all areas and buildings where services are delivered to individuals, including administrative offices and storage areas.

(ii) The inspection must be performed by:

(I) The Oregon Occupational Safety and Health Division;

(II) The provider organization's worker's compensation insurance carrier; or

(III) An appropriate expert such as a licensed safety engineer or consultant as approved by the Department; and

(IV) The Oregon Health Authority, Public Health Division, when necessary.

(iii) The inspection must cover:

(I) Hazardous material handling and storage;

(II) Machinery and equipment used at the service site;

(III) Safety equipment;

(IV) Physical environment; and

(V) Food handling, when necessary.

(iv) The documented results of the inspection, including recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider for five years.

(G) The provider organization must ensure that each service site has received initial fire and life safety inspections performed by the local fire authority or a Deputy State Fire

Marshal. The documented results of the inspection, including documentation of recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider for five years.

(H) Direct service staff must be present in sufficient number to meet health, safety, and service needs specified in the individual written agreements of the individuals present. When individuals are present, staff must have the following minimum skills and training:

(i) At least one staff member on duty with CPR certification at all times;

(ii) At least one staff member on duty with current First Aid certification at all times;

(iii) At least one staff member on duty with training to meet other specific medical needs identified in the individual service agreement; and

(iv) At least one staff member on duty with training to meet other specific behavior intervention needs as identified in individual service agreements.

(g) Provider organizations providing services to individuals that involve assistance with meeting health and medical needs must:

(A) Develop and implement written policies and procedures addressing:

(i) Emergency medical intervention;

(ii) Treatment and documentation of illness and health care concerns;

(iii) Administering, storing, and disposing of prescription and non-prescription drugs, including self-administration;

(iv) Emergency medical procedures, including the handling of bodily fluids; and

(v) Confidentiality of medical records;

(B) Maintain a current written record for each individual receiving assistance with meeting health and medical needs that includes:

(i) Health status;

(ii) Changes in health status observed during hours of service;

(iii) Any remedial and corrective action required and when such actions were taken if occurring during hours of service; and

(iv) A description of any restrictions on activities due to medical limitations.

(C) If providing medication administration when an individual is unable to self-administer medications and there is no other responsible person present who may lawfully direct administration of medications, the provider organization must:

(i) Have a written order or copy of the written order, signed by a physician or physician designee, before any medication, prescription or non-prescription, is administered;

(ii) Administer medications per written orders;

(iii) Administer medications from containers labeled as specified per physician written order;

(iv) Keep medications secure and unavailable to any other individual and stored as prescribed;

(v) Record administration on an individualized Medication Administration Record (MAR), including treatments and PRN, or "as needed", orders;

(vi) Not administer unused, discontinued, outdated, or recalled drugs; and

(vii) Not administer PRN psychotropic medication. PRN orders may not be accepted for psychotropic medication.

(D) Maintain a MAR (if required). The MAR must include:

(i) The name of the individual;

(ii) The brand name or generic name of the medication, including the prescribed dosage and frequency of administration as contained on physician order and medication;

(iii) Times and dates the administration or self-administration of the medication occurs;

(iv) The signature of the staff administering the medication or monitoring the self-administration of the medication;

(v) Method of administration;

(vi) Documentation of any known allergies or adverse reactions to a medication;

(vii) Documentation and an explanation of why a PRN, or "as needed", medication was administered and the results of such administration; and

(viii) An explanation of any medication administration irregularity with documentation of administrative review by the provider organization director.

(E) Provide safeguards to prevent adverse medication reactions, including:

(i) Maintaining information about the effects and side-effects of medications the provider organization has agreed to administer;

(ii) Communicating any concerns regarding any medication usage, effectiveness, or effects to the individual or the individual's legal or designated representative (as applicable); and

(iii) Prohibiting the use of one individual's medications by another individual or person.

(F) Maintain a record of visits to medical professionals, consultants, or therapists if facilitated or provided by the provider organization.

(h) Provider organizations that own or operate vehicles that transport individuals must:

(A) Maintain the vehicles in safe operating condition;

(B) Comply with Department of Motor Vehicles laws;

(C) Maintain insurance coverage on the vehicles and all authorized drivers;

(D) Carry a fire extinguisher and first aid kit in each vehicle; and

(E) Assign drivers who meet applicable Department of Motor Vehicles requirements to operate vehicles that transport individuals.

