

**Mississippi Department of Mental Health
Bureau of Intellectual and Developmental Disabilities**

ID/DD Waiver

Support Coordination Manual

January 1, 2012

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Introduction

This Manual provides information about implementing the requirements in the DMH Record Guide, DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Community Service Providers, the federally approved ID/DD Waiver program, and Medicaid policy pertaining to Support Coordination in the ID/DD Waiver. ***This does not relieve the Support Coordinator from the responsibility to follow all requirements in the aforementioned documents.***

The Manual is divided into processes, forms and instructions, and appendices. Throughout this document, the terms “individual” and “person” refer to the person receiving services. These terms also refer to the individual’s legal representative, whether it is a parent, other family member, guardian, or spouse.

Individuals must be provided copies of all documents they sign. Copies must be made available as soon as possible but no more than five (5) days after the date of the signature.

“Days” mean calendar days unless otherwise specified.

Part I

Processes and Procedures

A. Initial Referral Process

1. Referrals for the ID/DD Waiver are received and processed at each of the state's five (5) comprehensive Regional Centers which house the Diagnostic and Evaluation (D&E) Departments.
2. D&E staff mails an Application for Services to the individual. This application is the same as the one used when applying for admission to the Regional Center's Intermediate Care Facility for the Mentally Retarded (ICF/MR) program. D&E staff maintains documentation of when the application is mailed and when it is due to be returned. If the application is not returned within forty-five (45) days of when it was mailed, the D&E staff sends a reminder to the individual. If the application is not received back within thirty (30) days of the second notice, the intake staff removes the individual's name from the list of referrals but maintains the name in a separate log for future reference, if needed.

B. Initial Evaluation and Eligibility Determination Process

1. All evaluations for initial eligibility for the ID/DD Waiver are conducted by the D&E Team located at one of the state's five comprehensive Regional Centers. Individuals are evaluated at the Regional Center in whose catchment area they reside following the requirements outlined in the DMH Program Manual.
2. Within five (5) working days of receiving the completed Application for Services, the Diagnostic and Evaluation Department is responsible for contacting the individual to schedule the evaluation.
 - a. A person must be evaluated within ninety (90) working days of the date the D&E Team receives the completed Application for Services.
 - b. The evaluation conducted by the D&E Team is identical to the evaluation that is conducted when someone applies for admission to an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The required components of the evaluation are listed in the DMH Program Manual.
3. During the evaluation process, the D&E Team reviews all available options with the individual. This includes ID/DD Waiver services, ICF/MR services, and other types of appropriate community services.
4. If an individual meets ICF/MR level of care requirements, and has expressed an interest in ID/DD Waiver services, he/she must be informed there is a Statewide Planning List and that his/her name can be placed on the list if they do desire. It must be documented in writing whether the individual did or did not choose to have his/her name is placed on the ID/DD Waiver Statewide Planning list.
5. The D & E team forwards the following information to the SC Department by the 5th of each month (based on the previous month's completed evaluations) for each person whose name is to be placed on the ID/DD Waiver Statewide Planning List:
 - a. Last Name
 - b. First Name
 - c. Medicaid Number (if available)
 - d. Social Security Number
 - e. Date of birth
 - c. Date of application
 - d. Evaluation date
 - e. County of residence
 - f. DSM Axis I, II, and III codes
6. A copy of all evaluations and the Interdisciplinary Summary and Recommendations Report are made available to the SC Department.
7. By the 20th of the month, or at any time after a person has been informed they meet ICF/MR level of care criteria and have been asked for their name to be placed on the ID/DD Waiver Statewide Planning List, assigned SC Department staff contacts the individual to complete the ID/DD Waiver Projected Service Needs form to indicate the type of ID/DD Waiver services that would be of benefit in supporting him/her to remain at home and in the community. Individuals are asked to project their needs for the next five (5) years. This information is added to the Statewide Planning List using the appropriate service codes.

8. If the D&E Team determines a person does not meet ICF/MR level of care requirements, the individual is informed of and given a copy of the procedures for appealing the decision along with the evaluation report the individual receives. The date the individual is notified of the decision and provided a copy of the procedures for making an appeal is maintained in an electronic tracking log. The individual has thirty (30) days from the date on the Notice of Ineligibility for ICF/MR Level of Care to appeal the decision. (See Appendix B)
9. Everyone who is evaluated and placed on the ID/DD Waiver Statewide Planning List must be offered/referred to Case Management.

C. ID/DD Waiver Statewide Planning List Updates

1. Individuals who are on the ID/DD Waiver Statewide Planning List are contacted at least annually, according to their date of application, in writing, by one of the five (5) Support Coordination Departments to determine if they desire to remain on the ID/DD Waiver Statewide Planning List or if they would like their name removed. He/she is also asked to update contact information. (Appendix E)
2. If the individual does not respond within thirty (30 days) of the date on the letter, his/her name is removed from the ID/DD Waiver Statewide Planning List but is maintained in the Removed from Planning List spreadsheet.
3. Information returned by the individual is compared to the current information and is updated as needed. It is the individual's responsibility to contact the appropriate Support Coordination Department to update contact or other information any time it changes.

D. Initial Enrollment

1. BIDD staff manages the ID/DD Waiver Statewide Planning List. People's names are placed on the ID/DD Waiver Statewide Planning List based on their date of application. As funding becomes available, BIDD sends each of the five (5) Support Coordination Departments a list of individuals from their catchment area who can be offered the opportunity to be enrolled.
2. Upon receipt of the list of individuals from BIDD, the Support Coordination Department has thirty (30) days to notify each individual that they have the opportunity to be enrolled in the ID/DD Waiver program. The individual is notified in writing (see Appendix F). Upon receipt of the signed acceptance for enrollment, a Support Coordinator is assigned to the individual and begins the initial enrollment process.
3. The Support Coordinator ensures the following information is obtained and is current within ninety (90) days of submission to BIDD for consideration of enrollment:
 - a. An Addendum from the D&E Team which documents a record review of the individual's information and administration of the ICAP by phone. Additionally, the Social Summary must be updated. The record review and the ICAP will be documented as an evaluation addendum noting either:
 - (1) The individual continues to meet ICF/MR level of care requirements and the results from the most recent psychological evaluation (which meets the requirements in the DMH Program Manual) continue to be an accurate reflection of the individual's cognitive and adaptive functioning; or
 - (2) The individual will receive a comprehensive evaluation due to evidence that the previous evaluation results may not be an accurate reflection of the individual's present cognitive and adaptive functioning due to changes in age, environment, health, etc.
 - b. The Justification for Initial Certification which must include:
 - (1) The amount(s) and type(s) of services requested on the Plan of Care and
 - (2) A detailed justification for each requested service
 - (3) Current living arrangements and supports
 - (4) Description of individual's current abilities regarding daily living skills and community integration activities
 - (5) An indication of whether the individual is:
 - (a) Being enrolled from the ID/DD Waiver Statewide Planning List
 - (b) Being deinstitutionalized, from where, circumstances of the discharge, and the anticipated date of discharge
 - (6) Documentation that all recommendations made in the Interdisciplinary Summary and Recommendations report are addressed
 - c. A medical evaluation - The medical evaluation can be completed by the individual's personal physician/nurse practitioner or one associated with the D&E Team.
 - d. Plan of Care
 - e. ID/DD Waiver Initial Enrollment Agreement

- f. Rights of Individuals Receiving Services
 - g. Consent for Services
 - h. Consent(s) to Release Information to each provider identified on the Plan of Care (and others as needed)
 - i. Support Coordination Grievance and Complaint procedures
 - j. Medication/Emergency Information
 - k. Documentation of Choice of Provider
 - l. Face Sheet
4. The following information must be submitted to BIDD for consideration of approval:
- a. ID/DD Waiver Action Form
 - b. Plan of Care
 - c. Justification for Initial Certification
 - d. Medical evaluation
 - e. Interdisciplinary Summary and Recommendations Report and all evaluation reports and, if applicable, an Addendum from D&E
5. The BIDD has forty-five (45) days from the date of receipt of all information outlined above to make a determination regarding whether the individual meets all requirements for admission.
6. The Division of Medicaid determines the initial admission date and notifies the SC Department and BIDD.

E. Recertification Process

1. Continuing eligibility for the ID/DD Waiver must be determined at least annually.
2. All documents required for recertification must be current within ninety (90) days of the end of the individual's certification period (lock-in end date).
 - a. Individual Rights in the Program
 - b. ID/DD Waiver Enrollment Agreement
 - c. Complaint/Grievance Resolution Procedures for Support Coordination
 - d. Consent for ID/DD Services
 - e. Consent(s) to Obtain/Release Information, as needed
 - f. The Plan of Care
 - g. Documentation of Choice of Provider
 - h. ICAP
 - i. The Medication/Emergency Contact Information
 - j. ID/DD Waiver Action Form
 - k. Justification for Recertification
 - l. Face Sheet
3. The following information must be submitted to the BIDD for recertification within forty-five (45) days of the individual's certification lock-in end date:
 - a. ID/DD Waiver Action Form
 - b. Plan of Care
 - c. Justification for Recertification
 - d. Medical evaluation (required at a minimum of every three (3) years or when an individual's condition changes)
 - e. Interdisciplinary Summary and Recommendations Report and all evaluation reports for anyone who has had an evaluation since their last recertification
4. The BIDD has forty-five (45) days from the date of receipt of information to make a determination regarding whether the individual meets all requirements for recertification and to forward the information to Medicaid where the individual is assigned a certification lock-in begin date.
5. When the Support Coordinator receives an approved recertification, he/she sends the appropriate Notice of Certification form to the individual indicating the action(s) taken (including any changes to or denials of requested services).
6. If an individual's recertification is denied because the individual no longer meets ICF/MR level of care requirements, the BIDD notifies the individual and sends a copy of all communication to the Support Coordinator and to Medicaid.

F. Readmission Process

People can be readmitted if their discharge date is in the same fiscal year as the request to re-enter the ID/DD Waiver. An individual who is discharged from the ID/DD Waiver may be readmitted, depending on the circumstances of the discharge.

1. A person who is voluntarily discharged can be considered for readmission in the same fiscal year as the discharge. Failure to request readmission in the same fiscal year as the discharge may result in the individual's name being placed on the ID/DD Waiver Statewide Waiting List and enrollment will then will be based on his/her date of application and the availability of funded slots.
2. If a person is discharged because the environment or the individual pose a threat/risk to service providers, the individual has the right to appeal the discharge. The outcome of the appeal will determine whether readmission can take place.
3. The Director of the Bureau of Intellectual and Developmental Disabilities has the discretion to consider extenuating circumstances related to requests for admission after a discharge of any type.
4. The following information must be current within ninety (90) days of submission to the BIDD for consideration of approval:
 - a. Individual Rights in the Program
 - b. ID/DD Waiver Enrollment Agreement
 - c. Complaint/Grievance Resolution Procedures for Support Coordination
 - d. Consent for ID/DD Services
 - e. Consent(s) to Obtain/Release Information, as needed
 - f. The Plan of Care
 - g. Documentation of Choice of Provider
 - h. ICAP (can be conducted by SC)
 - i. The Medication/Emergency Contact Information form
 - j. Justification for Readmission
 - k. Medical evaluation (if the individual's condition has changed since the previous one or if the current one is more than three (3) years old)
 - l. Discharge summary from a DMH facility, hospital, nursing home, or rehabilitation facility (if applicable)
 - m. Face Sheet
5. The following information must be submitted to the BIDD for readmission and be current within ninety (90) days of the time of submission to the BIDD:
 - a. ID/DD Waiver Action Form
 - b. Plan of Care
 - c. Justification for Readmission
 - d. Medical evaluation (if applicable)
 - e. Discharge summary from a DMH facility, hospital, nursing home, or rehabilitation facility (if applicable)
 - f. Interdisciplinary Summary and Recommendations Report and all evaluation reports if new ones have been conducted
6. The BIDD has five (5) days from the date of receipt of all information outlined above to determine if the request meets the requirements for readmission and forward to the information to Medicaid who will determine the readmission date for the individual.

G. Individual Plan of Care Development

1. The Plan of Care describes the ID/DD Waiver services and all other supports and services a person receives, formal or informal and regardless of the funding source, that assist him/her to remain at home and in the community.
2. The Initial Plan of Care is developed after all evaluation information has been gathered by the Support Coordinator (psychological, adaptive, educational, etc., medical and ICAP).
3. Plans of Care for recertification and readmission are developed based on the expressed desires of the individual as well as all evaluation and other pertinent information that has been generated since the last certification.
4. The Support Coordinator reviews with the individual the services that are available through the ID/DD Waiver. The services and supports requested on the Plan of Care (both ID/DD Waiver and non-ID/DD Waiver) are based on the recommendations from the evaluation conducted by the D&E Team as well as what the individual believes would be beneficial in supporting him/her in a home and community based setting.
5. The Plan of Care is developed jointly by at least the following people:
 - a. The individual and his/her legal representative (if applicable)
 - b. The Support Coordinator
 - c. Anyone else the individual would like to have present
6. The Support Coordinator and individual must address every recommendation included in the Interdisciplinary Summary and Recommendations Report from the D&E Team for initial Plans of Care and for recertification and readmission Plans of Care when new/revised evaluation data is available. Issues/concerns/desires expressed by each person constitute the basis of the Plan of Care. There must be documentation in the Support Coordination record to indicate each item was identified and addressed.
 - a. The solution/action for every recommendation is not necessarily listed as a service/support on the Plan of Care. The recommendations of the D&E Team and the needs and desires of the individual may be addressed (and documented in the SC Contact Summaries) in one of the following ways:
 - (1) Directly by the Support Coordinator
 - (2) Making a referral to another agency or provider
 - (3) Service provision (either ID/DD Waiver or non-Waiver)
 - (4) Address at a later date (with justification why and timelines for follow-up)
 - (5) Natural supports
 - b. The Support Coordinator works with the individual to list, arrange, and prioritize all items and areas to be addressed in the "Services/Supports Required" section.

7. Outcome of the Service/Support

- a. The outcome of each service and/or support (Waiver or non-Waiver) is the intended result desired by the individual receiving services.
- b. The outcomes must be individualized.
- c. It is the Support Coordinator's job to assist individuals in meeting their identified outcomes by locating and coordinating needed supports and services.

8. ID/DD Waiver Services

- a. List the ID/DD Waiver services recommended by the D&E Team (for initial Plans of Care and for recertification and readmission if new evaluation data is available) and wanted by the individual which are necessary to assist him/her in meeting their identified outcomes.
 - (1) Every Plan of Care must have Support Coordination listed as the first service. The frequency is monthly.
 - (2) Each service must have a provider and frequency listed for each service when the Plan of Care is submitted to BIDD.

