NEW MEXICO DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD)

FISCAL YEAR 2019

STATE GENERAL FUND
Services for Individuals with Developmental Disabilities,
and
FAMILY INFANT TODDLER PROGRAM / MEDICAID EPSDT
Services for infants and toddlers (birth to three) with, or at risk of Developmental Delays and their families

SERVICE DEFINITIONS AND STANDARDS

EFFECTIVE JULY 1, 2018

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INTRODUCTION

These standards apply to the services provided under State General Funded provider agreements with the Developmental Disabilities Supports Division of the Department of Health for State Fiscal Year 2018 (July 01, 2017 through June 30, 2018). Services included in these standards are those provided to families of infants and toddlers (birth to 3) with or risk for developmental delays and those provided to individuals with developmental disabilities. For Early Intervention and other Family Infant Toddler Program services these standards clarify, interpret, and further enforce the Human Services Department regulations governing the provisions of 8.320.4 NMAC Medicaid Early Periodic Screening Diagnosis and Treatment services under "Special Rehabilitation Services" and the 7.30.8 NMAC Requirements of the Family Infant Toddler Early Intervention Services

The standards address each service provided under State General Funded Provider Agreements with the Developmental Disabilities Supports Division, with the exception of Outcome Based Services and Special Projects (Outcome Based Service and Special Project requirements will be individually described in each Scope of Service incorporated into the State General Funded Provider Agreements affected). These standards also include personnel requirements for people employed by or contracting with agencies providing State General Funded services, known herein as *the provider*. Individuals should expect to receive services that meet these standards.

GENERAL REQUIREMENTS

Pertinent laws and regulations governing the provision of services under the State General Funded Provider Agreement with the Developmental Disabilities Supports Division of the Department of Health includes, but is not limited to:

- Fair Labor Standards Act and Child Labor Laws
- New Mexico Nursing Practice Act (NMAC 26.12.2) and NM Board of Nursing requirements governing certified medication aides and administration of medications.
- The Federal Individuals with Disabilities Education Act (IDEA), Part C
- DDSD/DOH Requirements for Family Infant Toddler Early Intervention Services (NMAC 7.30.8)
- DDD/DOH Service Plans for Individuals with DD Living in the Community (NMAC 7.26.5)
- DDD/DOH Rights of Individuals with DD Living in the Community (NMAC 7.26.5)
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- DHI/DOH Statewide Incident Management System Policies and Procedures
- DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities
- Reporting and Documentation of DDSD Training Requirements
- Policies and Procedures for Centralized Admission and Discharge Process for New Mexicans with Disabilities
- Policy for Behavioral Support Services
- DHI/DOH Criminal Records Screening for Caregivers (NMAC 7.1.9)
- The Department of Health Provider Agreements for Fiscal Year 2019
- And any rules, regulations, policies, director's releases or interpretive memorandum published by DDSD/DOH that specify applicability to the State General Funded services described herein.

STANDARDS FOR SERVICE PERSONNEL

PURPOSE

The purpose of the standards for service personnel is to establish requirements for the provision of services under State General Funded Provider Agreements with the Developmental Disabilities Supports Division of the Department of Health. These standards apply to personnel who provide the following State General Fund services: Respite Services (Children and Adult), Adult DD Residential Services and Adult Day Services. The standards apply whether the personnel are directly employed or subcontracting with the provider agency and are in addition to the requirements set forth in the remaining sections of the State General Funded Service Standards.

INTRODUCTION

It is the intention of the Developmental Disabilities Supports Division that State General Funded providers comply with these personnel standards in order to promote the health and safety of individuals served.

GENERAL PERSONNEL REQUIREMENTS

All personnel must be of good integrity and possess adequate physical, mental and emotional stability to provide services in a safe and responsible manner.

The provider must screen all personnel regarding their qualifications, references, and employment history. In addition, all providers must comply with the **NMAC Title 7 Chapter 1 General health Provision Part 9 7.1.9.1: Caregivers Criminal History Screen Requirements** as implemented by the Department of Health.

EXCEPTION: Any agency providing Home Health Aide, Homemaker/Companion Services under a Home Health Care Agency pursuant to the New Mexico Department of Health, Health Facility Licensing and Certification Bureau (NMAC 7.28.2) is exempt from these personnel standards.

QUALIFICATIONS FOR DIRECT SERVICE PERSONNEL

Direct service personnel are persons paid to provide face-to-face including telehealth services to the individual and family.

Direct service personnel must be eighteen (18) years or older. *Exceptions: Habilitation services provided under Adult DD Vocational/Habilitation Services can employ direct care personnel under the age of 18 years, but the employee must work directly under a supervisor, who is physically present at all times; and the agency can assure the served individual is not limited in access to all services and supports.*

1. Direct service personnel should be available to communicate in the language required by the individual or in the use of specific augmentative communication system utilized by the individual.
2. Direct service personnel must meet the competencies specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities (2/23/07). (*Exception: Respite Services)*
3. Direct service personnel must have the ability to read and carry out the requirements in an Individualized Family Service Plan (IFSP) or an Individual Service Plan (ISP).

SUPERVISION REQUIREMENTS

Personnel who are directly responsible for the supervision of direct service personnel must meet the following requirements**.**

1. Employees who supervise direct service personnel or serve as a member of a supervisory team must be twenty-one (21) years of age or older.
2. Must possess a high school diploma or G.E.D.

3. Employees who supervise direct service personnel must have a minimum of one-year experience working with individuals with disabilities or related field; OR a degree in a related field may substitute for experience.
4. Employees who supervise direct service personnel must meet the competencies specified in the Developmental Disabilities Supports Division Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators.
5. Must have the ability to read and carry out the requirements in an IFSP or ISP.

RESPITE

Respite is a flexible family support service that provides short term, temporary care to people with disabilities or children who are at risk for developmental delay. This service allows families to take a break from the daily routine of care giving. Respite care providers assist the individual in activities of daily living, promote the individual's health and safety, as well as maintain a clean and safe environment. The family, in collaboration with the provider, will schedule respite services.

SCOPE OF SERVICE

Respite services include but are not limited to:

- Assisting the individual to enhance self-help skills and carry out activities of daily living;
- Providing non-medical health care;
- Preparing or assisting the individual in activities of daily living including preparation of meals, eating, sleeping, washing etc.;
- Providing opportunities for community and neighborhood integration and involvement;
- Providing opportunities for leisure, play and other recreational activities;
- Providing opportunities and support to the individual to make choices in regard to daily activities depending on age and skill level.

SERVICE REQUIREMENTS

Specific requirements and conditions that apply to respite services are:

- The staff to participant ratio is typically 1:1 or 1:2 in family household or community settings for the period of time in which an individual is receiving respite services. A decision based on the participant's needs and the respite provider's capabilities should be made on a case-by-case basis if the respite provider is going to serve more than one individual at time.
- Service provision in a small group is permissible when appropriate to the individual and family; however; a minimum of a 1:4 staff to participant ratio must be maintained if the respite is provided to a group.
- The decision regarding the location in which respite will be provided shall be made in consultation with the family. Locations where respite may be provided include the following:
    1. The individual's/family's home,
    2. The respite care provider's home,
    3. A community setting of the family's choice (e.g. community center, swimming pool, park etc.),
    4. A center-based setting, such as a respite home, provider location or day care center.
- Respite hours are allocated up to a maximum of 200 hours per year per eligible recipient. The agency may not allow any family to receive over 200 hours per year if they have a waiting list for respite services.
- The respite coordinator should meet with the family to determine each family's needs and how they will utilize respite. For example:
    - If the family wants 2 hrs per week in order to do laundry, this would amount to 104 hours (2hrs X 52 weeks) per year.
    - If the family wants one day per month for the parents to spend time together this would be 96 hours (8 hrs X 12months) per year.
- Families/Individuals may request respite care hours overnight or more than one day.

- If respite is provided in the respite provider's home, the homeowner or renter of the home where the service is provided shall ensure the safety of the home including but not limited to the presence of a smoke detector and fire extinguisher. Agencies providing respite services will verify that respite providers who provide respite services in their own home are made aware of this requirement.
- Respite providers should not provide skilled nursing tasks including G-tube replacement, oxygen adjustment, suctioning etc. The family or a qualified nurse working within their scope of practice must complete skilled nursing procedures.

ELIGIBILITY REQUIREMENTS FOR RESPITE SERVICES INCLUDES THE FOLLOWING:

- A child age birth through 3 years must be eligible for Early Intervention Services and have Respite identified as a service on the Individualized Family Service Plan (IFSP).
- A child who is between the age of 3 years through 21 must meet one of the following:
    - Have been previously eligible, under the established condition or the developmental delay eligibility criteria under the Family Infant Toddler Program (Age 3 through 5 only); or
    - Be eligible for Special Education under the Individuals with Disabilities Education Act (IDEA) Part B, administered by the Public Education Department (PED) under one of the following categories: i) Autism; ii) Developmental Delay (age 3 through 9 only); iii) Intellectual Disability; iv) Multiple Disabilities; and v) Traumatic Brain Injury; or
    - Determined to meet the eligibility of developmental disability in accordance with DDSD Policy and on the NM Developmental Disabilities Central Registry (waiting list).
- An adult age 22 or older must have been determined developmentally disabled in accordance with DDSD Policy and be on the Developmental Disabilities (DD) Central Registry (waiting list).

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative requirements:

- The provider will assure the eligibility of individuals receiving services and will maintain a participant record containing documentation pertinent to service delivery such as contact notes, hours of training, hours of service. The provider may require advance notice from the individual/family for the scheduling of respite.
- The provider will establish and maintain financial reporting and accounting for each individual/family served.
- The provider will prepare and submit quarterly summary reports to the DDSD - Family Infant Toddler Program staff assigned to their region of the State, using the format specified by the Family Infant Toddler Program.
- The provider shall not charge any fee to families for Respite. The provider may charge for meals or entrance fees is these occur during the time respite is provided.

B. Staffing Requirements:

The provider must adhere to the following requirements regarding employees or contract personnel hired as respite providers:

- A parent, spouse, primary caregiver or surrogate parent may not provide respite services if they reside in the same dwelling as the individual served.
- Respite care providers must be at least 18 years old.
- Respite care providers must be certified in First Aid and CPR. CPR must be obtained for the population for which they will be serving (either infants, adults or both).

- Respite care providers providing care to more than one participant must complete a forty (40) hour training program. Training can be specific to that participants needs. CPR and First Aid may count towards this requirement.
- Respite care providers recruited specifically for a single participant must complete a twenty (20) hour training program. Training can be specific to that participants needs. CPR and First Aid may count towards this requirement.
- Respite care providers may access the topics/requirements for training specified in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals. This training document is available from DDSD training unit and on the DDSD website.
- Respite care providers may receive individual-specific training by the parent or family of the individual who needs respite, which can count towards a portion of the training requirement.
- Respite care providers may take other training as relevant to participants such as: HIPAA Privacy, videotapes on specific conditions or syndromes, child abuse reporting, research on the Internet for specific conditions etc.
- The agency may allow a reasonable period of time for completing additional training requirements, but the time frame may not exceed 6 months from the date of hire.
- Respite care providers must also participate in ongoing training with a minimum of ten (10) hours per year after the first year. The respite provider and employer should agree on training topics to be covered.
- Criminal records checks are mandatory and must be completed in accordance with the DHI/DOH Criminal Records Screening for Caregivers (7 NMAC 1.9)
- Respite providers must meet the DDSD Standards for Service Personnel located in front of this document

REIMBURSEMENT

Request for reimbursement for respite services under State General Funds shall be submitted monthly in accordance with directions provided by the DDSD - Administrative Services Bureau (ASB) at the Department of Health.

Respite providers should utilize the service component that corresponds with the age of the individual. The component categories are as follows:

- Children's Respite (birth - 21): Reporting Category 700026
- Adult Respite (22 & older): Reporting Category 700015

The Unit Rate for all services = $ 13.25 per hour. A provider Agreement amendment is needed in order to move funds between the above Service Units

Reimbursement for Respite Services is based on an hourly rate, based on face-to-face contact.

Non-billable hours include:

- Travel to and from the individual's home, except when the individual is being transported.
- Attendance at training and other personnel development activities, which are not face-to-face contacts with the individual/family, preparation of billing statements, progress notes, and/or quarterly reports.

Respite Services provided under State General Fund (SGF) are not available to Medicaid Waiver recipients. Respite Services cannot be co-funded with Adult AGF DD Residential Services. Respite Services cannot be billed for the same hour (s) of the same day (s) with any other DDSD Service.

