

Part II

Supplemental Documents

Abbreviations

Abbreviations

AL	Assisted Living
ASD	Autism Spectrum Disorder
ASP	Activity Support Plan
BIDD	Bureau of Intellectual and Developmental Disabilities (now known as IDD CSO)
CMS	Centers of Medicare/Medicaid Services
COE	Category of Eligibility
CCO	Chief Clinical Officer
CSO	Community Services Office
CSP	Community Support Program
D&E	Diagnostic & Evaluation
DMH	Department of Mental Health
DOCP	Documentation of Choice of Provider
DOCS	Documentation of Choice of Services
DOM	Division of Medicaid
DSA	Day Services Adult
E&D	Elderly & Disabled
EVV	Electronic Visit Verification
FS	Face Sheet

HCBS	Home and Community Based Services
ICAP	Inventory for Client and Agency Planning
ICF/IID	Intermediate Care Facility/Individuals with Intellectual Disabilities
IDD	Intellectual and Developmental Disability
IDD CSO	Intellectual and Developmental Disability - Community Services Office
ID/DD	Intellectual Disability and Development Disability
IL	Independent Living
LIVR	Lock-In Verification Report
LOC	Level Of Care
LTSS	Long Term Services and Supports
MDRS-VR	Mississippi Department of Rehabilitation Services – Vocational Rehabilitation
NF	Nursing Facility
NOD	Notice of Determination
OD	Overall Decision
PN	Privacy Notice
PSS	Plan of Services and Supports
PV	Prevocational Services
RA	Risk Assessment

SA	Service Authorization
SE-JD	Supported Employment – Job Development
SE-JM	Supported Employment – Job Maintenance
SPA	State Plan Amendment
SPL	Supported Living
SSI	Social Security Income
TBI	Traumatic Brain Injury
TCM	Targeted Case Management / Manager

TCM Monitoring/Record Review

TCM Initial/Recertification Monitoring/Record Review

Initial _____ recert _____

Person Name and LTSS ID:				Certification Date:				Regional Program: NMRC SMRC ESS ESS- M HRC							
CSO Reviewer:				Date Reviewed:				Targeted Case Manager:							
Date Submitted:				Late?		Y	N	OK	Effective Date Correct:				Y	N	
Birthdate and age:				Date Clarification Request:				Date Approved:							
Contact Information for Person:	Y	N	Representative Information:	Y	N	Family Contact if other than Representative:	Y	N	Legal Guardian document	Y	N	Unk	N/A		
Indicate Current Services by adding the Frequencies of Services in PSS:															
Day Services – Adult			Prevocational			Supported Employment (Dev.)			Supported Employment (Maint.)						
Supported Living			TCM												
Frequencies Correct (mo/hrs):		Y	N	If no, describe:											
New Service(s) Requested?		Y	N	If yes, list service(s) and frequency(ies) (months/hours):											
New Services /Freq. Appr'd (months/hours)		Y	N	Modified	N/A	If no/modified, list reason(s):									
If applicable, check the following:															
Letter from MDRS		Y	N	Comments:											
CSP Services - Justification supports the number of hours/services requested?									Y		N				
If no, what information is needed:															
Start/End dates correct?			Y	N	If no, describe:										
Provider information correct?			Y	N	If no, describe:										
Non-Waiver Supports															
Appropriate?		Y	N	N/A	If no, describe:										
All listed in PSS?		Y	N	N/A	If no, describe:										
Natural Supports															
Y	N	If yes, listed correctly?			Y	N	If no, why not?								

TCM Initial/Recertification Monitoring/Record Review

Initial _____ recert _____

Physician Information									
Complete?	Y	N	If no, what is missing?						
Medication Information									
Medication Required?	Y	N	If so, all information completed?			Y	N	If no, describe:	
Recent Physical Complaints and/or Health Conditions									
All questions answered and information appropriate:					Y	N	If no, describe:		
Latest Exam Dates									
All questions answered and information appropriate:					Y	N	If no, describe:		
Allergies:	Y	N	If yes, reactions listed?			Y	N		
Medical and Mental Health Support Needs									
Medical Support Needs?	Y	N	If yes, described adequately?		Y	N	If no, describe:		
Mental Health Support Needs?	Y	N	If yes, described adequately?		Y	N	If no, describe:		
Communication & Equipment/Technology									
Method of communication described appropriately?	Y	N	Other items completed appropriately?		Y	N	If no, describe:		
Risk Assessment									
Date:			Each risk has a resolution?		Y	N	If no, describe:		
Back-up & Emergency Plans									
All questions addressed/answered appropriately?		Y	N	If no, describe:					
Family and Current Living Arrangements									
Describes location, ages of parents/those responsible for person's care, other information?			Y	N	If no, describe:				
Education									
Answered appropriately?		Y	N	If no, describe:					
Employment History (if age appropriate)									
Answered appropriately?		Y	N	If no, describe:					
Volunteer Activities (if age appropriate)									
Answered appropriately?		Y	N	If no, describe:					