9. Non-ID/DD Waiver Services

- a. If the individual is receiving any non-ID/DD Waiver service(s), list the service, the name of the provider and the date(s) the service(s) began (if known). These services include medical, social, educational, vocational, recreational, etc.
- b. If the service is needed and the Support Coordinator is in the process of linking the individual with the service, there will not necessarily be a start date or provider. This information will be completed when a provider is identified and the service(s) begin.
- c. Non-waiver services are included on the Plan of Care so the Support Coordinator can ensure all services provided are coordinated to address each individual's unique situation. This also helps avoid duplication of services.

10. Frequency

- a. The frequency of services involves two parts: 1) the number of hours, days, or cases (disposable underpants, blue pads, catheters); and 2) if the service is provided monthly or annually. Support Coordinators request the frequency based upon recommendations of the D&E Team (for initial Plans of Care and for recertifications and readmission when new evaluation data is available), the expressed needs of the person and/or family and other available information.
- b. Some services have limits. They are as follows:
 - (1) Day Services – Adult and Prevocational Services - the maximum amount is 130 hours per month; in months with 23 working days, a provider can bill up to 138 hours per month; in months with 22 working days, they can bill up to 132 hours/month. Regardless of the maximum allowable, a provider can only bill for the amount of service provided.
 - (2) Physical therapy – the maximum is thirteen (13) hours per month.

- (3) Occupational therapy – the maximum is nine (9) hours per month.
- (4) Speech/language/hearing therapy – the maximum is thirteen (13) hours per month.
- (5) Behavior Support/Intervention - The maximum amount for evaluation is ten (10) hours per certification year and 800 hours per certification year of direct services. The amount of direct service hours will be authorized after the completion of the evaluation. The BIDD determines the amount of direct service based on recommendations from the behavior support/interventionist.
- (6) ICF/MR Respite – The maximum amount is 30 days per certification year

11. DMH Certified Providers

- a. Individuals are informed about all certified providers for services they are requesting when the Plan of Care is developed/revised. Support Coordinators will give individuals written literature (approved by BIDD), when available, from the provider agencies and if requested by the individual.
- b. Enter the name of the provider the individual chooses for each service.
- c. A person may have more than one provider for a given service. In this instance, each provider must be authorized for a specific amount of service. The providers cannot exceed the amount for which they are authorized.

12. Start Date and End/Change Dates for ID/DD Waiver Services

- a. The provider start date is the day listed on the Service Authorization.
- b. The frequency start date is the date the approved frequency actually begins. If a person changes providers, the frequency begin date does not change.

13. Plans of Care are continually reviewed and revised to ensure approved ID/DD Waiver services and non-Waiver services are appropriate and adequate to ensure the individuals' health and welfare. Reviews happen, at a minimum, during the two (2) required monthly contacts and quarterly face-to-face visits in the individual's service setting(s).

H. Support Coordination Contact Summaries

Support Coordination (SC) Contact Summaries are used to document all contacts with or on the behalf of individuals participating in the ID/DD Waiver. The following are types of information to be maintained in the Contact Summaries in addition to other requirements from the other sections:

1. All contacts Support Coordinators make about a person. Document the reason for the contact as well as the content
2. All follow-up activities
3. Calls from third parties
4. The Support Coordinators' activities in helping people get what they need (ID/DD Waiver and other services)
5. Calls to providers to ask questions about or discuss someone's services
6. Serious incidents the Support Coordinator is made aware of either by phone or in person. Provide details about the incident and any action(s) taken by the Support Coordinator.
7. Calls from providers. Include the name of the provider, the service, the issue(s) and any necessary follow-up actions needed as a result of the call.
8. When, why and what type of information is received about a person
9. When, why and what type of information is sent to a provider or other party about a person
10. When and why providers and/or type/amount of service(s) change
11. Reason(s) for discharge from the ID/DD Waiver
12. Change in Support Coordinators. Document how individuals are informed of the change and arrangements for them to meet their new Support Coordinator and when the old Support Coordinator informs the new Support Coordinator of any outstanding needs or requests to be addressed.
13. Other situations based on individual circumstances

Contact Summaries must be filed in the electronic record no later than the 5th of the month following the month in which they are generated.

Revised 4/23/12

I. Requirements for Monthly Contacts

1. Monthly contacts must begin during the month of the lock-in begin date.
2. Documentation of contacts must be individualized.
3. Monthly contacts must consist of one or more of the following:
 - a. Two (2) telephone (verbal) contacts – at least one with the individual and one with the legal guardian.
 - b. A non-quarterly face-to-face visit with the individual and a phone contact with the legal guardian
4. Support Coordinators must stay in contact with individuals to be able to determine any emerging needs so they can be addressed as quickly as possible.
5. If the requirements for monthly contacts are not met, there must be documentation to explain the circumstances that prevented the contact(s). Medicaid billing may not be allowed for that month.
6. Two (2) phone contacts are not required in the months in which quarterly visits are conducted.
7. If a Support Coordinator visits the individual while he/she is at the Regional Center for an evaluation, and all requirements for a monthly contact are met, the visit can count as face-to-face visit, and two phone calls are not required. This may not count as a quarterly visit.
8. Detailed documentation of monthly contacts is maintained in the SC Contact Summaries and includes at least the following:
 - a. Review of most current service utilization data is required during one monthly contact unless there are questions since the last time the information was reviewed with the individual. The claims data on the Monthly Utilization Report is compared to the Plan of Care to determine if services are being provided according to the Plan of Care.
 - 1) If services are being under utilized, there must be documentation to indicate why
 - 2) If there are other types of discrepancies, complete the Documentation of Possible Discrepancies in Service Documentation form
 - b. Follow-up from previous issues
 - c. Satisfaction with current service(s)/provider(s), both ID/DD Waiver and non-ID/DD Waiver
 - d. If services are being delivered/received according to Plan of Care
 - e. If there is a need for new services/changes in amount(s) frequency of current services, ID/DD Waiver and/or non-ID/DD Waiver
 - f. Any changes in health status (has the person been to the doctor, what did the doctor say, any new medications, illnesses, etc.).

9. The Support Coordinator must talk with each of the individual's provider(s) at least one (1) time per quarter. The contact must take place with the staff that provides direct service to the individual or his/her immediate supervisor. The areas that must be addressed with agency staff are:
 - a. The individual's progress toward meeting outcomes on the Activity Plan
 - b. Any significant events which have taken place regarding the individual
 - c. Any needs the staff person thinks the individual might have that are not being addressed
 - d. Other information that the Support Coordinator or staff person deem pertinent
10. If a person is not yet receiving any of the services on his/her approved Plan of Care, it may be necessary to have more frequent contact with the individual informing them of the efforts being made to locate providers and to ensure all of their non-ID/DD Waiver service needs are being met.

Levels of Support Coordination

There are two levels of Support Coordination.

1. Normal is defined as:
 - a. A minimum of two (2) phone contacts (at least one with the individual and one with the legal guardian), a face-to-face visit, or a quarterly visit during a month (If someone is their own legal guardian, two (2) phone contacts with the individual are required)
 - b. Documentation of contacts made with the individual and any collateral contacts for the month

AND

 - c. Review of the monthly utilization report
2. High is defined as the requirements for normal level of Support Coordination plus one of the following:
 - a. Two (2) or more phone contacts with an individual/legal representative during a month
 - b. Two (2) or more collateral contacts during the month
 - c. A non-quarterly home visit
 - d. A face-to-face visit in a service setting
 - e. Travel on the individual's behalf that is not related to a quarterly visit or face-to-face visit

The Medicaid reimbursement rate for the High Level of Support Coordination is more than that for the Normal Level of Support Coordination. Therefore the Support Coordination provider must keep detailed documentation of the above listed activities to indicate why the High Level of Support Coordination is billed to Medicaid.

J. Quarterly Visits

1. Quarterly face-to-face visits must begin within three (3) months of the individual's lock-in begin date. This includes individuals who are readmitted to the ID/DD Waiver; time lines associated with any previous lock-in begin date are void.
2. Documentation of contacts of Quarterly Visits must be individualized.
 - a. There must be at least four (4) visits during an individual's certification year.
 - b. Quarterly visits must take place in setting(s) where the individual receives ID/DD Waiver services.
 - c. Quarterly visits must take place with the individual and legal guardian, even if separate contacts are required. Contact with the legal guardian can be by phone.
 - d. When someone receives more than one ID/DD Waiver service, the Support Coordinator must visit all service settings, with the individual present, during the individual's certification year. At least one (1) visit must take place in the home regardless of if a person receives any services in the home setting.
 - e. Service specific quarterly visit requirements are listed below.
 - (1) Services provided in the home – The Support Coordinator must make at least one (1) quarterly visit during the individual's certification year while direct support staff is in the home. If the person receives two in-home services, the Support Coordinator must see each type of provider in the home at least one time per certification year. If there are more than two (2) staff people for a service, it may not be possible to see both staff providing services.
 - (2) ICF/MR respite – The Support Coordinator must visit the individual at least one (1) time during the respite stay.
3. If the Support Coordinator is unable to conduct a quarterly visit within the specified time lines because of extenuating circumstances such as the individual is in the hospital, the legal guardian is out-of-town, the person is not at home at the scheduled time, etc., he/she must document the reason(s) why and reschedule the missed visit at the earliest time possible. The visit must take place.
4. Support Coordinators must document, at a minimum, the following items during each quarterly visit:
 - a. Date and time of visit, location of visit, and those present during the visit
 - b. Information about the individual's health and welfare including:
 - (1) Any changes in health status (including medication changes) which could necessitate changes or revisions to the Plan of Care
 - (2) Serious incidents
 - (3) Changes to/in the individual's living arrangements and/or family situation

- c. Information about the individual's satisfaction with all current service(s) and provider(s), both ID/DD Waiver and non-ID/DD Waiver (each service must be addressed). Also, if a person receives Supported Employment services, the individual's satisfaction with his/her job must be documented.
 - d. Information addressing if there is a need for a new service(s) (ID/DD Waiver and/or others) based upon expressed needs, concerns, or changing circumstances
 - e. Information addressing whether the amount/frequency of service(s) listed on the approved Plan of Care remains appropriate to assist the individual in remaining at home and in the community
 - f. If services are being delivered/received according to Plan of Care and if not, why
 - g. Review of ALL Individual Service/Activity Plans developed by agencies that provide ID/DD Waiver services to the individual for continued appropriateness and effectiveness, based on the expressed desires of the individual, and to ensure services are coordinated
 - h. Valued activities in all aspects of a person's life
 - i. Documentation of the review of the monthly Service Utilization Report to verify the amount and types of both ID/DD Waiver and Medicaid funded non-ID/DD Waiver services being received.
 - j. Comments/feedback from the provider
5. The Support Coordinator must inform the individual if any new agencies that provide services for which he/she is approved have been certified.
 6. Inquire if the person has received anything from Medicaid or the Social Security Administration regarding their Medicaid benefits/eligibility.

J. Transfers

1. If an individual transfers from one Regional Center catchment to another, he/she is NOT discharged from the ID/DD Waiver. His/her information (everything in the electronic record and all Contact Summaries) is transferred from the sending Regional Center to the receiving Regional Center.
2. The sending Regional Center informs the family about who to contact regarding their move. Additionally, the individual's SC follows-up with the receiving Regional Center to ensure contact has been made.
3. Careful coordination between the Support Coordinators helps ensure there is no break in service for the individual.
4. Depending on the service, he/she may keep their same provider or they may have to choose a new one based on the area to where they are moving.
5. The receiving Regional Center submits the Action Form once the individual's residence in the new catchment area is established and services have started.

Part II

Forms and Instructions

ID/DD Waiver Enrollment Agreement

Purpose

The Enrollment Agreement outlines what individuals can expect from Support Coordination services, rules and expectations regarding participation in the program, and reasons for discharge from the ID/DD Waiver. It also provides documentation that the individual is choosing ID/DD Waiver services rather than ICF/MR services.

Timeline

The Enrollment Agreement must be reviewed with the individual initially and at least annually thereafter, within ninety (90) days of the individual's certification end date.

General

The individual must sign the Enrollment Agreement to indicate he/she agrees to adhere to the requirements in order to receive any ID/DD Waiver services.

ID/DD Waiver Enrollment Agreement

Name _____

Medicaid Number _____

I have been offered the choice between institutional and home and community based services and choose:

Home and Community Based Services – ID/DD Waiver Institutional services

1. I agree with the contents and necessity of the services requested on the Plan of Care. I understand the type and amount of services requested on the Plan of Care must be approved by the Department of Mental Health, Bureau of Intellectual and Developmental Disabilities (BIDD). The BIDD can make changes to the type(s) and/or amount(s) of service(s) requested.
2. I understand that my eligibility for the ID/DD Waiver must be recertified at least annually. This is required in order for me to continue to receive services. I may be asked to obtain medical evaluations from my personal physician before enrollment and at least every three (3) years thereafter as part of the certification process. If I do not comply with these requests, my enrollment may be suspended until I provide the information to my Support Coordinator.
3. I understand that I will be contacted at least two (2) times per month by my Support Coordinator in order to assess any changing needs and my satisfaction with services. To the greatest extent possible, the calls will take place at a time convenient for me. However, failure to accept calls or make myself available could result in suspension of services.
4. I understand I will be visited by my Support Coordinator at least one (1) time every three (3) months and I will be available to meet with him/her at these scheduled times. Visits will take place in each setting where I receive ID/DD Waiver services. A least one (1) visit per year must be conducted in my home. These visits are to review my Plan of Care and to determine if it remains appropriate and adequate to assure my health and welfare needs are met.
5. I understand ID/DD Waiver services can only be provided by DMH certified providers. Only the type and amount of service approved by the DMH on my Plan of Care can be provided.
6. If I am unhappy with an agency that provides any of my services, I will notify my Support Coordinator. He/she will inform me about all other qualified providers for the service. The agency I choose will be authorized to begin providing services the 1st day of the following month. I may change providers immediately if:
 - a. My health and welfare are affected
 - b. I have not received any of the service during the month I ask to change.
7. The appeal procedures have been explained to me and I have been given a copy. I understand I can appeal the following:
 - a. A reduction in my services
 - b. Denial of requested types/amounts of services
 - c. Discharge from the ID/DD Waiver for the following reasons:
 - 1) I no longer require ICF/MR level of care as determined by the D&E Team at one of the states' comprehensive Regional Centers
 - 2) I require a level of care that cannot be provided through the ID/DD Waiver
 - 3) I/my environment pose a danger/risk to the provider

ID/DD Waiver Enrollment Agreement

Name _____

Medicaid Number _____

8. I understand the other reasons I may be discharged from the ID/DD Waiver:
- Funding for the program is terminated
 - I request to be discharged from the program or otherwise refuse services
 - I move from the State of Mississippi
 - I am admitted to an ICF/MR, residential treatment program, or nursing facility (NF) or require hospitalization for more than thirty (30) consecutive days
 - I become belligerent or abusive toward the service provider or am a danger to myself or others
 - I do not utilize any of the approved services that are available within six (6) months from the time I am made aware they are available
 - I do not adhere to the terms of the Enrollment Agreement
 - I am no longer eligible for Medicaid benefits
9. If I am discharged from the program because I enter an ICF/MR, nursing home, or am in the hospital or residential treatment program for more than thirty (30) days, my readmission to the program is contingent upon:
- Availability of funding
 - Changes in my level of care needs
 - Eligibility for Medicaid
10. I may withdraw from the ID/DD Waiver program at any time by contacting my Support Coordinator and signing a Notice of Voluntary Discharge.
11. If I am discharged from the ID/DD Waiver because I, a family member, or someone associated with me pose a risk to any provider, I may appeal the termination, but services **will not** continue pending the outcome of the appeal.
12. Each year, during the recertification process, the terms of this Enrollment Agreement and any updates or changes will be reviewed with me and/or my legal representative and I will be given a copy.
13. I understand I must agree to the terms of this Enrollment Agreement in order to receive services through the ID/DD Waiver program.