CHILD FIND AND PUBLIC AWARENESS

Child Find and public awareness activities promote identification and referral of eligible children with, or at risk for, developmental delays for early intervention services and assist the child in becoming Medicaid eligible (where appropriate). These activities include public awareness, child find activities and interagency planning, presentations and coordination to improve child identification and/or service delivery, and presumptive eligibility activities.

SCOPE OF SERVICE

Child Find and Public Awareness activities include but are not limited to the following:

- Development of materials to inform the general public about the benefits and availability of early intervention services that are of no cost to families. Provider agencies will use standardized FIT print materials in their child find and public awareness and ensure that reference to the Family Infant Toddler Program is included in agency print materials.
- Distribution of public awareness materials at sites that are frequented by parents of children of young children (Materials include those produced by the provider and those generated by the New Mexico Family Infant Toddler Program).
- Outreach to potential primary referral sources (including physicians; nurses; hospital staff; child care providers; social workers; Head Start / Early Head Start grantees; home visiting providers; tribal communities, Women Infant & Children (WIC); homeless and domestic violence shelters, CYFD etc.) regarding early intervention services and informing them of their responsibility of helping the family with making a referral if the family is concerned about their child's development or if the child is identified as having or being at risk for developmental delays.
- Providing opportunities for developmental screening and other child find activities within the geographical area that they serve including Native American tribes within those boundaries.
- Coordinating efforts with other agencies and organizations (including public schools, Head Start programs, health centers etc.) regarding child find activities and events such as public health fairs or community outreach clinics.
- Conducting presentations/ seminars within the geographical area served on issues regarding early intervention to heighten awareness regarding early intervention and the availability of services.
- As appropriate to the family need, conduct a PE-MOSAA (Presumptive Eligibility – Medicaid On Site Application Assistance) to assist families in accessing Medicaid eligibility

SERVICE REQUIREMENTS

The following conditions and requirements apply to Child Find and Public Awareness:

- Screening and other child find activities are available to any child who is birth to three years old if the family has a concern about their child's development. (Note: A child does not have to receive a screening to receive a developmental evaluation).
- Public Awareness materials developed should meet the cultural and linguistic needs of the population served.
- All public awareness materials developed must indicate that the provider agency is "funded in part by the NM Department of Health - Family Infant Toddler (FIT) Program".
- Child Find and Public Awareness activities must be provided to all communities, Indian reservations/Pueblos, and/or military bases within the geographical area served, as listed in the Provider Agreement. Providers should identify and target any underserved groups by comparing numbers served compared to Census data.

- Interagency collaboration with other providers (including Children's Medical Services, Medically Fragile, NMSD; NMBVI, etc.) is important to ensure a streamlined referral and intake process and to avoid duplication.
- In counties where there is more than one FIT provider agency, providers shall coordinate child find and public awareness activities and events to prevent duplication of effort and to efficiently use time and resources, (e.g. deciding who will do outreach to which referral sources; who will distribute FIT public awareness materials to which sites; and coordination of child find events, etc.) This coordination should be reflected in the annual Child Find / Public Awareness Plan that is submitted to the FIT Program.
- In counties where there is more than one FIT provider agency, referral sources should be informed that the referral is to the Family Infant Toddler (FIT) Program and that there are "x" number of FIT providers that provide service coordination and early intervention services in the county that can receive a referral. The provider will promote the FIT program by using the FIT public awareness materials that list all providers in that area. If there is a request for information regarding a specific agency, information regarding that agency can be passed out at that time.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- Establish and maintain financial reporting and accounting for expenditures under this service.
- Maintain a record of time spent by staff towards the scope of service listed above.
- Maintain a log of where, when and how (e.g. by mail, presentations, visit by staff etc.) materials have been distributed.
- Send one copy of all public awareness materials produced to the FIT Program Regional Coordinator.
- Ensure that demographic and referral information on all children and families is entered into the Family Infant Toddler Program database. Information must be entered on all children and families that are referred to early intervention, even if they are found to not be eligible for IDEA part C services.
- Ensure compliance with the regulations for the Family Infant Toddler Early Intervention Program NMAC 7.30.8.
- Submit a Quarterly Performance Report based on the federal annual performance indicators (APR) within the required timeframe and in the format provided by the Family Infant Toddler Program. In addition, submit an Annual Performance Report (APR) within the required time frame using the FIT supplied template. A timeline for due dates will be supplied by the FIT Program.
- Submit an Annual Child Find / Public Awareness plan using the FIT supplied template within the first 60 days of the fiscal year using the template provided by the FIT Program.
- Submit a report using the template provided by the FIT Program within 30 days of the end of each quarter.

B. Staffing Requirements

Any staff within the provider agency can conduct Child Find and Public Awareness activities. Screening activities should only be conducted under the direct supervision of a Developmental Specialist II or higher level of certification/licensure.

REIMBURSEMENT

Request for reimbursement for child find / public awareness shall be submitted monthly in accordance with directions provided by the DDSD - Administrative Services Bureau at the Department of Health.

Reporting Category 700024

Unit Rate: $1.00

Reimbursement shall be made based on cost reimbursement i.e. the invoice shall be based on the activity that occurred that month.

Reimbursement for Child Find / Public Awareness activities will not occur until the FIT Program has received and approved the annual Child Find / Public Awareness plan.

COMPREHENSIVE MULTIDISCIPLINARY EVALUATION

The Comprehensive Multidisciplinary Evaluation (CME) is required by IDEA Part C and is designed to inform the eligibility determination process through a timely, non-discriminatory, comprehensive and interdisciplinary approach. The evaluation determines the developmental status of the child and ~~to~~ determines eligibility for early intervention services. The evaluation shall include parent/caregiver report, information from a routines-based interview process, the child's health and medical status and must cover the following developmental areas:

- Cognitive development
- Physical (including vision and hearing) development
- Communication development
- Social or emotional development
- Adaptive development

SCOPE OF SERVICE

This service includes activities provided by early intervention personnel for completion of an initial comprehensive multidisciplinary developmental evaluation (in accordance with NMAC 7.30.8) for children who are referred to the FIT Program. Evaluation personnel should have an early childhood development background. Evaluation personnel should also be trained in FIT evaluation and eligibility procedures and the tool(s) that they are administering. Evaluation and assessment tools shall be used in accordance with the manual and established protocols for that tool. To ensure accurate evaluation results, evaluations should be conducted in an environment where the child typically spends his/her day and shall consider parent choice. It also can include observation in environments in which the child spends his/her day and/or environments in which concerns have been expressed.

Activities required include:

- If the team decides to first conduct a developmental screening for a child referred and in accordance with NMAC 7.30.8 10. E. the Ages and Stages Questionnaire (ASQ) shall be utilized.
- The Family Service Coordinator (FSC) and/or evaluation team shall use a routines-based interview process. The evaluation team shall use all phases of the Infant-Toddler Developmental Assessment (IDA) as the approved statewide tool as part of the Comprehensive Multidisciplinary Evaluation. Information from the routines-based interview process shall be included in the CME report noting child strengths and parent concerns. (For more information on assessment and evaluation: (www.cdd.unm.edu/ecln/FIT/FITStf/EvalAssessment.html)
- A review and summary of the child's records related to current health status and prior medical history.
- **For infants under one month of age (adjusted)** the IDA will **not** be used. Instead, one of the approved tools below shall be used together with informed clinical opinion. Informed clinical opinion is used to make a recommendation for initial and/or continuing eligibility for services under Part C and as a basis for planning services to meet child and family needs. For information on 'how to' use Informed Clinical Opinion for eligibility in the NM FIT Program, please see NMAC 7.30.8 G and the NM FIT Technical Assistance Document on Evaluation and Assessment – see link above) Informed clinical opinion shall include the following:
  - An evaluation of the child's level of functioning in each of the following developmental areas:
    - Cognitive development;
    - Physical development, including vision and hearing;
    - Communication development;
    - Social or emotional development;
    - Adaptive development.

- A review of the pertinent records related to the child's current health status and medical history and should include observation and parent input on feeding, sleeping, motor, behavior, state regulation, communication, visual tracking and auditory responses.

When Informed Clinical Opinion the CME report must include all 5 developmental domains and pertinent information as well as parent report. There must be documentation to justify the decision including a description of the child's abilities and areas of concern and how they differ from typical children of the same age. The evaluation report must be reviewed by a "second level reviewer" (someone who is not part of the evaluation team who has equal or higher-level certification or licensure) and shall include a statement of approval and second level of review signature indicating that Informed Clinical Opinion was used. (NMAC 7.30.8 G and the NM FIT Technical Assistance Document on Evaluation and Assessment)

Approved tools for infants under 1 month of age include:

1. (Alberta Infant Motor Scale) AIMS
2. TIMP (Test of Infant Motor Performance)
3. Motor Skills Acquisition Checklist
4. Newborn Individualized Developmental Care and Assessment Program (NIDCAP) - for use with newborns in the newborn intensive care setting only
5. Newborn Behavior Assessment Scale (NBAS)
6. The Newborn Behavioral Observations system (NBO)
7. Other tools as approved by the FIT Program via a memo

Due to the varying nature and purpose of the scores of each of the above approved tools, the scores themselves will not lead to eligibility, but rather they will provide additional information for the team to consider in reaching a determination of the child's developmental status and eligibility determination.

- **For infants over one month of age and under four months of age** including adjusted age, the IDA shall be used in conjunction with one of the following approved tools listed below. All 5 developmental domains shall be assessed and addressed in the CME report, including parent/caregiver information and information from the routines-based interview process.

  Approved tools for infants over one month of age (adjusted) and under four months include:

  1. Alberta Infant Motor Scale (AIMS)
  2. Test of Infant Motor Performance (TIMP)
  3. Infant Toddler Sensory Profile I & 2
  4. Peabody Developmental Motor Scale (PDMS-2)
  5. Motor Skills Acquisition Checklist
  6. REEL-3
  7. The Rossetti Infant Toddler Language Scale
  8. The Newborn Behavioral Observations system (NBO) (up to 3 months)
  9. Other tools as approved by the FIT Program via a memo.

- Other developmental domain specific tools may be used in addition to the IDA as part of the Comprehensive Multidisciplinary Evaluation (CME). If the IDA does not indicate a 25% delay, a developmental domain specific tool can be used to inform eligibility under developmental delay based on either a -1.5 Standard Deviation or greater in conjunction with Informed Clinical Opinion.

- **M-CHAT-RF Screening:**

  - For children referred between 18 months and 30 months of age the M-CHAT-RF Autism screening shall be conducted as part of their initial Comprehensive Multidisciplinary Evaluation (CME). The CME report shall indicate that the M-CHAT was completed, provide the results of the M-CHAT- RF, and discuss any outcomes such as follow up and referral as determined by the results of the M-CHAT-RF.

- For children referred who are younger than 18 months, the M-CHAT-R/F Autism screening shall be conducted once the child turns 18 months old and again at 24 months of age per the recommendations of the author and the American Academy of Pediatrics. (Personnel may bill for the time spent conducting the screening based on the location where the screening takes place). Referral for a diagnostic evaluation shall be made, with the consent of the parent(s)/caregiver, if the result of the M-CHAT-R/F, including completion of the supplemental/follow up questions is "High Risk". A medium risk score requires the completion of the follow up questions to determine the final risk score. A consultation with the Early Childhood Evaluation Program (ECEP) can occur when there is a low risk M-CHAT- R/F score with a moderate to high levels of provider concerns. Consultation with a supervisor or Provider Agency Evaluation Lead is recommended as well as consultation with NMSBVI and NMSD for children with vision and hearing loss regarding any questions about whether to pursue a referral to ECEP.

  The M-CHAT-RF authors do not recommend adjusting for prematurity (therefore do not adjust for prematurity. **(**http://mchatscreen.com/**)**

- The IDA was not designed to evaluate children with vision and/or hearing loss. If a vision or hearing diagnosis is known prior to the CME evaluation, NMSBVI or NMSD should be consulted to collaborate with the CME team.
- **Children with vision loss**: The CME must address the child's vision using the NMSVBI screening tool or formal vision testing results. A statement summarizing the results must be provided in the written evaluation report. If vision screening results indicate a concern, a referral shall be made to NMSBVI with consent of the parent/caregiver. NMSVBI will provide follow up to the family by collaborating with the child's Primary Care Provider and/or a pediatric ophthalmologist and the FIT provider agency. The Family Service Coordinator is responsible for following up on any vision concerns.