TCM Initial/Recertification Monitoring/Record Review

Initial _____ recert _____

Behavior Supports				
Addressed/answered appropriately?	Y	N	If no, describe:	
Serious Incidents				
Addressed/answered appropriately?	Y	N	If no, describe:	
Evaluation				
ICAP Date Current?	Y	N	Date of ICAP:	ICAP Score and Support Level:
Psychological information complete?	Y	N	If no, describe:	
Great Things About the Person				
Appropriate?	Y	N	If no, describe:	
Hopes and Dreams				
Appropriate?	Y	N	If no, describe:	
Important To/For				
Appropriate?	Y	N	If not Appropriate, what is recommendation:	
Working/Not Working				
Appropriate?	Y	N	If no, describe:	
All perspectives?	Y	N	If no, describe:	
Things People Need to Know to Support the Person				
Does the TCM include the person: preferences, Risk, likes-dislikes, routines, their must haves	Y	N	If no, indicate what should be included for a New person to Support the person:	
Person's Strengths				
Appropriate?	Y	N	If no, describe:	
Questions/Things to Figure out/Referrals				
Appropriate and adequate?	Y	N	If no, describe:	
Person Centeredness				
Appropriate and adequate?	Y	N	If no, describe:	

TCM Initial/Recertification Monitoring/Record Review

Initial _____ recert _____

Signatures			
All required with names?	Y	N	If no, describe:
Shared Planning			
Appropriate? Tied to Important To? Are action verbs used?	Y	N	If not Tied to Important To or Appropriate, describe: If no action verbs, describe:

Attachments for App Packet-Dated/Signed Appropriately	Yes or No
Freedom of Choice for Provider	
Freedom of Choice for Service	
Grievance Form	
Individual Rights Options	
Release of Information (for each provider)	
Signed Consent to Receive Services	
Signed Privacy Form	
Programs: Letters	Date
Notice of Determination of Services (w/in 10 days of previous PSS approval date)	
Previous PSS Overall Decision Date:	
Notice of Determination (modification), if applicable for change requests	
Personal Profile Documents	Yes or No
Service Authorizations (completed correctly, signed/dated by provider and TCM) (Initials/Recerts/Change Request)	
Activity Support Plans for each service	
Discharge/Transfer form, if applicable	
Reviewer should inform TCM and TCM Director of any missing documentation, enter date informed	Date

Attachments for PSS Date/signed appropriately	Yes or No
Signature Page	
Skills, Notes, Relationship Map	
Face Sheet	
Risk Assessment Tool	

Comments:

If no, Indicate missing Service Authorization date for previous recert year:
If no, indicate missing Activity Support Plan/Service:

TCM Initial/Recertification Monitoring/Record Review

Initial _____ recert _____

Services Notes																
Monthly? Check all the months reviewed	Y	N	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec		
Detailed? –Do the notes tell the persons story? Do they include info of: Who What, When, Where and How	Y	N	If no, what is recommended:													
If applicable, Did the TCM follow-up to concerns or issues in previous month: appointments, medical issues, persons interest etc.	Y	N	If not applicable enter NA. If follow up should be made, specify what the recommended follow up should be.													
Quarterly?	Y	N	Jan/Feb/March	April/May/June	July/Aug/Sept	Oct/Nov/Dec										
Date:																
Location:																
Provider Present?																
Detailed? Do you see the persons Story? Do they include info of: Who, What, When, Where and How	Y	N	If no, describe:													
Does the TCM inquire about Final Rule items: privacy, keys to locker or room, doing things alone or in groups, choices etc.	Y	N	If no, indicate recommendation or follow up: If follow up by TCM indicated but issue appears to continue, inform CSP Director or designee.													

IDD Brochure with Diagnostic Services Map



SUPPORTING HOPE AND PURPOSE

for Mississippians with Intellectual
and Developmental Disabilities



Through the ID/DD Waiver and IDD Community Support Program, the Mississippi Department of Mental Health is committed in charting a path for increased access to community-based care and supports through a network of service providers using a person-centered system of care.

IDD COMMUNITY SUPPORT PROGRAM (1915i)

Offering Support and Services for People with IDD and Autism Spectrum Disorders

ELIGIBILITY

The first step is undergoing an evaluation at your local Regional IDD Program. If you are determined eligible, you will be assigned a Targeted Case Manager to assist you with access to available services.

To be eligible, you must:

- Be 18 years of age or older
- Have completed education
- Have full Medicaid benefits
- Meet eligibility requirements

**Eligibility is determined using a needs-based criteria*

SERVICES PROVIDED

Day Services Adult – Assists individuals in gaining the greatest level of independence, while supporting them in meaningful activities of their choice throughout the day.

Prevocational Services – Teaches pre-employment skills and assists in exploring job opportunities in the community.

Supported Employment – Provides a job coach to assist in finding a job and training the person to work independently.

Supported Living – Provides persons who can live independently in their own home or apartment with limited support (max of 4 hours per day) to access their community, pay bills, shop for groceries, access medical care, and other personal assistance, as needed.

For additional information, visit www.dmh.ms.gov or contact the Department of Mental Health at 601-359-1288.

ID/DD HOME & COMMUNITY BASED WAIVER PROGRAM

Provides Individualized Support to People with IDD in Living Successfully at Home and in the Community

ELIGIBILITY

If you are determined eligible through an evaluation at your local Regional IDD Program, you will be placed on a statewide planning list. Early planning is essential for a successful future.