The above information has been reviewed with me and I understand the contents and agree to follow the requirements.

Individual/Legal Representative _____

ID/DD Waiver Support Coordinator _____

Date _____

Date _____

Medication/Emergency Contact Information

Purpose

Documentation of medications taken by the individual must be maintained while he/she is receiving services from a DMH certified agency or provider. The Medication/Emergency Contact Information is not to be used for the regular dispensing of medication. An important component is the documentation of all the individual's known allergic and/or adverse reactions. Emergency contact information must be completed to ensure immediate and appropriate response in the event of an emergency.

Timeline

The medications the individual is taking and the emergency contact information are recorded during the initial assessment. The information must be updated when medications are discontinued or added and at least annually.

Updates

The person entering updated information (new medications/changes to existing medications/discontinuing a medication) must write the date the changes were made and initial the form in the designated space. The same form can be used until all spaces for medications are filled. At that time, a new form must be completed to ensure clarity. If the emergency contact information changes, a new form must be completed and placed in the individual's record.

Staff Initials/Date Initiated

Each medication entry must be initialed by the person completing the form. If known, enter the date the individual began taking the medication. If this information is unavailable, signify such by entering "NK" in the "Date Initiated" column.

Medication

All sections must be addressed. The name of the medical professional prescribing each medication must be entered. All known or reported prescribed medications must be documented. Medication information regarding dosage and frequency must be listed exactly as written on the prescription. If there are no prescribed medications, the person completing the form must write "no meds" and his/her initials.

Date Terminated/Changed/Staff Initials

If a medication dosage or frequency is changed, enter the date in the column. This space is also to be used if a medication is terminated. The staff person entering the information must initial the form.

Allergies/ Adverse Reactions

Each of the individual's known allergies and his/her reactions to them must be documented. Include unusual reactions if applicable. Allergies may include, but not be limited to, medications, insect bites, plants, foods, fragrances/aromas, or anything else that produces an allergic or adverse reaction.

Medication/Emergency Contact Information

Name _____

ID Number _____

Name/Credentials of Staff Completing the form: _____

Initial Date of Completion:

List ALL known and/or reported medications the individual is currently taking regardless of type or purpose to include over-the-counter (OTC) medications (use additional pages, if needed):

Staff Initials	Date Initiated	Name of Medication	Prescribed by	Dosage/ Frequency	Date Terminated/ Changed	Staff Initials

Known Allergies/Reactions:

Emergency Information:
In case of emergency (when parent/legal representative cannot be reached) contact:
 Name: _____
 Phone Number: (primary) _____ (secondary) _____
 Address: _____
 Name of Doctor: _____
 Doctor's Phone: _____
 Doctor's Address: _____
 Hospital Preference: _____
 Insurance Carrier(s): _____
 Policy Number(s): _____

Rights of Individuals Receiving Services

Purpose

Each individual who receives services from a DMH certified agency or provider has legal, ethical, and privacy rights that must be protected. DMH certified agencies must maintain documentation showing each individual who receives services has been informed of these rights. This document also informs the individual receiving services of legal circumstances in which the provider will be required to release information concerning his/her treatment/services. After the individual receiving services has been informed of his/her rights, the individual is then offered the opportunity to consent to treatment.

Time Line

Individuals receiving services must be informed of his/her rights at the time of the initial assessment and before services are provided.

Individuals must be informed of his/her rights at least annually, on or before the anniversary date of the current form, as long as the individual continues to receive services.

Intake/Admission Date

The intake/admission date is the original date of intake/admission to the service. This date remains the same from year to year as long as the person is continuously enrolled in the service.

Rights

The rights can be read by or, if necessary, to the individual receiving services and/or to a person who is legally authorized to act on his/her behalf. The rights must be clearly explained to the individual receiving services and/or a person authorized to act on his/her behalf. The individual must be offered a copy of the form to take with them. The original signed copy must be maintained in the record.

Rights of Individuals Receiving Services

Name _____

ID Number _____

I, _____ Name _____ began receiving services provided by _____ Name of Provider _____
 on _____ Intake/Admission Date _____ and have been informed of the following:

1. My options within the program and of other services available
2. The program's rules and regulations
3. The responsibility of the program to refer me to another agency if this program becomes unable to serve me or meet my needs
4. My right to refuse treatment and withdraw from this program at any time
5. My right not to be subjected to corporal punishment or unethical treatment which includes my right to be free from any forms of abuse or harassment and my right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff
6. My right to voice my opinions, recommendations and to file a written grievance which will result in program review and response without retribution
7. My right to be informed of and provided a copy of the local procedure for filing a grievance/complaint at the local level or with the DMH Office of Constituency Services
8. My right to privacy in respect to facility visitors in day programs and residential programs as much as physically possible
9. My right regarding the program's nondiscrimination policies related to HIV infection and AIDS
10. My right to be treated with consideration, respect, and full recognition of my dignity and individual worth
11. My right to have reasonable access to the clergy and advocates and have access to legal counsel at all times.
12. My right to review my records, except when restricted by law
13. My right to fully participate in and receive a copy of my Individual Service Plan/Plan of Care. This includes: 1) having the right to make decisions regarding my care, being involved in my care planning and treatment and being able to request or refuse treatment; 2) having access to information in my clinical records within a reasonable time frame (5 days) or having the reason for not having access communicated to me; and, 3) having the right to be informed about any hazardous side effects of medication prescribed by staff medical personnel
14. My right to retain all Constitutional rights, except when restricted by due process and resulting court order
15. My right to have a family member or representative of my choice notified should I be admitted to a hospital
16. My right to receive care in a safe setting
17. My right to confidentiality regarding my personal information involving receiving services as well as the compilation, storage, and dissemination of my individual case records in accordance with standards outlined by the Department of Mental Health and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable

Additionally, rights for individuals in supervised and residential living arrangements:

18. My right to be provided a means of communicating with persons outside the program
19. My right to have visitation by close relatives and/or significant others during reasonable hours unless clinically contraindicated and documented in my case record
20. My right to be provided with safe storage, accessibility, and accountability of my funds
21. My right to be permitted to send/receive mail without hindrance unless clinically contraindicated and documented in my case record
22. My right to be permitted to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in my case record

I have been informed of, understand, and have received a written copy of the above information.

Individual Receiving Services

Date

Legal Representative

Date

Staff/Credentials

Date

Consent for Services

Purpose

In addition to all rights of individuals receiving services, each individual must provide his/her consent to receive services from the agency. Each individual receiving services must be presented with the provider's Grievance Procedure when they are being asked to give his/her consent to receive services.

Time Line

Individuals receiving services must be informed of and consent to services at the time of the initial intake and before services are provided.

Individuals must provide their consent for services at least annually, on or before the anniversary date of the current consent, as long as the individual continues to receive services.

Consent for Services

This section can be read by, or if necessary, read to the individual receiving services and/or a person who is legally authorized to act on his/her behalf. In either case, the Consent for Services must be clearly explained to the individual receiving services and/or a person authorized to act on his/her behalf. The information contained in the Consent for Services is different for mental health and IDD services because of the differences in the types of services and modes of delivery. An agency may have to ask an individual to consent for both mental health and IDD services, depending on how the service is defined. Refer to the Operational Standards for listings of services.

Grievance Procedure

The provider's grievance and complaint procedures must be provided to the individual and/or legal representative. The information can be read by, or if necessary, read to the individual receiving services and/or a person who is legally authorized to act on his/her behalf.

Consent for Intellectual/ Developmental Disabilities Services

Name _____
ID Number _____
Agency _____
Service(s) _____

The information which I have provided as a condition of receiving services is true and complete to the best of my knowledge. I request to receive the services listed above from the agency. I understand staff may discuss the services being provided to me, and that I may request the names of those involved. I further understand that my failure to comply with stated rules and regulations (that I have received a copy of) may result in my being discharged from the program. I have been informed of the policies and procedures for reporting a complaint or grievance concerning any treatment or services that I receive.

Individual/Legal Representative Signature

Staff Signature/Credentials

Date

Consent to Release/Obtain Information

Purpose

Providers must have prior written authorization before information regarding an individual receiving service can be released. A fully executed Consent to Release/Obtain Information must be in place in order to legally exchange, release, or obtain information between individuals, agencies and/or providers. The original Consent to Release/Obtain Information form must always be maintained in the individual's case record.

Release/Obtain Information

Enter the name and address of the agency from which action is required.

Complete the Release Information To when requesting a person/provider to send confidential information about an individual to another entity.

Complete the Obtain Information From section when confidential information regarding an individual receiving/requesting to receive services needs to be obtained from another entity.

The specific purpose for which the information is needed must be indicated. If the purpose is not for treatment and/or service coordination, specify the exact reason for obtaining/releasing the information.

Extent/Nature of Information

The specific extent and/or nature of the information to be disclosed must be checked. If 'Other' is checked, the specific extent/nature of the disclosure must be described in detail. A generic authorization for the non-specific release of medical or other personal information is not sufficient for this purpose.

Date/Event/Condition

In order to clearly show the point in time when the Consent will expire, the following information must be provided: 1) the month, day, and year, or 2) an event, or; 3) a condition that will deem the Consent form expired meaning no further action can be taken once the specific date/event/condition is satisfied. An example of an event or condition may be, "30 days after discharge or termination of services".

For children and youth receiving School-Based Services, a date period that covers a specific school year must be used.

Witness

The Consent to Release/Obtain Information requires the signature of a witness. If the witness is an employee of the program, he/she must include his/her credentials (if applicable).

Consent to Release/Obtain Information

Name _____
ID Number _____
Date _____

I hereby give my consent/permission for _____

(Agency Name and Address)

To release information to: _____
(Agency/Person Name/Title and Address)

To obtain information from: _____
(Agency/Person Name/Title and Address)

for the specific purpose of: Treatment
 Coordination of Services
 Other

The extent and nature of the information to be disclosed/obtained must be indicated (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Evaluations | <input type="checkbox"/> Prognosis and/or Recommendations |
| <input type="checkbox"/> Case Notes | <input type="checkbox"/> Psychiatric Records |
| <input type="checkbox"/> Substance Abuse Records | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Contact Summaries | <input type="checkbox"/> Planning |
| <input type="checkbox"/> Identifying Information | <input type="checkbox"/> Individual Service Plan |
| <input type="checkbox"/> Other | |

I understand that I may revoke this consent at any time except to the extent that action has been taken. I

further understand that this consent will expire upon _____

(Specific Date/Event/Condition)

and cannot be renewed without my consent.

Individual Receiving Services

Date

Legal Representative

Date

Witness/Credentials

Date

Re-Disclosure of Confidential Information: Any information obtained as a result of this release is confidential. State and federal laws and regulations prohibit any entity receiving confidential information from re-disclosing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations.

Face Sheet

Purpose

The Face Sheet contains relevant data and/or personal information necessary to readily identify the individual receiving services. Information on the Face Sheet is used for routine service provision activities such as scheduling, billing, and reference. It must also include current emergency contact information in order to be used if an emergency occurs while the individual is receiving services.

Timeline

The initial Face Sheet must be prepared at admission as part of the intake process. The Face Sheet must be updated whenever information or data changes or at least annually. When changes in information or data are made or at the annual update, a new/corrected Face Sheet must be placed in the individual record.

Face Sheet Information

Each DMH certified provider must maintain current and accurate data for submission of all reports and data as required by DMH. The Face Sheet can be generated as a report by the agency's database system once all the data has been entered into the agency's system. Depending on the specific data collection and reporting system that the agency uses, additional personal information may have to be added to complete the Face Sheet.

The following are some types of information that are not part of the DMH client data set that must be added to complete the Face Sheet:

- Address
- Home phone number
- Work phone number
- Medicaid eligibility date
- Medicare number and eligibility date
- Family/primary physician name, address and phone number
- Name of school currently attending (if applicable)
- Name of referral organization
- Detailed billing information

ID/DD Waiver Notice of Certification

Purpose

Each individual must be notified when they are initially approved for the ID/DD Waiver and annually thereafter upon recertification or if they are readmitted. The Notice of Certification also includes the types and amounts of service a person is approved to receive.

Timeline

The appropriate type of Notice of Certification must be sent to the individual within ten (10) days of the Support Coordinator's receipt of the approved Plan of Care from BIDD.

Types of Notices

There are four (4) types of notices a person may receive:

1. *Notice of Certification-Approved as Requested* – this form is sent to the individual when the Support Coordinator receives the Plan of Care from the BIDD and there are no changes to what the individual requested on the Plan of Care.
2. *Notice of Certification-Changes* - this form is sent to the individual when the Support Coordinator receives the Plan of Care from the BIDD and the BIDD changes one or more types/amounts of service(s) requested on the individual's Plan of Care. Attach the Appeal Procedures in Appendix G.
3. *Notice of Certification-Request Not Approved* – this form is sent to the individual when the Support Coordinator receives the Plan of Care from the BIDD and one or more requests for additional types and/or amounts of services are not approved. Attach the Appeal Procedures in Appendix G.
4. *Notice of Certification-Request Not Approved & Other Changes* - this form is sent to the individual when the Support Coordinator receives the Plan of Care from the BIDD and the BIDD does not approve a requested amount and/or type of service as requested and also changes other service(s) on the Plan of Care. Attach the Appeal Procedures in Appendix G.

Timelines for Appeal

Individuals have thirty (30) days to appeal the denial of additional types/amounts of services. Therefore, in the space provided for the date by which the appeal must be received, calculate thirty (30) days from the date the Notice of Certification is sent to the individual and enter that date. Attach a copy of the Appeal Procedures (Appendix G).

ID/DD Waiver Notice of Certification

Approved as Requested

Date: _____

To: _____

From: _____
ID/DD Waiver Support Coordinator

_____ Support Coordination Department

You are approved to receive the following services through the ID/DD Waiver effective:

Name of Service	Amount	Frequency
Support Coordination	_____	monthly
_____	_____	--- per ---
_____	_____	--- per ---
_____	_____	--- per ---
_____	_____	--- per ---
_____	_____	--- per ---
_____	_____	--- per ---

If you have questions, please call your ID/DD Waiver Support Coordinator, _____

at _____ .