  For a child who is blind, the CME team, in collaboration with NMSBVI, will administer The Oregon Project Skills Inventory, in lieu of the IDA, as it is designed as an assessment tool for blind and visually impaired children. (The Oregon Project Inventory Tool and training will be provided by NMSBVI).

  For a child who has visual impairments or low vision, but who is not blind, the IDA may be used with supplemental items from the Oregon Project Skills Inventory with consultation from NMSBVI:
  - The CME team will consult with NMSBVI to determine which tool and process will be most appropriate to measure the child's developmental skills, given his/her diagnosis:
  - The IDA may be used with supplemental items from the Oregon Project Skills Inventory and with consultation from NMSBVI; or
  - The Oregon Project Skills Inventory will be used in lieu of the IDA
  - NMSBVI can contribute vision information that will be included in the vision section of the CME report, but NMSBVI is **NOT** considered to be a second or third discipline on the CME team.
- **Children who are deaf or hard of hearing**: The CME must address the child's hearing through either documented Newborn Hearing Screening results (valid for only 6 months from the date of the screen); or a hearing screening that utilizes OAE. If a child does not pass/refers the OAE, then a tympanometry screening will be performed. Formal hearing test results can be used in place of the OAE and tympanometry. A statement summarizing the results must be provided in the written evaluation report. Children failing/referring on more than two consecutive hearing screens will be referred to their Primary Care Provider for medical/audiological follow-up. FIT providers will contact the NMSD Regional Supervisor for consultation and guidance regarding all children who have been identified as having a hearing concern. Once a permanent hearing loss is identified *or suspected*, a formal referral for services will be made to the NMSD Regional Supervisor, with family/caregiver consent. The Family Service Coordinator is responsible for following up on any hearing concerns.

  For a child that is hard of hearing and/or is deaf, the following tools are approved:

  - The Visual Communication and Sign Language Checklist,

- The McCarther-Bates Communicative Developmental Inventories
- The Language Development Scale

NMSD will consult with the CME team and/or administer one or more of these tools which have been normed on children who are deaf or hard of hearing and this information will be used to supplement developmental information gained from the IDA.

If appropriate, NMSD staff may function as an additional or third discipline for the CME as a Developmental Specialist. Consultation with NMSD shall occur:

- During the CME for a child who is hard of hearing
- During the CME for a child who can hear but whose parents are deaf, NMSD shall be consulted to assess the child's ASL skills. (NMSD would not be an ongoing member of the child's IFSP team as the child does not have a hearing loss)
- E & A as needed to assess a child's ASL skills when the child's parents are deaf post CME

The completed and typed Comprehensive Multidisciplinary Evaluation (CME) report written in family friendly language shall include:

- reason for referral,
- relevant medical history including current vision and hearing status,
- parent/caregiver concerns, and the child strengths and interests.

The CME written report shall also summarize the child's functioning in each developmental domain providing a picture of the child's overall functioning and ability to participate in family and community life. It shall also include a statement regarding the child's eligibility for the FIT Program and recommend approaches and strategies to be considered by the IFSP team when developing outcomes.

- A FIT Program "Evaluation Summary Form", which summarizes the evaluation results, **may** be used if the full evaluation report will not be completed at the time of the initial IFSP. However, the full evaluation report must be completed and given to the team, including the family, within 30 days of the evaluation.
- This service unit includes the participation of early intervention personnel in determining the child's eligibility for the FIT Program.

SERVICE REQUIREMENTS

These conditions and requirements apply to the Comprehensive Multidisciplinary Evaluation. The provider is responsible for determining eligibility for early intervention services and maintaining documentation of eligibility status on file.

Children are eligible for this service who:

- Are from birth to three years old (If a child is referred to the FIT Program fewer than 45 days prior to the child's third birthday an evaluation will not be conducted.)
- Reside in the state of New Mexico
- Have been referred for evaluation or early intervention services
- Parent/caregiver has given their prior informed consent

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- Establish and maintain financial reporting and accounting for each child.

- Establish and maintain a confidential record for each child/family served that includes signed consent and release forms, progress notes and contact logs.
- The typed report that addresses all developmental domains, vision, hearing, and medical information, shall serve as documentation for Comprehensive Multidisciplinary Evaluation.
- A Policy and Procedure Manual must be maintained and updated regularly to reflect current policies consistent with FIT Program requirements related to at least, the following activities:
    - Intake and referral
    - Comprehensive Multidisciplinary Evaluations
- A quality assurance plan will be developed that includes but is not limited to developing an ongoing monitoring process, which regularly reviews compliance, and provides for the evaluation of quality and the family's satisfaction with the Comprehensive Multidisciplinary Evaluation.
    - Ensure that demographic, eligibility data and evaluation data is entered into the FIT Program database FIT-KIDS (Key Information Data System) within 30 days following the respective activity.
    - Comprehensive Multidisciplinary Evaluations must be provided to all families referred in the geographical area served under the DDSD Provider Agreement.
    - Submit a Quarterly Performance Report based on the federal annual performance indicators (APR) within the required timeframe and in the format provided by the Family Infant Toddler Program and an Annual Performance Report (APR) within the required time frame.
    - Conduct Correction of Noncompliance activities, as necessary, in accordance with requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency) and must be twofold. (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant, and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (although late), unless the child is no longer within the jurisdiction of the early intervention program
    - The provider shall not charge any fee to families for the Comprehensive Multidisciplinary Evaluation.

B. Staffing Requirements

- The agency must provide adequate supervision to all staff providing Comprehensive Multidisciplinary Evaluation.
- Personnel conducting a Comprehensive Multidisciplinary Evaluation must have a BS/BA or higher and Developmental Specialists must be certified at level II or III. Personnel must be trained and/or licensed to administer instruments used in an evaluation.
- The Multidisciplinary evaluation team shall include two or more personnel from the following list of disciplines:
    1. Audiologist – licensure from the NM Audiology Board
    2. Developmental Specialist certification II or III –in accordance with Family Infant Toddler Program regulations (NMAC 7.30.8) and DDSD Policy
    3. Family therapist – licensure from the Counseling and Therapy Practice Board as a Family Therapist, Professional Clinical Mental Health Counselor, Professional Mental Health Counselor, or Registered Mental Health Counselor
    4. Nurse – licensure from the NM Board of Nursing as a registered nurse
    5. Nutritionist – licensure from the NM Nutrition and Dietetics Practice Board
    6. Occupational Therapist– licensure from the NM Board of Occupational Therapy Practice

7. Physical Therapist – licensure from the NM Physical Therapy Licensing Board
8. Psychologist – licensure from the NM Board of Psychologist Examiners
9. Social worker – licensure from the NM Board of Social Work Examiners
10. Speech/Language Pathologist – licensure from the NM Board Speech, Language Pathology, Audiology and Hearing Aid Dispensers Board

REIMBURSEMENT

Request for reimbursement for Comprehensive Multidisciplinary Evaluation shall be submitted monthly through the FIT-KIDS (Key Information Data System) in accordance with directions from the Department of Health. Staff entering data related to billing shall complete the online FIT-KIDS training.

Request for reimbursement for Comprehensive Multidisciplinary Evaluation shall be submitted in accordance with directions provided by the DDSD - Administrative Services Bureau (ASB) at the Department of Health.

Comprehensive Multidisciplinary Evaluation

Reporting Category	700023
Rate: $630.00	Unit: one completed evaluation
Medicaid	H2000 TL
Rate: $630.00	Unit: one completed evaluation

This unit is paid for the initial multidisciplinary developmental evaluation that is completed in accordance with 7.30.8 NMAC. This rate covers the work of multidisciplinary evaluation team members in conducting direct assessment activities, administering instruments and tools with child and family, reviewing medical and other records or reports, and writing the comprehensive developmental evaluation report. While the "Evaluation Summary Form" may be used to develop the IFSP, this time unit cannot be billed until the full CME report has been written.

This CME unit may be billed only one time per eligible child in FIT-KIDS and billing shall be submitted once the written evaluation report has been completed

- If a child is evaluated and determined not eligible for early intervention services and the child is re-referred to the FIT program, a second CME can be conducted in accordance with IDEA Part C to determine eligibility without prior authorization from the FIT Program. A screening is recommended prior to the CME to establish the need for a full CME.

If a Child received a CME and was found eligible for early intervention:

- The child's eligible status for EI services is valid for one year from the date of the evaluation determination
- If the child subsequently exits early intervention services for one of a variety of reasons and is re referred within the one year of the eligibility determination, the team will conduct an Evaluation and Assessment (E&A) using an ongoing assessment tool (AEPS or HELP) to update the child's development a complete a new IFSP within 30 days. No prior authorization is needed to conduct the E&A.
- If the child is re referred to early intervention services after the one-year period of eligibility, then a second CME can be conducted to determine eligibility for early intervention services and no prior authorization is needed from the FIT Program.

(Note): Billing for a second CME through DOH is processed through a 'paper claim' on agency letterhead that must be submitted with the monthly invoice. Billing for a second CME through Medicaid is done through the portal).

If the CME cannot be completed before the child moves to another community e.g. they are in temporary housing (shelter, foster home etc.) time spent conducting the evaluation can be billed as E&A under Early Intervention (see Early Intervention Services).

If a developmental screening is conducted in accordance with NMAC 30.30.8 10.E prior to the full CME, the screening is included in the reimbursement for the CME. If a developmental screening is conducted for a child referred and accordance with NMAC 30.30.8 10. E and it is determined that the child is not suspected of having a developmental delay and therefore does not receive a full CME, the agency may bill for the early intervention time taken to conduct the screening and bill according to the location where the screening occurred.

FAMILY SERVICE COORDINATION

Family service coordination services are activities carried out by a designated individual to assist and enable the families of children from birth to three, to access, and if determined eligible, receive early intervention services. The family service coordinator helps to develop the Individual Family Service Plan (IFSP); assists the family in receiving all services identified; coordinates those services; ensures that they are delivered in a timely manner and seeks additional services and or supports that may help the child or family. The Family Service Coordinator works with the family to determine their service needs and if the family chooses to be involved in service coordination responsibilities they should be supported in that role.

SCOPE OF SERVICE

Family service coordination includes but is not limited to the following:

- Coordinating intake, evaluations and assessments and the process of determining eligibility.
- Facilitating and participating in the development of the initial and annual Individual Family Service Plan (IFSP) as well as the 6-month review of the IFSP.
- Facilitating the completion of the initial and exit ratings for the Early Childhood Outcomes.
- Assisting families in identifying and accessing all available services and resources, not just those related to the child's condition (e.g. housing, mental health services etc.).
- Coordinating and monitoring the delivery of IFSP services (including subcontractors and providers from other agencies).
- Informing families of advocacy services and empowering the family to enhance their own Family Service Coordination skills.
- Coordinating with medical and health providers.
- Facilitating the development of a transition planning process for each child and family.
- Gathering and researching resource information for the family and making referrals where appropriate.

SERVICE REQUIREMENTS

These conditions and requirements apply to family service coordination:

- Family service coordination shall be provided upon referral of the child and family to the FIT Program. Family service coordination is therefore provided during the intake and evaluation process prior to determining the child's eligibility. (Note: For newborns the intake, evaluation and IFSP will be conducted after the child and family return home).
- If a child is referred to Part C fewer than 45 days prior to the child's third birthday an intake and evaluation will not be conducted. The Family Service Coordinator will let the family know of preschool options available in the community, e.g. preschool special education; Head Start; private preschools, etc. and will assist with a referral to those entities, with the permission of the parent(s).
- During the intake process the family service coordinator will have the family complete a "Freedom of Choice Form" to select a FIT Provider in counties where there is more than one provider agency. The Freedom of Choice Form will also be used when a family is transferring into a county where there is more than one FIT Provider agency.
- The Family Service Coordinator, the family and the evaluation team collaborate to determine eligibility for the FIT Program. The early intervention provider agency maintains documentation of eligibility status on file. If it is determined that the child does not meet any of the eligibility criteria, family service coordination will be discontinued. The Family Service Coordinator will provide information to the family about other early learning services in the community (Home Visiting, Early Head Start, child

care etc.) and inform the family that they can return for a developmental screening if they are concerned about their child's development in the future.