SERVICES PROVIDED

Day Program Services – Community Respite, Day Services Adult, Prevocational Services

Employment Services – Supported Employment, Job Discovery

Residential Services – Supervised Living, Shared Supported Living, Supported Living, Host Homes

In-Home Services – Home & Community Support, In-Home Respite, In-Home Nursing Respite

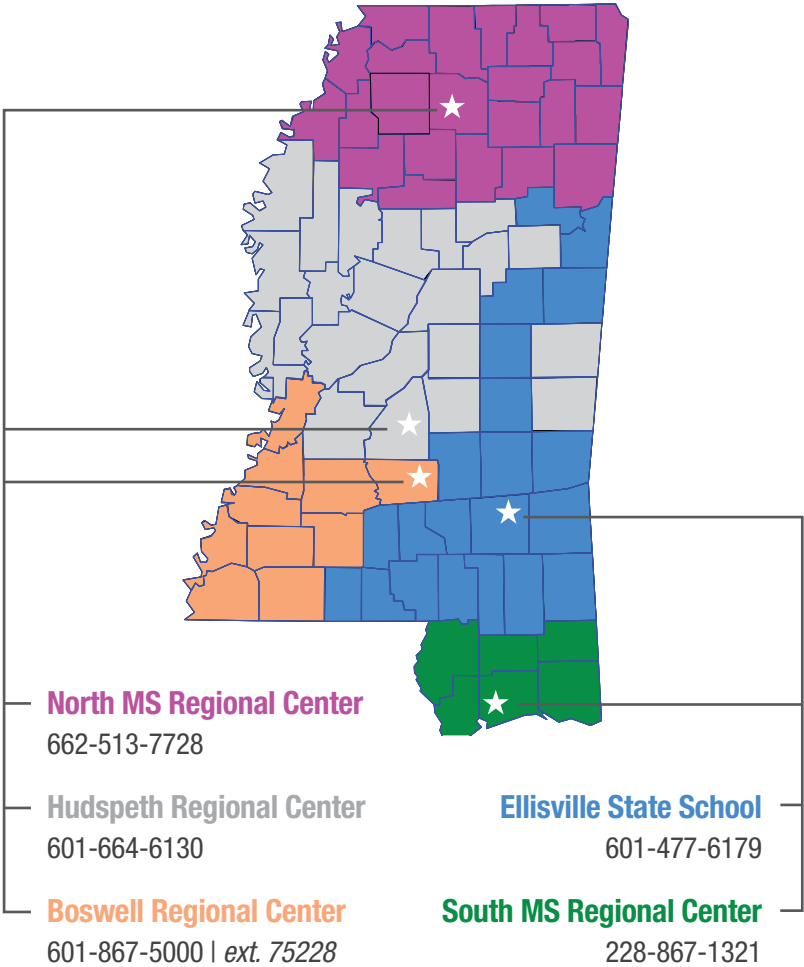
Behavior/Crisis Services – Behavior Support, Crisis Intervention, Crisis Support

Other Support Services – Transition Assistance, Specialized Medical Supplies, Therapies, Support Coordination

For additional information, visit www.dmh.ms.gov or contact the Department of Mental Health at 601-359-1288.



ID/DD WAIVER & IDD COMMUNITY SUPPORT PROGRAM EVALUATION SITES



Categories for Eligibility (COE) for IDD CSP

Categories of Eligibility (COE) For IDD CSP

The following codes have been identified by DOM as eligible COE for IDD CSP:

COE	Description
001	SSI Individual
002	SSI Retro Eligibility
003	DHS-IV-E DHS Refugee, AFDC/TANF, Foster Care, or Adoption Assistance
006	Protected SSI Child
007	Protected Foster Child
019	Disabled Child Living at Home
025	Working Disabled
026	DHS Foster Care or Adoption Assistance
045	Healthy MS Waiver
073	Children 6-19 with Income at or below 100% FPL
075	Parents/Caretakers of minor children
076	Adult Expansion
085	Medical Assistance for Intact Family
091	Poverty Level children under 19 under 100%
093	Cost of Living
094	Disabled Adult Child (DAC)
095	Widow(er) 60+
096	Widow(er) 50+

For persons with the following codes that want *IDD CSP only*, D & E should refer to Estel Stringer at Medicaid to determine if he/she meets financial eligibility for Full Medicaid Eligibility prior to the evaluation. If the person is interested in other programs such as ID/DD Waiver, D & E should evaluate regardless of the COE but not refer to Targeted Case Management until the review by Medicaid for financial eligibility.

COE	Description
029	Family Planning
031	QMB – Qualified Medicare Beneficiaries
035	Qualified Working Disabled Individual
051	Specified Low Income Medicare Beneficiaries
054	Qualified Individuals
099	Children age 1-19 with income between 133% and 200% FPL

Contact: Estel Stringer
 Division of Medicaid – Office of Mental Health Programs
 Phone (601)359-3546
 Email estel.stringer@medicaid.ms.gov

IDD CSP Appealing Ineligibility Instructions

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

Wendy D. Bailey - Executive Director

Intellectual and Developmental Disabilities Community Services Office

Process for Appealing Ineligibility for the Intellectual/Developmental Disabilities Community Support Program (IDD CSP)