ID/DD Waiver Notice of Certification *Changes*

Date: _____

To: _____

From: _____
ID/DD Waiver Support Coordinator
Support Coordination Department

You are approved to receive the following services through the ID/DD Waiver effective:

Name of Service	Amount	Frequency	
Support Coordination	_____	Monthly	
_____	_____	--- per	---
_____	_____	--- per	---
_____	_____	--- per	---
_____	_____	--- per	---
_____	_____	--- per	---

The following change(s) were made to the amount/type of service(s) you requested:

_____ was --- _____ --- per --- to _____ --- per ---
 for the following reason(s): _____

_____ was --- _____ --- per --- to _____ --- per ---
 for the following reason(s): _____

_____ was --- _____ --- per --- to _____ --- per ---
 for the following reason(s): _____

You have the right to appeal if the type/amount of service(s) you requested is changed. A copy of the procedures for appealing decisions made by the DMH is attached. To initiate the appeal process, you must submit a written appeal, supporting documentation, and a copy of this notice to the following address by:

Matt Armstrong, Director
 Bureau of Intellectual and Developmental Disabilities
 Department of Mental Health
 239 N. Lamar Street, Suite 1101
 Jackson, MS 39201

If you have questions, please contact the Bureau of Intellectual and Developmental Disabilities at 601-359-1288.

Revised 2-1-12

ID/DD Waiver Notice of Certification

Request Not Approved

Date: _____

To: _____

From: _____
ID/DD Waiver Support Coordinator
Support Coordination Department

You are approved to receive the following services through the ID/DD Waiver effective:

Name of Service	Amount	Frequency	
Support Coordination	_____	Monthly	---
_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---

The requested service(s) was not approved for the following reason(s):

Service/Request	Reason
_____	was not approved because: _____
_____	was not approved because: _____
_____	was not approved because: _____

You have the right to appeal if the type/amount of service(s) you requested are denied or changed. A copy of the procedures for appealing decisions made by the DMH is attached. To initiate the appeal process, you must submit a written appeal, supporting documentation, and a copy of this notice to the following address by:

Matt Armstrong, Director
 Bureau of Intellectual and Developmental Disabilities
 Department of Mental Health
 239 N. Lamar Street, Suite 1101
 Jackson, MS 39201

If you have questions, please contact the Bureau of Intellectual and Developmental Disabilities at 601-359-1288.

Revised 2-1-12

ID/DD Waiver

Notice of Certification

Request Not Approved/Other Changes

Date: _____

To: _____

From: _____

ID/DD Waiver Support Coordinator

Support Coordination Department

You are approved to receive the following services through the ID/DD Waiver effective:

Name of Service	Amount	Frequency		
Support Coordination		Monthly		
_____	_____	---	per	---
_____	_____	---	per	---
_____	_____	---	per	---
_____	_____	---	per	---
_____	_____	---	per	---

The following change(s) were made to the amount/type of service(s) you requested:

_____ was --- _____ --- per --- to _____ --- per ---

for the following reason(s): _____

_____ was --- _____ --- per --- to _____ --- per ---

for the following reason(s): _____

The request(s) was not approved for the following reason(s):

Service/Request

_____ was not approved because: _____

_____ was not approved because: _____

_____ was not approved because: _____

You have the right to appeal if the type/amount of service(s) you requested are denied or changed. A copy of the procedures for appealing decisions made by the DMH is attached. To initiate the appeal process, you must submit a written appeal, supporting documentation, and a copy of this notice to the following address by:

Matt Armstrong, Director
 Bureau of Intellectual and Developmental Disabilities
 Department of Mental Health
 239 N. Lamar Street, Suite 1101
 Jackson, MS 39201

If you have questions, please contact the Bureau of Intellectual and Developmental Disabilities at 601-359-1288.

Revised 2-1-12

ID/DD Waiver Determination of Request for Changes to the Plan of Care

Purpose

This form is used when an individual requests new/additional amounts/types of services be added to his/her Plan of Care during his/her certification year.

Timeline

The appropriate Determination of Request for Changes to the Plan of Care must be sent to the individual within ten (10) days of the Support Coordinator's notification from BIDD regarding the request.

General

1. *Determination of Request for Changes to the Plan of Care – Approval* form lists both the type/amount of service(s) a person requested as well as what was approved.
2. *Determination of Request for Changes to the Plan of Care – Disapproval* form lists what was requested, what was approved (in cases in which a partial approval is provided) and the BIDD's reason for not approving the request. The Support Coordinator must list the reason for disapproval on the Determination of Request for Changes to the Plan of Care **exactly as it written on the BIDD notification to the Support Coordinator.**

Timelines for Appeal

Individuals have thirty (30) days to appeal the denial of additional type(s)/amount(s) of service(s). Therefore, in the space provided for the date by which the appeal must be received, calculate thirty (30) days from the date the Notice is sent to the individual and enter that date. Attach a copy of the Appeal Procedures (Appendix G).

ID/DD Waiver

Determination of Request for Changes to the Plan of Care

Approval

Date: _____

To: _____

From: _____
ID/DD Waiver Support Coordinator

_____ Support Coordination Department

You requested that the following be added to your Plan of Care:

Name of Service	Amount		Frequency	
_____	_____	---	per	---
_____	_____	---	per	---
_____	_____	---	per	---

The following was approved by the Bureau of Intellectual and Developmental Disabilities:

_____	_____	---	per	---
_____	_____	---	per	---
_____	_____	---	per	---

If you have questions, please contact your ID/DD Waiver Support Coordinator, _____
 at the following phone number: _____ .

ID/DD Waiver

Determination of Request for Changes to the Plan of Care

Disapproval

Date: _____

To: _____

From: _____
ID/DD Waiver Support Coordinator

_____ Support Coordination Department

You requested that the following be added to your Plan of Care:

Name of Service	Amount	Frequency	
_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---

The following was approved by the Bureau of Intellectual and Developmental Disabilities:

_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---

The type/amount of service(s) you requested was not approved for the following reasons:

Requested Change	
_____	was not approved because: _____
_____	was not approved because: _____
_____	was not approved because: _____

You have the right to appeal if the type/amount of services your requested is denied or changed. A copy of the procedures for appealing decisions made by the DMH is attached. To initiate the appeal process, you must submit a written appeal, supporting documentation, and a copy of this notice to the following address by:

Matt Armstrong, Director
 Bureau of Intellectual and Developmental Disabilities
 Department of Mental Health
 239 N. Lamar Street, Suite 1101
 Jackson, MS 39201

If you have questions, please contact the Bureau of Intellectual and Developmental Disabilities at 601-359-1288.

ID/DD Waiver Documentation of Choice of Provider

Purpose

This form is used to document that individuals are informed about all qualified providers for the services approved on his/her Plan of Care and the one(s) he/she chooses for each service.

Timelines

People are informed of all qualified service providers in their area that provide the services on their Plans of Care at the following times:

1. When the Plan of Care is initially developed, at each recertification and upon readmission. The Support Coordinator and individual review the list of qualified providers for the services the person is requesting on his/her Plan of Care.
2. When the individual expresses dissatisfaction with a provider. The Support Coordinator informs the person about other DMH certified providers.
3. When a provider stops providing a service. The Support Coordinator informs the individual about other DMH certified providers of the service.
4. During quarterly visits after a new provider is certified for any of the services on the individual's Plan of Care

The form is not completed if the Support Coordinator reviews the list of providers with the person but no change(s) are made.

Providers

The Support Coordinator must list the name of every provider about whom he/she informs the individual. The individual may choose to contact the provider for an interview, visit a provider's program and/or review BIDD approved literature the agency has provided for the Support Coordinator.

If there is only one provider of a particular service available in someone's area, they have the choice of using that provider or waiting until another provider is certified. If they choose to wait, the Support Coordinator must document this in the SC Contact Summaries and continue to follow-up during monthly and quarterly contacts.

Individuals can request to change providers at any time during the month. However, the change can occur only at the following times:

1. The first of the month following the month in which a change is requested
2. At any time during the month if the individual has not yet received any of the particular service
3. When the individual's health and welfare are affected

Method of Informing

The Support Coordinator must indicate if he/she informed the individual of the qualified providers by phone, in person or through the mail.

ID/DD Waiver Documentation of Choice of Provider

Name: _____ Medicaid Number: _____

Support Coordinator: _____

Service: _____

Date: _____

Providers Offered:

Provider Chosen:

Method of Informing: ---

Service: _____

Date: _____

Providers Offered:

Provider Chosen:

Method of Informing: ---

Service: _____

Date: _____

Providers Offered:

Provider Chosen:

Method of Informing: ---

Service: _____

Date: _____

Providers Offered:

Provider Chosen:

Method of Informing: ---

ID/DD Waiver Service Authorization

Purpose

To inform a provider what type and amount of ID/DD Waiver service(s) they are authorized to provide to an individual and the begin and end dates for the authorization.

General

Initially and when updated, the Support Coordinator sends the most current Interdisciplinary Summary and Recommendations Report from the Diagnostic and Evaluation Team with the Service Authorization.

Providers/services/service sites must be certified by the DMH and be fully operational before ID/DD Waiver Support Coordinators can issue Service Authorizations for any service. "Fully operational" is defined as: the site (if applicable) has been certified by the DMH; vehicles used for transportation (if applicable) have been inspected and approved by the DMH; qualified personnel (as defined in the DMH Operational Standards) have been hired and trained for the service(s) he/she will provide.

Timelines

No service can begin before the start date on the Service Authorization. Before any services can begin, the provider must review the Interdisciplinary Summary and Recommendations Report from the Diagnostic and Evaluation Team and document the review in a Contact Summary in the individual's record.

The Support Coordinator must issue the Service Authorization(s) to the providers chosen by the individual and listed on the Plan of Care within five (5) days of receipt of the approved certification/change(s) from the BIDD.

1. *Initial Certification/Readmission* – The Support Coordinator will issue Service Authorization(s) within five (5) days of receipt of the approved initial certification/readmission request.
2. *Changes* – If, during the individual's certification year, there is a change in the type/amount of service a person receives, the Support Coordinator will send the provider an updated Service Authorization indicating there are changes within five (5) days of receipt of the Plan of Care from the BIDD. The Service Authorization will have the new type(s) and/or amount(s) of services being authorized along with the end date of the previously authorized types(s) and/or amount(s) of service.
2. *Recertification* – Annually, within five (5) days of receiving an individual's approved recertification, the Support Coordinator issues a new Service Authorization to the provider(s) reflecting the services and the amount(s) of service(s) the agency is authorized to provide. The effective date of the Service Authorization will be the individual's certification begin date and the end date will be the certification lock-in end date.

If the Support Coordinator does not receive a signed copy of the Service Authorization from an agency within ten (10) days, the Support Coordinator will ask the individual if he/she would like to be referred to another provider. At that time, the Support Coordinator sends the agency a Service Authorization with an end date for the service(s).

Another Service Authorization is issued for the next agency chosen. The start date for that agency cannot be the first day of the month. It must be no sooner than the end date of the previous Service Authorization.

Procedure Codes

List the procedure codes (including modifiers) for each service authorized on the Service Authorization. See Appendix H for procedure codes and modifiers.

Services, Frequency, and Amount

The Support Coordinator lists the name(s), amount(s) and frequency(ies) of the service(s) authorized to be provided.

Start and End Dates

All service amounts/frequencies will have an authorized start and end date. Service Authorizations are valid only for the dates listed on the form. The end date cannot exceed the person's current certification lock-in end date, regardless of the authorized start date.

1. Authorized Start Date
 - a. The date of the individual's certification, regardless of type
 - b. Date changes to the Plan of Care are approved by BIDD
2. End Date
 - a. Initial/readmission/recertification – the certification lock-in end date
 - b. Changes – The day the BIDD approves changes to the Plan of Care
 - c. When a service is terminated

If at any time a person chooses to change providers, the Service Authorization will be effective on the 1st day of the month following the request. (ex: Change in provider is requested July 12th; the Service Authorization will have an effective date of August 1st and the end date will be the individual's certification lock-in end date).

Exceptions:

- a. Suspected abuse or neglect or other situations in which the individual's health and welfare are at risk
- b. The individual is not receiving/has not received the particular service during the month in which the change in provider is requested.

Support Coordinator Comments/Information

The Support Coordinator lists any other information the provider may need to know.

Signature of Authorized Agency Representative

An authorized agency representative must sign and date the form to verify the information is accurate and return a copy to the ID/DD Waiver Support Coordinator listed at the top of the form BEFORE services can begin.

Support Coordinator Signature

Upon receipt of the completed Service Authorization, the Support Coordinator must sign and date the form to document the date it was received.

ID/DD Waiver Service Authorization

To: _____ <div style="text-align: center;">Name of Agency</div>	From: _____ <div style="text-align: center;">Support Coordination Department</div>
Re: _____ <div style="text-align: center;">Individual's Name</div>	_____ <div style="text-align: center;">ID/DD Waiver Support Coordinator</div>
_____ <div style="text-align: center;">Medicaid Number</div>	_____ <div style="text-align: center;">ID/DD Waiver Support Coordinator Phone/e-mail</div>

_____ Individual's Address and Phone Number

Change in type(s)/amount(s) of service

Procedure Code	Service	Amount	Frequency		Authorized Start Date	End Date
			---	---		
			---	---		
			---	---		
			---	---		
			---	---		
			---	---		
			---	---		

ID/DD Waiver Support Coordinator Comments/Information

Can the agency provide the service(s) requested? Yes No

Agency Comments

_____ **Signature of Authorized Agency Representative** _____ **Date**

To Be Completed by Support Coordinator

_____ **Date Received from Agency** _____ **Support Coordinator Signature**

Revised 1-26-12

ID/DD Waiver Plan of Care Outcomes for Activity Plans

Purpose

The purpose of this form is to ensure each provider of each service a person is approved to receive is providing services/supports necessary for the individual to achieve the outcome listed for the service(s) on the individual's Plan of Care.

General

For each service an agency is authorized to provide, the Support Coordinator will provide the "Plan of Care Outcomes for Activity Plans." These outcomes are listed on each individual's Plan of Care for each service he/she receives. The outcomes are to be used to develop each individual's Activity Plan which outlines specific activities necessary to reach the desired outcome(s) for each service.

Timelines

This form accompanies the Service Authorization when it is initially sent to an agency and at least annually thereafter. As updates are needed, they are sent to the provider who is responsible for updating the Activity Plan.

Signature of Support Coordinator

The Support Coordinator signs and dates the form to verify the information is accurate and forwards it to the provider.

Signature of Authorized Agency Representative

An authorized agency representative must sign and date the form to verify receipt and review of the outcomes and as an assurance that the outcomes will be addressed fully in the provider's Activity Plan.

ID/DD Waiver Plan of Care Outcomes for Activity Plans

Individual's Name _____

Medicaid Number _____

Service	Outcome of Service/Support

Support Coordinator Signature _____

Date _____

By signing this form I assure the Plan of Care Outcomes for Activity Plans have been reviewed and incorporated into the agency's Activity Plan(s) for the above named individual.