- A family will have only one Family Service Coordinator designated on the IFSP, regardless of whether the child may be eligible for more than one program. Families must be informed when there is a change in their Family Service Coordinator and if the Family Service Coordinator is on extended leave, another Family Service Coordinator must be assigned.
- The Family Service Coordinator will complete the Public and Private Insurance form with each family at intake and at least annually to determine if the child is or may be eligible for Medicaid or if they are covered under a private insurance plan.
- The Family Service Coordinator shall obtain consent from the parent(s) to bill their private and public insurance (including Medicaid) via signature on the Public and Private Insurance form.
- A family may direct the level of support and assistance that they need from their Family Service Coordinator and may choose to perform some of the Family Service Coordinator functions themselves. A family may not be paid to provide Family Service Coordination for their child and family.
- The Family Service Coordinator shall contact the family once a month, at a minimum, in order to meet the requirement for "coordinating and monitoring the delivery of services". If a face-to-face visit with the family does not occur that month due to a family reason, then that will be documented in the case notes in the child's record.
- The Family Service Coordinator will discuss with each family their need for family supports, including: parent-to-parent support; parent training; respite; and other resources and referrals.
- The Family Service Coordinator will coordinate the collection of information and data for the Early Childhood Outcome score in accordance with the ECO Manual. The ECO score is to be determined by the IFSP team within 60 days of the initial IFSP and at exit.
- The Family Service Coordinator will coordinate with the Medically Fragile Case Management Program if the child is also eligible for medically fragile services to align and avoid duplication of services. This may include joint meetings and sharing of records with the consent of the parent(s).
- If a child is transferring from another state or another FIT provider agency where the child/family received early intervention services, family service coordination will be provided to the family immediately, and the family's IFSP from their previous agency as a legal document will function as the plan for services until a new IFSP is developed.
- If the child is being transferred from another FIT Provider agency, the "FIT Program Child/Family Transfer" form must be completed by the transferring agency according to the specified requirements on the form. The form and documents must be sent to the receiving agency within four (4) working days of the receiving agency being notified of the transfer by phone. An exit ECO is not required for transfers. The receiving provider agency will use the child's initial ECO scores and hold an IFSP meeting to review and update as necessary within 30 days of the transfer.
- The family service coordinator will manage the transition process which begins with completion of Part I of the Transition Plan at the initial IFSP. Part II of the Transition Plan shall be updated by the child's 2nd birthday (24 months of age) and finalized at the Transition Conference. The family service coordinator will plan and schedule the Transition Conference to be held at least 3 months, but no more than 9 months prior to the child's third birthday. This includes sending the referral, assessment summary form and invitation to all parties who will be attending the meeting. The family service coordinator facilitates the transition conference and follows-up on implementation of the action steps to ensure a smooth and effective transition for the child and family. All children who will be exiting early intervention at age 3 shall have a Transition Conference. If a child is potentially eligible for Part B services, then the LEA must be present at the Transition Conference with parental consent. If a child is not eligible for Part B services and is exiting at age 3, then a Transition Conference shall be held and include the parent and FSC and other team members or community providers as requested by the parent. The family service coordinator with parent/caregiver permission~~,~~ will invite other people

providing services and supports to the child and family, including: child care staff; Early Head Start; other early learning providers; Home Visiting providers; WIC; medical providers; Medically Fragile Providers; respite providers; Infant Mental Health; Autism providers; etc. to the meeting.

- In order to exit a child and their family from services when there has been a series of unexcused no-shows, (i.e. the parent(s) did not notify the agency), the Family Service Coordinator (FSC) must follow up via a home visit or phone call with the child's parent(s) to discuss the reason for the no shows and explain the importance of regular early intervention, while at the same time remaining sensitive to any special family circumstances influencing participation patterns. If the FSC is not able to contact the parent(s), the agency shall send a Prior Written Notice informing them that early intervention services will end if they do not contact the agency by a given date. Prior Written Notice shall also be sent if the parent(s) informs the FSC that they no longer want to receive early intervention services. The FSC shall record the steps taken in the child's record. The parent(s) may request to be re-referred at any time.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- Establish and maintain financial reporting and accounting for each child served.
- Establish and maintain a confidential record for each child served, which include the following: signed consent and release forms; current evaluation and assessment results; documentation of eligibility determination; Medical and other appropriate records; IFSP documents; progress notes and contact notes.
- Contact notes/ case notes must include date, time in/time out, a brief description of the service provided and the first initial and last name of the Family Service Coordinator. Documentation must include all time spent with the family and work done on behalf of the family
- A Policy and Procedure Manual must be updated regularly to reflect current policies consistent with FIT Program requirements related to at least, the following activities:
    - Initial IFSP development
    - Annual IFSP development
    - IFSP review and revisions
    - Ongoing Assessment
    - ECO Early Childhood Outcomes
    - Transdisciplinary Team Approach
    - Consultation
    - Transition Plans and conferences
    - Exit procedures
- A quality assurance plan will be developed that includes, but is not limited to developing an ongoing monitoring process, which regularly reviews compliance, and provides for the evaluation of quality, effectiveness of the services provided and the family's satisfaction with the following required activities:
- Utilize the state FIT Program IFSP Forms for all eligible children and families.
- Ensure that all data is entered into the FIT Program database FIT-KIDS (Key Information Data System) within 30 days following the respective activity. This includes demographic data, IFSP data (including initial IFSP delay reasons), transition plan and conference dates (including conference delay reasons), Early Childhood Outcomes (ECO), delivered services data, and exit data.
    - Ensure compliance with the regulations for the Family Infant Toddler Early Intervention Program NMAC 7.30.8
    - Family Service Coordination must be provided from the time of referral to all eligible children and families in the geographical area served under the DDSD Provider Agreement.

- Submit a Quarterly Performance Report based on the federal annual performance indicators (APR) within the required timeframe and in the format provided by the Family Infant Toddler Program and an Annual Performance Report (APR) within the required time frame.
- Conduct “Correction of Noncompliance” activities, as necessary, in accordance with requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency) and must be twofold. (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant, and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (although late), unless the child is no longer within the jurisdiction of the early intervention program
- The provider shall not charge any fee to families for Family Service Coordination.
- Ensure that caseloads enable each Family Service Coordinator to perform all of the roles and responsibilities of Family Service Coordination adequately to all families on their caseload.

B. Staffing Requirements

Family Service Coordinators must possess one of the following qualifications:

- A bachelor’s degree in social work; counseling; psychology, nursing; special education; early childhood education or closely related field.
- Individuals with a bachelor’s degree in another field can substitute two (2) years of direct experience in serving individuals with disabilities and/or families.
- If there are no suitable candidates with the previously described qualifications, individuals with an Associates degree or a registered nurse (who does not have a baccalaureate degree in nursing) and who have a minimum of three (3) years of experience in community health or social service settings can be employed as a service coordinator.
- An exemption to the above requirements can be approved by the FIT Program in order to hire service coordinators who meet the cultural or linguistic needs of the population served or if the applicant is a parent of a child with special needs (NOTE a parent can not be paid to provide Family Service Coordination to their own family). The agency should submit a letter to the FIT Program requesting an exemption.
- Family Service coordinators must attend the required Family Service Coordination trainings (online and classroom) within 6 months of hire.
- Family Service Coordinators must take the non-credit on-line Family Service Coordination Training Part I and Part II every 3 years to update themselves on revised requirements.
- Provider will ensure that the Family Service Coordinators receive in-house training and mentoring, including observation of intake, IFSP, transition meetings, etc.) before working independently with families.
- Family Service Coordinators will receive reflective supervision at least once every month.

REIMBURSEMENT

Request for reimbursement for Family Service Coordination shall be submitted monthly through the FIT-KIDS (Key Information Data System) in accordance with directions from the Department of Health. Staff entering data related to billing shall complete the online FIT-KIDS training.

Request for reimbursement for Family Service Coordination under State General Funds shall be submitted in accordance with directions provided by the DDSD - Administrative Services Bureau (ASB) at the Department of Health.

Reporting Category	700021
Unit Rate: $160.00	1 (one) unit per month maximum
Medicaid	T2023 TL
Unit Rate: $160.00	1 (one) unit per month maximum

- Reimbursement for Family Service Coordination is a monthly rate.
- Reimbursement for Family Service Coordination is provided for both face-to-face contacts with the family and work done on behalf of the family (coordinating services, advocating, submitting applications etc.).
- A minimum of one (1) accumulated hour of Family Service Coordination must occur to be reimbursed for that month. Documentation must include all time spent with the family and work done on behalf of the family. Travel time may not be included.
- The Family Service Coordinator should keep clear records of their time spent with and on behalf of families for audit purposes.
- Family Service Coordination may be billed for the month(s) prior to the Initial IFSP being in place as part of the intake process.
- Family Service Coordination may be reimbursed for up to one (1) month after the child has successfully transitioned to preschool or another appropriate setting. This option is available to ensure that the transition process is smooth and effective and must be agreed upon by the family and documented in the IFSP transition plan. In order to be reimbursed a minimum of one hour per month must be provided.
- If the Family Service Coordinator has a dual role, (i.e. they provide another service to the child and family such as special instruction, speech therapy etc.) the time spent providing the other service should not be counted towards Family Service Coordination. All activities under each role should be documented separately and distinctly.
- If the child is transferred during the month and the transfer occurs after the 15th of the month, the "original" Family Service Coordinator is authorized to bill for that month. If the transfer occurs before the 15th of the month, then the new Family Service Coordinator bills for the entire month. Providers shall not postpone the transfer of a child until after the 15th of the month in order to bill.

EARLY INTERVENTION

Early Intervention services are designed to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities. Specific services, supports, and strategies such as coaching and TTA (transdisciplinary teaming approach) are designed to promote development in one or more of the following areas:

- Cognitive
- Physical/motor
- Communication
- Social or emotional
- Adaptive behavior

Early Intervention services support the parents in achieving child and family outcomes and are incorporated in the everyday routines, activities and places of the child and family.

SCOPE OF SERVICE

Early intervention services include the ongoing delivery of support provided to families in order to enhance their ability to meet their child's development. Early intervention services are provided within everyday routines, activities and places of the child and family. Early intervention services are selected in order to meet the child and family outcomes that are decided on by the IFSP team. Early intervention services may include:

- Assistive Technology devices, adaptive equipment, and services
- Audiological services
- Developmental Instruction
- Family Therapy, Counseling and Training
- Health Services (to enable the child to benefit from other early intervention services)
- Medical services (for diagnostic or evaluation purposes)
- Nursing services
- Nutrition services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Sign Language and Cued Language Services
- Social Work Services
- Speech/Language Pathology Services
- Transportation (to enable the child / family to receive early intervention services)
- Vision Services

SERVICE REQUIREMENTS

The following conditions and requirements apply to Early Intervention Services:

- Children who are eligible for this service who are between the ages of birth to three years old, and who meet eligibility requirements in accordance with NMAC 7.30.8 Requirements for Family Infant Toddler Early Intervention Services.

- Supports and services will be incorporated into the family's everyday routines, activities and places. Services will also be provided in the early childhood setting (Early Head Start, child care etc.), if that is where the child spends their day, utilizing inclusive practices, supporting the center staff and not pulling the child out of the classroom.
- The provider must provide flexible time/day options for services as needed to parents who work or who are in school.
- Services must be provided in natural environments, defined as places that are natural or normal for children of the same age who have no apparent developmental delay. Justification on the Individualized Family Service Plan (IFSP) is required if the team determines that outcomes cannot be met in a natural environment.
- If the provider operates early intervention services with a group of children in a center (where the parents are not present) the center must be licensed by CYFD in accordance with 8.16.2 NMAC or accredited by a national organization if not under the jurisdiction of CYFD.
- All services must be delivered in accordance with the frequency and intensity indicated on the IFSP.
    - IFSP frequency and intensity must be written at smallest denominator reasonable, e.g. 60 minutes per week, rather than 240 minutes per month.
    - Service provision in any given week / month may at times exceed the amount on the IFSP. Examples include (e.g. if an IFSP meeting is held that month OR early intervention services are provided twice in a week to make up for services missed OR if the early intervention session goes beyond the amount planned for on the IFSP). If a permanent change is needed to the IFSP, then a meeting will be held to update the services page
- Changes to the frequency, intensity, location or method of services on the IFSP shall be made by utilizing the amendment section on the Supports and Services page then adding the revised service on a new line. The same process would be used to end a service before the next IFSP. The family shall sign a Prior Written Notice form giving their consent to the change.