- (1) The person/legal representative will be notified of the determination of ineligibility for the IDD CSP, by the IDD Regional Program's Diagnostic and Evaluation Team and/or qualified staff from the Intellectual and Developmental Disabilities Community Services Office (IDD-CSO).
- (2) The person/legal representative must then submit an appeal, in writing, to the Director of the IDD-CSO by the date listed on the *Notice of Ineligibility for the IDD CSP*. Justification to support the written appeal must be included as well as a copy of the *Notice of Ineligibility for the IDD CSP*.
- (3) The IDD-CSO Chief Clinical Officer will respond to the appeal, in writing, within thirty (30) calendar days of receipt of the appeal. If sufficient justification is not submitted with the appeal, the IDD-CSO Chief Clinical Officer may request additional information before making a decision, thus extending the thirty (30) day timeline.
- (4) If the IDD-CSO Chief Clinical Officer disagrees with the decision regarding ineligibility for the IDD CSP, he/she will notify the person/legal representative as well as the appropriate IDD CSP Targeted Case Management and Diagnostic and Evaluation Departments.
- (5) If the IDD-CSO Chief Clinical Officer agrees with the determination of ineligibility for the IDD CSP, he/she will notify the person/legal representative as well as the appropriate IDD CSP Targeted Case Management and Diagnostic and Evaluation Departments.
- (6) The person has the right to appeal the decision of the IDD-CSO Chief Clinical Officer to the Executive Director of the Department of Mental Health. The request for further consideration must be received by the Executive Director within thirty (30) calendar days of the date listed on the notification from the IDD-CSO Chief Clinical Officer.
- (7) The Executive Director of the Department of Mental Health will respond, in writing, within thirty (30) calendar days. If sufficient justification was not submitted with the appeal, additional information may be requested before making a decision, thus extending the thirty (30) day timeline.
- (8) If the Executive Director disagrees with the IDD-CSO Chief Clinical Officer's determination of ineligibility for the IDD CSP, he/she will notify the individual, in writing, and send a copy to the appropriate IDD CSP Targeted Case Management and Diagnostic and Evaluation Departments.
- (9) If the Executive Director agrees with the determination of ineligibility for the IDD CSP, he/she will notify the person/legal representative as well as the appropriate IDD CSP Targeted Case Management and Diagnostic and Evaluation Departments.
- (10) The decision of the Executive Director of the Department of Mental Health is final.

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

Wendy Bailey - Executive Director

Bureau of Intellectual and Developmental Disabilities

Notice of Ineligibility for the Intellectual/Developmental Disabilities Community Support Program

To: _____
Re: _____
Date: _____

The diagnostic and evaluation process indicates that _____ does not meet the requirements for the Intellectual/Developmental Disabilities Community Support Program. Therefore, _____ is not eligible for services provided through the Intellectual/Developmental Disabilities Community Support 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, other supporting documentation, and a copy of this notice to the following address by: _____.

Kristin Merritte, Chief Clinical Officer
Intellectual and Developmental Disabilities Community Services Office
Department of Mental Health
239 N. Lamar Street, Suite 1101
Jackson, MS 39201

If you have questions, please contact _____
or the Intellectual and Developmental Disabilities Community Services Office at 601-359-4163.

IDD CSP Appealing Reduction, Denial, and Termination Instructions

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

Wendy D. Bailey - Executive Director

Intellectual and Developmental Disabilities Community Services Office Intellectual Developmental Disabilities Community Support Program

Process for Appealing the Reduction, Denial, or Termination of Intellectual Developmental Disabilities Community Support Program Services

1. The person whose service(s) has been reduced, denied, or terminated will be notified, in writing, by the IDD Targeted Case Manager and a copy will be sent to the Division Director of Community Support Program.
2. The person then has thirty (30) calendar days to submit an appeal to the Chief Clinical Officer of the Intellectual and Developmental Disabilities Community Services Office (IDD-CSO). The date the appeal must be received is provided. The appeal must be in writing. Justification to support the appeal must be included as well as a copy of the *Changes and/or Request Not Approved* form.
3. The IDD-CSO Chief Clinical Officer will respond to the appeal, in writing, within thirty (30) calendar days of its receipt. If sufficient justification was not submitted with the appeal, the IDD-CSO Chief Clinical Officer may request additional information before making a decision, thus extending the thirty (30) daytime line.
4. If the IDD-CSO Chief Clinical Officer disagrees with the decision to reduce, deny, or terminate a service(s), he/she will notify the individual, in writing, and send a copy to the Division Director of Community Support Program and the IDD Targeted Case Manager.
5. If the IDD-CSO Chief Clinical Officer 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 thirty (30) calendar days of the date listed on the notification from the IDD-CSO Chief Clinical Officer.
6. The Executive Director of the Department of Mental Health will respond to the appeal, in writing, within thirty (30) calendar days. If sufficient justification was not submitted with the appeal, additional information may be requested before

5-12-2021

Page 1 of 2

making a decision, thus extending the thirty (30) day timeline.

7. If the Executive Director disagrees with the IDD-CSO Chief Clinical Officer's decision to reduce, deny, or terminate a service(s), he/she will notify the individual, in writing, and send a copy to the IDD-CSO Chief Clinical Officer, IDD Director of Community Support, and the IDD Targeted Case Manager.
8. If the Executive Director agrees with the IDD-CSO Chief Clinical Officer'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 (DOM). The request for further consideration must be received by the Executive Director of the Division of Medicaid, along with the supporting documentation, within thirty (30) calendar days of receiving notification from the Executive Director of the Department of Mental Health. (A person appealing to Medicaid should include on the envelope the word "Appeals" for the letter to go to the appropriate DOM staff.
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 DMH Executive Director and IDD-CSO Chief Clinical Officer.
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 IDD Community Support Program, 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.