Authorized Agency Representative _____

Date _____

ID/DD Waiver Service Agreements and Fact Sheets for Home and Community Supports and In-Home Nursing Respite

Purpose

The individual's provider(s) inform the person about the services that can and cannot be provided through Home and Community Supports (HCS) and In-Home Nursing Respite.

Timelines

The Service Agreement(s) and Fact Sheet(s) are reviewed with the individual prior to or at the time the provider begins providing services and at least annually thereafter. Providers must send signed copies of the Service Agreement(s) to the individual's Support Coordinator by the 15th of the month following the month it is signed.

Fact Sheets

The provider includes the appropriate Fact Sheet for the service(s) a person is receiving and for which they are signing the Service Agreement.

Home and Community Supports Service Agreement

1. I understand Home and Community Supports (HCS) will, to the greatest extent possible, be scheduled on a regular basis to meet my unique needs, as identified on the Activity Plan. Only the amount of Home and Community Supports authorized on the Plan of Care will be provided. If a change in the amount is needed, I will contact my Support Coordinator.
2. I understand Home and Community Supports can be provided in my home and/or in the community and either with or without my parent/legal representative present, depending upon my identified support needs.
3. I understand HCS staff cannot be responsible for caring for others who may be in the house. HCS staff is only responsible for the person who is enrolled in the ID/DD Waiver. Also, the HCS staff person is not responsible for caring for pets. I cannot receive HCS at a staff person's home.
4. If a scheduled Home and Community Supports visit must be canceled (e.g. because of a doctor's appointment, I am ill, my family will be out of town, etc.), it is my responsibility to notify the provider as soon in advance of the cancellation as possible. I understand that three (3) cancellations for which no notice is given will result in a review of the Plan of Care to determine if Home and Community Supports are still necessary and appropriate.
5. I understand the HCS staff person will complete all forms necessary to document the provision of Home and Community Supports. I or my parent/legal representative will be asked to initial an Activity Note each time Home and Community Supports are provided to verify that the HCS staff indeed provided the amount of service documented. I further understand initialing false or fraudulent documentation is against the law.
6. I understand that the receipt of Home and Community Supports is voluntary. I may decline services by notifying my Support Coordinator.
7. I understand services may be terminated according to the provisions in the ID/DD Waiver Enrollment Agreement.
8. I understand if services are to be terminated, I will be notified as soon as possible. The Support Coordinator will assist me in locating other service options, if available. If I disagree with services being terminated, I may file an appeal according to established procedures. The services will not change until the outcome of the appeal is determined. If termination of services is due to the environment or persons in the environment posing a risk to the HCS staff, I cannot continue to receive services pending the outcome of the appeal.
9. Should any problems arise regarding the provision of Home and Community Supports, I will notify my ID/DD Waiver Support Coordinator immediately.
10. I understand Home and Community Supports cannot be provided on an overnight basis outside of my legal residence.
11. I understand HCS staff cannot provide medical treatment of any sort, as defined in the Mississippi Nurse Practice Act Rules and Regulations.
12. Home and Community Supports staff cannot accompany a minor child on a medical visit without the parent/legal representative.

Home and Community Supports Service Agreement

13. The ID/DD Waiver does not allow HCS staff to be a parent or legal guardian, a step parent of a minor, or a spouse or relative or anyone else who resides in the same home or who is normally expected to provide care.
14. Relatives who are ***not*** the parent or legal guardian, a step parent of a minor, or a spouse, relative or anyone else who resides in the same home or who is normally expected to provide care may be approved to provide Home and Community Supports. They must be employed by a DMH certified provider and meet the same qualifications for employment as staff who are unrelated. The employing provider must receive prior approval from the Director of the Bureau of Intellectual and Developmental Disabilities at the DMH before a relative can provide Home and Community Supports.

I understand the above information and the circumstances under which Home and Community Supports can be provided.

Individual/Legal Representative

Authorized Provider Representative/Credentials

Date

Date

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Edwin C. LeGrand III - Executive Director

ID/DD Waiver Home and Community Supports Fact Sheet

Home and Community Supports offer a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and community, and provide safe access to the community.

The expected outcome of Home and Community Supports is that people receive the services and supports necessary to remain at home and in the community.

HCS must consist of one or more of the following types of services, depending on each individual's identified needs:

- a. Activities of daily living (ranging from total support in these activities to partial physical support to prompting)
- b. Assistance in housekeeping directly related to the individual's health and welfare
- c. Assistance with the use of adaptive equipment
- d. Support and assistance for community participation, including appointments, banking, shopping, recreation/leisure activities, and socialization opportunities

HCS cannot be provided in schools or be a substitute for educational services or other day services for which the individual is appropriate (e.g., Day Services-Adults, Prevocational Services, Supported Employment, and/or Work Activity Services).

HCS providers are responsible for supervision and monitoring of the individual at all times during service provision whether in the individual's home, during transportation (if provided), and in the community.

HCS staff cannot accompany a minor on a medical visit without a parent/legal guardian.

HCS providers are not permitted to provide medical treatment as defined in Mississippi Nurse Practice Act.

HCS providers may assist individuals with money management, but cannot receive or disburse funds on the part of the participant. Individuals must maintain their own financial resources according to the following:

- a. No staff or agency name can appear on an individual's personal account(s); and
- b. No financial transaction can be made if the individual is not present.

In-Home Nursing Respite Service Agreement

1. I understand In-Home Nursing Respite services will, to the greatest extent possible, be scheduled on a regular basis to meet my unique needs, as identified on the Activity Plan. Only the amount of In-Home Nursing Respite authorized on the Plan of Care will be provided. If a change in the amount is needed, I will contact my Support Coordinator.
2. I understand In-Home Nursing Respite can be provided in my home and/or in the community (on a limited basis) and either with or without my parent/legal guardian present, depending upon my identified support needs.
3. I understand the nurse cannot be responsible for caring for others who may be in the house. The nurse is only responsible for the person who is enrolled in the ID/DD Waiver. Also, the nurse is not responsible for caring for pets. I cannot receive In-Home Nursing Respite in the nurse's home.
4. If a scheduled time for In-Home Nursing Respite must be canceled (e.g. because of a doctor's appointment, I am ill, my family will be out of town, etc.), it is my responsibility to notify the nurse as soon in advance of the cancellation as possible. I understand that three (3) cancellations for which no notice is given will result in a review of the Plan of Care to determine if In-Home Nursing Respite services are still necessary and appropriate.
5. I understand the In-Home Nursing Respite staff person will complete all forms necessary to document the provision of In-Home Nursing Respite. I or my parent/legal representative will be asked to initial the Activity Note each time In-Home Nursing Respite services are provided to verify that the provider indeed provided the amount of service indicated. I further understand initialing false or fraudulent documentation is against the law.
6. I understand that the receipt of In-Home Nursing Respite services is voluntary. I may decline services by notifying my Support Coordinator.
7. I understand services may be terminated according to the provisions in the ID/DD Waiver Enrollment Agreement.
8. I understand if services are to be terminated, I will be notified as soon as possible. The Support Coordinator will assist me in locating other service options, if available. If I disagree with services being terminated, I may file an appeal according to established procedures. The services will not change until of the outcome of the appeal is determined. If termination of services is due to the environment or persons in the environment posing a risk to the In-Home Nursing Respite staff person, I cannot continue to receive services pending the outcome of the appeal.
9. Should any problems arise regarding the provision of In-Home Nursing Respite, I will notify my ID/DD Waiver Support Coordinator immediately.
10. I understand medical treatment provided by nurses must be according to the Mississippi Nurse Practice Act Rules and Regulations. Non-nursing staff cannot provide medical treatment of any sort.
11. The ID/DD Waiver does not allow In-Home Nursing Respite staff to be a parent or legal guardian, a step parent of a minor, or a spouse or relative or anyone else who resides in the same home or who is normally expected to provide care.
12. Relatives who are **not** the parent or legal guardian, a step parent of a minor, or a spouse, relative or anyone else who resides in the same home or who is normally expected to provide care may be approved to provide In-Home Nursing Respite. They must be employed by a DMH certified agency and meet the same qualifications for employment as staff who are unrelated. The employing agency must receive prior approval from the Director of the Bureau of Intellectual and Developmental Disabilities at the DMH before a relative can provide In-Home Nursing Respite.

I understand the above information and the circumstances under which In-Home Nursing Respite can be provided.

Individual/Legal Representative

Date

Authorized Agency Representative

Date

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



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Edwin C. LeGrand III - Executive Director

ID/DD Waiver In-Home Nursing Respite Fact Sheet

In-Home Nursing Respite services provide temporary, periodic relief to those persons normally providing the care for an eligible individual. Respite services are also provided when the usual care giver is absent or incapacitated due to hospitalization, illness, or injury or upon their death.

In-Home Nursing Respite consists of one or more of the following types of services, depending on each individual's identified needs and according to individual's service plan:

- a. Assistance with personal care needs such as bathing, dressing, grooming, and toileting
- b. Assistance with feeding and meal preparation
- c. Assistance with transferring/ambulation
- d. Play/leisure/socialization activities
- e. Taking the individual in the community for activities such as exercise, recreation, shopping, or other purposes
- f. Assistance in housekeeping directly related to the individual's health and welfare
- g. Other individualized activities specified on the individual's Activity Plan

In-Home Respite is used only for the purpose of relieving the participant's caregiver from the constant demands of caring for the individual. Activities outside the home cannot be the main purpose of the service.

This service is only available to individuals living in a family home residence and is not permitted for individuals living alone, in any type of group home, in any type of staffed residence, or with a roommate.

Individuals cannot be left unattended at any time during the provision of in-home respite. Nurses who provide in-home respite must practice according the Mississippi Nurse Practice Act and Nursing Rules and Regulations.

ID/DD Waiver Home and Community Supports Activity Plan

Purpose

The purpose of Home and Community Supports (HCS) Activity Plan is to document the outcomes an individual would like to achieve as a result of participating in HCS as well as the activities necessary to achieve the desired outcomes.

General

The Activity Plan must be developed by the provider (administrative or direct support staff) and the individual/legal representative before services begin. The individual/legal representative must sign the Activity Plan before it is implemented. The Activity Plan can be developed via a phone conversation or face-to-face visit but it must be signed before services begin. Use as many pages as necessary to ensure all information is included. The individual must be offered a copy of the Activity Plan each time it is revised or rewritten.

The ID/DD Waiver Support Coordinator must review the Activity Plan during each required quarterly visit to ensure it being implemented as written and that it is meeting the individual's health and welfare needs.

Timelines

The Activity Plan must be completed before services begin but within thirty (30) days of the date the provider returns the signed Service Authorization to the Support Coordinator.

The provider must send a copy of the Activity Plan signed by the individual/legal representative to the ID/DD Waiver Support Coordinator by the 15th of the month following the month in which it is developed. It is the provider's responsibility to ensure the Activity Plan is updated as needed. Anytime there are updates/revisions, the revised Activity Plan must be sent to the ID/DD Waiver Support Coordinator according to the time line stated above.

Plans must be rewritten at least annually with signed copies submitted to the ID/DD Waiver Support Coordinator as required.

Outcomes

List the outcomes the individual would like to achieve through HCS. Outcomes are provided on the Service Authorization; however, additional outcomes may be added at any time, depending upon the individual's desire. Outcomes can be in the areas of activities of daily living, housekeeping directly related to the individual's health and welfare, use of adaptive equipment, socialization, leisure activities and community integration. Outcomes can be specific or general depending on the individual's interests and need(s) for assistance/support in the areas listed above. They can also relate to something the individual wants to achieve as well as areas in which he/she wants to continue or maintain in any aspect of his/her life.

Specific Activities

List the activities which the individual will participate in to assist him/her in meeting his/her stated outcomes. These must be individualized for each person and be specific to the activity(s) which will help the individual achieve/maintain the desired outcomes.

ID/DD Waiver In-Home Nursing Respite Activity Plan

Purpose

The purpose of In-Home Nursing Respite Activity Plan is to document the outcomes an individual would like to achieve as a result of participating in In-Home Nursing Respite as well as the activities necessary to achieve the desired outcome.

General

The Activity Plan must be developed in conjunction with a nursing care plan as required by the Nurse Practice Act Rules and Regulations. It must be developed before services begin and be signed by the individual/legal representative. He/she must be offered a copy of the Activity Plan each time it is revised or rewritten.

The ID/DD Waiver Support Coordinator must review the Activity Plan during each required quarterly visit to ensure it being implemented as written and that it is meeting the individual's health and welfare needs. Use as many pages as necessary.

In-Home Nursing Respite is provided by a licensed nurse.

Timelines

The Activity Plan must be completed before services begin but within thirty (30) days of the date the provider returns the signed Service Authorization to the Support Coordinator.

The provider must send a copy of the Activity Plan signed by the individual/legal representative to the ID/DD Waiver Support Coordinator by the 15th of the month following the month in which it is developed. It is the provider's responsibility to ensure the Activity Plan is updated as needed. Anytime there are updates/revisions, the revised Activity Plan must be sent to the ID/DD Waiver Support Coordinator according to the time line stated above.

Plans must be rewritten at least annually with signed copies submitted to the ID/DD Waiver Support according to the time line stated above.

Outcomes

List the outcomes the individual would like to achieve through In-Home Nursing Respite. Outcomes are listed on the Service Authorization and can be in the areas of activities of daily living, housekeeping directly related to the individual's health and welfare, use of adaptive equipment, socialization, and leisure activities. Additional outcomes can be added at any time, depending on the individual's desires for In-Home Nursing Respite. Outcomes can be specific or general depending on the family's need for relief from constant care giving and especially depending on the individual's interests and need(s) for assistance/support in the areas listed above.

Specific Activities

List the activities which the individual will participate in to assist him/her in meeting his/her stated outcomes and which provide relief for the family from constant care giving. These must be individualized for each person and be specific to the activity(s) which will help the individual achieve/maintain the desired outcomes.

ID/DD Waiver Community Respite Activity Plan

Purpose

The purpose of Community Respite Activity Plan is to document the outcomes an individual would like to achieve as a result of participating in Community Respite as well as the activities necessary to achieve the desired outcomes.

General

The Activity Plan must be developed by the provider (administrative or direct support staff) and the individual/legal representative before services begin. The individual/legal representative must sign the Activity Plan before it is implemented. The Activity Plan can be developed via a phone conversation or face-to-face visit but it must be signed before services begin. Use as many pages as necessary to ensure all information is included. The individual must be offered a copy of the Activity Plan each time it is revised or rewritten.

The ID/DD Waiver Support Coordinator must review the Activity Plan during each required quarterly visit to ensure it being implemented as written and that it is meeting the individual's health and welfare needs.

Timelines

The Activity Plan must be completed before services begin but within thirty (30) days of the date the provider returns the signed Service Authorization to the Support Coordinator.