- **Prior Authorization (July 1, 2018-September 30, 2018):** is required when ongoing early intervention services (excluding Family Service Coordination, consultation between personnel, respite, and other services not funded through the FIT Program) listed on the IFSP exceed 16 hours per month.
    - A Prior Approval Request form must be submitted within one week after the IFSP meeting.
    - The FIT Program will respond with a decision within ten (10) working days after the receipt of request.
    - Services should be provided at the level indicated on the IFSP while prior authorization is being sought.
    - In the case of a denial of the request, the IFSP team will need to revise the supports and services page to ensure that hours are kept under the maximum 16 hours per month.
    - Circumstances which may justify the need for services over 16 hours per month include: children with significant developmental or medical needs; a diagnosis such as autism spectrum disorder where intensity of intervention is recommended practice; complex family circumstances that may require time-limited intensive intervention. A center-based service model may not be used to justify services over 16 hours

- **Prior Authorization (October 01, 2018 – June 30, 2019)**
    - Prior authorization is required when ongoing early intervention services proposed by the IFSP team will exceed 16 hours per month. Ongoing services do not include: Family Service Coordination; consultation between personnel; respite; and other services not funded through the FIT Program. The team may provide up to 16 hours without prior approval from the FIT Program.
    - If the IFSP team recommends that more than 16 hours is needed to meet the outcomes on the IFSP, the family shall be informed of the need for approval for the additional hours. The team will complete an "IFSP Supports & Services Prior Authorization Form". The team may utilize a Transdisciplinary Team Approach meeting to complete the form.

- The “IFSP Supports & Services Prior Authorization Form shall be reviewed and signed by a designated agency representative (administrator, manager, supervisor etc.) before being submitted to the FIT Program Regional Coordinator.
- The FIT Program will respond with a decision within ten (10) working days after the receipt of the “‘IFSP Supports &Services Prior Authorization Form” for over 16 hours.
- Once the approval from the FIT Program is received, the FSC will meet with the family to update the services page on the IFSP.

- Circumstances which may justify the need for services over 16 hours per month include a diagnosis of autism spectrum disorder for which the intensity of intervention is a recommended practice; complex family circumstances that may require time-limited intensive intervention: NMSD, NMSBVI or PEI preschool intensive intervention setting.
- Families of children eligible under Biological / Medical Risk or Environmental Risk are limited to receive up to 24 hours of ongoing early intervention services per year. The year is from one IFSP to the next annual IFSP. The following **are not included in the 24 hours**:
- Participation at IFSP meetings; participation at transition conferences, Family Service Coordination; or Evaluation & Assessments and consultation between personnel.
- The provider is responsible for providing, purchasing or arranging through other community resources any services (listed above), listed on the IFSP.
- Each Early Intervention service, except for consultation and evaluation & assessment methods/service types, must be delivered within 30 days of the parent(s) consent to the start date for the service on the IFSP.
- If the family is also enrolled in a Federal, state or privately (including foundation) funded home visiting program, the IFSP process shall be used to determine the mix of services the child and family will receive, to meet the outcomes on the IFSP. This will enable services and strategies for the child and family to be aligned, avoid duplication, prevent parents from being overwhelmed and eliminate confusion.
- The team shall determine federally required Early Childhood Outcomes (ECO) scores in accordance with the FIT Program ECO Manual. The “Initial ECO” must be completed within 60 days of the initial IFSP. The “Exit ECO” must be completed before the child exits the program. If the child exits unexpectedly before their 3rd birthday and an Exit ECO was not completed before they exited, the team shall convene to complete an Exit ECO within 30 days of the exit date.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- Establish and maintain financial reporting and accounting for each child
- Establish and maintain a confidential record for each child served that includes the following: signed consent and release forms; documentation of Written Prior Notice as required by FIT Procedural Safeguards (7.30.8.14.D NMAC); current evaluation and assessment reports; IFSP documents; progress notes and contact logs.
- The provider shall keep ‘contact logs’/ ‘encounter sheets’ that must include: date; time in/ time out; a brief description of service provided; the first initial and last name of the person providing the service; and their discipline / qualification. A separate ‘contact log’/ ‘encounter sheet’ must be completed for each discipline providing a service, including co-visits. For group services time in/ time out shall be recorded for all attendees including staff.

- The provider will develop a quality assurance plan that includes but is not limited to developing an ongoing monitoring process that evaluates the quality, and effectiveness of services provided and the families' satisfaction with services.
    - Submit a Quarterly Performance Report based on the federal annual performance indicators (APR) within the required timeframe and in the format provided by the Family Infant Toddler Program and an Annual Performance Report (APR) within the required time frame.
    - Conduct "Correction of Noncompliance" activities, as necessary, in accordance with requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency) and must be twofold. (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant, and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (although late), unless the child is no longer within the jurisdiction of the early intervention program.
    - Ensure that all data is entered into the FIT Program database FIT-KIDS (Key Information Data System) within 30 days following the respective activity. This includes demographic data, IFSP data (including initial IFSP delay reasons), transition plan and conference dates (including conference delay reasons), Early Childhood Outcomes (ECO), delivered services data, and exit data.
    - Early intervention services must be provided in accordance with the IFSP to all eligible children and families in the geographical area served under the DDSD provider agreement.
    - The provider shall not charge any fee to families for early intervention services

B. Staffing Requirements

- All Developmental Specialists (including supervisors) are required to be certified and work within the scope of work allowed under the designated level of certification in accordance with Family Infant Toddler Developmental Specialist Certification manual. All newly hired personnel must apply for Developmental Specialist Certification within one month of the date of hire and the agency shall ensure that all Developmental Specialists are certified by the FIT Program before they can bill and renew their certification at the required time.
- Developmental Specialists, including sub-contractors, must receive reflective supervision at least once a month. Sub-contractors must find their own supervision, if the agency does not provide this for them. Supervision of therapists and other early intervention personnel is provided according to their licensing board's requirements.
- The provider may not subcontract for Developmental Specialists certified as a DS I Basic or DS I – Advanced.
- All Developmental Specialists must have a current written Individual Personnel Development Plan (IPDP), which includes the Self Assessment Tool, as required for re-certification in accordance with policy "Certification and Re-certification Requirements for Developmental Specialists". Subcontractors must also maintain current Individualized Personnel Development Plans (IPDP). All IPDPs must be updated at least annually.
- Early Intervention personnel must meet one of the following qualifications:
    1. Audiologist – licensure from the NM Audiology Board
    2. Developmental Specialist – Certification in accordance with FIT Program regulations (7.30.8 NMAC) and DDSD Policy
    3. Education of the Deaf and Hard and Hearing - Certification

4. Education of the Blind and Visually Impaired – Certification from NMSBVI and / or Teaching license
5. Family therapist – licensure from the Counseling and Therapy Practice Board as a Family Therapist, Professional Clinical Mental Health Counselor, Professional Mental Health Counselor, or Registered Mental Health Counselor
6. Nurse – licensure from the NM Board of Nursing as a registered nurse or licensed practical nurse
7. Nutritionist – licensure from the NM Nutrition and Dietetics Practice Board
8. Occupational Therapist (or Certified OT Assistant COTA) – licensure from the NM Board of Occupational Therapy Practice. AOTA practice and supervision standards as well as the NM Regulation and Licensing Department guidelines for practice, supervision and training must be followed.
9. Orientation and Mobility Specialist – Certification from ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals).
10. Physical Therapist (or PT Assistant PTA) – licensure from the NM Physical Therapy Licensing Board. APTA practice and supervision standards as well as the NM Regulation and Licensing Department guidelines for supervision, practice and training must be followed.
11. Psychologist (or Psychologist Associate) – licensure from the NM Board of Psychologist Examiners
12. Social worker – licensure from the NM Board of Social Work Examiners
13. Speech/Language Pathologist or ASL (Apprentice in Speech Language)– licensure from the NM Board Speech, Language Pathology, Audiology and Hearing Aid Dispensers Board, the American Speech Language Hearing Association (ASHA) Speech Language Pathology Assistant Scope of Practice (doi: 10.1044/policy. SP2013-00337) and NM Regulation and licensing Department guidelines for supervision, practice and training must be followed.

REIMBURSEMENT

Request for reimbursement for early intervention shall be submitted monthly through the FIT-KIDS (Key Information Data System) in accordance with directions from the Department of Health. Staff entering data related to billing shall complete the online FIT-KIDS training.

Reimbursement is for the direct intervention time (face-to-face) with the child and family (with the exception of consultation). Reimbursement for this service is based on where the early intervention activity occurred and whether the method of providing the service was to an individual child and family or to a group.

Method / **Location**	**INDIVIDUAL**	**GROUP**	**CONSULATATION**
DD Program (agency operated center < 50% typically developing children)	Center-Based (Individual) $ 13.50 / 15 mins $54.00 / hr	Center-Based (Group) $ 6.50 / 15 mins $26.00 / hr	Center-Based (Individual) $ 13.50 / 15 mins $54.00 / hr
Inclusive Provider Location (agency operated center > 50% typically developing children)	Center-Based (Individual) $ 13.50 / 15 mins $54.00 / hr	Center-Based (Group) $ 6.50 / 15 mins $26.00 / hr	Center-Based (Individual) $ 13.50 / 15 mins $54.00 / hr
Home (Family's Home)	Home & Community-Based (Individual) $ 27.00 / 15 mins $108.00 / hr	Home & Community-Based (Group) $ 13.00 / 15 mins $52.00 / hr	Home & Community-Based (Individual) $ 27.00 / 15 mins $108.00 / hr
Community Based Setting (e.g. child care Early Head Start, park, pool etc.)	Home & Community-Based (Individual) $ 27.00 / 15 mins $108.00 / hr	Home & Community-Based (Group) $ 13.00 / 15 mins $52.00 / hr	Home & Community-Based (Individual) $ 27.00 / 15 mins $108.00 / hr
Other Setting (e.g. doctor's offices, hospital, a specialty clinic (seating clinic, orthotics clinic, feeding clinic etc.) to support parents etc.)	Home & Community-Based (Individual) $ 27.00 / 15 mins $108.00 / hr	Home & Community-Based (Group) $ 13.00 / 15 mins $52.00 / hr	Center-Based (Individual) $ 13.50 / 15 mins $54.00 / hr

Home & Community (Individual):

"Home & Community Individual" is defined as a location away from the provider site (including but not limited to: the family's or a relative's home; child care setting; park or play area; or other community setting etc.), which involves travel for the early intervention personnel and is a location in which children without disabilities typically spend time. *Home & Community (Individual)* is a service that is provided to an "individual" child and their family.

Reporting Category	700022
Unit Rate: $ 27.00	Unit: Quarter Hour / 15 minutes
Medicaid	T1027 TL
Unit Rate: $ 27.00	Unit: Quarter Hour / 15 minutes

Home & Community (Group)

"Home & Community (Group)" is defined as an **inclusive** service location away from the provider agency site (including, but not limited to a play area, swimming pool, park, Chapter House, community center, child care or a family's home), which involves travel for the early intervention personnel. *Home & Community (Group)* is provided to two or more eligible children/ families at the same time. Services delivered in a *Home & Community (Group)* must be documented as a strategy to meet the individualized child/ family's outcomes in their IFSP. The purpose of community-based groups is to 1) assist children and families in learning from and with other children and families in the community, and / or 2) facilitate integration/ participation of children and families into inclusive community settings. The ratio of staff to eligible children in *Home & Community (Group)* will be no greater than 1:4 (one staff to four eligible children).

Reporting Category	700022
Unit Rate: $13.00	Unit: Quarter Hour / 15 minutes
Medicaid	T1027 TL TJ
Unit Rate: $13.00	Unit: Quarter Hour/ 15 minutes

Center-Based (Individual):

"Center-Based (Individual)" is defined as a service location that is operated by the provider, where the early intervention personnel providing services do not have to travel and where the child / family receive services individually. Note: If the FIT provider agency operates a licensed child care program, *center based (individual)* may be used to provide early intervention to an eligible child served in that setting, if the intervention is directed to one eligible child in that classroom and not a group of eligible children.

Reporting Category	700022
Unit Rate: $ 13.50	Unit: Quarter Hour / 15 minutes
Medicaid	T1027 TL TT
Unit Rate: $13.50	Unit: Quarter Hour / 15 minutes

Center-Based (Group):

"Center-Based (group)" is defined as a service location that is operated by the provider, where the early intervention personnel providing services do not have to travel and where two or more eligible children / families receive services at the same time.