ICAP Support Levels

ICAP SUPPORT LEVELS

Description	ICAP Levels	Support Levels	Degree of Support
Fairly independent, may need intermittent support with living activities like cooking and cleaning	9	1	Low
May need assistance getting ready for the day, household chores, accessing places in their community, purchasing groceries	7 & 8	2	Low
Moderate support needs, may need reminders to complete daily living activities such as bathing, may use alternative means for communication	5 & 6	3	Medium
Extensive support needs, likely medical and behavioral support, physical assistance with daily life activities	3 & 4	4	High
Require constant support, significant hands on assistance with daily life activities, support with communication, and maintain health and safety	1 & 2	5	High

**Medicaid's ID/DD Community Support
Program (1951i) Procedure Code Fee
Schedule**

ID/DD Community Support Program (1915i)
Procedure Code Fee Schedule
*** Modifier U7 Must Be Added To Every Procedure Code ***
Effective January 1, 2019

Service	New Procedure Code	Second Modifier	Third Modifier	Rates	Max. Allowable Units	Provider Type	Place of Service
Targeted Case Management	T2023	HW	None	\$151.01 per month	1 unit per month	X00	99
Supported Living							
Supported Living, 1 Person	S5135	None	None	\$6.34/15 min. unit	4 hours per day	X05	12 99
Supported Living, 2 Person	S5135	UN	None	\$3.97/15 min. unit			
Supported Living, 3 Person	S5135	UP	None	\$3.17/15 min. unit			
Day Services Adult							
Low Support (Level 1&2)	S5100	None	None	\$3.78/15 min. unit	6 hours per day/ 138 per month	X05	99
Medium Support (Level 3)	S5100	TF	None	\$4.10/15 min. unit			
High Support (Level 4&5)	S5100	TG	None	\$4.66/15 min. unit			
Pre-Vocational							
Low Support (Level 1&2)	T2015	None	None	\$12.48/hr.	6 hours per day/ 138 per month	X05	99
Medium Support (Level 3)	T2015	TF	None	\$13.28/hr.			
High Support (Level 4&5)	T2015	TG	None	\$14.64/hr.			
Supported Employment							
Job Development	H2023	None	None	\$8.80/15 min. unit	90 hours per certification year	X05	99
Supported Employment							
Job Maintenance - 1 Person	H2025	None	None	\$8.35/15 min. unit	100 hours per month	X05	99
Job Maintenance - 2 Person	H2025	UN	None	\$5.22/15 min. unit			
Job Maintenance - 3 Person	H2025	UP	None	\$4.17/15 min. unit			

No Contact Sample Letter

Regional Center's Letterhead

Date

Name

c/o Representative's name

Address

City, State ZIP

Dear [Person's name / Representative's name]:

I have attempted to contact you on [insert dates that messages were left] as required as part of the Community Support Program guidelines which were outlined at your PSS meeting. I am required to make contact with you at least monthly on the phone and quarterly in person.

Please note that your file will be closed if I do not hear from you or your representative on or before [pick a date, maybe 3-4 weeks after the date of the letter]. You are welcome to contact me at any time should you choose to pursue CSP services at a later date. My contact information can be found below.

Regards,

[TCM name]

Targeted Case Manager

[Regional Center Name] Regional Center

[Phone Number] / [email address]

Home and Community-Based Services (HCBS) Final Rule



For Consumers and Families

People with intellectual and developmental disabilities are provided many home and community-based services across our state. These services are paid for with state and federal money from the federal Centers for Medicare and Medicaid Services (CMS). Mississippi must comply with what is called the Home and Community-Based Services (HCBS) Final Rule. This rule sets requirements for HCBS settings, which are places where people live or receive services. Each state has until March 2022 to help providers comply with the HCBS Final Rule.

The HCBS Final Rule Applies To:

- Residential and non-residential settings
- Day programs and other day-type services
- Employment options and work programs

The HCBS Final Rule Does Not Apply To:

- Nursing Homes
- Hospitals
- Intermediate Care Facilities for individuals with intellectual disabilities (ICF/IID)
- Institutions for mental diseases (IMD)

What is the Goal of the HCBS Final Rule?

To enhance the quality of services provided by:

- Maximizing opportunities and choices for individuals
- Promoting community integration by making sure individuals have full access to the community
- Making sure individuals have the opportunity to work and spend time with other people in their community who do not have disabilities
- Ensuring individual preferences are supported and rights are protected
- Establishing person-centered service planning requirements, which includes a process driven and directed by the individual to identify needed services and supports

All Settings

The Final Rule requires that you can:

- Spend time in and be a part of your community
- Work alongside people who do not have disabilities
- Have choices regarding services and supports, and who provides them
- Have control of your schedule and activities

Residential Settings

Provider Owned or Controlled

In addition to the requirements for all settings, the Final Rule requires that you have:

- Choice about your roommates
- Privacy in your room, including a lock on your door
- The ability to have visitors of your choosing, at any time
- Freedom to furnish and decorate your room
- A lease or other legal agreement, protecting you from eviction



For Providers

How will your service as a provider change?

If you are a service provider who provides services to multiple consumers in the same location, we have to make sure these services do not isolate individuals from the community. The Final Rule says that settings must be integrated and support full access to the community. As a provider, you may need to modify where and how your service is delivered to meet the HCBS Final Rule. Policies and program designs may need to be changed and training to your staff may be necessary to assure their understanding of the new expectations.