The provider must send a copy of the Activity Plan signed by the individual/legal representative to the ID/DD Waiver Support Coordinator by the 15th of the month following the month in which it is developed. It is the provider's responsibility to ensure the Activity Plan is updated as needed. Anytime there are updates/revisions, the revised Activity Plan must be sent to the ID/DD Waiver Support Coordinator according to the time line stated above.

Plans must be rewritten at least annually with signed copies submitted to the ID/DD Waiver Support Coordinator as required.

Outcomes

List the outcomes intended to be achieved during Community Respite. Outcomes are provided on the Service Authorization; however, additional outcomes may be added at any time, depending upon the individual's desire. Outcomes can be in the areas of activities of daily living, socialization, leisure activities and community integration. Outcomes can be specific or general depending on the individual's interests and need(s) for assistance/support in the areas listed above. They can also relate to something the individual wants to achieve as well as areas in which he/she wants to continue or maintain in any aspect of his/her life.

Specific Activities

List the activities which the individual will participate in to assist him/her in meeting his/her stated outcomes. These must be individualized for each person and be specific to the activity(s) which will help the individual achieve/maintain the desired outcomes.

Termination Summary

Purpose

When an individual is no longer receiving services from the facility or provider, a Termination Summary must be completed and placed in the individual's record. The service provider must use the Termination Summary to summarize the services provided, the reason for the termination of services and any referrals made at the time of termination. It must be noted that additional actions may be necessary in addition to completion of the Termination Summary in order to close the case.

Timeline

The effective date of the termination must be documented.

Reason for the Termination

Indicate which category most appropriately describes the reason for the termination.

Referral Information

If the individual was referred to another provider or to other services, this should be indicated by selecting one or more categories that most appropriately describes the service or provider referral(s).

Instructions/Additional Information

If any instructions were provided to the individual or legal representative at the time of termination, these must be described. Additional information specific to the termination may be included.

ID/DD Waiver Notification of Discharge

Purpose

This form is used when someone is discharged from the ID/DD Waiver and it is not a voluntary discharge.

Reasons for Discharge and Timelines

Support Coordinators send a Notice of Discharge if one of the following occur:

1. The individual moves from the state of Mississippi - The Notice of Discharge is sent as soon as the Support Coordinator becomes aware of an impending move or one that has already taken place. It is considered a move if an individual's Mississippi Medicaid benefits are terminated. The effective date is the date the individual moved.
2. The individual is admitted to an ICF/MR, hospital, nursing facility or treatment facility for more than 30 days – Send the Notice of Discharge on the 31st day of the individual's stay in one of the listed facilities. The effective date is the 31st day (the day the notice is sent).
3. The individual does not utilize available services for six (6) months – The Support Coordinator must have documentation in the SC Contact Summaries to indicate they have made the individual aware of this requirement at least two (2) times before the action can take place. The Support Coordinator must consult the Support Coordination Director for him/her to authorize this action before sending the Notice of Discharge. The effective date is dependent upon several factors and is set by the SC Director. Send a copy of the Appeal Procedures found in Appendix G.
4. The individual, family member or someone associated with the individual become belligerent toward the service provider or is a danger to him/herself – The Support Coordinator sends the Notice of Discharge when he/she receives a complaint from the provider, in writing, documenting the circumstances. The Support Coordinator is to consult the Support Coordination Director and BIDD before terminating services for this reason. The effective date is dependent upon several factors and is set by the SC Director and BIDD. Send a copy of the Appeal Procedures found in Appendix G.
5. The individual does not comply with the terms of the ID/DD Waiver Enrollment Agreement. The Support Coordinator is to consult the Support Coordination Director and BIDD before terminating services for this reason. Send a copy of the Appeal Procedures found in Appendix G.

At any time a person's services are terminated for one of the above listed reasons, the Support Coordinator must send a Service Authorization to the provider(s) indicating they are no longer authorized to provide service(s) to the individual.

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
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Edwin C. LeGrand III - Executive Director

Bureau of Intellectual and Developmental Disabilities

Notification of Discharge from the Intellectual Disabilities/Developmental Disabilities Waiver

To: _____
Re: _____
Date: _____
From: _____

_____ is being discharged from the ID/DD Waiver for the following

reason(s): _____

The effective date of the discharge is: _____ . _____

If you have questions, please contact your ID/DD Waiver Support Coordinator at the following number: _____ . _____

ID/DD Waiver Request for Voluntary Discharge

Purpose

If a person would like to be discharged from the ID/DD Waiver because he/she no longer needs or wants the services this form must be completed.

Timeline

The form is completed when the Support Coordinator is notified by the individual that he/she would like to leave the program. The form must be mailed within two (2) days of the date the Support Coordinator is notified by the individual. The contact and date the form is mailed must be documented in the SC Contact Summaries.

General

The Support Coordinator can send the form in the mail for the individual to complete or make a home visit/visit to a service site. The Support Coordinator must make two (2) documented attempts to secure a signed form. All efforts at doing so must be documented in the SC Contact Summaries.

When the discharge date is established, the Support Coordinator submits the appropriate Action Form to the BIDD and sends a Service Authorization to all of the individual's providers with an end date for services.

ID/DD Waiver Request for Voluntary Discharge

Name _____ Medicaid Number _____

I am requesting to be discharged from the ID/DD Waiver program for the following reason(s):

- I no longer need the services.
- I do not want to receive the services
- Other (please describe):

I request to be discharged effective: _____ .

If I choose to leave the program, there is no guarantee I will be readmitted. I understand that readmission takes place at the discretion of the Director of the BIDD and is contingent upon such factors as funding and length of the ID/DD Waiver Planning List.

Individual/Legal Representative

ID/DD Waiver Support Coordinator

Date

Date

ID/DD Waiver Monthly Lock-In Verification Report

Purpose

To verify each person is eligible for Medicaid on a monthly basis and is appropriate locked-in to the ID/DD Waiver.

General

Designated Support Coordination Department Staff are to compare the Monthly Lock-In Verification Report (LIVR) upon receipt from Medicaid to the Support Coordination Department's list of individuals who are currently enrolled in the ID/DD Waiver. If an individual's name is not listed on the LIVR but the Support Coordination Department has documentation to indicate his/her name should be on the list, the name is submitted to the BIDD on the ID/DD Waiver Lock-In Verification Issues report.

Before submitted a name on the report, check the following:

1. Is the person missing from the LIVR for a known reason (Medicaid eligibility issues, mainly)? If so, do not report because they are not supposed to be on the report; therefore it is not a discrepancy
2. Check Envision...is the person locked-in to the ID/DD Waiver? If so, only report the names of those individuals whose recertification information was received back more than five (5) days before the end of the month. If the recertification was received back less than five (5) days before the end of the month, the person's name will not appear until the next monthly report. Verify eligibility using Envision.
3. Have you received the recertification back and they are not locked-in to the ID/DD Waiver in Envision? Report.
4. Have you not received a recertification back and they are locked-in in Envision? Report the need for a copy of the recertification.
5. Have you not received the recertification back and they are not locked-in in Envision? Report.

Also, report the names of anyone who is on the Support Coordination Department's LIVR but whose name should be on another Support Coordination Department's report.

Location Codes (Loc Code)

The location codes are as follows:

- 01 = North Mississippi Support Coordination Department
- 02 = Hudspeth Support Coordination Department
- 03 = Ellisville State School Support Coordination Department
- 04 = Boswell Support Coordination Department
- 05 = South Mississippi Support Coordination Department

Timelines

This form must be submitted to the BIDD by the 15th of each month. BIDD combines the reports from all five (5) Support Coordination Departments and sends it to Medicaid. Medicaid researches the issues, makes corrections/comments and returns it to the BIDD. Upon receipt of information from DOM, BIDD will forward the information to each Support Coordination Department.

ID/DD Waiver Lock-in Verification Issues

Month _____ Year _____

Loc Code	Last name	First Name	Medicaid Number	SC Dept. Issue	DMH Finding/Issue/Question	DOM Action/Comment

ID/DD Waiver Statewide Planning List Reports

Purpose

To maintain a statewide list of individuals who have met eligibility requirements for the ID/DD Waiver and have agreed to have their name placed on the ID/DD Waiver Statewide Planning List until such time there is an opportunity for enrollment.

General

Each Support Coordination Department is responsible for maintaining the ID/DD Waiver Statewide Planning List for their catchment area. An individual's name is placed on the ID/DD Waiver Statewide Planning List after the D&E Team notifies the SC Department that an individual is eligible. The following information is maintained on the electronic Statewide Planning List:

Reg Ctr	Last Name	First Name	Medicaid Number	Social Security Number	Date of Birth	Date of Application	1st evaluation date	Current Evaluation Date	County
---------	-----------	------------	-----------------	------------------------	---------------	---------------------	---------------------	-------------------------	--------

Services Needed	DSM Axis II	DSM Secondary	Why still on list pre-2001 and/or post enrollment opportunity	In an ICF/MR or NF? (Yes/No)	Referral from IL Waiver? (Yes/No)
-----------------	-------------	---------------	---	------------------------------	-----------------------------------

Each Support Coordination Department's Planning List is submitted to the BIDD by the 10th of each month and the five (5) are combined into a single Statewide Planning List for the ID/DD Waiver.

Based on the information from the ID/DD Waiver Projected Service Needs list, use the following codes for the services on the ID/DD Waiver Statewide Planning List. Enter them in alphabetical order and do not use any punctuation between the codes (if there is more than one)

Code	Service
BSI	Behavior Support/Intervention
CR	Community Respite
DME	Durable medical equipment (pads, catheters, disposable briefs)
DSA	Day Services – Adult
HCS	Home and Community Supports
OT	Occupational Therapy
PT	Physical Therapy
PV	Prevocational
RH	Residential Habilitation
RSP	In-Home Nursing Respite
SE	Supported Employment
SLT	Speech/Language Therapy

Timelines

The ID/DD Waiver Statewide Planning List spreadsheet and Removed from Planning List spreadsheet must be submitted to the BIDD by the 10th of each month.

ID/DD Waiver Documentation of Possible Discrepancies in Service Documentation

Purpose

To document possible discrepancies in the amount/type of service a person receives and the Monthly Utilization Report.

General

Support Coordinators must compare the amount(s)/type(s) of services a person receives with the Monthly Utilization Report to ensure only the amount(s)/type(s) services approved on the Plan of Care are provided. Additionally, the Support Coordinator reviews the Monthly Utilization Report with the individual at least one time per month to verify the services are being provided as billed.

The form must be completed whenever the Support Coordinator becomes aware of a discrepancy between the type/amount of service authorized on the Plan of Care and the type/amount of service billed based on claims information in the Monthly Utilization Report. The form is submitted to the BIDD and BIDD forwards it to Medicaid.

ID/DD Waiver Documentation of Possible Discrepancies in Service Documentation

Month/Year _____ Provider/Agency Name _____

Service: _____ Service Site: _____

Individual's Name: _____ Medicaid Number: _____

Please check and complete all that apply for this particular service for the month/year indicated above:

Over bill or Under bill due to calculation error

Number of units of service documented: _____
 Number of units of service requested on the claim form: _____

Exceeded authorized amount of service

Number of units of service authorized: _____ month or week

	Week 1 (dates)	Week 2 (dates)	Week 3 (dates)	Week 4 (dates)	Week 5 (dates)
Exceeded authorized amount in the following week(s): (if applicable)	_____	_____	_____	_____	_____
	by	by	by	by	by
	_____ units	_____ units	_____ units	_____ units	_____ units

Staff name(s): _____ If authorized per month, list the number of units billed for the month which exceeded the authorized amount: _____

Late/Missing Documentation (list what is late/missing and when it was due)

Insufficient documentation to justify amount of service billed to Medicaid
 (provide brief description, including dates, name(s) of staff, and number of units involved)

Improper completion of forms (provide brief description, including dates, name(s) of staff, and number of units involved)

Services provided were outside the scope of the service definition.
 (provide brief description, including dates, name(s) of staff, and number of units involved)

Inappropriate/unapproved forms used to document service provision (attach a copy)

Other (describe or attach documentation)

 Name of person completing this form

 Authorization for submission to BMR/Div. of HCBS

 Date

 Date

Appendix A

Evaluation Requirements

A. Initial and Update Evaluations

1. The evaluation conducted by the D&E Team is identical to the evaluation that is conducted when someone applies for admission to an ICF/MR. Requirements for the evaluation are found in the DMH Program Manual and include the following:
 - a. A psychological evaluation consisting of:
 - (1) An intellectual assessment
 - (2) An assessment of adaptive functioning
 - (3) Observation of behaviors
 - (4) Diagnosis (in current DSM form)
 - (5) Recommendations for placement and programming
 - (6) A summary
 - b. A medical examination consisting of:
 - (1) Physical examination
 - (2) Medical history
 - (3) Drug history (if applicable)
 - (4) Diagnosis
 - (5) A Summary
 - c. A Social Summary consisting of:
 - (1) A description of primary presenting and secondary problems (onset, treatment efforts, family attitude, assessment, age at onset of disability, and any other problems related to this)
 - (2) A history of presenting problem(s)
 - (3) A history of previous services and placements as well as information on any services currently being received
 - (4) A developmental and medical history
 - (5) A family history
 - (6) An educational/vocational history and achievement
 - (7) The name(s) of people providing the information
 - (8) Information about the person concerning residential facility placement, if applicable, including the name of the facility, the date of application, date of admission, and date of discharge, when applicable
 - c. A nutritional evaluation
 - d. Other pertinent evaluations, as needed and appropriate for each person, including:
 - (1) Hearing screening and/or audiological evaluation
 - (2) Visual acuity screening
 - (3) Educational/vocational assessment
 - (4) Speech/language evaluation
 - (5) Dental evaluation
 - (6) Physical therapy evaluation
 - (7) Occupational therapy evaluation
 - (8) Psychiatric evaluation
 - (9) Other information the psychologist considers pertinent
 - e. The Inventory for Client and Agency Planning (ICAP)

2. The D&E Team may choose to use evaluations conducted by outside sources such as school districts, private psychologists, University of Mississippi Medical Center, etc.
 - a. The D&E Team must document their review of the data and verify it is considered a valid estimate of the individual's functioning level.
 - b. The review and use of the information must be included in the Interdisciplinary and Summary Recommendations Report.
3. If a person's evaluation is more than two (2) years old at the time he/she is offered an opportunity to be enrolled in the ID/DD Waiver program, the D&E Team has the discretion, in the professional judgment of its team members, to determine which, if any, evaluations must be updated/re-administered.
 - a. The ICAP is the only instrument which is required be re-administered.
 - b. The medical must be current within ninety (90) days of submission to the BIDD.
 - c. There must be an Addendum to the original evaluation to indicate any actions taken and any changes noted or either a full evaluation.