(i) If assisting with management of funds, the provider organization must have and implement written policies and procedures related to the oversight of the individual's financial resources that include:

(A) Procedures that prohibit inappropriately expending an individual's personal funds, theft of an individual's personal funds, using an individual's funds for staff's own benefit, commingling an individual's personal funds with the provider organization's or another individual's funds, or the provider organization becoming an individual's legal or designated representative; and

(B) The provider organization's reimbursement to the individual of any funds that are missing due to theft or mismanagement on the part of any staff of the provider organization, or of any funds within the custody of the provider organization that are missing. Such reimbursement must be made within 10 working days of the verification that funds are missing.

(j) Additional standards for assisting individuals to manage difficult behavior.

(A) The provider organization must have, and implement, a written policy concerning behavior intervention procedures. The provider organization must inform the individual, and as applicable the individual's legal or designated representative, of the behavior intervention policy and procedures prior to finalizing the individual's written service agreement.

(B) Any intervention to alter an individual's behavior must be based on positive behavioral theory and practice and must be:

(i) Approved in writing by the individual or the individual's legal or designated representative (as applicable); and

(ii) Described in detail in the individual's record.

(C) Psychotropic medications and medications for behavior must be:

(i) Prescribed by a physician through a written order; and

(ii) Monitored by the prescribing physician for desired responses and adverse consequences.

(k) Additional standards for supports that involve protective physical intervention.

(A) The provider organization must only employ protective physical intervention:

(i) As part of an individual's ISP;

(ii) As an emergency measure, but only if absolutely necessary to protect the individual or others from immediate injury; or

(iii) As a health-related protection prescribed by a physician, but only if necessary for individual protection during the time that a medical condition exists.

(B) Provider organization staff members who need to apply protective physical intervention under an individual's service agreement must be trained by a Department-approved trainer and documentation of the training must be maintained in the staff members' personnel file.

(C) Protective physical intervention in emergency situations must:

(i) Be only used until the individual is no longer a threat to self or others;

(ii) Be authorized by the provider organization director or the individual's physician within one hour of application of the protective physical intervention;

(iii) Result in the immediate notification of the individual's legal or designated representative (as applicable); and

(iv) Prompt a review of the individual's written service agreement, initiated by the provider organization, if protective physical intervention is used more than three times in a six month period.

(D) Protective physical intervention must be designed to avoid physical injury to an individual or others and to minimize physical and psychological discomfort.

(E) All use of protective physical intervention must be documented and reported according to procedures described in OAR 411-340-0040. The report must include:

(i) The name of the individual to whom the protective physical intervention is applied;

(ii) The date, type, and length of time of the application of protective physical intervention;

(iii) The name and position of the person authorizing the use of the protective physical intervention;

(iv) The name of the staff member applying the protective physical intervention; and

(v) Description of the incident.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695

411-340-0180 Standards for General Business Providers Paid with Support Services Funds
(Amended 12/28/2013)

(1) General business providers providing services to individuals and paid with support services funds must hold any current license appropriate to function required by the state of Oregon or federal law or regulation, including but not limited to:

(a) For a home health agency, a license under ORS 443.015;

(b) For an in-home care agency, a license under ORS 443.315;

(c) For providers of environmental accessibility adaptations involving building modifications or new construction, a current license and bond as a building contractor as required by either OAR chapter 812 (Construction Contractor's Board) or OAR chapter 808 (Landscape Contractors Board);

(d) For environmental accessibility consultants, a current license as a general contractor as required by OAR chapter 812, including experience evaluating homes, assessing the needs of an individual, and developing cost-effective plans to make homes safe and accessible;

(e) For public transportation providers, the established standards;

(f) For private transportation providers, a business license and drivers licensed to drive in Oregon;

(g) For vendors and medical supply companies providing specialized equipment and supplies, a current retail business license including enrollment as Medicaid providers through the Division of Medical Assistance Programs if vending medical equipment;

(h) A current business license for providers of personal emergency response systems; and

(i) Retail business licenses for vendors and supply companies providing special diets.

(2) Services provided and paid for with support services funds must be limited to the services within the scope of the general business provider's license.

Stat. Auth.: ORS 409.050, 427.402, and 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400 to 427.410, 430.610, 430.620, and 430.662 to 430.695