CMS HCBS Final Rule Requirements

The setting:

1. Is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.
2. Is selected by the individual from among setting options including non-disability-specific settings and an option for a private unit in a residential setting.
3. Ensures an individual's rights of privacy, dignity and respect, as well as freedom from coercion and restraint
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to: daily activities, physical environment, and with whom to interact.
5. Facilitates individual choice regarding services and supports, and who provides them.

In provider-owned or controlled residential settings:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable lease agreement by the individual receiving services.
2. Each individual has privacy in their sleeping or living unit; including doors lockable by the individual, choice of a roommate if sharing a unit, and the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
4. Individuals are able to have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.

Where Can I Find More Information?

For more detailed information on the HCBS Final Rule and Mississippi's Statewide Transition Plan, please visit:

www.dmh.ms.gov/idd/

www.medicaid.ms.gov/submitted-ms-statewide-transition-plan/

www.medicaid.gov/medicaid/hcbs/index.html

Lock-in Verification Report

CSP Waiver Lock-in Verification Issues

Regional Program: _____

Month _____ Year _____

Last name	First Name	Medicaid Number	Regional Center Issue	DMH Finding/Issue/Question	DOM Action/Comment

Before you submit a name, 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 and you know why.
2. Check Envision...is the person locked-in to the CSP? If so, do not report. If not, report.
3. Have you received the recert back and they are not locked-in to the CSP in Envision? Report.
4. Have you not received a recert back and they are locked-in in Envision? Report (you need a copy of the recert).
5. Have you not received the recert back and they are not locked-in in Envision? Report.
6. Questions? Call IDD CSO before reporting a name.

Naming Documents in LTSS

IDD Community Support Program Forms

File Names, Abbreviations and Locations in LTSS

Document Name	Abbreviation	Electronic Document Name	Location in LTSS	Notes
Activity Support Plan	ASP	yyyymmdd-lastnamefirstname-ASP-service-providername	Person's Profile/Attachments/CSP/Other	Received from providers by 15 th of month following the month it is developed
Consent for Services	Consent	yyyymmdd-lastnamefirstname-Consent	App Packet	Use the form from the current DMH Record Guide.
Consent to Release/Obtain Information	ConInfo	yyyymmdd-lastnamefirstname-ConInfo-providername	App Packet PSS for Change Requests	End date of Consent to Release/Obtain Info can be "upon termination of services." If this is the end date, the Consent to Release/Obtain Info does not have to be completed annually.
Notice of Determination (Modification/Change Request)	NOD/Changes	System generated	Programs/Letters/CSP Letters	Notice sent to person/legal guardian within 10 days of approval/modification/denial of a Change Request.
Notice of Determination (Initials/recerts)	NOD	System generated	Programs/Letters/CSP Letters	Must be sent to person/legal guardian within 10 days of initial certification/recertification Overall Decision.
Transfer Form – CSP/TCM	CSPtran	yyyymmdd-lastnamefirstname-CSPtran	Person's Profile/Attachments/CSP/Other	To be completed and placed in LTSS by the sending Regional Program.
Face Sheet (as required by the Operational Standards)	FS	yyyymmdd-lastnamefirstname-FS	PSS	Required at least annually or if there are changes.
Freedom of Choice of Providers	DOCP	yyyymmdd-lastnamefirstname-DOCP	App Packet PSS for Change Requests	Must be completed annually and when new providers are selected.
Freedom of Choice of Services	DOCS	yyyymmdd-lastnamefirstname-DOCS	App Packet PSS for Change Requests	Must be completed annually and when new services are added to the CSP. Or when a new service is selected.
Grievance Procedures	Grievance	yyyymmdd-lastnamefirstname-Grievance	App Packet	Must be completed upon initial admission and annually thereafter.
Guardianship (date equals guardianship was signed by judge)	Guardian Or Conservatorship	yyyymmdd-lastnamefirstname-Guardian yyyymmdd-lastnamefirstname-conservatorship	Person's Profile/Attachments/PersonLevel/Other	Indicate in PSS if person has a guardian and who it is. Also complete the appropriate fields in the Person's Profile.
IDD Employment Profile	EmpProf	yyyymmdd-lastnamefirstname-EmpProf	Person's Profile/Attachments/CSP/Other	Received from provider by the 15 th of the month following the month it is developed.

Document Name	Abbreviation	Electronic Document Name	Location in LTSS	Notes
Information from MS Department of Rehabilitation Services	MDRS	yyyymmdd-lastnamefirstname-MDRS- brief description of what the document is	PSS	Information pertaining to services received and/or ineligibility/release from MDRS services. In the Service Notes, document all contacts with MDRS in the category of "Vocational Rehabilitation Contact."
Medical	Med	yyyymmdd-lastnamefirstname-Med	App Packet	Not required by CSP but placed in App Packet if available.
Miscellaneous	Misc	yyyymmdd-lastnamefirstname-Misc- brief description of what the document is	Person's Profile/Attachments/CSP/Other	Any miscellaneous letters or documentation received not otherwise named
Notes, Skills, Relationship Map	NoteSkRel	yyyymmdd-lastnamefirstname-NoteSkRel	PSS	One running document, with each form dated. Attached to PSS for all initials and recertifications.
Privacy Notice	PN	yyymmdd-lastnamefirstname-PN	App Packet	Upon initial admission and at least annually thereafter.
Provider Discharge Summary	ProvDis	yyyymmdd-lastnamefirstname-ProvDis	Person's Profile/Attachments/CSP/Other	Providers send this to TCMs when they discharge someone from services. TCMs do not have to complete this form.
Rights of Individuals Receiving Services	Rights	yyyymmdd-lastnamefirstname-Rights	App Packet	Upon initial admission and at least annually thereafter.
Risk Assessment	RA	yyyymmdd-lastnamefirstname-RA	PSS	TCM completes, initially and at least annually or when risks change.
Service Authorization	ServAuth	yyyymmdd-lastnamefirstname-Serv-Auth-service-providername	Person's Profile/Attachments/CSP/Other	Upon initial approval of services and any time a service or frequency changes.
Sign-in sheet from PSS meeting	Signin	yyyymmdd-lastnamefirstname-Signin	PSS	Initial PSS meeting and annually thereafter