B. Re-evaluation Timelines

1. Individuals ages 0 – 15 years, 11 months:
 - a. Psychological and adaptive evaluations (at a minimum; other evaluations must be administered as indicated by the individual's current situation and based on professional judgment) at least every three (3) years or more often if the individual's situation warrants
 - b. Medical evaluation – at least every three (3) years unless there are changes in the child's condition which warrant additional medical evaluations
2. Individuals ages 16 years and up
 - a. Psychological and adaptive (at a minimum; other evaluations must be administered as indicated by the individual's current situation and based on professional judgment) are required when needed to verify the individual continues to meet ICF/MR level of care or at any other time the individual's condition warrants
 - b. Medical evaluation - at least every three (3) years unless there are changes in the person's condition which warrant additional medical evaluations

Appendix B

Notice of Ineligibility for ICF/MR Level of Care and the ID/DD Waiver Appeal Procedures

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Edwin C. LeGrand III - Executive Director

Bureau of Intellectual and Developmental Disabilities

Notice of Ineligibility for ICF/MR Level of Care and the Intellectual Disabilities/Developmental Disabilities Waiver

To: _____
Re: _____
Date: _____

The diagnostic and evaluation process indicates _____ does not meet the requirements for the level and type of care provided at an intermediate care facility for the mentally retarded. Therefore, _____ is not eligible for services provided through the Intellectual Disabilities/Developmental Disabilities Waiver program.

You have the right to appeal this decision. A copy of the procedures for appealing this decision is attached. To initiate the appeal process, you must submit a written appeal, supporting documentation, and a copy of this notice to the following address by:

Matt Armstrong, Director
Bureau of Intellectual and Developmental Disabilities
Department of Mental Health
239 N. Lamar Street, Suite 1101
Jackson, MS 39201

If you have questions, please contact _____
or the Bureau of Intellectual and Developmental Disabilities at 601-359-1288.

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Edwin C. LeGrand III - Executive Director

Bureau of Intellectual and Developmental Disabilities

Process for Appealing Ineligibility for ICF/MR Level of Care and the Intellectual Disabilities/Developmental Disabilities Waiver

- (1) The person/legal representative will be notified of the determination of ineligibility for ICF/MR (intermediate care facility for the mentally retarded) level of care and, thus, ID/DD Waiver Services, by the Regional Center's Diagnostic and Evaluation team and/or qualified staff from the Bureau of Intellectual and Developmental Disabilities (BIDD).
- (2) The person/legal representative must then submit an appeal, in writing, to the Director of the BIDD by the date listed on the *Notice of Ineligibility for the ID/DD Waiver*. Justification to support the written appeal must be included as well as a copy of the *Notice of Ineligibility for the ID/DD Waiver*.
- (3) The BIDD Director will respond to the appeal, in writing, within fifteen (15) calendar days of receipt of the appeal. If sufficient justification is not submitted with the appeal, the BIDD Director may request additional information before making a decision, thus extending the fifteen (15) day time line.
- (4) If the BIDD Director disagrees with the decision regarding ineligibility for ICF/MR level of care, he/she will notify the person/legal representative as well as the appropriate ID/DD Waiver Support Coordination and Diagnostic and Evaluation Departments.
- (5) If the BIDD Director agrees with the determination of ineligibility for ICF/MR level of care, he/she will notify the person/legal representative as well as the appropriate ID/DD Waiver Support Coordination and Diagnostic and Evaluation Departments.
- (6) The person has the right to appeal the decision of the BIDD Director to the Executive Director of the Department of Mental Health. The request for further consideration must be received by the Executive Director within fifteen (15) calendar days of the date listed on the notification from the Director of the BIDD.
- (7) The Executive Director of the Department of Mental Health will respond, in writing, within fifteen (15) calendar days. If sufficient justification was not submitted with the appeal, additional information may be requested before making a decision, thus extending the fifteen (15) day time line.
- (8) If the Executive Director disagrees with the BIDD Director's determination of ineligibility for ICF/MR level of care, he will notify the individual, in writing, and send a copy to the appropriate ID/DD Waiver Support Coordination and Diagnostic and Evaluation Departments.
- (9) If the Executive Director agrees with the determination of ineligibility for ICF/MR level of care, he/she will notify the person/legal representative as well as the appropriate ID/DD Waiver Support Coordination and Diagnostic and Evaluation Departments.
- (10) The decision of the Executive Director of the Department of Mental Health is final.

Revised 5•8•12

Appendix C

ID/DD Waiver Projected Service Needs

Projected Service Needs

Purpose

This form is to be used for planning purposes to estimate the type and amount of services people on the ID/DD Waiver Statewide Planning List have indicated are necessary to meet their individual needs. The information gathered here is to be transferred to the Support Coordination Department's ID/DD Waiver Planning List according to the required format.

Timelines

By the 20th of the month, or at any time after a person has been informed they meet ICF/MR level of care criteria and have been asked for their name to be placed on the ID/DD Waiver Statewide Planning List, assigned SC Department staff contacts the individual to complete the ID/DD Waiver Projected Service Needs form to indicate the type of ID/DD Waiver services that would be of benefit in supporting him/her to remain at home and in the community. People should be encouraged to look five (5) years ahead and consider issues such as transition, aging, resources, etc. This information is added to the Statewide Planning List.

ID/DD Waiver Projected Service Needs

Name: _____

Medicaid Number: _____

Date: _____

Regional Center: _____

Based on current evaluation information and the stated needs of the individual, it is projected that the following types and amounts of services would be necessary to assist the individual in living successfully at home and in the community:

Name of Service	Amount	Frequency	
_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---
_____	_____	---	per ---

These estimates are in no way a guarantee of receipt of any type(s) and/or amount(s) of ID/DD Waiver services when the individual is enrolled. This information is used for planning purposes only.

Other pertinent information:

Completed by:

Appendix D

Information to Update the ID/DD Waiver Statewide Planning List

Information to Update the ID/DD Waiver Statewide Planning List/ Removed from Planning List

Purpose

This letter is sent at least annually, based on the date of application, to all individuals on the ID/DD Waiver Statewide Planning List to determine if they wish to remain on the ID/DD Waiver Statewide Planning List, to update contact information or have their name removed from the list. This process is handled through the Support Coordination Department.

General

If someone indicates they are not interested in services at this time but would like his/her name to remain on the Planning List, indicate such by using the appropriate code listed below:

NI-MM/DD/YY	Not interested at this time – requested to remain on list
A	Placed in nursing home on (MM/DD/YY) – requested to remain on list
B	Placed in ICF/MR on (MM/DD/YY) – requested to remain on list
O-brief description	Other + brief description (ex:O-missed 3 D&E appts; O-moved out of state, reinstated 12/08; O-closed MM/DD/YY but requested reinstatement on MM/DD/YY)
R-MM/DD/YY	Remain - offered enrollment MM/DD/YY but declined and wants to remain on list

If someone indicates they would like their name removed from the Statewide Planning List, move their name to Removed from Planning List spreadsheet and use one of the following codes to indicate why their name was removed:

- | | |
|---|---|
| <ul style="list-style-type: none"> E Enrolled in ID/DD Waiver 4 Voluntary discharge 2 Refused services 3 No longer meets program requirements 4 Death | <ul style="list-style-type: none"> 5 Entered NF and does <u>not</u> wish to remain on list 6 Entered ICF/MR facility and does <u>not</u> wish to remain on list 7 Remained in hospital > 30 days 8 Moved out of state 9 Could not contact/no response O Other |
|---|---|

Revised 4/23/12

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Edwin C. LeGrand III - Executive Director

Date: _____

Dear: _____

Our records indicate you applied for ID/DD Waiver services on _____
and your name was placed on the ID/DD Waiver Statewide Planning List at that time.

Do you want to remain on the ID/DD Waiver Statewide Planning List? Yes No

If YES, please verify if the following information remains correct. If the information is not correct,
provide the correct information. This is the information that will be used to contact you in the future.

Information on file

**If not correct, provide the correct
information**

Address: _____

Medicaid Number: _____

Phone Number: _____

Legal Guardian _____

If no, please indicate why: _____

Signature of Individual/Legal Guardian

Date

Please return this form to _____

by _____ If we do not receive a response by this date, your name will be

removed from the ID/DD Waiver Statewide Planning List.

Appendix E

Opportunity for Enrollment in the ID/DD Waiver

Opportunity for Enrollment in the ID/DD Waiver

Purpose

The purpose of the letter is to notify individuals who have been on the ID/DD Waiver Statewide Planning List that they now have the opportunity to be enrolled in the ID/DD Waiver and begin receiving services. Also, they must return the form indicating whether they do or do not wish to be considered for enrollment at this time.

Identifying Information

List the address on file for the individual.

Date of Application

Using data from the ID/DD Waiver Statewide Planning List, insert the date on record for the individual's date of application.

Time Lines

The individual has thirty (30) days from the date the letter offering the opportunity for enrollment is mailed to return the form indicating his/her desire to seek enrollment in the ID/DD Waiver. If the Support Coordination Department does not receive a reply by the end of the thirty (30) days, they will try to contact the individual by phone. If this is unsuccessful, the individual's name will be moved to the Removed from Planning List spreadsheet. If the individual does not wish to be enrolled at this time, he/she chooses one of the options listed on the form for the reason.

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Edwin C. LeGrand III - Executive Director

Date: _____

Dear: _____

The Department of Mental Health is enrolling individuals from the Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver Statewide Planning List.

If you would like to begin the enrollment process, return this form no later than:
_____.

If you would like to be considered for enrollment, you will be contacted by a Support Coordinator from _____. He/She will review with you the information/documentation needed to complete the enrollment application.

If we do not receive this form back by _____, you may not be able to be considered for enrollment again during this fiscal year (July 1-June 30).

If you do not wish to be enrolled, please check one of the following and return the form:

- I am **not interested in enrollment at this time** but would like my name to remain on the ID/DD Waiver Statewide Planning List.
- I do not want to be enrolled** and do not want my name maintained on the ID/DD Waiver Statewide Planning List.

Return the form to:

Sincerely,

ID/DD Waiver Support Coordination Director

pc:

Appendix F

Appeal Procedures for Reduction/Denial/Termination of Types/Amounts of Services

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Edwin C. LeGrand III - Executive Director

Bureau of Intellectual and Developmental Disabilities Intellectual Disabilities/Developmental Disabilities Waiver

Process for Appealing the Reduction, Denial, or Termination of Intellectual Disabilities/Developmental Disabilities Waiver Services

1. The person whose service(s) has been reduced, denied, or terminated will be notified, in writing, by the ID/DD Waiver Support Coordinator.
2. The person then has thirty (30) calendar days to submit an appeal to the Director of the Bureau of Intellectual and Developmental Disabilities (BIDD). The date the appeal must be received is provided. The appeal must be in writing. Justification to support the appeal must be included.
3. The Director of the BIDD will respond to the appeal, in writing, within fifteen (15) calendar days of its receipt by the BIDD. If sufficient justification was not submitted with the appeal, the Director may request additional information before making a decision, thus extending the fifteen (15) day time line.
4. If the Director of the BIDD disagrees with the decision to reduce, deny or terminate a service(s), he will notify the individual, in writing, and send a copy to the ID/DD Waiver Support Coordinator.
5. If the Director of the BIDD agrees with the decision to reduce, deny, or terminate a service(s), the person has the right to appeal the decision to the Executive Director of the Department of Mental Health. The request for further consideration must be received by the Executive Director within fifteen (15) calendar days of the date listed on the notification from the Director of the BIDD.
6. The Executive Director of the Department of Mental Health will respond, in writing, within fifteen (15) calendar days. If sufficient justification was not submitted with the appeal, additional information may be requested before making a decision, thus extending the fifteen (15) day time line.

- (7) If the Executive Director disagrees with the BIDD Director's decision to reduce, deny, or terminate a service(s), he will notify the individual, in writing, and send a copy to the ID/DD Waiver Support Coordinator.
- (8) If the Executive Director agrees with the BIDD Director's decision to reduce, deny, or terminate a service(s), the person has the right to appeal the decision to the Executive Director of the Division of Medicaid. The request for further consideration must be received by the Executive Director of the Division of Medicaid, along with the supporting documentation, within fifteen (15) calendar days of receiving notification from the Executive Director of the Department of Mental Health.
- (9) If the Executive Director of Medicaid disagrees with the DMH Executive Director's decision to reduce, deny or terminate a service(s), he/she will notify the individual, in writing, and send a copy to the ID/DD Waiver Support Coordinator.
- (10) The decision of the Executive Director of Medicaid is final and binding.
- (11) If the individual determines the need for further redress, he/she may seek relief in a court of competent jurisdiction.

Other Information

- ◆ If a person's request for a new service is denied, the person cannot begin receiving the denied service unless the initial decision to deny the service is changed.
- ◆ If a person currently receiving a service is notified the service will be reduced in amount or terminated completely, the service must continue at the amount/frequency the person was receiving until the appeal is resolved.
- ◆ If it is recommended a person be terminated from the ID/DD Waiver, he/she must be allowed to continue receiving all approved services while the outcome of the appeal is being decided; however no new services or any increases in current services can be approved.
- ◆ The written notification during each stage of the appeal will contain a date indicating when the reduction or termination will take place. If there is no appeal by the date listed, the decision will be final and binding.