Reporting Category	700022
Unit Rate: $ 6.50	Unit: Quarter Hour
Medicaid	T1027 TL HQ
Unit Rate: $6.50	Unit: Quarter Hour

- The following activities built into in the unit rate and may not be billed separately:
  - Travel to and from the home or community location (except transporting the child to receive early intervention services)
  - Attendance at training and other personnel development activities
  - Impromptu meetings with other personnel or administrative staff meetings
  - Preparation of billing statements, progress notes, or reports, data entry
  - Supervision time
  - Preparation time for early intervention activity

The following are additional parameters regarding billing for Early Intervention Services:

- ***Transdisciplinary Team Consultation***:

  Consultation between IFSP team members for the purposes of integrating and planning effective early intervention strategies.
  - Up to 12 hours a year of Transdisciplinary Team Consultation can be billed per discipline. The team decides the schedule regarding how often to meet and for how long (e.g. every other week for ½ hour; every month for an hour) and enters this in the Transdisciplinary Team Consultation section of the IFSP. Transdisciplinary Team Consultation may also be used for the team to review the assessment information, develop the Early Childhood Outcomes score, prepare for the IFSP, etc.
  - Each of the IFSP team members participating in the transdisciplinary team consultation can bill for their time and can include team members participating via teleconference or web / video-conference. Note: billing can occur for the IFSP members who attend, even if one or two team members are absent.
  - Transdisciplinary team consultation participants are those that provide an early intervention service on the IFSP
    Reimbursement: for transdisciplinary team consultation: is reimbursed at the 'Center-based Individual' rate.
    FIT-KIDS coding: Service Type 'Ongoing'; Method 'TTA Consultation'; Location 'Inclusive Provider Location' or 'DD Program' or 'Other'
    Documentation: A joint 'contact log' / 'encounter sheet' may be completed for each transdisciplinary team consultation with each personnel participating signing and in indicating their time in and out or individual log notes may be completed.

- ***Collaborative Consultation:***
  Collaborative Consultation by IFSP team members for the purposes of integrating and planning effective early intervention strategies, including but not limited to:
  - With Early Head Start, child care or home visiting personnel (e.g. to share strategies for promoting the child's development).

- With the child's doctor or other medical specialist (e.g. to align early intervention strategies with the medical management of the child
- At ECEP evaluations (Note: only the time spent sharing information about the child and family up to 1 hour per discipline).
- With Child Protective Services (e.g. to share information regarding the child's development and to align strategies to support the foster parents, birth parents or both) and with Community Infant Teams, where applicable and includes testifying in court on behalf of the child and family when requested.
- IFSP meetings (e.g. to plan and align early intervention outcomes, strategies and services to support the family to promote their child's development).
- Transition Conference / IEP meeting (e.g. to share information and align strategies to facilitate a smooth transition to preschool services).
- Follow-up with preschool personnel after the child has transitioned (e.g. to provide information regarding effective strategies to preschool personnel during follow-up services). Note: Reimbursable for up to four (4) hours within 30 days of the child's transition or them starting at the new setting.
- When there is a team that consists of an FSC and only one early intervention personnel, the EI provider may bill for team meeting time to discuss family concerns and needs that require FSC attention and follow up (e.g. concerns regarding safety, food, housing etc. and/or worrisome concerns regarding the child)
- Collaborative consultation is reimbursed for in-person consultation (face-to-face) not over the telephone.
- Collaborative Consultation does not need to be entered on the IFSP.

Reimbursement: for Collaborative consultation is at the Home & Community-based Individual rate.
FIT-KIDS coding: Service Type 'Ongoing' ('follow-up' if for follow-up services); Method 'Collaborative Consultation'; Location 'Community' or 'Home'
Documentation: Each personnel providing collaborative consultation must complete a 'contact log' / 'encounter sheet'

- ***Co-visits:***
  - Are used when more than one early intervention personnel provide intervention supports and services to the child/ family. Co-visits support transdisciplinary and interdisciplinary practice and enhance the integration of services by supporting a transdisciplinary teaming approach.
  - Are reimbursed based on the location where the activity occurred.
  - Must be documented in the IFSP as one of the strategies to be used to meet the child/ family outcome(s) but does not need to be listed on the IFSP Supports and Services page.
  - Cannot be used to provide supervision to staff or to travel together to reduce travel costs.

    Reimbursement for a co-visit: is at the Home & Community-based Individual rate.
    FIT-KIDS coding: Service Type 'Ongoing'; Method 'Individual'; Location 'Community' or 'Home'
    Documentation: Each personnel providing co-visit must complete a 'contact log' / 'encounter sheet'

- ***Ongoing-Assessment:***
  - **Definition**: Using observation, parent input, and assessment tools to identify the unique strengths, needs, and developmental functioning and progress of a child, and to inform intervention practices. On-going assessment information should be used at a minimum to inform the following:
    - IFSP goals and strategies
    - Exit ECO ratings
    - Annual re-determination of eligibility
    - Changes in services and supports.
  - **Process:** Ongoing assessment is a process that occurs at every visit. It includes the use of observation, thinking together with a family around the child's skills and behaviors in every

day routines and activities, and the use of a FIT approved assessment tools that provide a framework for intervention.

- **Documentation**: The protocols that record the results of the ongoing assessment tools shall be updated in the child's file at least two times per year: once before the 6-month review and at the time of the annual re-determination of eligibility. Ongoing assessment protocols may be updated more often based on the guidelines of the tool and/or child and family need.
  - **Approved Tools:**
    - Assessment, Evaluation, and Programming System for Infants and Children (AEPS)
    - Hawaii Early Learning Profile (HELP)
    - Oregon Project Skills Inventory
    - Other tools as approved by the FIT Program
  - **Billing:**
    - Assessment may be billed when the child transfers to another community agency before the CME is completed (e.g. for children temporary housing such as shelter, foster home etc.).
    - Assessment may be billed for the time spent conducting a screening during intake if the team decides that there is an indication that the child may not be eligible based on the referral
    - E &A does not need to be listed on the IFSP Services and Supports page if the service is already listed as an ongoing service
    - The service needs to be listed on the IFSP Services and Supports page if the service will be provided as a one-time 'E&A'. Time spent writing the Evaluation and Assessment report or addendum to a report is not billable.
    - Ongoing assessment is reimbursed based on the location of the assessment activity conducted.

  Reimbursement: is at the 'Home & Community-based - individual' or 'Center-based – individual'

  FIT-KIDS coding: Service Type 'Ongoing' or 'Pre-IFSP'; Method 'Individual'; Location 'Community', 'Home' or 'Inclusive Provider Location'

- ***Telehealth (video-conferencing):*** may be provided in accordance with Medicaid policy 8.310.13, which includes:
  - A telehealth communication system must include both interactive audio and video and be delivered on a real-time basis at the originating (where the child and family are) and at any distant-sites (where the early intervention personnel are) using HIPPA compliant means of communication.
  - Use of the telehealth communications system fulfills the requirement for a face-to-face encounter.
  - Telehealth must be documented on the IFSP as one of the strategies to be used to meet the child/ family outcome(s) but does not need to be listed on the Supports and Services page.
  - The local provider agency will discuss telehealth options with families including pros and cons and methods to be used.
  - Parents may decline telehealth services at any time and this shall be documented in the child's file and service changes will be/shall be documented using a prior written notice
  - Prior to adding telehealth services as a strategy for providing early intervention services the local early intervention provider agency representatives will first establish rapport with the family.
  - A Direct Service provider (see page 24) will be in the home and will facilitate the telehealth meeting for the family and the provider at the distant location.
  - Telehealth services will be evaluated after 6 sessions to obtain parental feedback and documentation of this shall be kept in the child's file (FSC, DS notes)

    Reimbursement is at the 'Home & Community-based - individual' for the personnel at the originating site (home) (with the child and family and 'Center-based – individual'-for the personnel at the (distant) location

FIT-KIDS coding: Service Type ‘Ongoing’; Method ‘Individual’; Location depending on whether the personnel is at the originating site with the child and family which would be ‘Home’ or if personnel were at the distant location which would be the ‘Inclusive Provider Location’ The rendering provider agency at the distant site will bill for the early intervention service provided at the center-based rate.
Documentation: Each personnel providing telehealth services must complete a ‘contact log’ / ‘encounter sheet’

RESIDENTIAL SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

Adult Developmental Disabilities (DD) Residential Services are Supported Living and Independent Living services for individuals age 22 and older. *(Exception**:** This service is available with DDSD prior written approval to individuals age 21 and under who are living independently in the community, receiving no other residential supports, and have unmet support needs.)* Residential services are provided in accordance with each person's Individual Service Plan (ISP), as developed under 7 NMAC 26.5 ("ISP Development Process"). The use of natural and generic supports is encouraged in order to promote the individual's inclusion in the community as well as to reduce the need for paid provider services. Adult DD Residential Services are intended to provide the necessary assistance and support to meet the daily living and safety needs of individuals.

Supported Living: Supported Living Services are an intervention and support service that enables persons with developmental disabilities to live in a home setting with no more than four individuals and must be available up to 24-hours a day. Services and supports are provided in the individual's home, with the exception of activities that naturally occur in the community (banking, grocery shopping, etc.) For Supported Living Services, substantiated clinical necessity criteria includes documentation by the provider and the IDT that the individual needs paid staff care and support at least 340 hours each month.

Independent Living: Independent Living Services are an individual intervention and support service that enables persons with developmental disabilities to live independently in their own home or with family members in a more independent environment than Supported Living. Staff support is available as needed and is furnished on a planned periodic schedule of at least 20 hours of direct support per month. Services and supports should be provided in the individual's home, with the exception of activities that naturally occur in the community (banking, grocery shopping, etc.). This service is intended to assist individuals to develop, improve and maintain specific skills to live as independently as possible. Generally, this service is provided with a 1:1 staff to participant ratio; however, services may be provided to up to three individuals when individuals have similar learning goals. The Individual Service Plan for each individual must clearly document the rationale for providing services in a group setting.

SCOPE OF SERVICE

Adult DD Residential Services typically include, but are not limited to:

- Assistance with money management
- Meal planning and preparation
- Routine household maintenance and chores
- Training and education on self-advocacy and sexuality
- Individual health maintenance and monitoring
- Arrangement of medical and dental appointments
- Arrangement of transportation
- Personal Care or activities of daily living (such as bathing, eating, dressing, and individual hygiene)
- Supervision of nursing duties, as needed
- Nutritional counseling services, as needed
- Assistance to individuals who require a wheelchair for mobility and need physical assistance for bathing, dressing and transfers.
- Activities in support of therapy plans. This includes Behavioral Consultation that may be a part of an individual's services and any private or Medicaid funded therapies and individual may receive.
- Assistance with development of natural support networks.
- Development of social and individual relationships
- Community integration/ access/ utilization
- Service coordination activities such as writing the ISP or other service coordination functions
- Assistance with self-administration of medication and/or monitoring of medication and pharmacy needs

SERVICE REQUIREMENTS

Services shall be provided to adults, twenty-two (22) or older, who have been determined to meet developmental disabilities definition in accordance with the NMSA Chapter 16 Developmental Disability Community Services Act. The individual must have a developmental disability defined as:

A severe chronic disability other than mental illness that is: attributable to a mental or physical impairment, including the result from trauma to the brain, or combination of mental and physical impairments; the disability must have occurred before the person reaches the age of 22; it is expected to continue indefinitely; and, results in substantial functional limitations in three or more of the following areas:

(1) self-care,

(2) receptive and expressive language,

(3) learning,

(4) mobility,

(5) self-direction,

(6) capacity for independent living, and,

(7) economic self-sufficiency.

The severe chronic disability must reflect the person's need for a combination and sequence of special, interdisciplinary or generic care treatment or other special support and services that are of a life-long or extended duration and are individually planned and coordinated. Services to individuals with developmental disabilities under twenty-two may be provided with prior approval by DDSD.

Service requirements of the Adult DD Residential Services direct service provider include, but are not limited to:

- Adult DD Residential Services must be available for up to 365 days a year.

- The total hours of service each month must meet the minimum requirements for each individual, as specified on their Individual Service Plan (ISP) and the minimum requirements for each specific service to allow for reimbursements.
- A special provision is listed below for the order of selection for the State General Fund Service Slots. A greater priority for selection for an SGF slot will be granted for individuals who are in crisis, as defined by DDSD Policy and Procedure.