Supported Decision Making (SDM)



SUPPORTED DECISION MAKING (SDM)

Defined

Everyone uses supports in their daily lives to make decisions. We may consult a professional, such as a doctor or a tax preparer, or we may ask advice of friends and family. This is no different for people who experience disability in their life. What is different is that people who use supports in their daily lives may not have had opportunities to learn decision making. Decision making is an experiential skill. You have to do it to get good at it. Ideally, small decision-making grows into big decision-making. Sometimes, because of illness or incapacity, people need immediate assistance and advocacy with decisions as they relate to safety, medical care, living arrangements, goods and services. The Arc of Mississippi, in partnership with the Mississippi Department of Mental Health, provides Supported Decision-Making services state-wide, upon request, and without charge to the person served.

WHAT SDM IS

- Monthly and as-needed communication to verify well-being and assist with decisions related to day-to-day life.
- Provide surrogacy services in some cases to facilitate medical care, end-of-life decisions, advocacy, and identify support needs.
- Use face-to-face Discovery as needed to understand who the person is, experience their current situation, or be present for planning and celebration.
- Timely response to challenges and opportunities such as crises or medical emergencies.
- An additional entity in a person's life according to Evidence Based Practices to combat the danger of over-control by a single, or limited number of paid service providers.

WHAT SDM IS NOT

- The Arc of Mississippi does not control, have access to, or provide financial resources or other assets to the people we support through SDM. We do not have a slush fund we can tap into to offer. We consider the control of a person's resources and SDM services to be a direct conflict of interest.
- We do not provide transportation of any kind. The Arc of MS is held to services that are specifically requested and approved by DMH.
- We are not a service provider. We are advocates. We are not certified by DMH to provide any services such as Supported Employment or Respite. Our DMH certification is for advocacy and as subject matter experts.
- We are not responsible for providing communication services. DMH Operational Standards (2020) Rule 14.4.A. requires all service providers to "provide bilingual employees and interpreter services at no cost to people." These services "must be offered at all points of contact with the person while he/she is receiving services." Your plan for these services must be in all provider's policies and procedures.

It takes all of us in tandem, working together, to help the people we care about and support to live their best life. We all have important roles to play. Thank you for what you do.

GUIDING PRINCIPLES

- √ Decision-making is a fundamental right as described in the United States Supreme Court's *Olmstead* decision of 1999, the Americans with Disabilities Act of 1990, and Article 12 of the United Nations Convention on the Rights of Persons with Disabilities.
- √ All people need help making decisions at different times in their life.
- √ People experiencing disability should be allowed and encouraged to contribute to the management of their own life. Some will require more assistance and guidance than others.
- √ Guardianship is a last resort, not a first response, to assisting people with disabilities. It has been widely used, often abused, and is no longer the best-practice in the United States for supporting an individual with ID/DD.
- √ It is not the intent of The Arc of Mississippi to gain control of the financial assets or responsibilities of a person using SDM.
- √ Supported Decision Making is person-centered and based on principles of Discovery to learn what is important to and important for an SDM partner.
- √ Choice is not unlimited. Everyone has restrictions to choice based on resources. The goal is to maximize choice and control based on the resources at hand.
- √ People must be met at their level of communication in order for them to be fairly supported.
- √ It is not enough for people to have rights: people must know what their rights are and be free to exercise those rights. With rights come responsibility.
- √ Presume capacity.

Timelines

IDD CSP Timelines

Initial Certification		Timeline
D&E sends referral to TCM		15 days from evaluation date
TCM first contact with person		5 days of receipt of referral from D&E
TCM completes Plan of Services and Supports & initial certification documentation & submits to IDD CSO/ Division of IDD CSP		45 days of receipt of referral from D&E
IDD CSO/Division of IDD CSP determination		30 days from submission
Recertification		
ICAP, Plan of Services and Supports, & supporting documentation		90 to 45 days prior to end of Certification Year
Recertification submitted to IDD CSO/ Division of IDD CSP		45 days prior to end of Certification Year
IDD CSO/Division of IDD CSP determination		Prior to start of upcoming Certification Year
All Certifications		
Clarification Request on the PSS from IDD CSO/Division of IDD CSP		5 business days to be resubmitted with requested information
Notice of Determination of Services letter mailed to person along with copies of all signed documents		5 days from receipt of Overall Decision
Service Authorization and PSS sent to each provider along with any evaluations		5 days from receipt of Overall Decision
Provider signs Service Authorization and returns to TCM		10 days from receipt of Service Authorization
The person whose service(s) has been reduced, denied, or terminated will be notified, in writing, by the IDD Targeted Case Manager and a copy will be sent to the Division Director of CSP		Within 5 days of the notification from OCS/IID CSP of reduced, denied, terminated services
Other Timeline Events		
Enter Service Notes into LTSS		The day of contact when possible, but no later than 5 days after contact.
Lock-in Verification Report (LIVR) reported to Division of IDD CSP with or without discrepancies		By the 10 th of the month
Notice of Discharge letter		Within 10 days of discharge and prior to Overall Decision in LTSS
Email regarding Discharge		Within 10 days of discharge