Appendix G

ID/DD Waiver Procedure Code Fee Schedule

ID/DD Waiver Procedure Code Fee Schedule Effective July 1, 2011

Modifier U3 Must Be Added to Every Procedure Code

Service	Procedure Code	Second Modifier	Rates	Max. Allowable Units	Provider Type	Place of Service
Behavioral Support Intervention by Masters	H2019	HO	\$35.00/hr. ÷ 4 = \$8.75/15 min. unit	Max 800 hrs/year	W08	12 99
Behavioral Support Intervention by Bachelors	H2019	HN	\$25.00/hr. ÷ 4 = \$6.25/15 min. unit			
Behavioral Support Evaluation	H0002	None	\$70.00/hr. ÷ 4 = \$17.50/15 min. unit	10 hrs/yr	W08	12 99
Day Care Services for Adults	S5100	None	\$14.28/hr ÷ 4 = \$3.57/15 min unit	Min ≥ 4hrs/day Max 130 hrs/month	W08 W07	99
Home and Community Supports	S5125	None	\$16.00/hr ÷ 4 = \$4.00/15 min unit	None	W06 W07	12 99
HCS – 2 people same location	S5125	UN	\$24.00/hr ÷ 4 = \$3.00/15 min unit			
HCS – 3 people same location	S5125	UP	\$27.00/hr ÷ 4 = \$2.25/15 min unit			
Occupational Therapy Prior authorization Required	G0152	None	\$70.00/hr. ÷ 4 = \$17.50/15 min. unit	2 hours a week = 8 units of 15 min increments	T00	12 99
Physical Therapy Prior authorization Required	G0151	None	\$70.00/hr. ÷ 4 = \$17.50/15 min. unit	3 hours a week = 12 units of 15 min increments	T01	12 99
Pre Vocational Services	T2015	None	\$11.00/hr	130 hrs/month	W07 W08	99
Residential Habilitation Must be age 21 or older	S5136	None	\$55.00/day	1 unit a day	W07 W08	12
Respite – In Home Companion or Community	S5150	None	\$16.00/hr ÷ 4 = \$4.00/15 min unit	None	W02 W07 W08	12 99
Respite – ICF/MR	H0045	None	\$264.00/day	30 days over cert period	G2 G7	54

**ID/DD Waiver Procedure Code Fee Schedule
Effective July 1, 2011**

Modifier U3 Must Be Added to Every Procedure Code

Service	Procedure Code	Second Modifier	Rates	Max. Allowable Units	Provider Type	Place of Service
Respite – In Home Nursing	T1005	None	\$23.00/hr ÷ 4 = \$5.75/15 min unit	None	W03 W08	12
Speech Therapy Prior authorization Required	G0153	None	\$65.00/hr. ÷ 4 = \$16.25/15 min. unit	3 hours a week = 12 units of 15 min increments	T02	12 99
Support Coordination	T2022	None	\$125.00/month	1 unit / month	W08	12
2 nd Level Support Coordination	T2022	TF	\$150/00/month	1 unit / month		
Supported Employment	H2023	None	\$25.00/hr. ÷ 4 = \$6.25/15 min. unit	None	W08 W07	99
SE – 2 people same location	H2023	UN	\$32.00/hr. ÷ 4 = \$4.00/15 min. unit			
SE – 3 people same location	H2023	UP	\$36.00/hr. ÷ 4 = \$3.00/15 min. unit			

**ID/DD Waiver Procedure Code Fee Schedule
Effective July 1, 2011**

Modifier U3 Must Be Added to Every Procedure Code

Service	Procedure Code	Second Modifier	Rates	Max. Allowable Units	Provider Type	Place of Service
Specialized Medical Supplies:					I00 I01 I02 I03 I04 I05	None
Blue Pads	A4554	SC	\$.28 a unit			
Diapers – small	T4521	SC	\$.55 a unit			
Diapers – medium	T4522	SC	\$.65 a unit			
Diapers – Large	T4523	SC	\$.95 a unit			
Diapers – extra large	T4524	SC	\$.95 a unit			
Intermittent straight tip urinary catheter	A4351	SC	\$1.35 a unit			
Intermittent curved tip urinary catheter	A4532	SC	\$5.14 a unit			
Intermittent urinary catheter with insertion supplies	A4353	SC	\$5.60 a unit			
Insertion Tray without catheter or drainage bag	A4310	SC	\$5.25 a unit			
Lube Sterile packet	A4332	SC	\$.30 a unit			
Foley 2-way	A4338	SC	\$9.81 a unit			
Indwelling cath-special	A4340	SC	\$21.59 a unit			
Indwelling Foley Silicone	A4344	SC	\$11.71 a unit			
Indwelling Foley 3-way	A4346	SC	\$13.89 a unit			
Insertion tray with drainage bag without catheter	A4354	SC	\$6.60 a unit			
Bedside drainage bag	A4357	SC	\$6.60 a unit			
Urinary leg or abdominal bag	A4358	SC	\$4.74 a unit			

Appendix H

Arrangement of Electronic Support Coordination Record

Arrangement of Electronic Support Coordination Record

Purpose

Each electronic Support Coordination record must be maintained in a consistent manner.

General

Records must be named as follows: lastname-firstnameMedicaid number.

Documentation/information must be filed by certification year in the Certification, Communications, and Service Monitoring folders. There are no subfolders for these folders.

Use the dates specified on the chart for naming documents.

Contact Notes must be filed according to certification year unless the Regional Center's data system files them according to calendar year. Regardless, the four quarters in each certification year must be in each certification year's completed file.

Documentation/information must be placed in the appropriate individual's record by the 15th of the month following when it was received, developed or signed.

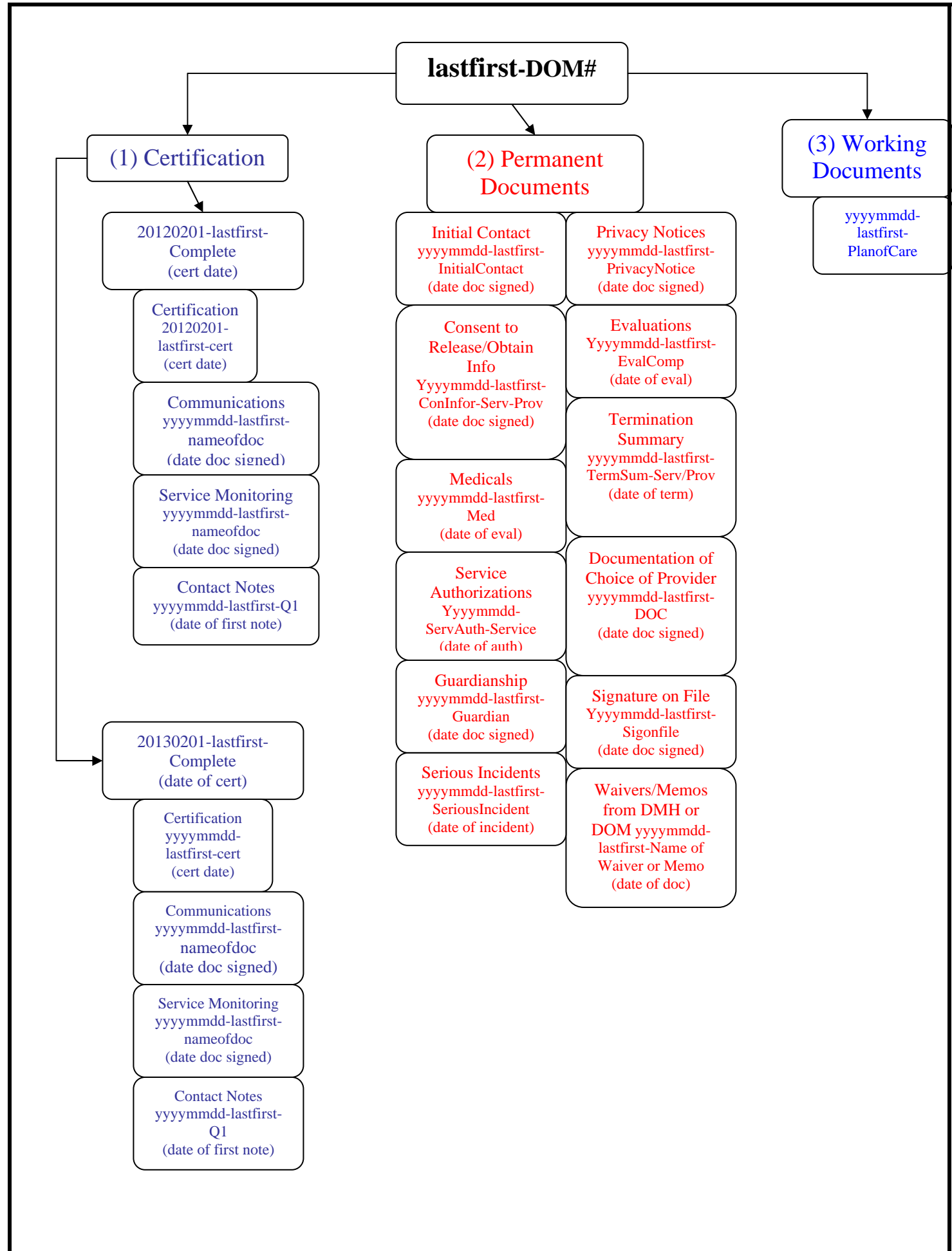
During each review visit, BIDD must have access to every individual's record the Regional Center serves.

Arrangement of Electronic Support Coordination Record

Active Folder	
last-firstMedicaid number	
(1) 20111201-lastfirst-Complete	
Certification (Certification Date)	20111201-lastfirst-Certification (Running cert document submitted to BIDD)
Communications (Date Signed)	yyyyymmdd-lastfirst-NOC
	yyyyymmdd-lastfirst-ReqChange
	yyyyymmdd-lastfirst-DRChanges
	yyyyymmdd-lastfirst-Appeal
	yyyyymmdd-lastfirst-AppealDecision
	yyyyymmdd-lastfirst-Misc
Contact Notes (Date of first contact note)	yyyyymmdd-lastfirst-Q1
	yyyyymmdd-lastfirst-Q2
	yyyyymmdd-lastfirst-Q3
	yyyyymmdd-lastfirst-Q4
Service Monitoring (Date Signed)	yyyyymmdd-lastfirst-Rights
	yyyyymmdd-lastFirst-EnrollAgree
	yyyyymmdd-lastFirst-Grievance
	yyyyymmdd-lastFirst-Consent
	yyyyymmdd-lastFirst-MECI
	yyyyymmdd-lastFirst-ServAgree
	yyyyymmdd-lastFirst-AP
	yyyyymmdd-lastFirst-DisReport
	yyyyymmdd-lastfirst-BSIEval/Ass
	yyyyymmdd-lastfirst-BSIServPlan
	yyyyymmdd-lastfirstBSImonthly
	yyyyymmdd-lastFirst-FS
	(2) Permanent Documents
(Date Signed)	Initial Contact
	yyyyymmdd-lastfirst-InitialContact
	Privacy Notices
	yyyyymmdd-lastfirst-PrivacyNotice
	Consent to Release/Obtain Info
	yyyyymmdd-last first-ConInfo-Serv-Prov
	Evaluations (Date of eval)
	yyyyymmdd-lastfirst-EvalComp
	Medical (Date of eval)
	yyyyymmdd-lastfirst-Med
	Documentation of Choice of Provider
	yyyyymmdd-lastfirst-DOC
	Projected Service Needs
	yyyyymmdd-lastfirst-PSN

	Termination Summary (Term Date)
	yyyymmdd-lastfirst-TermSum-Serv/Prov
	yyyymmdd-lastfirst-NOD
	yyyymmdd-lastfirst-VD
	Service Authorization
	yyyymmdd-lastfirst-ServAuth-Service
	Guardianship
	yyyymmdd-lastfirst-Guardian
	Signature on File
	yyyymmdd-lastfirst-Sigonfile
	Serious Incidents (Date of Incident)
	yyyymmdd-lastfirst-SeriousIncidents
	Waivers/Memos from DMH or DOM
yyyymmdd-lastfirst-Name of Waiver or Memo (Date of Document)	
(3) Working Folder	
(Next Certification Year)	yyyymmdd-lastfirst-POC
	yyyymmdd-lastfirst- other active documents

Abbreviations	
AP	Activity Plan
BSIEval-Ass	Behavior Support/Intervention Evaluation/Assessment
BSIServPlan	Behavior Support/Intervention Service Plan
BSImonthly	Monthly progress notes/updates from provider
ConInfo	Consent to Release/Obtain Information
Consent	Consent for Services
DOC	Documentation of Choice of Provider
DisReport	Discrepancy Report
DRChanges	Determination of Request for Changes to the Plan of Care
EnrollAgree	Enrollment Agreement
EvalComp	Evaluations-Comprehensive
FS	Face Sheet
MECI	Medication/Emergency Contact Information
Med	Medical
Misc	Miscellaneous
NOC	Notice of Certification
NOD	Notice of Discharge
PSN	Projected Service Needs
Q	Quarter
ReqChange	Request for Changes to the Plan of Care
Rights	Rights of Individuals Receiving Services
ServAgree	Service Agreement
ServAuth	Service Authorization
Serv-Prov	Service/Provider
TermSum	Termination Summary
VD	Voluntary Discharge



Addendums

ID/DD Waiver Request for Changes to the Plan of Care

Purpose

This form is used to request changes to an individual's Plan of Care during their certification period.

Justification

Describe the circumstances which warrant a change in the services on the person's currently approved Plan of Care. The following information must be included in the justification section:

1. Living situation
2. Diagnosis
3. General description of functioning level in activities of daily living
4. Currently approved services
5. Change requested
 - a. Description of what has changed in the person's situation to warrant a change to the Plan of Care
 - b. Detailed description of the change requested
 - c. How the additional service/additional amount of service will be used especially with regard to the necessity of ensuring the individual's health and welfare needs are being met.

Timeline

Staff from BIDD will review the request and make a determination within 10 days of receipt.

ID/DD Waiver Request for Changes to the Plan of Care

Date: _____

Name: _____ Medicaid Number: _____

Support Coordinator: _____ Support Coordination Department: _____

Change Requested: _____

Justification for Change:

Division of HCBS Staff: _____

Approved

Disapproved

ID/DD Waiver Signature on File Form

Purpose

This form is required by Medicaid for all persons who receive Medicaid services. By signing the form, the recipient of services is authorizing Medicaid to make benefit payments on his/her behalf to the service provider.

Timelines

This form is to be signed upon admission and is valid for the person's lifetime unless revoked in writing.

Signature on File Form

Name _____

Medicaid Number _____

I request that payment of authorized Medicaid benefits be made on my behalf to _____ .

I authorize any holder of medical or other information about me to release to the Division of Medicaid or the fiscal agent any information needed to determine these benefits or the benefits payable for related services.

*** This Authorization is good for my lifetime unless revoked in writing. ***

Recipient's Signature:

Date:

When the authorization is obtained, the provider should indicate "SIGNATURE ON FILE" in the patient's signature space on the claim form.

If you are submitting a signed claim form or if you are maintaining signature on file, the recipient's signature requirement remains the same. Be sure the recipient signs his/her name. If the recipient cannot write his/her name, he/she should sign by a mark have a witness sign the recipient's name and indicate by whom the name was entered. If the recipient is a minor or otherwise unable to sign, any responsible person, such as a parent or guardian must enter the recipient's name, write "BY" , sign his/her own name and address in the space, show his/her relationship to the recipient and explain briefly why the recipient cannot sign:

Criteria for Changes Services & ICF/MR Respite

Purpose

To establish the criteria under which the BIDD can consider requests for changes in services.

Criteria

Requests for changes in services will be considered for approval under the following circumstances:

1. The death of the individual's primary caregiver.
2. The transition of an individual from high school and in need of day services (i.e. Prevocational Services or Day Services – Adult).
3. A documented health crisis of the individual. Documentation by a physician or nurse practitioner of the health crisis is required.
4. A documented deterioration of the individual's condition. Documentation by a physician or nurse practitioner is required.
5. A debilitating situation which affects the health of the primary caregiver. Documentation by a physician or nurse practitioner is required.
6. Behavior Support/Intervention Services that are designed to be used on a short term basis to prevent an increased need for other services (with documentation from the provider) are being requested.
7. Specialized medical supplies (diapers, catheters, blue pads) for someone turning twenty-one (21) are needed or for someone whose condition has deteriorated and the need for such supplies exists.
8. Eligibility for services through the MS Department of Rehabilitation Services (MDRS) has been exhausted and Supported Employment Services are being sought for the individual. Documentation from MDRS is required.
9. An increase in the amount of Supported Employment Services is being requested as a result of an increase in the individual's work hours. The increase of work hours is required and must be documented.
10. The primary caregiver is on active duty in the military.

5-9-12