When there is a vacancy in residential or day services, providers must consult with the Regional Office to determine the order of selection to fill the vacancy. Generally, order of selection will be based on first come, first serve, based on registration date on the Central Registry. Individuals who are registered on the Central Registry who are determined to be in "crisis" by DDSD Policy and Procedure will be given first priority for State General Funded services. These individuals will be granted the first open slot regardless of the "first come, first serve" basis that has historically governed the selection process.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- An ISP is necessary for each individual in Adult Residential Services. The provider agency must develop the ISP annually in accordance with the individual's ISP term and update periodically as outlined in the 7 NMAC 26.5 regulations. If an individual receives both Adult Residential and Adult Day services, the residential agency will develop the ISP.
- Written quarterly reports summarizing individualized participant progress in meeting outcomes from the ISP's are required. Quarterly reports are to be written according to the individual's ISP term. The reports shall be sent to the local Regional Office of the DDSD by October 15th, January 15th, Aril 15th and July 15th.
- Monthly residential direct support hours can consist of the standard services listed under 'scope of services' as well as a maximum of two hours per month of accrued, non-face-to-face hours. The two non-face-to-face hours of direct support per month can be billed as long as the services are not defined as non-billable in these Standards (see Reimbursement Section below). Non-face-to-face direct support hours may include, but are not limited to, additional staff planning sessions for an individual to meet his or her Individual Service Plan outcomes, pre-vocational tasks, tasks to incentivize vocational or community integration or other innovative tasks or activities.

Supported Living: 340 hours of direct support per month.

Independent Living: 20 hours of direct support per month.

- Complete and submit monthly Form B: "Adult SGF Day Service or Residential Service Reports."

B. Participant Funds

- A person receiving services will be presumed able to manage his or her own funds unless the ISP documents and justifies his or her limitations regarding self-management and, where appropriate, reflects a plan to increase this skill.
- When an agency is the representative payee or when the service plan for the individual includes assistance with budgeting, money management, banking etc., the provider agency must have policies and procedures in place to ensure appropriate and equitable use of the individual's SSI payments or other personal funds. This must include a detailed accounting of all spending by the agency.

C. Staffing Requirements

- Provide adequate staffing to assure reasonable health, safety, and promote positive development.
- Responsible for the identification and provision of the appropriate staffing pattern.
- A parent, spouse, primary caregiver or surrogate parent may not provide Adult Residential services if they reside in the same dwelling as the individual served.
- Agencies must have an RN on staff or contract to perform and/or supervise nursing duties to address the needs identified on the ISP, if required.
- Agencies must have agreements or contracts in place for nutritional counseling services, in order to address the needs identified on the ISP, if required.
- Agency staff shall complete required trainings within established timelines, as stipulated in the Policy Governing the Training Requirements for Direct-Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities in Community-Based Programs Funded Through the Developmental Disabilities Medicaid Waiver Program or State General Funds (2/23/07).
- Agencies shall report to the DDSD Statewide Training Database as stipulated in the Reporting and Documentation of DDSD Training Requirements Policy (2/23/07) when staff members are hired, complete trainings, change positions, and/or leave the agency.

REIMBURSEMENT

Request for reimbursement for Adult DD Residential Services under State General Funds shall be submitted monthly in accordance with directions provided by the DDSD - Administrative Services Bureau (ASB) at the Department of Health, using the following Component and Service Unit:

Reporting Category 700017

Unit Rate = ***$1,530.00***, 12 Units per Year Maximum

Independent Living: 20 hours of direct service per month will allow a provider to bill the entire monthly rate. If the number of hours of residential direct supports that are needed are between 0 and below 5 hours, the provider should transition/ move the participant into day services (i.e. the participant no longer needs residential services). No billing can be made for participants being served for less than 5 hours per month. If the provider provides between five and less than 10 hours per month, the provider can only bill for 25% of the total monthly rate. If the provider provides between 10 and less than 15 hours per month, the provider can only bill for 50% of the total monthly rate. If the provider provides between 15 and less than 20 hours per month, the provider can only bill for 75% of the total monthly rate. Providing 20 hours or more of service per month entitles the provider to bill the entire monthly rate. Generally, this service is provided with a 1:1 staff to participant ratio; however, services may be provided to up to three individuals when individuals have similar learning goals. The Individual Service Plan for each individual must clearly document the rationale for providing services in a group setting.

Supported Living: 340 hours of direct service per month will allow a provider to bill the entire month. Partial billing units are not allowed for Supported Living Services.

Reimbursement for Adult DD Residential Services is calculated on a monthly rate based upon Legislative appropriation.

Costs for room and board are the responsibility of the individual receiving the services. These costs may be paid through SSI or other personal funds.

Non-billable hours include:

- Travel to and from the individual's home, except when the individual is being transported.
- Attendance at training and other personnel development activities that are not face-to-face with the individual.

- Preparation of billing statements, progress notes, or quarterly reports.

Adult DD Residential Services **CANNOT** be co-funded with Respite Services. Adult DD Residential Services cannot be billed at the same time as any other DOH funded service, except Behavior Consultation. Individuals can receive SGF services as long as they are not receiving any Medicaid Waiver or Personal Care Option Services.

DAY SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

Day services for adults with developmental disabilities provide a variety of community inclusion services to individuals age 22 and older. *(Exception: This service is available with DDSD prior written approval to individuals age 21 and under who are not currently participating in public education services.*) Services are provided in accordance with each person's Individual Service Plan (ISP), as developed under 7 NMAC 26.5 ("ISP Development Process"). The use of natural and generic supports is encouraged in order to promote the inclusion of the individual into the community as well as to reduce the need for paid provider services.

Day services are defined as those parts of an adult's waking hours when it can be clearly demonstrated that the individual is engaged in purposeful work, learning, skill development or community inclusion activities that are directly linked to the vision, outcomes and action plans documented in the Individual Service Plan (ISP). Day service activities may take place at any time during the individual's waking hours.

Individuals with developmental disabilities, who wish to work, will be offered employment as a priority service over all other day service options. Individual placements are the preferred service. All services will demonstrate appropriately high expectations, enriched opportunities for learning, skill building and use of least restrictive environments. Role development through Community Access services is also preferred as a way to connect individuals with their community in valued social roles.

Individuals are eligible for Adult Day Services provided that all other public funding sources (i.e. DVR and IDEA) have been exhausted prior to accessing State General Funded Adult Day Services. A new referral to DVR should be made under the following conditions:

1.) the individual is unemployed and wants employment supports to obtain employment; or,

2.) the individual is seeking different work; or,

3.) When someone has just been allocated to State General Fund Services and the individual is unemployed and wants employment supports to obtain employment.

Service Options

Adult DD Day Services is inclusive of, but not limited to, one or more of the following service models, as well as other related support services:

Individual Supported Employment: Face-to-face support of persons placed in community-based employment. Face-to-face support includes contact with current employers on behalf of specific individuals when required by the Individual Service Plan. Supported Employment also includes job development services provided by State General Fund Providers. Job development and related services **prior** to the job placement may be furnished for a maximum of ninety days per year. Job development services may only extend beyond the 90 days within a contractual year with DDSD written approval. Employment services are to be available 365 days a year, 24 hours a day. Services are driven by the individual's desired outcome and the individual's job schedule. Wages must be paid in accordance with federal, state and local wage and labor laws and regulations.

Group Supported Employment: On-site supervision of persons with developmental disabilities working as part of an integrated group in community-based employment. These services can be offered to enclaves or integrated work crews or models, but not in a center-based provider facility. An integrated work setting is defined as a work setting in which at least 50% of the people employed in the setting are non-disabled, not including job coaches or other provider staff who work directly or indirectly with the individual. Wages must be paid in accordance with federal, state and local wage and labor laws and regulations.

Community Access: Access is defined as an individual having an identified place within a community, which matches their interests and skills. Access is achieved when an individual has developed a natural

association and relationships within an informal or formal group/organization that share an interest and come together on a regular basis for a common purpose. Individuals should not be just physically present in their community but should be active members of their community. This includes engaging and interacting with non-disabled people in their neighborhood and community who share the person's interests, passions, and desired role. If wages are obtained, the person needs to move to Supported Employment Services. Community Access services are designed to assist individuals in the development and maintenance of valued social roles.

Community Access is generally provided in a one to one staff to participant ratio; however, services may be provided to up to three individuals with DDSD approval when each individual has similar goals. The Individual Service Plan for each individual must clearly document the rationale for providing services in a group setting.

Habilitation: A daily program of group activities designed to increase the individual's skills in performing routine functions. These services furnish opportunities for participants to develop and sustain functional skills to maximize an individual's independent actions in areas such as choice-making, communication, self-care, identifying and pursuing vocational and leisure interests, and socialization. Adult Habilitation services take place outside the individual's residential setting. In-home Adult Habilitation services must be pre-authorized in writing by the Regional Office.

Work Services: Department of Labor certified or exempted programs of structured activities for groups of individuals fall under the category of work services. Work services consist of individuals engaged in training and/or sheltered work for wages. The setting for the program is a center-based facility or non-integrated work crews. Work services typically include subcontract work, prime manufacturing or retail sales.

For vocational services, compliance to the Federal Fair Labor Standards Act and applicable state and local wage and labor laws and regulations is required. The Department of Labor must certify or declare exempt programs of structured activities for groups of individuals engaged in training and sheltered work for wages.

Adult DD Day Services should be provided at the appropriate level for each individual to promote choice, growth and maintain health and safety.

SCOPE OF SERVICE

Adult DD Day Services typically include, but are not limited to:

- Arrangement of transportation
- Assistance with self-administration of medication and/or monitoring of medication and pharmacy needs
- Assistance with the development of choice making skills
- Assistance with the development of natural support networks
- Facilitation of the implementation of behavior support plans
- Co-worker training,
- Development of social and individual relationships
- Education on rights and responsibilities in the work place
- Education on self-advocacy
- Employer negotiations
- Facilitation of job accommodations and use of assistive technology
- Job coaching/ development/ placement
- Job sampling and on-site analysis
- Personal care activities of daily living
- Personal growth and development
- Service coordination activities such as writing or updating the ISP or other service coordination functions
- Supervision of nursing duties, as needed
- Nutritional counseling services, as needed

SERVICE REQUIREMENTS

Services shall be provided to adults, twenty-two (22) or older, who have been determined to meet the definition of developmentally disability in accordance with the NMSA Chapter 16 Developmental Disability Community Services Act (see above). Service requirements of the Adult DD Day Services direct service provider include, but are not limited to:

- Adult DD Day Services must take place outside the individual's home or any other residential setting unless written approval for in-home services has been obtained from the DDSD Regional Office.
- Supported Employment services under Adult DD Day Services must be in an integrated work setting. An integrated work setting is defined as a work setting in which at least 50% of the people employed in the setting are non-disabled, not including job coaches or other provider staff who work directly or indirectly with the individual.
- Supervision and support under Adult DD Day Services is usually furnished on a continual basis, as specified in the ISP and as scheduled by the provider. Supervision and support may include full or part-time supervision by the employer.

When there is a vacancy in residential or day services, providers must consult with the Regional Office to determine the order of selection to fill the vacancy. Generally, order of selection will be based on first come, first serve, based on registration date on the Central Registry. Exceptions to this include the following two circumstances: (1) Selection priority is granted for individuals who are in crisis or (2) for individuals who have utilized all of their DVR eligibility for job development and training and need ongoing "follow along" services.

Individuals who are registered on the Central Registry who are determined to be in "crisis" by DDSD Policy and Procedure will be given first priority for State General Funded services. Individuals will be granted the first open slot regardless of the "first come, first serve" basis that has historically governed the selection process.

Similarly, individuals who are going into services with the Division of Vocational Rehabilitation (DVR) prior to coming into SGF services will be given a priority status so that when they are discharged from DVR services, they will have the first chance at a vocational slot. These individuals would be given priority on the list for Supported Employment services under SGF.

Individuals who are on the Central Registry but reside in long-term care facilities (i.e. nursing home), are eligible for SGF funded Adult Day Services. The Regional Office and the provider of Adult Day Services should consult and coordinate with the long-term care facility to ensure appropriate planning and implementation of services.

AGENCY REQUIREMENTS

The provider must adhere to the following:

A. Administrative Requirements

- An ISP is necessary for each individual in Adult Residential Services. The provider agency must develop the ISP annually in accordance with the individual's ISP term and update periodically as outlined in the 7 NMAC 26.5 regulations. If an individual receives both Adult Residential and Adult Day services, the residential agency will develop the ISP.
- Written quarterly reports summarizing individualized participant progress in meeting outcomes from the ISP's are required. Quarterly reports are to be written according to the individual's ISP term. The reports shall be sent to the local Regional Office of the DDSD by October 15th, January 15th, Aril 15th and July 15th.