**MS Department of Rehabilitation Services
Supported Employment Referral Form**



A. Record Information about the Individual Being Referred to MDRS

Social Security Number: Click here to enter text.	Date of Birth: Click here to enter text.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name: Click here to enter text.	First Name: Click here to enter text.	Middle Name: Click here to enter text.
Mailing Address: Click here to enter text.		County: Click here to enter text.
Current Physical Address: Click here to enter text.		
Daytime Phone Number: Click here to enter text.		<input type="checkbox"/> Phone <input type="checkbox"/> TTY <input type="checkbox"/> Fax <input type="checkbox"/> Cell Phone
Alternative Phone Number: Click here to enter text.		
Projected Extended Services Provider: Click here to enter text.	Transportation Available: <input type="checkbox"/> Yes or <input type="checkbox"/> No Provided by: Click here to enter text.	
Client's Primary Disability: Click here to enter text.	Client's Secondary Disability: Click here to enter text.	
Other Disability: Click here to enter text.		
Benefits: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Waiver <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare		
Enrolled in B21?: <input type="checkbox"/> Yes or <input type="checkbox"/> No If so, navigator's name: Click here to enter text.		
Name of Legal Guardian / Power of Attorney: Click here to enter text.		
Contact Number: Click here to enter text.		

B. Functional Capacity Areas Affected: (Check two or more). Supporting Documentation must be attached for any box checked below.

<input type="checkbox"/> Self-Care <input type="checkbox"/> Mobility	<input type="checkbox"/> Work Tolerance <input type="checkbox"/> Work Skills	<input type="checkbox"/> Communication <input type="checkbox"/> Interpersonal Skills	<input type="checkbox"/> Self-Direction <input type="checkbox"/> Other
Self-Care	Ability to perform activities of daily living including eating, toileting, grooming, dressing, cooking, shopping, washing, housekeeping, money management, and health and safety needs to participate in training or work related activity.		
Mobility	Ability to move from work or within a work environment, including walking, climbing, coordination, accessing, and using transportation, as well as use of spatial and perceptual relationships.		
Self-Direction	Ability to independently plan, initiate, organize, make decisions, and carry out daily		

	life activities necessary for employment after self-care needs have been met.
Work Skills	Ability to demonstrate specific tasks and work-related behaviors to carry out job functions as well as the capacity to benefit from training necessary to obtain and maintain appropriate employment.
Work Tolerance	Capacity to meet the demands of the work place regardless of the work skills already possessed by the individual. Limitations may be due to physical disability, stamina/fatigue, effects of medication, or psychological factors.
Communication	Ability to transmit and/or receive information through spoken, written, or other nonverbal means.
Interpersonal Skills	Ability to establish and/or maintain personal, family, or community relationships as it effects job performance.

<p>Past Relevant Educational and Vocational History: Click here to enter text.</p>
<p>Current Vocational Interests: Click here to enter text.</p>
<p>Suggested Employment Goal: Click here to enter text.</p>
<p>Health Information (Including medication): Click here to enter text.</p>
<p>Attitudinal, Behavioral, and Environmental Factors: Click here to enter text.</p>
<p>Assistive Devices, Transportation, and ADL Needs: Click here to enter text.</p>
<p>Services Consumer is Currently Receiving: Click here to enter text.</p>

Please List Reports Attached:

- | | |
|--|---|
| <input type="checkbox"/> ID/DD Waiver Individual Plan of Care | <input type="checkbox"/> Discovery Profile |
| <input type="checkbox"/> ID/DD Waiver Notice of Certification | <input type="checkbox"/> Social Services Department Evaluation |
| <input type="checkbox"/> Certificate of Development Disability [AL1] | <input type="checkbox"/> Individual Support Plan |
| <input type="checkbox"/> Medical Records/Current Physical | <input type="checkbox"/> Psychological Reports |
| <input type="checkbox"/> Provide copy of photo I.D. and S.S. card | <input type="checkbox"/> Other: Click here to enter text. |
| <input type="checkbox"/> Plan of Services and Supports | |

C. Information About the Individual Making the Referral to MDRSOrganization Name, if any: [Click here to enter text.](#)Name: [Click here to enter text.](#)Job Title: [Click here to enter text.](#)Relationship to person being referred: [Click here to enter text.](#)Daytime Phone Number: [Click here to enter text.](#)☐ Phone ☐ TTY ☐ Fax ☐ Cell PhoneOther Phone Number: [Click here to enter text.](#)☐ Phone ☐ TTY ☐ Fax ☐ Cell PhoneE-mail Address: [Click here to enter text.](#)

**Please send referral form with any reports to VRSEreferrals@mdrs.ms.gov, fax 601-853-5354
or mail to Supported Employment Program, P.O. Box 1698 Jackson, MS 39215-1698**