- Monthly Day/Employment direct support service hours can consist of standard day services listed under 'scope of services' as well as a maximum of two hours per month of accrued, non-face-to-face hours. The two non-face-to-face hours of direct support per month can be billed as long as they are not defined in these Standards as non-billable (see Reimbursement Section below). Non-face-to-face direct support hours may include, but are not limited to, additional staff planning sessions for an individual to meet his or her Individual Service Plan outcomes, pre-vocational tasks, tasks to incentivize vocational or community integration or other innovative tasks or activities.
- Complete and submit monthly Form B: "Adult SGF Day or Residential Service Reports."
- ISP – Individual Service Plan must be completed every year.
- Community Access services are to be available 365 days a year, 24 hours a day based on individualized activity schedules.
- Employment services are to be available 365 days a year, 24 hours a day. Services are driven by the individual's desired outcome and the job requirements of the employer.

B. Participant Funds

- A person receiving services will be presumed able to manage his or her own funds unless the ISP documents and justifies limitations to self-management and where appropriate, reflects a plan to increase this skill.

C. Staffing Requirements

- Provide adequate staffing to assure reasonable health, safety and promote positive development.
- Responsible for the identification and provision of the appropriate staffing pattern.
- Agencies may not employ or subcontract with an immediate family member or a spouse of the individual served to work in the setting in which the individual is served or to work directly with the individual.
- Must have arrangements in place for an RN or LPN to perform and/or supervise nursing duties and have arrangements in place for nutritional counseling services, in order to address the needs identified on the ISP, if required.
- Employees shall complete required trainings within established timelines, as stipulated in the Policy Governing the Training Requirements for Direct-Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities in Community-Based Programs Funded Through the Developmental Disabilities Medicaid Waiver Program or State General Funds (02/23/07).
- Agencies shall report to the DDSD Statewide Training Database as stipulated in the Reporting and Documentation of DDSD Training Requirements Policy (2/23/07) when staff members are hired, complete trainings, change positions, and/or leave the agency.

REIMBURSEMENT

Request for reimbursement for Adult DD Day Services under State General Funds shall be submitted monthly in accordance with directions provided by the DDSD - Administrative Services Bureau (ASB) at the Department of Health, using the following Component and Service Unit:

Reporting Category 700016

Unit Rate = ***$739.00***. 12 Units per Year Maximum

Billable Units for Day/ Vocational Services:

The full monthly unit may be billed as long as the individual receives 40 hours per month of any combination of day/ vocational services listed under the "Service Options" above. When the individual is engaged in Supported Employment, the hours that the individual is working will satisfy the service criteria as long as the individual receives at least 4 hours of direct service support each month. If the participant is working an average of 10 hours per week and the provider is providing at least 4 hours of direct support per month, the full monthly amount can be billed.

If the participant is working less than an average of 10 hours per week or is receiving any other day service, the provider must provide an average of 10 hours of service per week to bill the full monthly amount.

Partial Monthly Billing:

Reimbursements for all Adult Day Services are calculated on a monthly rate of $739.00 per month. Partial Months can be billed in cases where the individual has been served for periods of less than one month. Partial billings should be calculated on the basis of quarter units with a quarterly unit rate of $184.75. The following is a breakdown of the hour requirements to bill a quarter unit of each service type:

Supported Employment (including Individual and Job Development): One hour = one quarter unit

All other Adult Day Services: Ten hours = one quarter unit

The Division reserves the right to grant exceptions to the reimbursement standards outlined above in order to promote innovative approaches to service provision.

Non-billable hours include:

- Travel to and from the individual's home, except when the individual is being transported,
- Attendance at training and other personnel development activities which are not face-to-face with the individual
- Preparation of billing statements, progress notes, or quarterly reports.

Adult DD Day Services cannot be billed or reported along with any other DOH Service for the same hours of the same day, except Behavior Consultation. Individuals can receive SGF services as long as they are not receiving any Medicaid Waiver or Personal Care Option Services.

SELF-DIRECTED FAMILY SUPPORT PROGRAM

Self-Directed Supports are flexible and individual/family driven. Each eligible individual/family leads the decision-making process and determines the type and amount of good or support needed up to the allowable stipend per individual/family. Individuals/families choose the supports and goods to be received based upon their needs and preferences. This program makes use of structured supports, as well as informal and natural supports from friends, neighbors, extended family and others within the community to support the individual/family in addressing needs (functional, social and medical) that relate to the individual's disability. Supports may be aimed at supporting the individual and/or other family members.

SCOPE OF SERVICE

Goods and supports that center around the person with disabilities may include, but are not limited to: health care, diagnosis and assessment, therapies (including alternative and/or non-traditional approaches), home health care, personal care, recreational and social activities, supports that promote community inclusion and/or employment, clothing, supports or food for special diets, transportation, retrofitting of a vehicle, adaptive equipment, supplies and training on their use, housing adaptation, and health insurance deductibles/co-payments.

Goods and supports that center on family members may include, but are not limited to: respite, family counseling, education for parents and siblings related to the needs of the individual with disabilities, daycare or other types of care for the individual with disabilities, mutual support groups, and housing modifications. Funds may also be used for fees related to training the employee/subprovider, specific to the individual's needs (e.g. CPR, positioning, use and maintenance of adaptive devices and equipment).

NOTE: The New Mexico State Auditor in a 1998 letter of interpretation to the Department of Health quotes Article IX, Section 14 of the New Mexico Constitution, commonly referred to as the anti-donation clause, which states in part, that "…neither the state nor any county … shall directly or indirectly lend or pledge its credit or make any donation to or in aid of any person … Nothing in this section shall be construed to prohibit the state or any county or municipality from making provision for the care or maintenance of sick or indigent persons …" They further break this descriptive down as "… the long-term enrichment or benefit to the recipient." They also state in their interpretation that, "Mortgage payments, rent and improvements, other than environmental modifications, appears to go beyond exceptions allowing provision of care and maintenance of sick and indigent persons." Also, "The intent of the program … would allow the purchase of adaptive equipment, home renovation and additional personal attendant services."

SERVICE REQUIREMENTS

Eligibility:

The applicant must be a New Mexico resident. Individuals must meet the New Mexico definition for Developmental Disabilities. The individual must be registered with the Department of Health, Developmental Disabilities Supports Division Central Registry. This service is dependent upon the availability of State General Funds and participants are prioritized based on date registered on the Central Registry. Individuals are eligible for participation in Self-Directed Family Supports for a maximum of two fiscal years, unless they have placed their Developmental Disabilities Waiver allocation "On Hold" with the DDSD eligibility unit. In the case where an individual has placed their DD Waiver allocation "On Hold," the individual may continue to receive Self-Directed Family Supports until they choose to accept DD Waiver allocation.

Funding Categories:

Goods and supports are based upon an approved Service Support Plan (SSP) and budget and must fall within one of the categories found below. The SSP will document the need for each support or good and will provide justification for all payroll and non-payroll expenditures. The SSP and SSP budget must be approved by the local DDSD Regional Office or State General Fund Program Manager. The SSP will be

reviewed and updated as needed, with a minimum of at least one review annually. The Family Resource Specialist or the DDSD Regional Office may be contacted for other available resources in each region that may be of assistance.

Items that may be purchased through this program are identified as Assistive Devices or batteries for assistive devices, nutritional supplements, incontinence aids, therapeutic wedges, positioning supports, instructional supports, instructional/vocational books and electronic devices (for educational and health/safety needs.) Health care covers insurance or health care expenses not otherwise covered under either Medicaid or traditional insurance plans. This includes preventative equipment, therapeutic interventions and acupuncture. Other health care expenses may be covered with written permission from the SGF Program Manager. Respite/Personal Care covers after school care, child care needs and adult or child respite. This category may also cover a personal assistant for the individual to participate in certain activities both within the community and home. Housing supports may be used to cover rent and utility deposits, household start-up expenses for the individual (this would not include household expenses for individuals who live with their immediate family), and home modifications (including environmental accommodations with health/safety justifications) that are directly related to the disability. Living Expenses includes appliances, furniture, and clothing. Transportation/Travel Assistance will cover bus passes, mileage to activities or appointments, travel expenses and retrofitting of a vehicle with specialized equipment, major car repairs (if approved by steering committee), and accommodations based on health and safety. Social/Community Supports includes peer companions for activities, pets, recreational activities, job coaching, and community guides. Fees/Memberships are defined as tuition for school of any type, membership fees to community organizations or clubs, and gym/health club fees. Educational supports include tutoring, educational software, and special classes.

Additionally, all goods and supports approved through this program must meet at least one of the following criteria:

1. Increase the individual's functioning as related to the disability
2. Increase the individual's safety in the residence or community
3. Support community inclusion or employment opportunities
4. No other public funds are available to cover the item or support

This program does not cover the following expenses, regardless of justification: fees for conferences or memberships where the individual does not participate, ongoing utilities, ongoing rent or mortgage payments, taxes, basic foods and non-specialized personal care items (i.e. shampoo, soap, toothpaste, etc). Also uncovered is direct payment to the parents of a minor child for respite, personal care or community access needs.

Individuals/families utilizing Self-Directed Supports will be the employer of record. As an alternative to employment, individuals/families may contract for supports. Individuals/families utilizing Self-Directed Supports must use the DDSD identified fiscal intermediary.

The individual/family will utilize the registration packet and information provided by the fiscal intermediary to guide them in their responsibilities as employer. The individual/family must attend trainings provided by the fiscal intermediary related to being an employer.

The individual/family will identify training needs and arrange appropriate training for direct care staff. The individual/family will provide authorization for supports and goods purchased. The individual/family will submit requests for payment to the fiscal intermediary on a timely basis. All payment requests must be submitted within 90 days of the date of purchase or support billing. The fiscal intermediary will distribute, collect and process all workers' time sheets as summarized on payroll summary sheets completed by the individual/family receiving supports.

AGENCY REQUIREMENTS

The fiscal intermediary will provide monthly statements of expenditures and declining balances to the individual/family and the DDSD. The fiscal intermediary will withhold, file and deposit funds in accordance with federal Internal Revenue Service (IRS) and the Department of Labor (DOL) and State of New Mexico rules. The fiscal intermediary will complete reports required by the IRS and Social Security Administration, including preparation of the report for signature and filing by the individual/family. The fiscal intermediary will assure that workers are paid hourly rates in accordance with the federal and state laws and regulations, including local minimum wage.

The fiscal intermediary will process all non-labor invoices, including paying vendors as specified (according to the SSP budget) by the individual/family, if applicable. The fiscal intermediary will provide a customer service system that will respond to calls from the individual/family employers and their workers regarding issues such as withholdings, net payments, lost or late checks, reports and other documents.

The fiscal intermediary will act on behalf of the individual or family receiving supports and goods for the purpose of payroll reporting and non-payroll expenditures. The fiscal intermediary will make related payments as approved in the SSP budget, authorized by the state and the individual/family. The individual/family will provide the fiscal intermediary with authorization for all payroll reporting and non-payroll expenditures. The fiscal intermediary will provide an application package for use by individuals who hire their own staff.

REIMBURSEMENT:

Payment for goods and supports will be made in accordance with procedures established by the fiscal intermediary and will be consistent with the following criteria:

Only after notice of approval of the SSP will supports be provided or the goods purchased in the amount or quantity approved. In the case of payroll billing, a timesheet containing the following information will be submitted to the fiscal intermediary for payment:

- Name of employee
- Social Security Number
- Complete name and mailing address of the employer
- Dates of the time period covered by this billing
- Daily record of time worked
- Total hours worked during the time period
- In the case of a non-payroll billing, a receipt or invoice must include the following information:
    - Name of the payee
    - Complete mailing address of the payee
    - A description of the goods and/or support purchased
    - Date goods and/or services were purchased
    - Name of the person receiving the goods and/or support
    - Total amount due

The fiscal intermediary will assure a clear audit trail by maintaining appropriate records and documentation for the Self-Directed Family Supports Program that will include:

- A current account balance for each individual receiving this service
- A current account balance for each DDSD region in which services are provided.
- The fiscal intermediary will submit a monthly report to the individual/family

The fiscal intermediary will submit a monthly summary report to the DDSD SGF Program Manager.